



GOVERNMENT OF PUERTO RICO
Office of the Commissioner of Insurance

March 27, 2023

RULING LETTER NO. CN-2023-332-AS

TO ALL DISABILITY INSURERS AND HEALTH INSURANCE ORGANIZATIONS
WRITING HEALTH INSURANCE PLANS IN PUERTO RICO

**FORM AND RATE FILINGS SUBMISSIONS TO BE EFFECTIVE FOR CALENDAR
YEAR 2024**

Dear Sirs and Madams:

In accordance with Chapters 8 and 10 of the Health Insurance Code of Puerto Rico ("HICPR"), Disability Insurers and Health Insurance Organizations (including, "HMOs") that write individual and small group health plans, including small groups health plans for bona fide associations, in Puerto Rico must submit to the Office of the Commissioner of Insurance ("OCI") each year, for review and approval, all the forms and rates in relation to metallic plans, all rates for metallic plans even if no change has been made, and rate increases equal to or greater than 10% of current rates. The requirements to file rates with the OCI, as set forth in Section 19.080(2)(a) of the Puerto Rico Insurance Code, 26 L.P.R.A., sec. 1908(2)(a), must be complied only by HMOs writing health coverage in the individual and small group market and all rate changes or modifications, including all rates for metallic plans, must be filed even if no change has been made.

To implement appropriate guidelines to promote an orderly form and rate filing submission for metallic plans to be effective on January 1, 2024, the OCI is hereby implementing the following standards:

IMPORTANT UPDATE NOTICE: NEW REGULATIONS AND HEALTH BENEFITS HAS BEEN IMPLEMENTED BY LAW: Read Carefully. This letter contains ten (10) attachments and important updates regarding Forms and Rates requirements for 2024 metallic plans. The use of outdated checklists and forms may result in a delay in the review and approval process of your filing.



I. Rates Submission

A. Timeline

Rate filings for non-grandfathered Individual plans that will be effective on January 1, 2024 must be submitted to the OCI on or before May 31, 2023. **The OCI will not guarantee the approval of the submitted rates for individual plans before October 1, 2023, if the carrier does not comply with the established submission deadline.** If the filing has to be returned to the carrier because the use of outdated checklists or non-compliance with the requirements of this letter, then the submission will be considered as not in compliance with the established submission deadline. As previously informed by the OCI, carriers must obtain approval of the metallic plans rates and forms before October 1st of each year. Carriers whose rates and forms have not been approved before October 1, 2023, will have to market, and make available for everyone, all of their metallic plans in the individual market, without a waiting period, throughout the open enrollment period (October 1 to December 31, 2023) and the entire year 2024, instead of just the open enrollment period.

Rate filings for non-grandfathered Small Group plans, including small group health plans for bona fide associations, must be submitted to the OCI on or before July 1, 2023. A carrier¹ wishing to have quarterly rate changes on small group plans, including small group health plans for bona fide associations, in 2023 must file rates for all quarters on or before July 1, 2023. **The OCI will not guarantee the approval of the submitted rates before November 1st for small group plans, if the carrier does not comply with the established submission deadline.**

Grandfathered individual and small group rate increase for HMOs and rate increases over 10% for Disability insurers must be filed at least ninety (90) days before they are to be used.

B. Rate Filing Submission Requirements

1. Every filing should be properly submitted through the SERFF system, **including all the information required in this ruling letter and its attachments.** See SERFF Rate Filing Submissions Instructions in Section I(F) of this ruling letter.
2. Rates for additional optional benefits by endorsements (if applicable) must also be submitted in the Rate Schedule tab in SERFF.
3. All Excel files should also be submitted also in PDF print out format.

¹ Term use in this ruling letter to refer to a Disability insurer and an HMO.

4. All rate filings should be submitted in accordance with the requirements established in the Puerto Rico Rate Filing Instruction Manual (See Attachment 1).
5. The Federal Rate Review Justification Part I - Unified Rate Review Template (URRT) must be submitted in Excel and PDF under the corresponding Tab in SERFF (See Attachment 2). The PDF version must show all the submitted plans as shown in the Excel version.
6. The following documents must be included as part of the rate submission under the Supporting Documentation tab in SERFF (Please identify each document in SERFF with a name that match with the content of the document, otherwise the filing will be returned without evaluation and will not be considered received):
 - a. Actuarial Memorandum shall comply with the requirements of Puerto Rico, and Part III Actuarial Memorandum and Certification Instructions (See Attachment 3). **The Actuarial Memorandum must be structured in the same format and order established in the mentioned Part III.**
 - b. Puerto Rico Actuarial Certification (should be identified as "Certification of Data Accuracy";
 - c. Actuarial Value Calculator Screenshots (for metallic plans only). Each plan must be identified with the name of the plan and its corresponding metallic level (i.e. Bronze, Silver, Gold, and Platinum). The screenshots must be submitted in Excel and PDF. Also, the PDF version of each AV Calculator must be fitted in only one page, as shown in the Excel version. The Actuarial Value Calculator to be used is the HHS 2014. If the filed rates apply to a POS plan, the actuarial value calculator must be properly completed;
 - d. SERFF Rate template in Excel and PDF (**one metallic plan per page**). The template must include the effective date of the rates. Also, the Plan Id column of the template must include the name of the plan with its respective metallic level;
 - e. Rate Manual. The manual must include the following:
 - i. Quantitative development of the complete process to determine the final rate. This must include a detail explanation of the process from the base rate to the final rate of each of the submitted plans.
 - ii. Each factor used in developing the rates,
 - iii. Each adjustment factor used to determine the rates,
 - iv. The federal standard age curve, and
 - v. An illustrative example of the calculation of the family rate;

- f. Puerto Rico Benefits Map in Excel and PDF. The Benefit Map must include for each proposed plan the benefit package to be offered by the carrier for the Small Group and Individual markets. (See Attachment 4);
 - g. Puerto Rico 2023 updated Rate Filing Checklist. The use of a checklist from previous years will result in a rejection of your filing. For each item that does not apply to the filed plan, the Actuarial Memorandum must explain the reasons for not applying. All separate documents required in this checklist must be identified as follows and the content must match with the name of the document, otherwise the filing will be returned without evaluation: (See updated 2023 Attachment 5)
 - i. Comparative Table Rate Increase;
 - ii. Calculation demonstration of Rate Increase;
 - iii. Current and Proposed Age Distribution;
 - iv. Quantitative development of Factors for rating;
 - v. Comparative Table Cost Sharing Changes;
 - vi. Quantitative development of New EHB;
 - vii. Quantitative development of optional additional benefits;
 - viii. Quantitative development of Prescription Drug coverage cost sharing design;
 - ix. Quantitative demonstration of Paid to Allowed;
 - x. Quantitative development of plan adjusted index rate;
 - xi. Quantitative development of consumer adjusted premium rate.
 - h. Public form of the rate filing information to be placed on the OCI (OCS) website.
 - i. Certification of Unique Plan Design. If the plan has a unique plan design that does not work with the Federal Actuarial Value Calculator, a certification of Unique Plan Design shall be attached to the Supporting Documentation tab on SERFF. For details refer to Section VII of Attachment 1.
 - j. If applicable, present in excel and PDF separate evidence of the experience with any additional benefits to the basic coverage that is included in the policy without additional cost to the insured as an added value.
7. In compliance with the provisions on rate increases for medical plans required in Sections 10.050(B),(E) and (H) of the Health Insurance Code, if after conducting an analysis of the increase, our Office understands that the richness of the benefits of the plan under our consideration was reduced by the insurer or health service organization in comparison to that of the prior year plan, resulting in the rate increase being unreasonable in relation to the

benefits provided and the population that is expected to be covered, will be grounds for denying the rate increase. Reduction in benefit richness means a decrease in covered benefits, an increase in copayments, coinsurance and deductibles applicable to the insured, changes less favorable to the insured in the terms of the plan and additional limitations in the plan.

8. If a rate increase includes coinsurance of 90% or more in the first level of coverage of the Prescription Drug benefit and this Office demonstrates that in the AV Calculator there is a more favorable combination of copayments and coinsurance for the insured without changing the metallic level of the plan, the insurer or health services organization must place the most favorable combination of copayments and coinsurance for the insured, without this resulting in an additional increase in the rate. Failure to do so will be grounds for denying the rate increase.

C. Use of Approved Rates and Prospective Revisions

1. The carriers **must only use** the rates filed and approved by the OCI.
2. Lower or higher rates cannot be used, even if the revised rate is on a group level and the rate is not higher than the approved one. Please note that audits will be made to verify that only approved rates are being used.
3. Carriers will not be allowed to implement rate changes to current rates before January 1, 2024, unless a carrier can justify the OCI that their financial solvency will be dangerously low without a rate change.
4. Once rates are approved, they cannot be changed during the year.
5. For the small group market, including small group health plans for bonafide associations, if the rates are increased on a quarterly basis they should be pre-filed all at the same time. No other quarterly rate increases will be accepted.

D. Rates to be made Public

The following documents will be published on the OCI website, after the approval of the rate submission:

- a. The rates structures (SERFF Rate Template),
- b. Preliminary Justification Part II: Written explanation of any rate increase that is 10% or over;

E. Grandfathered Rates Submission

1. Every filing must be properly submitted through the SERFF system, including all the information required in this ruling letter and its attachments, as applicable. See SERFF Rate Filing Submissions in Section I(F) of this ruling letter.
2. All Excel files must be submitted in both Excel format and PDF print out format.
3. All HMOs rate increases and all Disability insurers rate increases equal to or greater than 10% of rates one year prior must be submitted in accordance with the requirements established in the Puerto Rico Rate Filing Instruction Manual (See Attachment 1).
4. The documents previously mentioned in items I(B)(5) and (B)(6) of this ruling letter must be included as part of the rate submission.

F. SERFF Rates Filing Submissions

1. Every SERFF filing **must include the correct Type of Insurance (TOI), Sub-Type of Insurance (Sub-TOI), Market Type and Filing Type**. Incorrect TOI, Sub-TOI, Market Type, or Filing Type **will result in the filing's rejection without evaluation**.
2. SERFF filings must comply with Circular Letter No. CC-2015-1870-AV/AS of December 1, 2015 entitled "General SERFF Instructions for Form and Rate Submissions". Please read carefully the mentioned circular letter before any submission.
3. SERFF filings shall be accompanied with a Transmittal Letter including the name of the carrier making the filing under the signature of an authorized person, in compliance with Section 3(a)(1) of Rule XXIV of the Regulations of the Insurance Code of Puerto Rico.
 - i. The transmittal letter must be attached in the "Supporting Documentation Tab".
 - ii. The carrier must identify in the transmittal letter all the metallic levels of the rates being submitted. For example: "we are submitting rates for two (2) Silver plans and one (1) Gold plan for a total of tree (3) metallic plans."
 - iii. The transmittal letter must include the filing number of the previously approved rate filing, the filing number where the Forms applicables to the

rates are being reviewed, the rate increase percent requested by plan and overall and, if applicable, identify any optional benefit rates.

4. All the fields required in the "Rate/Rule Schedule Tab" must be completed. **A failure to complete them will result in the filing's rejection without evaluation.**
5. All supporting documentation must be included in the "Supporting Documentation Tab", including the Puerto Rico Actuarial Memorandum, Federal Actuarial Memorandum and Certification, Puerto Rico Actuarial Certification, Exhibits (if applicable), Actuarial Value Calculator Screenshots, Rate Manual, Puerto Rico Benefits Map, and the Puerto Rico Rate Filing Checklist.
6. The submitted rates to be approved must be included in the "Rate/Rule Schedule Tab".
7. Documents **must be saved in a non-protected PDF and Excel format**, as applicable, so that the file remains searchable and text can be copied from the document. **The submission of protected documents will prevent the filing's approval. It is the carrier's responsibility to verify before the filing's submission that all documents comply with this item.**
8. Every communication (e.g. any request for additional time to respond to an objection letter, any request of status) must be included in SERFF as a "Note to Reviewer". Every objection letter must be answered by means of a "Response Letter". The OCI will not accept responses to objection letters in a "Note to Reviewer". Other ways of communication will **not** be deemed as received.

II. Forms Submissions

A. Timeline

Forms filings for non-grandfathered individual plans that will be effective on January 1, 2024 must be submitted to the OCI on or before May 31, 2023. **The OCI will not guarantee the approval of the submitted forms before October 1, 2022, if the carrier does not comply with the established submission deadline.** As previously informed by the OCI, carriers must obtain approval of the metallic plans rates and forms before October 1st of each year. Carriers whose rates and forms have not been approved before October 1, 2023, will have to market, and make available for everyone, all their metallic plans in the individual market, without waiting period, throughout the open enrollment period (October 1st to December 31st, 2023) and the entire year 2024, instead of just the open enrollment period.

Form filings for non-grandfathered small group plans, including small group health plans for bona fide associations, must be submitted to the OCI on or before July 1, 2023.

B. Forms Filing Submission Requirements

1. As a reminder, we inform you that the annual submission of the metallic level plans is considered by our Office as a new product and therefore entails a comprehensive evaluation in its entirety. Therefore, any policy language in the forms that in the opinion of the analyst or the OCI or in accordance with the Insurance Code and the Health Insurance Code represents vague, unclear, or ambiguous language that may lead to error, confusion or misunderstanding will be pointed out to the insurers in a uniform way or in a specific way depending on the case that applies, regardless of whether said language has been approved in previous years. The approval of any policy language in a given year does not bind the OCI's evaluation of said language in subsequent years and does not bar a further review or revision or disapproval of the language in future filings or submissions.
2. Every filing must be properly submitted through the SERFF system and **include all the information required in this ruling letter and its attachments**. See SERFF Form Filing Submissions in Section II(E) of this ruling letter.
3. No endorsement to modify a previously approved metallic plan will be accepted.
4. Optional endorsements with additional benefits are accepted, as long as they are consistent with the coverage of the health plan and comply with the provisions of the Puerto Rico Insurance Code and Health Insurance Code. Rates must be filed concurrently with forms.
5. Attachments must be submitted in Adobe Acrobat (PDF) format unless another format is specifically required by a Reviewer or by this Ruling Letter. If a Reviewer requires that an attachment be submitted in another format (e.g., Excel), an additional copy of the attachment with the same name must also be submitted in PDF format. Scanned documents will not be accepted.
6. In compliance with Act No. 162 of December 30, 2020, which requires that the evidence of coverage and the medical plan identification card is provided in the Braille system for blind subscribers; the insurer shall submit a Certification of translation within the next sixty (60) days from the date of approval of this filing via new SERFF filing under the Supporting Documentation tab. The cover letter of the translation should make reference to the tracking number of the approved filing. You are advised that failure to comply with the aforementioned provisions of law will entail the imposition of sanctions.

7. The following documents must form part of the form submission:
- a. Essential Health Benefit and Preventive Services 2023 updated Checklist (See Attachment 6);
 - b. Puerto Rico Form Filing 2023 updated Checklist (See Attachments 7A or 7B);
 - c. Drug Formulary in accordance with the Essential Health Benefit Benchmark for Puerto Rico, if applicable. The formulary must be in final print format as it will be delivered to the insured.
 - i. The formulary shall include a complete list of all covered drugs, including any tiering structure that it has been adopted and any restrictions on the manner in which the drug can be obtained and in a manner that is easily accessible to insureds, prospective insureds, OCI, and the general public.
 - ii. The drugs in the formulary must be grouped into the same categories as the Essential Health Benefit Benchmark for Puerto Rico.
 - iii. **The drug formulary filed with the forms must be the final formulary negotiated with the PBM and the one to be used by the carrier during the entire 2024.**
 - iv. Once the formulary is marked with the Received and Filed stamp, it cannot be changed during the year, except for the changes allowed by Section 4.060(2) of the HICPR.

The carrier's website cannot require the individual to create or access an account or enter a policy number to view the formulary. If the carrier offers more than one plan, then the website must identify which formulary drug list applies to which plan.
 - d. Providers Directory (The Directory must be in final print format as it will be delivered to the insured.)
 - e. Table of Copayment, Coinsurance and Deductibles to be published in the OCI website (See Attachment 8 – 2022 updated). Please notice that this table does not replace the table of copayment, coinsurance and deductibles that must form part of the contract. The table of the contract must include the cost sharing for each covered service. This table must be submitted in a way that when printed the same it can be legible (size of the letter no less than 10 point).

- f. Puerto Rico Contraceptives Methods Checklist (See Attachment 9). The Coverage of FDA-approved Contraceptive Products includes but is not limited to the list in Attachment 9.
 - g. Prescription Drug EHB-Benchmark Plan Benefits by Category and Class (See Attachment 10)
8. All metallic plans and the copayment and coinsurance structure must be filed concurrently and cannot be changed during the year.
 9. The metallic plans to be effective for calendar year 2024 must provide that any cost-sharing involved with the prescription drug benefit is included in the overall Maximum Out of Pocket (MOOP) total calculation. This Office has determined that the annual MOOP limit for calendar year 2024 is \$6,350 for individual coverage and \$12,700 for all other coverage.
 10. During the open enrollment period, carriers must market all their metallic plans approved by the OCI; provided that carriers who voluntarily decide to offer their metallic plans outside the open enrollment period must market all said plans during the whole year 2024 and must not limit said marketing to special enrollment (qualifying events) instances. Additionally, the transmittal letter must disclose that the carrier voluntarily decided to offer or not during the whole year 2024 all the metallic plans approved by the OCI .
 11. Essential health benefits discrimination is not allowed. One example, without excluding others, of such discrimination has been observed in the maternity benefit. Plans that offer maternity benefits and dependent coverage are required to offer maternity coverage for dependents. The legal and regulatory standards for nondiscrimination in health-related insurance and other health-related coverage are applicable to individual, small group—including small group health plans for bona fide associations—and large group metallic plans, and to grandfathered and transitional health plans. *See* 45 CFR Part 92.
 12. A plan or issuer must cover and may not impose cost sharing with respect to a colonoscopy conducted after a positive non-invasive stool-based screening test or direct visualization screening test for colorectal cancer for individuals described in the USPSTF recommendation. As stated in the May 18, 2021 USPSTF recommendation, the follow-up colonoscopy is an integral part of the preventive screening without which the screening would not be complete. The follow-up colonoscopy after a positive non-invasive stool-based screening test or direct visualization screening test is therefore required to be covered without cost sharing.

13. It is not allowed in the policy any exclusion of treatments and/or prescription drugs by generic or brand name that are to treat a specific disease when there is a state or federal law that requires coverage of treatments and/or prescription drugs for said disease.
14. An explanatory document must be presented with an adequate justification for any exclusion of medications and/or treatments by name in the policy related to a specific disease. In addition, the explanation must include the covered drug options offered by the insurer or health service organization in its drug formulary to treat said disease.
15. It is not allowed in the policy to impose more restrictive conditions related to mental health and substance use disorder services than with medical-surgical services in terms of documents and operation, in accordance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
16. Each carrier is responsible for notifying providers about the ICD10 and dental health codes related to all the preventive services covered, in order to guarantee that such services are provided without cost sharing. Said codes must be published via the carrier's website for the attention of providers and consumers. **An updated evidence of compliance with this requirement must be presented as part of the submission in the Supporting Documentation Tab.**

C. Use of Approved Forms

1. Carriers **must only use** the forms filed and approved by the OCI, including the drug formulary, which forms part of the contract.
2. Once the forms are approved, they cannot be changed during the year.

D. Benefits that are legislated during the year.

If during the year 2023, after the issuance of this letter and before the completion of the health plans' review and approval process, the implementation of any new benefit is required by a state or federal law, ruling letter, circular letter, executive order, decree, or resolution; this Office will require that the language of the new benefit is incorporated in the policies pending approval. An insurer or health services organization is not exempted from complying with the legal or regulatory implementation of the new benefits just because this Office, for any reason, cannot carry out the aforementioned requirement.

E. Forms Information to be made Public

Each metallic plan description of benefits and metallic level, together with their corresponding table of copayment, coinsurance and deductibles, will be made public by the OCI. The Table of Copayment, Coinsurance, and Deductibles to be published in the OCI website must be submitted in both Excel and PDF format. (See 2023 updated Attachment 8).

F. SERFF Forms Filing Submissions

1. Every SERFF filing must include the correct **Type of Insurance (TOI), Sub-Type of Insurance (Sub-TOI), Market Type, and Filing Type**. An incorrect TOI, Sub-TOI, Market Type, or Filing Type will result in the filing's rejection without evaluation. Please refer to the NAIC Life, Accident & Health, Annuity and Credit Product Coding Matrix.
2. SERFF filings must comply with Circular Letter No. CC-2015-1870-AV/AS of December 1, 2015 entitled "General SERFF Instructions for Form and Rate Submissions" and Circular Letter CC-2015-1869-AV/AS of December 1, 2015 entitled "General Guidelines and Requirements for Forms Submissions". Please read carefully these circular letters before making any submission.
3. SERFF filings shall be accompanied with a Transmittal Letter including the name of the carrier making the filing under the signature of an authorized person, in compliance with Section 3(a)(1) of Rule XXIV of the Regulations of the Insurance Code of Puerto Rico. The transmittal letter must be attached in the "Supporting Documentation Tab".
4. In addition to the transmittal letter, an explanatory memorandum shall be submitted, containing sufficient information to review the filing, including, without limitation, the following:
 - a. Identify the metal level(s) of coverage:

_# of Platinum # of Gold #of Silver # of Bronze
 - b. Explain how each submitted form will be used. Any additional benefit to the basic coverage that is intended to be included in the policy as an added value at no additional cost, must include a detailed explanation of how the process will work from the subscription to the benefit to the

payment of claims for said benefit. In addition, the benefit administration process must comply with all applicable provisions of the Puerto Rico Insurance Code and Health Insurance Code.

- c. A list of all changes made to the forms (including changes due to new legal requirements, as well as any other changes, such as the deletion of previously approved language or the addition of new language) setting forth the page numbers where the changes are found and the explanation for each changes. If we noted that the insurer does not include all changes, the filing will be returned without evaluation.
- d. If the OCI approved an application (and enrollment form, if applicable) for use in a prior year, and the carrier intends to continue using the approved form without change in the upcoming plan year, include the form number and SERFF tracking number of the file containing the application. In this case, no resubmission of the form is needed.

However, if the previously approved application does not provide for delivery of documents and/or underwriting by electronic means and the insurer intends to use the application for these purposes, then the application must be amended for compliance with Rule 102 of the Regulations of the Insurance Code and submitted for our review and approval.

- e. If the OCI approved an endorsement form with optional and/or additional benefits for use in a prior year, and the carrier intends to continue using the approved form without change in the upcoming plan year, include the form number and SERFF tracking number of the file containing the endorsement. In this case, no resubmission of the form is needed.
- f. For small group plans, including small group health plans for bona fide associations, identify the conversion policy that the carrier will use to provide the individual conversion benefit.

We have permitted unaffiliated companies to provide the individual conversion benefit where the group issuer does not offer any individual policies. From now on, however, the contractual arrangement between the two companies and sufficient details to verify its compliance with Section 17.070 of the Insurance Code of Puerto Rico must be submitted under the Supporting Documentation tab.

- g. Identify the type of plan (HMO, PPO, POS, EPO, etc.)
 - h. For individual plans, disclose whether the carrier voluntarily decided to offer or not during the whole year 2024 all the metallic plans approved by the OCI.
5. All forms must be submitted in final format. No draft highlighted or redlined copy form should be included in the "Form Schedule Tab". **Every form included on the Form Schedule tab must be submitted in a clean final print, as intended for use. No insert pages will be accepted.**
 6. All the fields required in the "Form Schedule Tab" and "General Information Tab" must be completed. A failure to complete them **will result in the filing's rejection without evaluation.**
 7. Only forms that need to be approved by the OCI should be included in the "Form Schedule Tab". The OCI will not approve any forms that have not been included in the Form Schedule Tab (i.e. forms included in a "Note to Reviewer").
 8. There must be only one attachment per schedule item on the Form Schedule. Multiple documents must not be included in one attachment.
 9. Forms and documents **must be saved in a non-protected PDF format** so that the file remains searchable and text can be copied from the document. **The submission of protected documents will prevent the filing's approval. It is the carrier's responsibility to verify before the filing's submission that all forms and documents comply with this item.**
 10. Any supporting documentation must be attached to the "Supporting Documentation Tab", including evidence of previous approval, the table with copayments, coinsurance and deductibles to be published, certifications, memorandum of variable material, highlighted documents, and redlined copies, among others.
 11. A memorandum of variable material is required if any forms contain bracketed variable text. The Statement of Variables (SOV) must contain an index to all brackets in the forms and fully explain the purpose for the variable text. It must also disclose the text that will be inserted into the brackets or explain under what circumstances the bracketed text will either be included or removed in its entirety. **Essential health benefits, uniform clauses of the Code and cost sharing values must not be variable.**

12. A Summary of Benefits and Coverage (SBC) for each plan must be included in the Supporting Documentation tab. The carrier must use the most recent template available from the U.S. Department of Labor.
13. Once submitted, a form filing generally cannot be changed. **DO NOT** file amendments to a filing , except where (a), (b), or (c) below, is true:
 - a. Changes to the forms are required to be made in response to a form objection in the filing; or
 - b. Changes to the forms are required to be made in response to a rate objection. In this case, send a Note to Reviewer in the form filing requesting an amendment to the filing in response to a rate objection. The Note to Reviewer must be sent in the filing you are requesting to change, and include specific details of the change requested, including the SERFF Tracking Number for the corresponding rate filing; or
 - c. The filer has requested and been granted authorization to submit a change through an Amendment on the filing via Note to Filer in SERFF. To request a change to a form filing send a Note to Reviewer requesting to make a change to any SERFF field or to replace, modify, add, amend, or withdraw a form after it has been submitted for review.
 - i. The Note to Reviewer must be sent in the filing where the change will be made, and include specific details of the change requested, as well as the reason for the change.
 - ii. The reviewer analyst will notify in a Note to Filer whether the request is accepted or denied.
 - iii. If the request is accepted, the filing may be updated as directed in the Note to Filer.
 - iv. Do not make any modifications other than as specifically authorized in the Note to Filer. Otherwise, the reviewer analyst will require the removal of any unauthorized modifications.
 - d. Filings modified without proper authorization will be disapproved.
14. Every communication (e.g., a request for additional time to respond to an objection letter, a request of status) must be included in SERFF as a "Note to Reviewer". Every objection letter must be answered by means of a "Response Letter". The OCI will not accept responses to objection letters in a "Note to Reviewer". Other ways of communication will **not** be deemed as received.

15. Provide substantive responses to all objections and include the page numbers where the requested changes appear. If a requested change is not made, an explanation that includes sufficient legal justification for not making the change must be provided.
16. The documents mentioned in item II(B)(5) of this ruling letter must be included as part of the form submission in the "Supporting Documentation Tab" of SERFF.

G. Plan Renewal

1. The HICPR and the guaranteed renewability provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Affordable Care Act provide that if a carrier offers health plan in the group or individual market, it must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.
2. A carrier that renews a plan in the group or individual market (including a renewal with modifications) must provide written notice of such renewal as follows:
 - a. For metallic plans in the individual market, the carrier must provide to each individual market policyholder a written notice of renewal before the first day of the next annual open enrollment period.
 - b. For transitional plans in the individual market, grandfathered and non-grandfathered coverage in the group market, the carrier must provide to each plan sponsor or individual, as applicable, a written notice of renewal at least (60) calendar days before the date of the renewal of the coverage.
3. The renewal notices must include the following essential content:
 - a. Information about changes, if any, to the enrollee's premiums;
 - b. Information about changes, if any, to the enrollee's coverage;
 - c. A statement disclosing that upon the termination of the enrollee's current plan, the enrollee is free to choose another health plan offered by the current carrier or by another carrier;
 - d. Information about other health plan options from the carrier;

- e. Contact information from the carrier for the enrollee to call with questions; and
- f. The notice must be written in a clearly understandable manner.

H. Plan discontinuation

1. Under the guaranteed renewability provisions of the HICPR, if a carrier decides to discontinue offering a particular health plan in the group or individual market, that plan may be discontinued by the carrier only if, among other things, the carrier provides in writing notice of such discontinuation to each plan sponsor or individual (and to all enrollees included under such coverage) at least (90) calendar days prior to the date of the discontinuation. The purpose of the discontinuance notice prior to the end of coverage is to inform enrollees that their current health plan is being terminated and that they have other health plan options.
2. Written notice must be provided as follows:
 - a. Individual metallic plans: the discontinuation notice must be sent on or before the first day of the open enrollment period. Since Puerto Rico's open enrollment period runs from October 1st until December 31st every year, the notices must be sent on or before October 1st.
 - b. Transitional plans in the individual and group markets (including large group plans), small group metallic plans, including small group health plans for bona fide associations, and grandfathered plans: the discontinuation notices must be sent at least (60) days before the termination or renewal date of the health plan.
 - c. The discontinuation notices must include the following essential content:
 - i. A statement that the health plan is being discontinued;
 - ii. Suggestion of enrollment into a health plan of the carrier that is similar the discontinued plan, with information about the changes in the benefits and premiums arising out of the change from the old plan to the new plan; and a statement disclosing that upon the termination of the plan, the enrollee is free to choose another health plan offered by the current carrier or by another carrier;
 - iii. Contact information from the carrier for the enrollee to call with questions

- iv. Information about other health plan options from the carrier;
- v. The notice must clearly explain the options for the employer or individual to obtain or renew health plan coverage; and
- vi. The notice must be written in a clearly understandable manner.

III. Large Group Rates and Form Filings

Large group rate filings, including large group health plans for bona fide associations, must not be submitted for the OCI's evaluation and approval. This rate filing exemption will apply to all health insurance organization or issuer underwriting health insurance coverage in the large group market, including healthcare service organizations (HMO).² However, rate increases of 10% or more over the previous year's rates for large group health insurance coverage, including large group health plans for bona fide associations, must be filed with the OCI for approval at least ninety (90) days before they are to go into effect, as their use requires the OCI's prior approval.

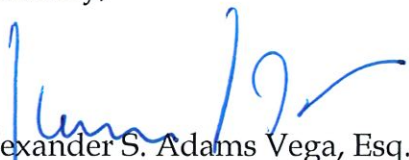
In addition, we must point out that all forms for the large group market, including large group health plans for bona fide associations, are subject to review and approval. Large group forms must comply with all the applicable provisions of the HICPR, which include among others, no Annual or Lifetime Limits, Coverage of Preventive Health Services, Extension of Dependent Coverage, and Preexisting Condition Exclusions.

IV. Supplemental Health Care Exhibit (SHCE)

All carriers are hereby required to complete and submit the Supplemental Health Care Exhibit to the NAIC and the OCI before March 30 of each year for Disability insurers, and before March 31 of each year for HMOs. **The carrier must include a copy of this exhibit as part of the rate filing requirements in the "Supporting Documentation Tab".**

Strict compliance with the provisions of this ruling letter is hereby required.

Cordially,



Alexander S. Adams Vega, Esq.
Commissioner of Insurance

² The term "health insurance organization or insurer" includes also health services organizations (HMO), as defined in the Chapter 2 of the Puerto Rico's Health Insurance Code.

Puerto Rico

Rate Filing Instruction Manual

Overview

This instruction manual supports implementation of the requirement of Ruling Letter No. CN-2017-218-AS of March 6, 2017. For all ACA compliant products, rates for new products and all rate changes must be submitted to the OCI for approval.

For all grandfathered products only rate increases must be filed with the OCI. Under Section 2794 of the Public Health Service Act, as amended by Section 1003 of the Federal Patient Protection and Affordable Care Act (“PPACA”), disability insurers that write medical plans in Puerto Rico have the obligation to submit to the Office of the Commissioner of Insurance (“OCI,” “OCS”), for review and approval, any rate increase for non-grandfathered plans where the average increase is equal to or greater than ten percent (10%) of current rates, effective September 1, 2011. For Health Service Organizations all rate increases must be submitted to OCI no matter the amount of the increase. The purpose of this requirement is to allow the OCI (OCS) to determine whether the proposed rate increase for small group and individual markets is unreasonable. Rates that are subject to approval by the OCI (OCS) must be submitted at least sixty (60) days before the effective date.¹ If there is an objection from the OCI (OCS), the time required for the objection to be answered will not be included in the 60 days and therefore may delay the implementation date.

The carrier **MUST** only use the rates filed and approved.

A complete rate filing must include all of the information required by Ruling Letter No. CN-2017-218-AS, as applicable. The manual and templates do not supersede the regulations, they merely standardize and make explicit the information already required or allowed to be requested by those regulations.

Carriers must use SERFF to submit their rate filings as required by Ruling Letter 2012 140-AV of February 7, 2012. Carriers must fill out all the SERFF data elements, including Affordable Care Act (“ACA”) data elements, or the filing will be rejected as incomplete. ACA requires that if there is any rate change to an ACA compliant product, rates for all ACA compliant products in that market (individual or small group) must be filed together. That is if any rates change all previously filed rates must be filed again with the new rates.

Under the Affordable Care Act and rules that became effective on 9/1/2011, carriers with average rate increases of more than 10% per year must submit rate justification information to the Federal Center for Consumer Information and Insurance Oversight (“CCIIO”). For non-ACA compliant products², the federal rate summary worksheet and Preliminary Justification also should be submitted to the Centers for Medicare & Medicaid Services (“CMS”) on the same date as the filing with the OCI (OCS). Please note that the information submitted to the OCI (OCS) should be consistent with the information submitted to the “CCIIO” and “CMS.” In Puerto Rico, all rate increases by HMOs must be filed with the OCI (OCS) if they are ACA compliant or not.

¹ To ensure that rates are approved before they are effective the OCI is requesting that all rates be filed 90 days before they are used. This will be May 30, 2014 for rate filings for 2015 rates.

² Non-ACA compliant policies include grandfathered policies and transitional policies.

Consistent with ACA, the OCI (OCS) requires rate filings to include the following parts, if there is any change in rates or plans offering of ACA compliant products in a market. For all ACA compliant products the following should be filed once a year even if there is no rate change. For ACA compliant products and all grandfathered HMO rate increases and non-HMO rate increases over 10% should also submit the following:

- 1) Federal Rate Review Justification Part I: Unified Rate Review Template (URRT);
- 2) Public form of the rate filing information to be placed on the OCI (OCS) website and used for the HIOS Federal Rate Review Justification Part II: Written explanation of any rate increase that is 10% or over;
- 3) Actuarial Memorandum meeting the requirements of Puerto Rico and the federal 2014 Actuarial Memorandum and Certification Instructions 2.0 (Part III).
- 4) Puerto Rico actuarial certification;
- 5) Actuarial value calculator screenshots (for ACA compliant only);
- 6) SERFF Rate template;
- 7) Rate manual
- 8) Puerto Rico Benefits Map (if different from the Benefits Map already filed with the OCI (OCS) or not Benefits Map has been filed; and

Section I: Unified Rate Review Template (URRT)

Provide a copy of the URRT template in Excel and also in a PDF printout version. The URRT should be completed with all HIOS information.

For a more complete description of the items in the URRT, please refer to the Department of Health and Human Services (HHS) instructions.

Section II: Written Explanation

For all rate increases that are greater than the review threshold, a brief written explanation of the rate increase must be submitted. This written explanation must include a simple and brief narrative describing the data and assumptions that were used to develop the rate increase. This includes:

- 1) Brief description in simple language the reasons why the rate increase is being requested;
- 2) Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increase reported in the rate increase summary; and
- 3) Brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.

This summary will be uploaded to the OCI website for public use and it will also be used for the HIOS Preliminary Justification Part II that is required for all rate increases over 10%.

Section III: Federal Actuarial Memorandum and Certification³

The Actuarial Memorandum and Certification documents the methodology used in developing the rates and includes an actuarial opinion signed by a qualified actuary providing an opinion that the rate filing was developed according to actuarial standards and principles and the laws of Puerto Rico.

A Part III Federal Actuarial Memorandum, including a corresponding actuarial certification, must be submitted with each Part I Unified Rate Review Template.

The purpose of the Part III actuarial memorandum is to provide support for the values entered into the Part I Unified Rate Review Template. The documentation should clearly identify the plans applicable to each piece of information. All assumptions should be adequately justified with supporting data, where possible, and the rationale for the use of the chosen assumptions.

For a more complete description of the items in the Part III Actuarial Memorandum and Certification, please refer to the Department of Health and Human Services (HHS) instructions.

Section IV: Puerto Rico Actuarial Memorandum

In order to review rates in Puerto Rico the OCI requires information in addition to the federal actuarial memorandum. We encourage carriers to submit both the federal information and the additional Puerto Rico information in the same document. Information that we believe to be in addition to the federal requirements is italicized below. This difference may change in the future as the federal requirements change.

The carrier must provide a detailed description of the method used to develop the premium rates. Since there is much overlap with the Federal Actuarial Memorandum, one actuarial memorandum can be submitted as long as it contains all of the information required in both memorandums. The major difference is the Puerto Rico requirements is the addition of quantitative support for assumptions. The memorandum should also include more detail on any item that the carrier believes is driving the rate increase projections or would be of particular concern when reviewing the rate filing.

Overview of Rate Increase

Provide a brief explanation of why a rate increase is being requested and on what policy forms including the names of the policy forms affected.

Describe the scope and driving factors impacting the rate increase including a description of how the rates were determined.

Provide a description of:

- 1) Type of Products;
- 2) Benefits;
- 3) General Marketing Method;

³ See Appendix A for Actuarial Certification

- 4) Premium Classifications or Rating Factors; and
- 5) Underwriting Method (grandfathered only).

Rate increase information including:

- 1) Historic rate increases for the last 3 years;
- 2) Proposed effective date of the rate increase (grandfathered only);
- 3) Requested minimum, maximum and average rate increase – from current rates and annual from one year prior; and
- 4) Effective through date and any rate increase schedule applicable (small group only).⁴

Base Period Experience

Provide an explanation of the base period experience used indicating the basis of the data used, the first incurred date included and the last incurred date included. The last paid date used should be provided, which indicates the paid through date for the base period experience.

Provide an explanation of how incurred claims were estimated from paid claims including the average completion factor⁵ used and an explanation of adjustments made to base period claims experience.

If contract reserves were established for these contracts, describe what they are for, how they were developed and how they impacted the rate development.

Describe the treatment of large claims and claims pooling, if any.

Treatment of commercial reinsurance, if any. This is separate from the Transitional Federal Reinsurance program, but is adjustments for commercial reinsurance purchased by the carrier to protect against the risk of large claims.

Provide an exhibit showing current age distribution and the age distribution anticipated for projection period, if different.

Capitation Payments

Describe what is covered by any capitation payments and the PMPM impact.

Projection Factors and Claims Trends

Provide documentation of all assumptions and methodologies used in the development of the impact of morbidity and enrollee mix.

If there were changes in the benefits covered, provide a description of all benefit changes and quantitative support of their impact.

⁴ Small group rate increases can only be on a quarterly basis.

⁵ The average completion factor is the ratio of the incurred claims for a period of time to the paid claims for the same period as of the last paid date used for the base period experience. The incurred claims are the total claims that are expected to be paid in the base experience. The paid claims are the amounts that have actually been paid as of any point in time. As time goes on more claims are paid and the ratio is higher.

For each Essential Health Benefit (EHB) not covered previously, the additional cost per-member-per-month (PMPM) with an actuarial explanation of how the additional cost was developed.

Provide a description of all changes in the rating structure, if any, and provide quantitative support of their impact including all assumptions used.

Provide quantitative support of the impact due to changes to network, if any.

If there are other changes impacting rates, provide a description and quantitative documentation of all factors, including any adjustments for past experience due to actual loss ratios differing from target loss ratios.

Provide quantitative documentation of the trend development including as well as an explanation of the data, assumptions, and periods used.

Provide:

- Changes in medical cost trend by major service categories for the past three years and future projections.
- Changes in the use of services by major service categories for the past three years and future projections.

Historic cost and utilization assumptions used compared to the actual trends experienced. Until 2015 filings for the 2016 rates, there may be little or no information, but starting in 2015 you should provide the past projections compared to the actual experience.

Please explain significant changes in assumptions from the prior filing assumptions.

Manual Rate Development

If the experience for the product is too small to be considered credible, alternative claims experience can be used. Include detail description of all alternative experience data used and how it was adjusted to be appropriate for the market including any adjustments similar in type to the adjustments made to base data.

Credibility

Indicate the credibility methodology and credibility level of the base period experience.

Paid to Allowed Ratio

Provide a quantitative demonstration of the development of the paid to allowed ratio.⁶ Since Puerto Rico has different claims distribution patterns than those used as the basis of the AVC, it has been determined that company specific projections, which will not be similar to the AVC outputs, should be used for Puerto Rico rate development and in the URRT Market Experience worksheet cell V33.⁷

Risk Adjustment and Reinsurance

Risk adjustment and reinsurance do not apply to Puerto Rico.

⁶ This ratio is actually the incurred claims to allowed claims ratio

⁷ The AVC should be used for the determination of metal levels unless it is replaced by a Puerto Rico specific calculator

Non-Benefit Expense Projections

The methodology used to project non-benefit expenses, including gain/loss margins, should be explained. If a loss ratio approach was used, the carrier should explain how the target loss ratio was developed.

Administrative Costs

Identify the main factors that affect changes in administrative costs. Discuss how changes in projected administrative costs and profit are impacting the rate increase and what is driving these changes.

If budgets were used, the carrier should explain when the budgets were developed and for what time period.

Provide actual administrative expenses PMPM for the last three years and explain any significant changes in administrative expenses from the prior filing.

Provide a breakdown of projected administrative expenses with any marketing, commission, and quality improvement costs separated. If there are no quality improvement costs in the administrative costs, indicate zero.

If administrative expenses vary by plan explain why.

Projected Gain/Loss Margins

Provide an explanation of how the projected gain/loss margins were developed and any changes from prior filings.

Taxes and Fees

Provide a description of applicable taxes and fees, their impacts, and an explanation of how they were allocated across plans.

Provide a breakdown of projected taxes with amounts of each and their quantitative development.

Medical Loss Ratio

Describe how the projected federal medical loss ratio was calculated. Describe how the credibility adjustment was determined. A demonstration of the projected loss ratio using the federal loss ratio formula should be provided including the values used.

If the loss ratio is less than the federal rebate requirement, explain the plan to comply with the Federal MLR requirement.

Index Rate

This documentation should provide a descriptive and quantitative development of the plan index rates starting with the market index. This development should be supported by excel exhibits with formulas intact. The following steps should be explicit:

- 1) Plan level adjustments

- a. Projected ratio of incurred claims to allowed claims (pricing actuarial value) for each plan and any adjustment to utilization due to cost sharing (separate, if possible);
 - b. Provider network, delivery system and utilization management adjustment;
 - c. Benefits in addition to EHBs (the estimate of these benefits should be shown in a quantitative development);
 - d. Impact of the eligibility for the catastrophic plan; and
 - e. Administrative costs.
- 2) Calibration for base characteristics to base market allowed:
- a. Weighted average age;⁸
 - b. Calibration for family composition;⁹, and
 - c. Calibration for tobacco usage.¹⁰

Provide quantitative documentation of the rating factor for tobacco.

Provide an example procedure of determining a family rate. Demonstrate that this family rating complies with the federal rating rules of the ACA.

AV Metal Values

The AV Metal Values must be determined using the Federal Actuarial Value Calculator. If an alternative methodology was used due to a unique plan design, it must be well documented.

Plan Adjusted Index Rate

Provide quantitative development in excel with all formulas of the plan adjusted index rate. This development should start with the market index rate and show all adjustments in the development of the plan adjusted index rate. The plan adjusted index rate divided by the average age factor should result in the plan base rate (age 21 non-tobacco rate).

Membership

Provide documentation of all assumptions used to project membership and provide support for those assumptions.

Company Financial Condition

Describe the financial situation of the company, including surplus, if any. Provide 5 years of RBC ratio levels.

Provide historic loss ratios for the last five years.

⁸ The federal instructions only ask for a weighted average age, but we are requesting the calibration factor, which is typically the inverse of the weighted average age factor.

⁹ This calibration is for the situation where there are more than three children, but only three can be included in the premium.

¹⁰ At this time we believe that the federal instructions will be to add this calibration to the actuarial value adjustment, but we would like to see it separated out.

Small Groups Affected

The carrier should provide a list of all small groups affected by the proposed rate increase, the proposed increase for each group, the date of the group's contract renewal, and the effective date for each group 30 days prior to implementation. The list of small groups affected and renewal dates will depend on the proposed effective date of the rate increase. The carrier should list all small groups that will receive a rate increase in the next 30 day period with each group's average rate increase, renewal date and rate increase effective date in an Excel file attached to an email to the OCI. This information will eventually be posted to the OCI website.

Section V: Public Information

Every carrier must provide a written summary of the rate filing to be displayed on the OCI (OCS) public website. For rate increases over 10% this will also serve as the Preliminary Justification Part II that should be uploaded to HIOS.

Section VI: Rate Template

Provide the federal SERFF Rates Template in excel. This may need to be uploaded in a zip file if they are too large to upload to SERFF.

Section VII: Benefits Map and Actuarial Value

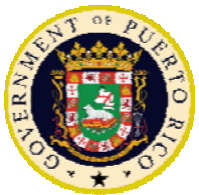
Every carrier should provide to the OCI a benefits map which shows, for all plans, all benefits covered and their respective cost sharing amounts and limits. If the benefits map for a plan has not changed from the prior filing, it does not need to be resubmitted. The carrier should submit a list of plans with an indication of which Benefits Maps are included and the date submitted for any that were submitted previously.

Also for all plans, screenshots of the federal Actuarial Value Calculator (AVC) populated with plan cost share information should be submitted. If the plan has a unique plan design that does not work with the federal Actuarial Value Calculator, a certification of unique plan should be submitted to the OCI as well as quantitative documentation of all adjustments and explanation of all differences that could not be accommodated using the AVC. If the plan decides not to use the AVC, they should provide a certification of unique plan design, an explanation of why they did not use the AVC, and quantitative support for the calculation of each plan's actuarial value.

If several plans are offered at the same metal level in the same region, the sponsor should provide further information on them describing what differentiates them and what the target market is for each.

Section VIII: Rate Manual

If the rate manual has changed or if a carrier has a new product, it should file the rate manual with the OCI.



GOVERNMENT OF PUERTO RICO
Office of the Commissioner of Insurance

Appendix A – Standardized Actuarial Certification Letter

Certification

Standardized Excel Worksheet/Written Filing Documentation/Rate Manual

I _____ hereby certify that I was in charge of the preparation, revision or supervision of the worksheet data information corresponding to the submitted rate increase filing. In addition, I certify that the submitted information is accurate, true and complete.

I also acknowledge responsibility for the validity, accuracy and completeness of the contents of the Written Filing Documentation and the Rate Manual.

Signature

Title

Carrier

Date



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850



Part I Unified Rate Review Template Instructions

February 3, 2014

Part I Unified Rate Review Template v2.0.1

The Part I Unified Rate Review template is required to be submitted by all issuers in the individual, small group and/or combined markets that are proposing a rate increase on any single risk pool compliant products. In addition, all issuers applying to offer at least one QHP in the state must submit the template for the market in which the QHP would be offered. The template may also be required by regulatory authority for products in the single risk pool. Issuers are required to submit the annual rate change (i.e. January rate changes). In addition, quarterly rate increases for the small group market are allowed if allowed by the state regulatory authority. See the Appendix for additional detail on the timeframe for submission.

All issuers are required to set the Index Rate for an effective date of January 1 of each year, and file the Index Rate with the applicable regulatory authority. Subject to state requirements, small group issuers are allowed to file subsequent submissions that reset the Index Rate for the remaining quarters of the calendar year.

The Part I Unified Rate Review template is intended to:

- Demonstrate compliance with the Single Risk Pool requirement of 45 CFR Part 156.80,
- Provide support for the development of the Index Rate which is defined in 45 CFR Part 156.80(d),
- Identify product level rate increases to determine whether a rate increase is subject to review under 45 CFR Part 154, and
- Provide supporting information to State or Federal regulators for product level rate increases

Additional information about how CCIIO uses or discloses information from the template is described in the Appendix.

Specific instructions for the treatment of dental plans within the Part I Unified Rate Review template have been developed for plans offered in 2015 and beyond.

- Only embedded pediatric dental benefits within a medical plan should be reflected in the Part I Unified Rate Review Template. Further, in order for the dental costs to be included in the Part I Unified Rate Review Template the dental costs must be spread across the entire single risk pool in accordance with the market rating rules in calculating the projected Index Rate.

- Under no circumstances should stand-alone dental plans be reflected in the Part I Unified Rate Review Template.

Further details explaining how dental plans should be reflected in the template can be found in the instructions for Worksheet 2.

Beginning with plans effective in 2015 and beyond, ALL benefits to be offered in a plan must be included in that plan. So if an issuer wants to offer an “optional” benefit, there are two options an issuer can use to meet this goal.

- The issuer can create a separate plan with the required EHBs and the “optional” benefit included.
- The issuer can offer a separate policy which is a supplemental policy providing non-EHB benefits.

The concept of “optional riders” is incongruent with federal rating rules and the single risk pool requirements.

It is critically important that information be entered into the template as accurately as possible with the information available to the issuer at the time of submission. Failure to provide accurate information in the first submission increases the likelihood of the need to provide additional data to the State or Federal regulators reviewing the template. Failure to provide accurate information also slows the speed of any required approvals or certification and puts the products and plans at risk for missing critical deadlines to be offered in the markets.

Beware, if an issuer copies and pastes values into cells that do not match the formatting requirements of those cells, the mismatch may cause validation or submission errors resulting in either submissions being rejected or requiring resubmissions at a later date. Issuers should verify the data entered in the Part I Unified Rate Review Template is consistent with formatting requirements and instructions to avoid delays in the approval process.

Under no circumstances should issuers attempt to overwrite protected cells. For example, the totals in column F of Worksheet 2 are protected and calculated by formula. Issuers should not attempt to overwrite the values calculated by the template. Any overwriting of the workbook’s protection is likely to result in delays and resubmissions.

The following should be considered an instructional tool in developing issuer pricing, as allowed under the market and rating rules for the single risk pool.

ACA & MARKET RATING RULES - ALLOWABLE RATING & PRICING

Allowable rating methods and factors

- The Single Risk Pool should include ALL (non-grandfathered) covered persons (lives) an issuer has in a state, within a market (individual, small group or combined). This includes transitional products/plans for purposes of base period experience used to demonstrate the single risk pool. The projection period should reflect experience of transitional policies to the extent the issuer anticipates the members in those policies will be enrolled in fully ACA-compliant plans during the projection period.
- The Index Rate is defined as the EHB portion of projected allowed claims divided by all projected single risk pool lives. As a result, the Index Rate should be the **same** value for ALL non-grandfathered plans for an issuer in a state and market. This includes claims and enrollment in transitional products/plans in the experience period, and in the projection period to the extent the issuer anticipates the members in those policies will be enrolled in fully ACA-compliant plans during the projection period. Note that if an issuer opted to continue policies under the President's transitional memorandum, experience for these policies should be included in the issuer's 2013 experience for developing rates for the 2015 year. Appropriate adjustments should be made in Worksheet 1 – Section II of the Unified Rate Review Template to bring these policies in line with all requirements of non-grandfathered policies projected in the Single Risk Pool in 2015. For example, in the projection period, include projected experience and membership at the point when these products become ACA-compliant and the membership renews to the ACA-compliant plan, or at the point when the members in these plans move to an ACA-compliant plan, if the plans are closed to new membership in 2015.
- The Market Adjusted Index Rate is the Index Rate adjusted for Risk Adjustment, Reinsurance and Exchange Fees (with impacts and costs spread across the whole risk pool). As a result, the Market Adjusted Index Rate should be the **same** value for ALL non-grandfathered plans for an issuer in a state and market.
- The Plan Adjusted Index Rate is the Market Adjusted Index Rate further adjusted for plan specific factors allowed by 45 CFR Part 156.80(d)(2) such as provider network, utilization management, benefits in addition to Essential Health Benefits (EHBs), actuarial value and cost sharing, distribution and administrative costs (less Exchange fees) and catastrophic plan eligibility variation.
- Note, fees and costs are included in the premium and applied at the plan level as part of the distribution and administrative costs adjustment. The only exception is the application of the Exchange User fees, which are applied at the market level to the Index Rate. All other fees must be included in the development of the Plan Adjusted Index

Rate, prior to the application of member level rating factors, such as age factors. No additional fees may be charged outside of the development of the Plan Adjusted Index Rate. For example, if it costs an issuer \$35 to process an application, that cost must be included in the premium rate development of all policies (new issues and renewals) and subject to the member level rating factors such as age and geographic region factors. The issuer may not, in that example, charge a \$35 fee per policy for submission of the application.

- A calibration may be required to allow the rating factors to be directly applied in order to generate the Consumer Adjusted Premium Rates.

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

The calibration with respect to the age curve is allowed and identifies the value on the age curve associated with the weighted average age on the standard age curve. The Plan Adjusted Index Rate and the age curve can then be used to generate the schedule of premium rates for all ages for each plan. Calibration may be required for the geographic factors and tobacco factors. More detailed instructions are provided later in this document regarding the requirements for the calibration.

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

The result of this calibration process should be that the Plan Adjusted Index Rate calibrated for geography and tobacco (but not age), multiplied by the geographic factor for a given region should be similar to the Premium Rate for that particular plan for a non-tobacco user in the given geographic region for the weighted average age (rounded to a whole number) of the projected single risk pool.

- The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual, family, or small employer group utilizing the rating and premium adjustments as articulated in the applicable Market Reform Rating Rules. The Consumer Adjusted Premium Rate is developed by calibrating the Plan Adjusted Index Rate to the age curve as described above, calibrating for geography and tobacco if

necessary, and applying the allowable rating factors. Allowable rating factors are Age (3:1 standard age curve or state specific age curve), Tobacco, Geography and Family tiering/structure, unless otherwise prohibited by state law.

Once the Plan Adjusted Index Rate is calibrated to the age curve using the weighted average age, the entire set of age rates is determined using the standard age factor of each age relative to the standard age factor for the rounded weighted average age. The age factors must be the standard age curve set by HHS or a state specific age curve (if the state requires different age factors than the standard federal age curve).

The tobacco factors can be issuer specific but cannot vary by product/plan for an issuer (i.e. an issuer must use the same tobacco factors across all products/plans within a state and market).

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

Family structure takes into account family composition and the maximum of 3 child dependents. This is further clarified in regulation that the premium for family coverage is determined by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account; this adjustment does not result in a separate rating factor. Family tiering only occurs in states that use pure community rating and are uniformly applied to all plans in the risk pool (and published to the ccio.cms.gov website).

Worksheet 1 – Market Experience

The purpose of Worksheet 1 is to capture information at the market level for non-grandfathered products, consistent with the requirement to set premium rates using a single risk pool, as defined in 45 CFR Part 156, §156.80. The worksheet is not intended to prescribe a rate development methodology. Rather, the worksheet captures experience period data and key assumptions consistent with those used in the development of the proposed premium rate increases. The worksheet uses the data to show that the average gross premium rate complies with the requirements of the single risk pool, and reports the total and annualized change in the gross premium relative to the experience period. These calculated changes in the average premium are not equal to the average rate increase of the pool, but rather provide information

on how the average gross premiums have changed over time. There are four sections in this worksheet.

- The General Information section captures information about the issuer, state and the health insurance market to which the proposed rate increases will apply. This information is displayed on all worksheets of the Part I Unified Rate Review Template.
- Section I captures summarized historical financial and enrollment information from a recent historical experience period.
- Section II captures historical claims experience on a more granular level, along with the key assumptions employed to project the experience period information forward to the projection period of the effective date.
- Section III displays the assumptions used to adjust the projected allowed claims to incurred claims at the average anticipated benefit level. Administrative expense loads and risk/profit charge loads are also captured. Using this information, the average gross premium for the single risk pool is generated.

General Information

Company Legal Name: Enter the organization's legal entity name.

The name entered in this cell must be the name that is associated with the HIOS Issuer ID.

State: Enter the state that has regulatory authority over the policies. A separate template must be completed for each state in which the issuer is applying for QHP certification or proposing a rate increase on non-grandfathered policies in the individual, small group or combined markets.

HIOS Issuer ID: Enter the HIOS ID assigned to the legal entity.

Market: Select the applicable market from the drop-down box. Valid markets are Individual, Small Group, or Combined.

The market chosen must be consistent with the state's determination of their allowable markets (e.g. if a state chooses to merge the individual and small group market, the issuer must choose "Combined").

Effective Date: Enter the effective date for which rates are being submitted.

If the submission is for the individual or combined markets, the effective date must be January 1 of the year for which rates are being submitted. If the submission is for the small group market, enter the effective date for which the Index Rate is being revised. For example, if the small group submission revises the Index Rate for July 1, 2015

effective dates and includes a trend increase applicable on October 1, 2015, enter July 1, 2015. See the Appendix for further guidance on trend increases in the small group market.

All issuers are required to file the Part I Unified Rate Review Template and Part III Actuarial Memorandum annually for an effective date of January 1 of each year. Subject to state requirements, small group issuers are allowed to file subsequent submissions that reset the Index Rate for the remainder of the calendar year. However, the change in the Index Rate is only allowed to occur for the remainder of the calendar year and subsequent submission is required for the beginning of the next calendar year.

For example, if a small group issuer submits the Part I Unified Rate Review Template for January 1, they may submit a subsequent Part I Unified Rate Review Template that resets the Index Rate effective July 1 of that same year. The Part I Unified Rate Review Template effective July 1 in this example is only allowed to contain a trend increase for October 1 of that same year. Quarters after October 1 would be included in the next annual submission effective January 1 of the next calendar year.

All products and plans must have the same effective date; however, some products or plans may have a 0% rate change. The term “product” is defined as a unique combination of benefits, various cost sharing options and a network design(s) to a particular service area. “Product” has the same meaning as included in 45 CFR Part 154. The term “plan” is defined as a unique combination of benefits to a specific set of cost sharing options and network design(s) to a particular service area. Most products will be made up of multiple plans produce an actuarial value equal to one of the metal levels permitted under Title I of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA).

Section I

The financial and enrollment information entered in this section should reflect the experience of all non-grandfathered policies for the specified market and state. The information is intended to reflect the single risk pool for the market as required by the ACA and 45 CFR 156.80. The information in this section should reflect historical financial and enrollment information for the identified legal entity only.

Experience Period: Enter the first date of the experience period.

The Experience Period must be a twelve month period. The template calculates the end date of the experience period such that the period is twelve months long.

For individual and combined market submissions, the Experience Period must be a calendar year period. It should be the most recently completed calendar year; if not, include an explanation in the Part III Actuarial Memorandum. Therefore, the first date of the Experience Period must be January 1. For small group market submissions, the first date of the Experience Period must be the first date of a calendar quarter, i.e., January 1, April 1, July 1, or October 1.

If an experience period other than that required to be shown is used in the derivation of the Index Rate, then the credibility manual rate section should be used to show the Index Rate development and described in the Part III Actuarial Memorandum.

The Experience Period reflects a period during which premiums were earned and claims were incurred. For example, if the Experience Period is January 1, 2012 through December 31, 2012 the issuer may include claims payments through a date beyond the end of the experience with dates of service within the Experience Period (e.g., February 28, 2013) when estimating the total claims incurred during the period. The paid through date is not captured in the template, but is requested in the Part III Actuarial Memorandum.

Premiums (net of MLR Rebate) in Experience Period: Enter the amount of premium earned during the experience period, net of rebates to policyholders on an incurred basis due to the medical loss ratio (MLR) requirements as defined in 45 CFR Part 158.

Start with premiums earned during the experience period. Subtract the actual or estimated MLR rebates incurred during the experience period.

Enter the aggregate net premium dollars earned. The template will calculate the per member per month (PMPM) premium amount and the percent of premium.

Do not subtract amounts from the net earned premium that would be subtracted from earned premium in the denominator of the MLR calculation, such as taxes and fees. For portions of the experience period for which the MLR rebate has not been finalized, include a best estimate of the rebates in the reported net premium. See the Part III Actuarial Memorandum instructions for required documentation of the method used to estimate rebates.

Incurred Claims in Experience Period: Enter total claims incurred in the Experience Period.

Enter the aggregate incurred claims. The template calculates the PMPM incurred claims amount and the incurred claims as a percent of premium. The calculated percent of premium attributable to claims is not equivalent to the MLR, and therefore may be less than 80%.

Incurred claims are defined as allowed claims (defined immediately below) less member cost sharing and cost sharing paid by HHS on behalf of low-income members.

Member cost sharing is defined as payments made against the allowed claims by the member for health care services (e.g., deductible, coinsurance and copayments). This does not include premium or the amount of billed charges the member must pay in excess of the issuer's contractual allowed amount (often described as "balance billing").

Allowed Claims: Enter total allowed claims with dates of service during the Experience Period.

Allowed Claims are defined as the total payments made under the policy to healthcare providers on behalf of covered members, and include payments made by the issuer, member cost sharing, and cost sharing paid by HHS on behalf of low-income members. Consequently, they include actual payments made or estimates of costs incurred but not yet paid during the period. See Part III of the Actuarial Memorandum instructions for guidance related to incurred but not paid claim reserve documentation. They also include claims not tied to a specific date of service, such as capitation or risk sharing payments, if the payments were for services provided during the Experience Period. They include claims for essential health benefits (EHB) as well as benefits other than EHB. This would not include the amount of billed charges the member must pay in excess of the issuer's contractual allowed amount (often described as "balance billing").

By definition, "Allowed Claims" do not include:

- Ineligible claims such as duplicate claims, third party liabilities (e.g. coordination of benefits claims), and any other claims that are denied under the policy terms.
- Payments for services other than medical care provided, (e.g., medical management, quality improvement, and fraud detection and recovery expenses) even if these amounts are included in claims for MLR reporting purposes.
- Recovery payments the issuer may receive from private reinsurance or internal large claim pooling mechanisms. These types of adjustments should be handled in the Other adjustment factor found in Section II of Worksheet 1.
- Active life reserves (policy reserves, contract reserves, contingency reserves, or any kind of reserves except traditionally defined reserves for claims incurred but not paid) or change in such reserves.

Index Rate of Experience Period: Enter the Index Rate underlying the Experience Period. The value entered in this field must be a whole dollar value (i.e. the rate must be rounded to the nearest \$1). Please note, if an issuer copies and pastes a value in this cell which contains decimals, the Part I Unified Rate Review Template submission could be rejected or an issuer

may be required to make a resubmission later in the process which could delay the rate review process and approval.

The Index Rate represents the average allowed claims PMPM for essential health benefits. It is the legal entity-specific rate for the market that is being submitted – i.e., the issuer’s individual market, small group market or combined market. It should not be adjusted for payments and charges under the risk adjustment and reinsurance programs or for Exchange user fees. It is simply allowed claims PMPM for essential health benefits.

The Index Rate should be developed using all covered members, even if premium was not explicitly collected for all members. For example, if the number of members in a given family or policy was capped for premium setting purposes either voluntarily by the issuer or as required by law, all family members covered by the policy should be included.

The experience period Index Rate should be adjusted to exclude benefits that are in excess of essential health benefits, but should not be adjusted to include essential health benefits that were not covered during the experience period, such as, in some cases, maternity coverage in the individual market.

Experience Period Member Months: Enter the total number of months of coverage in the Experience Period for all members that had coverage during any portion of the Experience Period.

For example, if a given member had coverage for five months during the Experience Period, that member would contribute five member months to the total member months for the period. The number entered must be an integer. For partial months, issuers should define a methodology for counting partial months and apply the methodology consistently to all members. Possible methodologies include but are not limited to rounding up, rounding down, rounding to nearest, counting the member month if the member is active on the 15th of the month, etc.

Include all covered members even if premium was not explicitly collected for all members. For example, if the number of members in a given family or policy was capped for premium setting purposes either voluntarily by the issuer or as required by law.

Section II: Allowed Claims, PMPM basis

Projection Period: The projection period is determined by the template. The Projection Period starts on the effective date entered in the General Information section of the template. The Projection Period end date is calculated such that the Projection Period is a twelve month

period. The template also calculates the number of months between the midpoint of the Experience Period and the midpoint of the Projection Period.

Benefit Category

Several fields that follow require issuers to enter data by Benefit Category. Issuers are required to describe the Benefit Category definitions in the Part III Actuarial Memorandum. The preferred definitions of the Benefit Category follow:

Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the 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 payments are included in facility fees.

Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services.

Capitation: Includes all services provided under one or more capitated arrangements.

Prescription Drug: Includes drugs dispensed by a pharmacy. This amount should be net of rebates received from drug manufacturers.

Experience Period on Actual Experience Allowed

The experience entered in this section needs to reflect the state and market identified in the General Information section and the Experience Period identified in Section I of this worksheet. The actual experience for this period, state and market should be entered in the template, regardless of the credibility level.

Utilization Description: For each Benefit Category, choose the appropriate measurement unit that reflects the utilization per 1,000 covered members per year from the drop down menu. Valid entries are shown below.

Admits (for Inpatient service category only)
Days (for Inpatient service category only)
Benefit Period (for Capitation service category only)
Visits

Services
Prescriptions (for Prescription Drug service category only)
Other

In cases where “Other” is selected provide additional descriptions of the measurement units in the Part III Actuarial Memorandum.

Utilization per 1,000: Enter the total utilization per 1,000 covered members per year for claims incurred during the Experience Period.

The utilization must be entered on an annualized basis. Include any necessary estimates of utilization related to claims incurred but not yet paid.

Average Cost/Service: Enter the average allowed cost per unit of service for claims incurred during the Experience Period.

While not required, issuers may adjust the average cost per service for claims incurred but not yet paid if the issuer estimates the claims not yet paid to have a different average cost per service than those already paid. If an adjustment is made it should be described in the Part III Actuarial Memorandum.

PMPM: The Allowed Claims PMPM is calculated by the template, and is equal to utilization per 1,000 times average cost per service, divided by 12,000. The template sums the PMPM from each Benefit Category to calculate the total PMPM. The calculated PMPM must equal the Allowed Claims PMPM calculated by the template in Section I of Worksheet 1.

Adjustments from Experience to Projection Period

Population risk Morbidity: Enter the assumed change in morbidity of the covered population from the Experience Period to the Projection Period.

“Change in morbidity” means that component of the change in average allowed claims PMPM (as described earlier in these instructions) that will occur under the circumstances where all demographic (e.g., age, gender, and region) and product mix, all provider network contracts and time parameters (i.e., trends = 0) are held constant on the population that exists in the Experience Period.

The change in morbidity must be entered as 1 plus the total anticipated percent change in morbidity from the Experience Period to the Projection Period. For example, if in a 24 month period from the Experience Period to the Projection period the morbidity is expected to increase by 10%, enter 1.100. Similarly, if the morbidity is expected to *decrease* by 10% over the 24 month period, enter 0.900.

This category may include a number of adjustments since the market rules during the Projection Period may be significantly different from those in the Experience Period. In addition, the impact of new market rules is expected to vary significantly state to state. Some of the adjustments issuers might include are:

- Guarantee issue
- Take-up rate of the uninsured (the percent of currently uninsured that purchase coverage during the projection period)
- Health status of newly insured
- Enrollment from prior high risk pools
- Induced demand of newly insured
- Pent-up demand of newly insured
- Subsidy effects

Expected changes in the demographic mix (e.g. age, gender, and region) and tobacco status should not be included in this factor. These factors can be included in the “Other” factor.

A description of the methodology used to develop the adjustment must be included in the Part III Actuarial Memorandum.

Other: Enter the assumed change in cost related to things other than a change in population morbidity, cost trend, and utilization trend. Cost trend and utilization trend are defined in the section immediately following.

The other change must be entered as 1 plus the total anticipated percent change in cost from the Experience Period to the Projection Period, similar to the Population risk Morbidity adjustment.

Some of the adjustments an issuer might include in this section are:

- Changes in covered services
- Significant changes in the provider network, such as adding or removing a provider system, or introducing a limited network option. Shifts in the distribution of services across existing network providers should be reflected in the Cost Trend.
- Projected changes in cost related to demographics of the projected covered population
- Projected changes in pharmacy rebates relative to the pre-rebate prescription drug allowed claims

- In the event an issuer has capitation in the experience period but does not expect to have capitation in the projection period, the issuer should enter a near-zero value in the “Other” projection factor to remove the costs. It is not anticipated that other EHB categories would need to remove the experience for the entire benefit category.

A description of the methodology used to develop the adjustment must be included in the Part III Actuarial Memorandum.

Annualized Trend Factors

Cost Trend: Enter the assumed change in cost per service from the Experience Period to the Projection Period.

The Cost Trend must be entered as 1 plus the annualized trend assumption. For example, if the period from the midpoint of the Experience Period to the midpoint of the Projection Period is 24 months and if costs in the projection period are expected to be 10.25% higher than the Experience Period, then the annual trend is 5.0% ($\sqrt[12]{1.1025} - 1$). In this example, the user should enter 1.050 ($\sqrt[12]{1.1025}$).

Include only the increase in cost for a fixed basket of services. Changes in cost related to changes in mix of services should not be reflected here (they will be reflected in utilization trend described below). Changes in cost related to a change in the distribution of services across network providers should be included. Significant changes in network, such as adding or removing a provider system, or introducing a limited network option should be reflected in the “Other” adjustment and described in the Part III Actuarial Memorandum.

Projected changes in prescription drug cost related to manufacturer rebates should be reflected in the “Other” adjustment.

Utilization Trend: Enter the assumed change in utilization per 1,000 members from the Experience Period to the Projection Period.

The Utilization Trend must be entered as 1 plus the annualized trend assumption, in the same manner as the cost trend.

Utilization Trend should include the change in the number of units per 1,000 members for a fixed level of illness burden. If utilization is expected to increase/decrease due to a change in the average health status of the population, that change should be reflected in the Population risk Morbidity adjustment described above.

Utilization Trend should include assumed changes in the mix or intensity of services provided for a fixed level of illness burden.

Utilization Trend should also reflect changes related to shifts in product mix. This includes changes in induced demand related to product shifts. It also includes any effects of selection since this cannot be reflected in the relative cost of the various products and plans offered.

Projections, before credibility Adjustment

Projections before credibility adjustment are calculated by the template.

Utilization per 1,000: The template calculates projected utilization per 1,000 by multiplying the experience period utilization per 1,000 by the Population risk Morbidity adjustment and the utilization trend assumption. The Utilization Trend assumption in this calculation is raised to the power of the number of months between the midpoint of the Experience Period and the midpoint of the Projection Period (calculated previously by the template), divided by 12.

Average Cost/Service: The template calculates the projected average cost per service by multiplying the experience period average cost per service by the Other adjustment and the cost trend assumption. The Cost Trend assumption in this calculation is raised to the power of the number of months between the midpoint of the Experience Period and the midpoint of the Projection Period (calculated previously by the template), divided by 12.

PMPM: The projected allowed claims PMPM is calculated by the template, and is equal to projected Utilization per 1,000 times projected Average Cost/Service, divided by 12,000. The template sums the PMPM from each Benefit Category to calculate the total PMPM.

Credibility Manual

The credibility manual Utilization per 1,000 and Average Cost /Service need only be populated with values greater than zero if the experience period claims data is less than 100% credible for projecting future premium rates. When the experience period claims data is 100% credible zeros must still be entered in the credibility manual section so as not to produce errors when the template is validated. While credibility may not be applied in this manner in rate development, it must be shown in this manner for reporting purposes.

Utilization per 1,000: Enter the assumed utilization per 1,000 for the data underlying the credibility manual.

The Utilization per 1,000 must reflect the population and covered services for which rates are being submitted. If the issuer uses another credible block of business as the credibility manual, for example, the utilization of that population should be adjusted to reflect morbidity consistent with the projected population. Other adjustments may be necessary. The source of the credibility manual Utilization per 1,000 and the adjustments applied to it should be described in the Part III Actuarial Memorandum.

Average Cost/Service: Enter the assumed average cost per service for the data underlying the credibility manual.

The cost per service must reflect the projected cost for the population and covered services for which rates are being submitted. If the issuer uses another credible block of business from a different geographic region as the credibility manual, for example, the cost for that population should be adjusted to reflect differences in provider contracting of the two regions. The source of the credibility manual average cost per service and the adjustments applied to it should be described in the Part III Actuarial Memorandum.

PMPM: The projected credibility manual PMPM is calculated by the template, and is equal to the credibility manual Utilization per 1,000 times the credibility manual Average Cost/Service, divided by 12,000. The template sums the PMPM from each Benefit Category to calculate the total PMPM.

Section III: Projected Experience

Projected Amounts After Credibility

Credibility Percentage: Enter the assumed level of credibility to be applied to the experience period claims that have been projected to the rating period.

The percentage must be between 0% and 100%. Describe the methodology used to determine the Credibility Percentage in the Part III Actuarial Memorandum.

The template calculates the credibility to be assigned to the credibility manual, and is equal to 1 minus the credibility assigned to the projected experience claims.

Projected Allowed Experience Claims PMPM (w/ applied credibility if applicable): The template calculates this value as the sum of the projected experience PMPM multiplied by its credibility, and the credibility manual PMPM multiplied by the complement of the credibility (calculated previously by the template).

Paid to Allowed Average Factor in the Projection Period: Enter the average paid to allowed factor for the Projection Period.

This amount is not from the AV calculator. It should equal the total expected paid claims that are the liability of the issuer divided by the total expected allowed claims for the Projection Period, for the population anticipated to be covered in the Projection Period. Allowed claims have the same definition as in Section I. Paid claims are analogous to the Incurred Claims defined in Section I. Paid claims are net of member cost sharing and cost sharing paid by HHS on behalf of low-income members. The Paid to Allowed Average Factor in the Projection Period should reflect the average benefit level anticipated during the projection period. For example, if the issuer's members were enrolled

primarily in Silver plans in the experience period, but are anticipated to shift to Bronze, then the Paid to Allowed Average Factor in the Projection Period should reflect Bronze cost sharing levels.

Since the paid claims in the numerator are the trended amounts for the Projection Period, they should reflect any leveraging of fixed dollar cost sharing inherent in the benefit plans. That is, if no change in benefit mix is anticipated relative to the Experience Period, the paid to allowed ratio should be higher in the projection period than what was realized in the experience period due to the leveraging of cost sharing.

Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM: The template calculates this value by multiplying the Projected Allowed Experience Claims PMPM (w/ applied credibility if applicable) by the Paid to Allowed Average Factor in the Projection Period.

Projected Risk Adjustments, PMPM: Enter the projected PMPM amount of net federal risk adjustment transfers (i.e., net effect of risk adjustment payments and charges) for the Projection Period, and net of risk adjustment user fees.

The risk transfers should reflect the projected morbidity, including any projected Population risk Morbidity changes in column J in Section II.

If the issuer expects to receive a projected risk adjustment charge, then the entry should be a positive value. If the issuer expects to make a projected risk adjustment payment, then the entry should be a negative value.

Risk adjustment user fees should be reflected here, and not in the Taxes & Fees.

The calculation of the projected risk adjustments should consider the appropriate published transfer equation. Please describe the methodology for estimating the PMPM amount in the Part III Actuarial Memorandum.

Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM: The template calculates this value by subtracting the Projected Risk Adjustments, PMPM from the Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM.

Projected ACA Reinsurance Recoveries, Net of Premium: Enter projected reinsurance recoveries, referred to as reinsurance payments in the HHS Notice of Benefit and Payment Parameters, from the Federal reinsurance program, less contributions made to the program (referred to as "Premium" in the template).

Recoveries should be entered as positive amounts. For example, in the individual market where recoveries will likely exceed assessments the amount should be positive. In combined markets, the value may be positive or negative depending upon the portion of the market that is expected to be comprised of individuals and small groups. In a

combined market, the pooled reinsurance adjustment should be based only on the portion of the issuer's individual market business eligible for reinsurance payments. For the small group market, this amount only reflects the reinsurance assessment and should be entered as a negative number.

Projected Incurred Claims: The template calculates this value by subtracting Projected Risk Adjustments, PMPM and Projected ACA Reinsurance Recoveries, Net of Premium from Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM.

Administrative Expense Load: Enter the administrative expense load included in the premiums being filed for the effective date.

Enter the load as a percentage of premium. The template uses the percentage to calculate the PMPM administrative expense load.

If the Administrative Expense Load varies by product or plan, enter the average expense load for the single risk pool, using a premium-weighted average.

The Administrative Expense Load should include expense loads related to quality improvement and fraud detection/recovery, even if those expenses are considered part of incurred claims for purposes of MLR rebate calculations. It should also include loads for taxes and fees that may not be subtracted from premium in the MLR rebate calculation. For reporting purposes, it should not include the profit and risk load or the taxes and profit load, both described below, even though they are considered administrative expenses for purposes of adjusting the Index Rate to arrive at premium in the pricing process.

Profit & Risk Load: Enter the profit and risk load included in the premiums being filed for the effective date.

Enter the load as a percentage of premium. Not-for-profit issuers should enter the load for contribution to surplus in this entry. The template uses the percentage to calculate the PMPM profit and risk load.

If the Profit & Risk Load varies by product or plan, enter the average profit and risk load for the single risk pool, using a premium-weighted average.

Since taxes (including any federal income tax) are captured separately in the Taxes & Fees input, the profit and risk load should reflect after-tax amounts.

Note that for pricing purposes, profit and risk load is considered part of administrative expenses, per 45 CFR Part 156, §156.80(d). It is shown separately on the template to facilitate rate review.

Taxes & Fees: Enter the taxes and fees included in the premiums being filed for the effective date.

Enter only the portion of any load that is for taxes and fees that may be subtracted from premiums for purposes of calculating MLR. This includes federal income tax. However, do not include any contributions to the Federal transitional reinsurance program or risk adjustment user fees in this amount despite their treatment in MLR calculations, since Federal reinsurance and risk adjustment amounts are expressed in the template net of reinsurance premium and risk adjustment user fees. Any additional load for taxes and fees should be reflected in the Administrative Expense Load. The template uses the percentage to calculate the PMPM Taxes & Fees.

If the Taxes & Fees percentage varies by product or plan, enter the average Taxes & Fees percentage for the single risk pool, using a premium-weighted average.

Note that for pricing purposes, taxes and fees are considered part of administrative expenses, per 45 CFR Part 156, §156.80(d). It is shown separately on the template to facilitate rate review.

Single Risk Pool Gross Premium Avg. Rate, PMPM: The template calculates this value by dividing the Projected Incurred Claims by 1 minus the Administrative Expense Load percentage less the Profit & Risk Load percentage less Taxes & Fees percentage.

Index Rate for Projection Period: Enter the projected Index Rate.

As noted in Section I, the Index Rate represents the average allowed claims PMPM for essential health benefits. This legal entity-specific rate for the projection period should not reflect any adjustments for payments and charges under the risk adjustment and reinsurance programs or for Exchange user fees. It is simply projected allowed claims PMPM for essential health benefits. If the submission is for the individual or combined market, the projected Index Rate should reflect the twelve month projection period, or rating period. For the individual or combined market, if the issuer will not be covering benefits in excess of EHB, the Index Rate for the projection period will be equal to the Projected Allowed Experience Claims PMPM (w/ applied credibility if applicable). If the submission is for the small group market and includes prospective trend adjustments (only if permitted by the state), then the Index Rate for Projection Period should reflect the member weighted average of the projected trended Index Rates applicable for each effective date in the submission. See Section I for additional information about the Index Rate. See the Appendix for further guidance on calculation of the small group weighted average projected Index Rate.

% increase over Experience Period: The template calculates this value which represents the percent increase in the projected average gross premium PMPM over the average gross premium PMPM in the experience period. The average gross premium PMPM for the

experience period is calculated by the template in Section I (Premiums (net of MLR Rebate) in Experience Period).

The calculated increase is not the proposed rate increase. The calculated increase may include changes in premium PMPM related to shifts in the covered benefit, age, geographic area, or tobacco status of the population, some of which may be charged to the consumer through allowable rating factors.

The period of time over which the increase is calculated is dependent upon the Experience Period entered by the issuer. For example, if the length of time between the Experience Period and the Projection Period is two years, the increase calculated will represent a two-year increase.

% increase, annualized: The template calculates this value by annualizing the % increase over Experience Period. Like the % increase over Experience Period, the calculated increase may include changes in premium PMPM related to shifts in the covered benefits, age, geographic area, or tobacco status of the population, some of which may be charged to the consumer through allowable rating factors.

Projected Member Months: Enter the number of member months expected to be covered during the Projection Period.

See 'Experience Period Member Months' in Section I for more information on how to calculate member months. Since the Projection Period must be a one-year period, the projected member months might be equal to 12 times the projected enrollment in the first month of the Projection Period, for example. Issuers should describe how the member months were projected in the Part III Actuarial Memorandum.

Include all covered members even if premium is not expected to be explicitly collected for all members, for example if the number of child members in a given family exceeds three and must be capped for premium setting purposes as required by law.

Projected Period Totals: The template calculates aggregate dollar amounts for Section III PMPM values entered into or calculated by the template. The amounts are calculated by multiplying the Projected Member Months by the applicable PMPM value.

Worksheet 2 – Plan Product Information

The purpose of Worksheet 2 is to capture information at the product and plan level. The worksheet captures information on experience period data, the projection period data and other information related to each product or plan. There are four sections in this worksheet.

- Section I captures information about each product and plan. This includes general information such as the plan and product IDs, along with more specific information such as the effective date, actuarial values and proposed rate increase.
- Section II displays the proposed rate increase by major service category and the expected increase in cost sharing on a per member per month basis for each product and plan.
- Section III captures historical information such as premium and claims in a more detailed manner than in Worksheet 1. Information regarding the portion of the premium and claims related to the EHBs and non-EHBs is required, as well as information related to risk transfer charges and payments, Federal reinsurance payments, and cost sharing reduction amounts.
- Section IV contains the same information collected in Section III, but for the twelve month period following the effective date shown in the rate filing for each product.

If a product contains both grandfathered and non-grandfathered insurance policies, the experience of grandfathered policies may be included on Worksheet 2 if the grandfathered policies share the same rating practices as non-grandfathered policies, including pooling of risks and common rate increases or as permitted by the governing state regulatory body. If experience of grandfathered policies is included, then the total experience on Worksheet 2 will exceed that shown on Worksheet 1 which includes only non-grandfathered experience.

Plan level data is required because it could be used in calculating the advance premium tax credits and cost sharing subsidy advance payments. If the plan level data is not provided for each plan, the calculation of the advance premium tax credit and cost sharing subsidy advance payments may be incorrect for an issuer which may result in significant over or under advance payments.

In all cases, reasonable projected values are to be entered for all plans, either directly or by using the plan averaging option. For example, if an issuer chooses to enter information separately for each plan, all information input into the Part I Unified Rate Review Template for each plan must reflect experience or best estimate projections for each specific plan. For example, projected member months must reflect the issuer's best estimate of expected enrollment in each plan. With the exception of terminated plans, no plan should have expected membership of zero, and all membership projections should be supportable and represent the actuary's best estimate of enrollment. If zeros are entered in the Part I Unified Rate Review

Template, an issuer may be required to resubmit the template which may cause delays in the rate review and approval process.

Section I

Product: Enter the product name in the corresponding column(s).

The term “product” is defined as a unique combination of benefits, various cost sharing options and a network design(s) to a particular service area. “Product” has the same meaning as included in 45 CFR Part 154.

All products included in the single risk pool experience shown on Worksheet 1 must be entered in this section of Worksheet 2. This includes any products that are terminated but have experience included in the single risk pool during the experience period. It also includes any products that were not in effect during the experience but were made available thereafter.

If multiple products will be closed prior to January 1, 2015, these products may be combined for reporting purposes and shown as a single product in the template. The term “Terminated Products” should be entered as the plan name in this case. The list of product names for the terminated products should be included in the Part III Actuarial Memorandum.

Currently, HIOS does not report product names containing special characters, e.g., %. It is recommended that products containing special characters spell out the name of the special character, e.g. “20Percent Coinsurance” for “20% Coinsurance.”

Product ID: Enter the product ID that corresponds with each product. The two-letter state code portion of the Product ID must be entered using capital letters.

The “Product ID” should be the product number assigned by HIOS. Each product included in the single risk pool during the Experience Period, as well as new products that are part of the rate filing, must be identified in Worksheet 2 of the template.

If multiple products will be closed prior to January 1, 2015, these products may be combined for reporting purposes and shown as a single product in the template. Enter the Product ID for the largest product (measured by member months during the experience period) being terminated. A list of Product IDs for the terminated products should be included in the Part III Actuarial Memorandum.

Metal: For each “plan” within a product, choose the corresponding metal level from the drop down menu in the template. Plans that are included in a QHP certification application must show the same Metal as is shown in the QHP application.

In these instructions, the term “actuarial value” is used to describe a manner of estimating the value of a plan, but not a specific manner. AV Metal Value refers to the federal definition of actuarial value as prescribed in 45 CFR Part 156, §156.20. AV Pricing Value is defined below.

The ACA requires that all plans offered in the market must have an actuarial value that corresponds to a defined metal level. For guidance on the definition of “plan” please see the definition of “Plan Name” in these instructions. The metal actuarial values are defined as “the percentage paid by a health plan of the percentage of the total allowed costs of benefits.”¹ There are five levels of coverage that can be offered: Platinum, Gold, Silver, Bronze and Catastrophic. The actuarial values for each of these metal levels are shown in the table below. The actuarial value used in determining the metal level must be based on the Actuarial Value Calculator (AV Calculator) or an acceptable alternative if a health plan’s design is not compatible with the AV Calculator. For further guidance on the calculation of the AV Metal Value in the determination of the metal level, please see the instructions for the Part III Actuarial Memorandum.

The actuarial value used to determine the metal level must be within a de minimis variation from the actuarial values defined in the ACA. The Secretary has provided guidance that the de minimis variation standards will be ± 2 percentage points. For example, plans with an AV value between 68% and 72% meet the requirements for a silver level plan.

Metal Level	AV Requirements
Platinum	90%
Gold	80%
Silver	70%
Bronze	60%
Catastrophic	Not specified by law*

*Catastrophic level – a plan offered in the individual market only and is only available to individuals below the age of 30 or those for whom premium for minimum essential coverage exceeds 8% of income.

For products that are reported on a combined basis as terminated products prior to January 1, 2015, enter “Catastrophic”.

¹ 45 CFR Part 156, §156.20

AV Metal Value: For each plan, enter the corresponding AV value that results from the AV Calculator or a permissible alternative method that complies with 45 CFR Part 156 §156.135(b).

For products that are reported on a combined basis as terminated products prior to January 1, 2015, enter zero.

For Catastrophic plans, enter an approximate AV Metal Value for the plan (e.g., 0.580). Since there is not a Catastrophic continuance table within the AV Calculator, the actuary should use their best judgment in estimating the AV Metal Value.

AV Pricing Value: For each plan enter the corresponding AV Pricing Value.

It is important to note that the AV Pricing Value may be different from the AV Metal Value for several reasons. 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 Rate. It is likely to have a spread from one plan to another that emulates the spread in the Plan Adjusted Index Rates of the same plans.

The AV Metal Value compares the amount paid by a health plan to total allowed costs of benefits for the given plan (e.g. the estimated paid costs for a gold plan is compared to estimated allowed costs for a gold plan to generate a ratio between 0.78 and 0.82).

Another difference between the AV Pricing Value and the AV Metal Value is the data used to generate the ratios. The AV Pricing Value is determined from the Issuer'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. In addition the AV Pricing Value should reflect all of the allowable plan level adjustments to the Index Rate that are used by the issuer. This may include some or all of the following adjustments, so long as the adjustments do not include any assumptions related to the morbidity of the members assumed to select a given plan:

- The cost-sharing design of the plan. This adjustment may include expected differences in utilization of services based on differences in cost sharing. For example, lower cost sharing is generally associated with higher utilization of services, independent of health status. This adjustment must not include any differences in utilization due to differing health status of people with different cost-sharing designs.
- The plan's provider network and delivery system characteristics, as well as utilization management practices.
- Plan benefits in addition to the essential health benefits. The additional benefits must be pooled with similar benefits provided in other plans to determine the allowable rate variation for plans that offer those benefits.

- Administrative costs, excluding Exchange user fees.
- For catastrophic plans, the expected impact of specific eligibility categories for these plans.

Plan Type: Select the applicable plan type from the drop-down box. Valid Plan Types are Indemnity, PPO, POS, HMO or EPO.

In the event that the list of plan types does not describe an issuer's plan exactly, the issuer should select the closest plan available and provide further explanation of the Plan Type in the Part III Actuarial Memorandum.

Definitions of each of these categories can be found on the Healthcare.gov website in the glossary. However, each state may have its own definition of these terms which would dictate the plan type.

Plan Name: Enter the name of each plan within a product.

The term "plan" is defined as a unique combination of benefits to a specific set of cost sharing options and network design(s) to a particular service area. Most products will be made up of multiple plans that produce an actuarial value equal to one of the metal levels permitted under the ACA. The Plan Name is the marketing name used when referring to the specific set of benefits and cost sharing values. The Plan Name shown should be consistent across submissions (e.g., QHP application, state filings).

All plans included in the single risk pool experience shown on Worksheet 1 must be entered in this section of Worksheet 2. This includes any plans that are terminated but have experience included in the single risk pool during the Experience Period. It also includes any plans that were not in effect during the Experience Period but were made available thereafter. Issuers should not enter cost sharing reduction plan variations separately, since as described in 45 CFR 156.400-156.420, plan variations are not separate plans, but rather variations of the corresponding standard plans, with the same premium, benefits, and network as the standard plan. Further instructions are provided in Sections III and IV, below, on how to account for cost sharing reductions in this template.

For products that are closed to new entrants prior to January 1, 2015, the issuer should indicate that there is one plan in the product when completing the template. The Plan Name for the product or grouping of terminated products should be entered as "Terminated Products."

Currently, HIOS does not report plan names containing special characters, e.g., %. It is recommended that plans containing special characters spell out the name of the special character, e.g. "20Percent Coinsurance Plan" for "20% Coinsurance Plan."

Plan ID: Enter each assigned Plan ID. The two-letter state code portion of the Plan ID must be entered using capital letters.

The Plan ID is a unique identifier for the set of benefits and cost sharing values offered within a product by the HIOS issuer, or in other words, a unique identifier of each plan. Plan IDs contain three digits. This field must be entered as a text input and must include any leading zeros (e.g. 001).

For products that are closed to new entrants prior to January 1, 2015, the issuer should indicate that there is one plan in the product when completing the template. The Plan ID for the product or grouping of terminated products should be populated with the Product ID discussed above.

Exchange Plan: For each plan, enter an indicator (yes or no) as to whether the plan will be offered inside a State-based or Federally Facilitated Exchange or Small Business Health Options Program (SHOP), regardless of whether or not it will also be offered in the outside market. If an application for qualified health plan status is pending, enter “yes.” This indicator should not be used to identify whether a plan is offered on a private exchange.

Historical Rate Increases: For each product, enter the historical rate increase for the period two years prior to the current calendar year, one year prior to the current calendar year, and the current calendar year.

For example, if the template is submitted in 2013 for an Effective Date of January 1, 2014, the current calendar year is 2013. Rate increases are therefore required to be entered for 2011, 2012, and 2013.

Rate increases must reflect the full rate increase that is applied to a policy during the applicable year. For example, if rate tables in the market change quarterly but each policyholder’s premium rates change annually, then the rate increase for policies renewing during the year must reflect the total rate change that applies to each policyholder during that year, which is the cumulative effect of the four quarterly rate changes.

If multiple rate increases were implemented during the calendar year period being reported, enter the premium weighted average rate increase across the entire calendar year. For example, assume the submission is for the small group market in which 50% of groups (representing 50% of the annual revenue) renew in January, 25% renew in April, and 25% renew in October. The calendar year increases are 7% in January, 6% in April, and 5% in October, then the calendar year average rate increase is 6.25% ($=7\%*50\% + 6\%*25\% + 5\%*25\%$).

For the current calendar year, include all rate changes that have been approved, are currently under review by the applicable regulatory agency, or are anticipated to be

submitted. For example, if the template is being submitted in April 2013 for an effective date of January 1, 2014 for a market in which rates change quarterly, include in the average rate increase for 2013 any rate increases that have already been approved or are intended to be implemented in 2013 including those implemented after the submission (e.g., effective July 2013 and October 2013).

For new plans, enter a value of -999% in the Historical Rate Increases. If a plan was recently offered for the first time, and therefore does not have experience in the Experience Period, enter the actual Historical Rate Increases in the same manner as other existing plans. If an existing plan has not previously had a rate increase, enter 0.00%.

For terminated products, the historical rate increase fields are optional. However, since the template expects an entry, enter -999% to avoid validation warnings.

Effective Date of Proposed Rates: For each plan, enter the corresponding effective date of the proposed rate increases.

See Worksheet 1 instructions for Effective Date. All products and plans must have the same effective date. If some products or plans will have a rate change and others will not, then a 0% rate change may be entered in the "Rate Change % (over prior filing)" field described immediately below for those plans that will not have a rate change on the product's effective date.

As on Worksheet 1, if the submission is for the small group market, enter the effective date on which the products' rates will change due to the Index Rate being revised. For example, if the small group submission revises the Index Rate for July 1, 2015 effective dates and includes a trend increase applicable on October 1, 2015, enter July 1, 2015.

Rate Change % (over prior filing): Enter the average change in premium rates over the rates included in the prior filing for each plan.

For new plans enter 0.00% in this field.

Cum'tive Rate Change % (over 12 mos prior): Enter the average change in premium rates over the twelve month period prior to the effective date for each plan. This should be the premium-weighted average of the 12-month increases that apply at renewal.

For new plans enter -999.00% in this field. It is important to enter this value in the template in this case so other calculated fields in the template are correctly generated.

Proj'd Per Rate Change % (over Exper. Period): For each plan, the percentage change in rates between the Experience Period and the Projection Period is shown. This is a calculated field.

Product Threshold Rate Increase %: The template calculates the threshold rate increase for each product. This is the rate increase that determines whether the rate increase is subject to review, per 45 CFR Part 154 §154.200.

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

This section can be completed with variations only at the product level or variations at each plan level within a product.

If the information is entered with the product level variation, this means the issuer enters the information for the total product spread evenly across all plans within the product. If the issuer chooses this methodology, the proposed rate increase for each plan within the product must be identical.

If the issuer chooses to enter the information separately for each plan within a product rather than use the simplified approach of entering the product averages, the proposed rate increase for each plan can vary for items allowable by state and Federal laws and regulations. If an issuer chooses to enter information separately for each plan, all information input into the Part I Unified Rate Review Template for each plan must reflect experience or best estimate projections for each specific plan. For example, projected member months must reflect the issuer's best estimate of expected enrollment in each plan. With the exception of terminated plans, no plan should have expected membership of zero. If zeros are entered in the Part I Unified Rate Review Template, an issuer may be required to resubmit the template which may cause delays in the rate review and approval process.

Inpatient: Enter the portion of the increase in the premium rate that corresponds to benefits provided for inpatient services for each plan. See the instructions for Worksheet 1, Section II for the definition of Inpatient Hospital services.

Outpatient: Enter the portion of the increase in the premium rate that corresponds to benefits provided for outpatient services for each plan. See the instructions for Worksheet 1, Section II for the definition of Outpatient Hospital services.

Professional: Enter the portion of the increase in the premium rate that corresponds to benefits provided for professional services for each plan. See the instructions for Worksheet 1, Section II for the definition of Professional services.

Prescription Drugs: Enter the portion of the increase in the premium rate that corresponds to benefits provided for prescription drugs for each plan. See the instructions for Worksheet 1, Section II for the definition of Prescription Drug services.

Other: Enter the portion of the increase in the premium rate that corresponds to benefits provided for services defined in the “other” benefit category for each plan. See the instructions for Worksheet 1, Section II for the definition of Other Medical services.

Capitation: Enter the portion of the increase in the premium rate that corresponds to benefits provided for services defined under capitation for each plan. See the instructions for Worksheet 1, Section II for the definition of Capitation.

Administrative Expenses: Enter the portion of the increase in the premium rate that corresponds to administrative expenses incorporated in the premium rates for each plan. See the instructions for Worksheet 1, Section III for the definition of Administrative Expense Load.

Taxes & Fees: Enter the portion of the increase in the premium rate that corresponds to the taxes and fees incorporated in the premium rates for each plan. Also include expected changes in the payments and charges under the risk adjustment and reinsurance programs, in addition to the administrative costs associated with these programs. Since the total rate increase is affected by changes in anticipated transfer payments, these need to be reflected in order for the total to be calculated correctly.

Risk & Profit Charges: Enter the portion of the increase in the premium rate that corresponds to the risk and profit charges incorporated in the premium rates for each plan. See the instructions for Worksheet 1, Section III for the definition of Profit & Risk Load.

Total Rate Increase: This is a calculated field and equals the sum of the benefit categories, administrative expenses and the risk and profit charges for each plan. It should equal the difference between the projected Average Rate PMPM and the Average Current Rate PMPM.

Member Cost Share Increase: Enter the expected increase in the member’s cost sharing portion from the period underlying the current rate for the plan to the projected rating period of the plan. This includes cost sharing paid by HHS on behalf of low-income members.

This might reflect the impact of trend on coinsurance, for example. This would not include any increase in the member’s cost associated with the increase in premium rates.

Average Current Rate PMPM: Enter the average premium rate on a per member basis for each plan for the most recently approved rates.

The Average Current Rate PMPM should be generated using the projected membership, not the currently enrolled membership.

In the case of small group rates where a trend factor is filed and approved, the Average Current Rate PMPM should reflect the latest approved rate. For example, assume the current rates were filed for effective dates between January and December with a

quarterly trend factor. The current rates that should be entered in the rate filing would be the rates with effective dates October through December.

For new plans (i.e., those with Cum'tive Rate Change % (over 12 mos prior) entered as -999.00% as instructed above), enter the projected average rate PMPM for each plan in this field. It is understood that these new plans do not actually have current rates. However, it is necessary to populate this field with the projected average rate so that the projected Average Rate PMPM in Section IV is calculated correctly by the template. It is also understood that the calculated Average Current Rate PMPM across all plans will not reflect the true current average in the event that there are new plans or very recently offered plans with Projected Member Months (which are used to calculate the overall average) but whose current rate reflects a rate for a later effective date than the remaining plans that are not new. In fact, any time the Projected Member Months have a different distribution across plans than the current distribution, the Average Current Rate PMPM will not represent the true current average rate.

Projected Member Months: Enter the projected member months by plan that correspond to the effective period of the rates for each plan. See the instructions for Worksheet 1, Section II for the definition of Projected Member Months. The sum of the Projected Member Months for each of the plans should equal the Projected Member Months on Worksheet 1.

The total Member Months in the projection period should be consistent with the Projected Member Months entered in Section III of Worksheet 1. However, the member months may differ if there are different effective dates for the products/plans. The template includes a "Warning" indicator if there is a significant difference between the member months found in Worksheet 1 and in Worksheet 2. In these cases, support for the member months in both worksheets should be documented in the Part III Actuarial Memorandum.

If an issuer chooses to enter information at the plan specific level, projected member months entered in the template must reflect an issuer's best estimate of projected enrollment for that specific plan. With the exception of terminated plans, the projected member months for a plan should not be zero. If the projected membership does not meet this criteria, issuers may be required to resubmit the Part I Unified Rate Review Template which may cause delays in the rate review and approval process.

Section III: Experience Period Information

The information shown in this section captures the historical data for the twelve month period used in the base period experience. This should be the same time period as the Experience Period found in Worksheet 1. See the instructions for Worksheet 1 for the definition of the Experience Period.

Similar to Section II of this worksheet, the information requested in this section can be entered at the product level or at the plan level. See Section II for a description of these variations.

Average Rate PMPM: Enter the average premium rate PMPM for each plan during the experience period. The average should be generated using membership consistent with the Experience Period for each plan.

It is anticipated that the overall Average Rate PMPM during the Experience Period should be similar to the average premium rate found in Section I of Worksheet 1. The template includes a “Warning” indicator if there is a significant difference between the average premiums on the two worksheets. If the Warning is indicated, additional information should be provided in the Part III Actuarial Memorandum that explains the differential.

Member Months: Enter the total member months during the Experience Period. See the instructions for Worksheet 1 for the definition of Experience Period Member Months.

The total Member Months in the Experience Period should be consistent with the Experience Period Member Months entered in Worksheet 1. The template includes a “Warning” indicator if there is a significant difference between the member months found in Worksheet 1 and in Worksheet 2. In these cases, support for the member months in both worksheets should be documented in the Part III Actuarial Memorandum.

Total Premium (TP): The total premium earned in the Experience Period for each plan is calculated as the Average Rate PMPM multiplied by the Member Months in a given plan.

The Total Premium (TP) in the experience period should be consistent with the total premium found in Section I of Worksheet 1. The template includes a “Warning” indicator if there is a significant difference between the total premiums shown on both worksheets. If the Warning is indicated, additional information should be provided in the Part III Actuarial Memorandum that explains the cause.

EHB Percent of TP: Enter the percentage of the total premium that is associated with EHB services in each plan (including administrative expenses and profit associated with those services). Note these fields are optional for submissions with an experience period that ends prior to January 1, 2014.

When calculating the EHB Percent of TP, the Administrative Expense Load, Profit & Risk Load, and Taxes & Fees should be allocated to the various categories in this section (EHB, state mandated benefits that are not EHB, and other benefits) of the template in proportion to the claims expenses. For example, if 95% of claims are EHB and 5% of claims are other benefits, then the EHB Percent of TP should be 95%. Similarly, the Other benefits portion of TP should be 5% in the example and would be calculated as

such by the template. Administrative expenses and profit should not be disproportionately allocated to one benefit over another. The sum of the EHB percentage, the state mandated benefits percentage and the other benefits percentage should equal 100%.

If abortion services are included in the EHB package, the portion of the premium related to these services is to be handled using two different methods in accordance with the criteria described below.

- If the plan is a QHP offered in the Federally Facilitated Exchange or State-Based Exchange, the percentage of the premium associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB benchmark package). The EHB percentage will be used in the calculation of subsidy amounts. Since subsidy payments may not be provided for costs associated with abortion services, they must be excluded from the EHB proportion.
- If the plan is not a QHP offered in the Federally Facilitated Exchange or State-Based Exchange, but rather is only offered in the outside market, the percentage of premium associated with abortion services should be included in the EHB percentage.

If abortion services are not included in the EHB benchmark package, any covered abortion services should be reflected in either the state mandated benefits portion or the other benefits portion regardless of whether the plan is sold inside or outside of the exchange.

State mandated benefits portion of TP that are other than EHB: Enter the percentage of the total premium for each plan that is associated with state mandated benefits that are not part of the EHB package. Note these fields are optional for submissions with an experience period that ends prior to January 1, 2014.

Similar to the EHB percentage, the state mandated benefit percentage of the total premium should include the portion of administrative expenses, taxes and fees and risk and profit loads associated with these services.

State mandated benefits that are not part of the EHB package that are required to be offered only (i.e. it is the choice of the insured as to whether or not to purchase the benefits) should **not** be included in this component as the benefit is optional from the purchaser's perspective. The premium associated with these types of benefits should be included in the Other benefits portion of the premium, which is defined below.

The percentages in these fields are required (except for the optional treatment described above) as states will need to fund the portion of the premium for state mandated benefits that are not included in the EHB package.

Other benefits portion of TP: This is a calculated field which generates the remaining percentage of the total premium based on the values entered from the EHB and state mandated benefits portions, described above.

As stated previously, the sum of the EHB portion, the state mandated benefit portion not associated with EHBs and the other benefits portion should equal 100%.

Total Allowed Claims (TAC): Enter the total allowed claims for each benefit plan with service dates within the Experience Period.

The Total Allowed Claims (TAC) across all benefit plans for the Experience Period should be consistent with the Allowed Claims entered in Section I of Worksheet 1. The template includes a “Warning” indicator when the allowed claims between Worksheet 1 and Worksheet 2 are significantly different. If a Warning is indicated, the issuer should provide additional support for the difference between the total allowed claims between Worksheet 1 and 2 in the Part III Actuarial Memorandum.

EHB Percent of TAC: Enter the percentage of the total allowed claims that are associated with EHB services in each plan during the Experience Period. Note these fields are optional for submissions with an Effective Date, as shown on Worksheet 1, in calendar year 2015.

If abortion services are included in the EHB package, the portion of the allowed claims related to these services is to be handled in two different methods in accordance with the criteria described below.

- If the plan is a QHP offered in the Federally Facilitated Exchange or State-Based Exchange, the percentage of the allowed claims associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB package).
- If the plan is not a QHP offered in the Federally Facilitated Exchange or State-Based Exchange, but rather is only offered in the outside market, the percentage of allowed claims associated with abortion services should be included in the EHB percentage.

If abortion services are not included in the EHB package, any covered abortion services should be reflected in either the state mandated benefits portion or the other benefits portion regardless of whether the plan is sold inside or outside of the exchange.

State mandated benefits portion of TAC that are other than EHB: Enter the percentage of the total allowed claims for each plan that are associated with state mandated benefits that are not part of the EHB package. Note these fields are optional for submissions with an experience period ending prior to January 1, 2014.

State mandated benefits that are not part of the EHB package that are required to be offered only (i.e. it is the choice of the insured whether the benefits are purchased) should **not** be included in this component as the benefit is optional from the purchaser's perspective. The allowed claims associated with these types of benefits should be included in the Other benefits portion, which is defined below.

Other benefits portion of TAC: This is a calculated field which generates the remaining percentage of the total allowed claims based on the values entered from the EHB and state mandated benefits portions, described above.

As stated previously, the sum of the EHB portion, the state mandated benefit portion not associated with EHBs and the other benefits portion should equal 100%.

Allowed Claims which are not the issuer's obligation: Enter the portion of the allowed claims (as defined on Worksheet 2) that were paid by the insured or other funds for each plan separately during the experience period. These would include the following types of payments:

- Member cost sharing (i.e. deductible, coinsurance and copays). This should be based on the cost sharing associated with the benefits of each plan. For those plans with reduced cost sharing subsidies for the member, the cost sharing amount included this value should reflect both the amount paid by the member and the subsidies. For example, for the silver plan variation with 94% cost sharing, the value of the cost sharing included in this field should reflect the approximately 6% cost sharing expected from the member and the approximately 24% cost sharing covered by the federal subsidy for a total cost sharing value of approximately 30% (6% + 24%).
- Risk transfer charges or payments associated with the risk adjustment program. In this case, risk adjustment charges made to the program should be entered as a negative amount and payments received from the program should be entered as a positive amount. The issuer should estimate the risk transfer charge or payment by plan and provide detailed information in the Part III Actuarial Memorandum on the methodology used to allocate the payments between plans. The risk adjustment user fees should not be included since they are not part of allowed claims.
- Federal reinsurance payments received should be included in this field. The federal reinsurance payments should be entered by plan. Payments should be entered as positive amounts. The method used to determine these payments by plan should be described in the Part III Actuarial Memorandum. The federal reinsurance contributions should not be included since they are not part of allowed claims.

- Other claims that are not described above but included in this cell should be described in detail in the Part III Actuarial Memorandum.

Portion of above payable by HHS's fund on behalf of insured person, in dollars: Enter the portion of the total dollars that are attributable to HHS during the Experience Period. This is the cost sharing reduction subsidies.

Portion of above payable by HHS on behalf of insured person, as %: This is a calculated field and displays the percentage of claims covered by HHS over the value of all claims not covered by the issuer.

Net Amt of Rein: Enter the Federal reinsurance amount received for each plan during the Experience Period.

This value should be calculated consistently with the federal reinsurance amount included in the Allowed Claims which are not the issuer's obligations. However, it will differ from that amount in that this field is net of the reinsurance contribution amount.

For time periods prior to 2014, the value should be zero, as the program was not operational until 2014.

Net Amt of Risk Adj: Enter the risk transfer charge or payment during the Experience Period for each plan.

This value should be calculated consistently with the risk transfer charge or payment included in the Allowed Claims which are not the issuer's obligation. However, it will differ from that amount in that this field is net of the risk adjustment user fees. If the transfer amount is a charge (liability payment made to other issuers) the value should be a negative amount. If the transfer amount is a payment received from other issuers the value should be entered as a positive amount.

For time periods prior to 2014, the value should be zero, as the program was not operational until 2014.

Section IV : Projected (12 months following effective date)

The information shown in this section captures the projected data for the twelve month period following the effective date for each plan. Similar to Sections II and III of this worksheet, the information requested in this section can be entered at the product level or at the plan level. See Section II for a description of these variations.

It is expected that in general, the projection period found in this section should be the same as the Projection Period found in Section II of Worksheet 1. However, there are circumstances

where the projection periods may differ. These circumstances occur in the small group market when prospective trend is included in the submission (if permitted by the state). In this case:

Similar to the Index Rate for Projection Period on Worksheet 1, the Plan Adjusted Index Rate must reflect the member weighted average of the projected trended plan adjusted Index Rates applicable for all effective dates in the submission. See the Appendix for more information on the calculation of the member weighted average Index Rate.

Member months should be consistent with those reflected on Worksheet 1. Since the single risk pool requires the Index Rate be based on ALL enrollees in the market in the state for that issuer, the member months should reflect all projected member months for the single risk pool in the projection period, regardless of the expected renewal month.

Since Total Premium (TP) for the projection period is calculated as the Plan Adjusted Index Rate multiplied by the member months, this will reflect the weighted average Plan Adjusted Index Rates for all effective dates.

All data entered in the Claims Information section (rows 86 through 96) should be consistent with the projection period shown on Worksheet 1. Therefore, the amount of trend reflected in the claims section will differ from that reflected in the premium information.

Plan Adjusted Index Rate: Enter the projected Plan Adjusted Index Rate into these cells for each plan ID for the effective period of the proposed rates.

The Plan Adjusted Index Rate is the Market Adjusted Index Rate (defined in the introduction of these instructions) further adjusted for plan specific factors allowable by 45 CFR Part 156.80(d)(2) such as provider network, utilization management, benefits in addition to Essential Health Benefits (EHBs), actuarial value and cost sharing, distribution and administrative costs (less Exchange fees) and catastrophic plan eligibility variation.

The overall weighted average of the Plan Adjusted Index Rates should be similar to the Single Risk Pool Gross Premium Avg. Rate, PMPM found in Section III of Worksheet 1. The template includes a “Warning” indicator if there is a significant difference between the average premiums on the two worksheets. If the Warning is indicated, additional information should be provided in the Part III Actuarial Memorandum that explains the differential. One explanation that may apply is that the small group Plan Adjusted Index Rates reflect the member weighted average of the rates for all effective dates in the filing, whereas the Worksheet 1 Single Risk Pool Gross Premium Avg. Rate reflects the effective date of the change in the Index Rate.

Member Months: The template populates the projected Member Months using the Projected Member Months entered in Section II of the worksheet.

Total Premium (TP): The total premium earned in the projection period for each plan is calculated as the Average Rate PMPM multiplied by the Member Months in a given plan.

The Total Premium (TP) in the projection period should be similar to the total premium found in Section III of Worksheet 1. The template includes a “Warning” indicator if there is a significant difference between the total premiums shown on both worksheets. If the Warning is indicated, additional information should be provided in the Part III Actuarial Memorandum that explains the cause.

EHB Percent of TP: Enter the percentage of the total premium that is associated with EHB services in each plan. It is critical that this percentage be entered correctly, and consistently with any QHP application. It is likely that this field will be used by CCIO to calculate the advance premium tax credits for subsidy-eligible enrollees. If the values in this field are not entered correctly, the calculation of the advance premium tax credits may be incorrect for an issuer.

For non-terminated ACA compliant plans, the value entered into the EHB Percent of TP field must be greater than zero. It is critical that this percentage be entered correctly as it is likely it will be used to calculate the advance premium tax credits for subsidy-eligible members.

For pre-ACA plans and terminated plans, the field may be left blank.

When calculating the EHB percentage, the Administrative Expense Load, Profit & Risk Load, and Taxes & Fees should be allocated to the various categories in this section of the template in proportion to the claims expenses. The sum of the EHB percentage, the state mandated benefits percentage and the other benefits percentage should equal 100%.

If abortion services are included in the EHB package, the portion of the premium related to these services is to be handled using two different methods in accordance with the criteria described below.

- If the plan is a QHP offered in the Federally Facilitated Exchange or State-Based Exchange, the percentage of the premium associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB benchmark package). The EHB percentage will be used in the calculation of subsidy amounts. Since subsidy payments may not be provided for costs associated with abortion services, they must be excluded from the EHB proportion.
- If the plan is not a QHP offered in the Federally Facilitated Exchange or State-Based Exchange, but rather is only offered in the outside market, the percentage of premium associated with abortion services should be included in the EHB percentage.

If abortion services are not included in the EHB benchmark package, any covered abortion services should be reflected in either the state mandated benefits portion or the other benefits portion regardless of whether the plan is sold inside or outside of the exchange.

Submission of the Part I Unified Rate Review Template and corresponding Part III Actuarial Memorandum satisfies the requirements of 45 CFR 154.215 and 156.470.

State mandated benefits portion of TP that are other than EHB: Enter the percentage of the total premium for each plan that is associated with state mandated benefits that are not part of the EHB package.

Similar to the EHB percentage, the state mandated benefit percentage of the total premium should include the portion of administrative expenses, taxes and fees and risk and profit loads associated with these services.

State mandated benefits that are not part of the EHB package that are required to be offered only (i.e. it is the choice of the insured whether the benefits are purchased) should **not** be included in this component as the benefit is optional from the purchaser's perspective. The premium associated with these types of benefits should be included in the Other benefits portion of the premium, which is defined below.

The percentages in these fields are required as states will need to fund the portion of the premium for state mandated benefits that are not included in the EHB package.

Other benefits portion of TP: This is a calculated field which generates the remaining percentage of the total premium based on the values entered from the EHB and state mandated benefits portions, described above.

As stated previously, the sum of the EHB portion, the state mandated benefit portion not associated with EHBs and the other benefits portion should equal 100%.

Total Allowed Claims (TAC): Enter the total allowed claims for each benefit plan with service dates within the projection period. See the instructions for Worksheet 1 for the definition of Allowed Claims.

The Total Allowed Claims (TAC) across all benefit plans for the projection period should be consistent with the total allowed claims, the projected risk adjustments and the projected ACA reinsurance recoveries entered in Section III of Worksheet 1. The template includes a "Warning" indicator when the sum of the allowed claims, the projected risk adjustments and the projected ACA reinsurance recoveries in Worksheet 1 and the allowed claims in Worksheet 2 are significantly different. If a Warning is indicated, the issuer should provide additional support for the difference between these amounts in the Part III Actuarial Memorandum.

EHB Percent of TAC: Enter the percentage of the total allowed claims that are associated with EHB services in each plan during the projection period. If abortion services are included in the EHB package, the portion of the allowed claims related to these services is to be handled in two different methods in accordance with the criteria described below. It is critical that this percentage be entered correctly. This field is used by CCIO to calculate cost sharing reduction advance payments for subsidy-eligible enrollees. If the values in this field are not entered correctly, the calculation of the cost sharing reduction advance payments may be incorrect for an issuer.

- If the plan is a QHP offered in the Federally Facilitated Exchange or State-Based Exchange, the percentage of the allowed claims associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB package).
- If the plan is not a QHP offered in the Federally Facilitated Exchange or State-Based Exchange, but rather is only offered in the outside market, the percentage of allowed claims associated with abortion services should be included in the EHB percentage.

If abortion services are not included in the EHB package, any covered abortion services should be reflected in either the state mandated benefits portion or the other benefits portion regardless of whether the plan is sold inside or outside of the exchange.

Submission of the Part I Unified Rate Review Template and corresponding Part III Actuarial Memorandum satisfy the requirements of 45 CFR 154.215 and 156.470.

State mandated benefits portion of TAC that are other than EHB: Enter the percentage of the total allowed claims for each plan that are associated with state mandated benefits that are not part of the EHB package.

State mandated benefits that are not part of the EHB package that are required to be offered only (i.e. it is the choice of the insured whether the benefits are purchased) should **not** be included in this component as the benefit is optional from the purchaser's perspective. The allowed claims associated with these types of benefits should be included in the Other benefits portion, which is defined below.

Other benefits portion of TAC: This is a calculated field which generates the remaining percentage of the total allowed claims based on the values entered from the EHB and state mandated benefits portions, described above.

As stated previously, the sum of the EHB portion, the state mandated benefit portion not associated with EHBs and the other benefits portion should equal 100%.

Allowed Claims which are not the issuer's obligation: Enter the portion of the allowed claims (as defined in Worksheet 2) that were paid by the insured or other funds for each plan separately during the projection period. These would include the following types of payments:

- Member cost sharing (i.e. deductible, coinsurance and copays). This should be based on the cost sharing associated with the benefits of each plan. For those plans with reduced cost sharing subsidies for the member, the cost sharing amount included this value should reflect both the amount paid by the member and the subsidies.
- Risk transfer charges or payments associated with the risk adjustment program. In this case, risk adjustment charges made to the program should be entered as a negative amount and payments received from the program should be entered as a positive amount. The issuer should estimate the risk transfer charge or payment by plan and provide detailed information in the Part III Actuarial Memorandum on the methodology used to allocate the payments between plans.
- Federal reinsurance payments expected to be received should be included in this field. The federal reinsurance payments should be entered by plan. Payments should be entered as positive amounts. The method used to determine these payments by plan should be described in the Part III Actuarial Memorandum.
- Other claims that are not described above but included in this cell should be described in detail in the Part III Actuarial Memorandum.

Portion of above payable by HHS's fund on behalf of insured person, in dollars: Enter the portion of the total dollars that are attributable to HHS during the projection period. This is the cost sharing reduction subsidies.

These estimates should be based on the issuer's expected enrollment of cost sharing reduction eligible members. The methodology used to estimate these values should be explained in the Part III Actuarial Memorandum.

Since this value is a portion of the payments entered in the Allowed Claims which are not the issuer's obligations (described above), the same methodology to estimate these payments should be employed.

Portion of above payable by HHS on behalf of insured person, as %: This is a calculated field and displays the percentage of claims covered by HHS over the value of claims not covered by the issuer.

Net Amt of Rein: Enter the Federal reinsurance amount expected to be received for each plan during the projection period, net of the reinsurance assessments.

This value should reflect both assessments charged and payments received under the program. The amount entered should be consistent with the amount that reflects payments received or assessments charged under the Federal reinsurance program that is included in the Allowed Claims which are not the issuer's obligations.

Net Amt of Risk Adj: Enter the amount of any risk transfer payment expected to be received during the projection period for each plan. If a risk transfer charge is anticipated to be assessed, the value entered should be negative.

This value should be consistent with the risk transfer payment, if any, included in the Allowed Claims which are not the issuer's obligation. If the transfer amount is expected to be a payment received from other issuers the value should be entered as a positive amount. If the transfer amount is expected to be a charge (liability payment made to other issuers) a negative value should be entered.

Validation and Finalization of Part I Unified Rate Review Template (URRT) in HIOS

An issuer must validate the URRT submission in order to complete the upload process within HIOS. The following steps are to be taken in order to complete the process.

1. The issuer creates the initial submission and uploads the required documentation. At this point the submission is in the Pre-Validation status.
2. The issuer must check the validation box on the submission summary. Once the issuer checks this box, the submission is in the Record Validated status.

Appendix

Single Risk Pool and Index Rate Requirements

The Single Risk Pool and Index Rate Requirements are specified in 45 CFR Part 156.80.

45 CFR Part 156.80(a), (b), and (c) require that health insurance issuers consider the claims experience of all enrollees in all non-grandfathered health plans subject to section 2701 of the Public Health Services Act and offered by the issuer in the state to be members of a single risk pool for each of the individual, small group, and combined markets.

45 CFR Part 156.80(d) requires that a health insurance issuer establish an Index Rate for each of the individual, small group, or combined markets annually. The Index Rate for each market is based on the total combined claims costs for providing Essential Health Benefits within the Single Risk Pool for that state market.

Timeframe for Part 1 Unified Rate Review Template Submissions

The following table provides the guidelines for the submission of the Part 1 Unified Rate Review Template for rates associated with the different types of public exchanges (i.e. FFM/SPM), and non-QHPs. This applies to filings for January 1 effective dates in all markets.

Type of Filing	Issuer Submission Date for 2015 Rates
QHP Filing – FFM/SPM	[TBD]
QHP Filing – SBM	Based on state regulatory agency requirements
Non-QHP Filing	Based on state regulatory agency requirements

In addition, issuers may file revised rates for small group plans on a quarterly basis, subject to other state requirements. For example, a state may not allow issuers to submit revised rates for fourth quarter. The table below shows suggested guidance for a timeline of submission of these plans. However, the specific submission dates may vary from these guidelines depending upon specific requirements for individual states.

Small Group Quarterly Submission Schedule (Non-Grandfathered Single Risk Pool Plans)

Type of Filing	Issuer Submission Date	Finalization Date for 2015 Rates
QHP Filing – FFM/SPM	At least 90 days prior to effective date	At least 45 days prior to effective date
QHP Filing – SBM	At least 90 days prior to effective date	At least 45 days prior to effective date
Non-QHP Filing	Based on state regulatory agency requirements	At least 45 days prior to effective date

Use of the Data Submitted in the URRT

CCIIO uses the data submitted in the URRT in a variety of ways.

In states where CCIIO performs the Market Reform Rules compliance reviews, CCIIO uses the URRT in conjunction with other information to perform the compliance reviews.

CCIIO's Financial Management may use certain fields in the calculation of Advance Premium Tax Credit (APTC) payments and Cost Sharing Reduction (CSR) advance payments.

Disclosure of the URRT data

Upon completion of the Freedom of Information Act review that is underway, CCIIO will disclose the data included in the URRT on its website.

URRT Submission Statuses

URRT submissions are in the following statuses under various circumstances.

The URRT contains no rate increases that are subject to review

Pre-validation – the issuer has successfully created the URRT submission

Record Validated – this issuer has validated the URRT submission. Once the issuer has validated the submission, the issuer must request authorization if they need to revise the submission.

Pending Resubmission – the URRT submission has been “unlocked” to allow the issuer to upload a revision to one or more of the documents. The URRT submission needs to be re-validated after the revised documents have been uploaded.

Rate Filing Accepted – review of the URRT submission has been completed. If any revisions are necessary after the submission is put into this status, the submission will need to be deactivated and the issuer will need to create a new URRT submission

The URRT contains one or more rate increases that are subject to review

Pre-validation – the issuer has successfully created the URRT submission

Record Validated – this issuer has validated the URRT submission. Once the issuer has validated the submission, the issuer must request authorization if they need to revise the submission.

Pending Resubmission – the URRT submission has been “unlocked” to allow the issuer to upload a revision to one or more of the documents. The URRT submission needs to be re-validated after the revised documents have been uploaded.

Submission Filed – preliminary review of the submission has been completed by the appropriate regulator.

Review in Progress – submission is pending final determination.

Review Complete – final determination has been entered by the appropriate regulator.

How to Request a Revision to a URRT Submission

While a submission is in the “Pre Validation” status, the issuer may revise the submission at will.

Once the issuer has validated the submission, the issuer must request authorization if they need to revise the submission. To request authorization to revise the submission, send an email to ratereview@cms.hhs.gov with the following information:

- Submission tracking number.
- Description of the specific changes you are requesting. Include any necessary explanation of the revisions and the reasons the revisions are required.
- An indication that the appropriate regulator has authorized the requested revision.
- An indication of whether the submission contains any Exchange plans.
- An indication of whether the Index Rate will change as a result of the revisions to the submission.

If the requested revision is authorized, the issuer needs to re-validate the submission after the revised documents have been uploaded.

Guidance for Quarterly Rate Increases

This appendix provides guidance on a methodology for the completion of the Part I Unified Rate Review template in the small group market when an issuer chooses to file rates with predefined quarterly trend increases. The guidance provided is not the required methodology, but rather an example of how the template could be completed.

Premium rates for products in the small group market may be allowed to change on a quarterly basis for trend, if not prohibited by the state. If an issuer chooses to increase rates on a quarterly basis for trend, the issuer may file for trend increases for a specified period of time. However, the Index Rate for the projection period must be reflective of each of the trended rates effective during the period.

A methodology that could be used to calculate the Index Rate would be to develop a weighted average using each effective premium rate and the expected number of members at the corresponding premium level. This would be performed for each renewal month during the twelve month period. For example, in the template filed for a January effective date, the Index Rate would be calculated for each renewal month (January through December). The December rates in this example would be weighted with the expected enrollment for December renewals

for the twelve-month rating period from December of that year through November of the next year. The table below shows an example of this calculation and the Index Rate that could be entered into the Part I Unified Rate Review template.

The example is an issuer that wishes to change their small group rates on a quarterly basis using an annual trend of 5%. The template is submitted for a January 1 effective date.

	Effective Dates				
	January	April	July	October	Total Single Risk Pool
Member Months	1000	500	1000	500	3000
Base Allowed Claims	\$ 250.00	\$ 250.00	\$ 250.00	\$ 250.00	\$ 250.00
Months of Trend	24	27	30	33	
Annual Trend Rate	5%	5%	5%	5%	
Single Risk Pool Projected Allowed Claims	\$ 275.63	\$ 279.01	\$ 282.43	\$ 285.90	\$ 280.17
Index Rate Entered in January Template	\$ 280.17				
Effective Date Entered in January Template	1/1/xxxx				

The quarterly trend factor for each quarter should be included in the Part III Actuarial Memorandum, and support should be provided. Please see the instructions for the Part III Actuarial Memorandum for further information.

Product-Plan Data Collection

Company Legal Name:
HIC's Issuer ID:
Effective Date of Rate Change(s):

State:
Market:

Product/Plan Level Calculations

Section I: General Product and Plan Information	
Product	
Product ID	
Metal	
AV Metal Value	
AV Pricing Value	
Plan Type	
Plan Name	
Plan ID (Standard Component ID):	
Exchange Plan	
Historical Rate Increase - Calendar Year - 2	
Historical Rate Increase - Calendar Year - 3	
Historical Rate Increase - Calendar Year U	
Effective Date of Proposed Rates	
Rate Change % (over prior filing)	
Cum'lve Rate Change % (over 12 mos prior)	
Proj'd Per Rate Change % (over Expt. Period)	
Product Threshold Rate Increase %	

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total
inpatient	#REF!
Outpatient	#REF!
Professional	#REF!
Prescription Drug	#REF!
Other	#REF!
Capitation	#REF!
Administration	#REF!
Taxes & Fees	#REF!
Risk & Profit Charge	#REF!
Total Rate Increase	#REF!
Member Cost Share Increase	#REF!

Average Current Rate PMPM	#REF!
Projected Member Months	#REF!

Section III: Experience Period Information

Plan ID (Standard Component ID):	Total
Average Rate PMPM	#REF!
Member Months	#REF!
Total Premium (TP)	#REF!
EHB Percent of TP, [see instructions]	#REF!
state mandated benefits portion of TP that are other than EHB	#REF!
Other benefits portion of TP	#REF!
Total Allowed Claims (TAC)	#REF!
EHB Percent of TAC, [see instructions]	#REF!
state mandated benefits portion of TAC that are other than EHB	#REF!
Other benefits portion of TAC	#REF!
Allowed Claims which are not the issuer's obligation:	#REF!
Portion of above payable by HHS's funds on behalf of insured person, in dollars	#REF!
Portion of above payable by HHS on behalf of insured person, as %	#REF!
Total incurred claims, payable with issuer funds	#REF!
Net Amt of Reim	#REF!
Net Amt of Risk Adj	#REF!
Incurred Claims PMPM	#REF!
Allowed Claims PMPM	#REF!
EHB portion of Allowed Claims, PMPM	#REF!

Section IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total
Plan Adjusted Index Rate	#REF!
Member Months	#REF!
Total Premium (TP)	#REF!
EHB Percent of TP, [see instructions]	#REF!
state mandated benefits portion of TP that are other than EHB	#REF!
Other benefits portion of TP	#REF!
Total Allowed Claims (TAC)	#REF!
EHB Percent of TAC, [see instructions]	#REF!
state mandated benefits portion of TAC that are other than EHB	#REF!
Other benefits portion of TAC	#REF!
Allowed Claims which are not the issuer's obligation	#REF!
Portion of above payable by HHS's funds on behalf of insured person, in dollars	#REF!
Portion of above payable by HHS on behalf of insured person, as %	#REF!
Total incurred claims, payable with issuer funds	#REF!
Net Amt of Reim	#REF!
Net Amt of Risk Adj	#REF!

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850



Part III Actuarial Memorandum and Certification Instructions

February 3, 2014

Actuarial Memorandum and Certification

A Part III Actuarial Memorandum, including a corresponding actuarial certification, must be submitted with each Part I Unified Rate Review Template. Please see the instructions for completing the Part I Unified Rate Review Template for circumstances in which the template must be completed and for which products.

All issuers are required to set the Index Rate for an effective date of January 1 of each year, and file the Index Rate with the applicable regulatory authority. Subject to state requirements, small group issuers are allowed to file subsequent submissions that reset the Index Rate for the remaining quarters of the calendar year.

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I Unified Rate Review Template, which supports compliance with the market rating rules and reasonableness of applicable rate increases. All assumptions should be adequately justified with supporting data, where possible, or other rationale for the use of the chosen assumptions.

While these instructions outline the minimum requirements, issuers are encouraged to provide as much detail and supporting documentation as possible with their original submission to potentially reduce the amount of time in review. Additional information will be required if, given the facts and circumstances of the submission, the regulator determines that it is necessary to properly complete its review of the rate submission.

The actuarial memorandum must also capture appropriate actuarial certifications related to:

- the methodology used to calculate the AV Metal Value for each plan
- the appropriateness of the essential health benefit portion of premium upon which advanced payment of premium tax credits (APTCs) are based,
- the Index Rate is developed in accordance with federal regulations and the Index Rate along with allowable modifiers are used in the development of plan specific premium rates

State specific required information or certifications may also be included at the actuary's discretion. If an actuary chooses to exclude this information from the Part III Actuarial Memorandum, this information would need to be provided to the state regulatory agency, under separate cover.

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

ACA & MARKET RATING RULES - ALLOWABLE RATING & PRICING

Allowable rating methods and factors

- The Single Risk Pool should include ALL (non-grandfathered) covered persons (lives) an issuer has in a state, within a market (individual, small group or combined). This includes transitional products/plans for purposes of base rate experience used to demonstrate the single risk pool. The projection period should reflect experience of transitional policies to the extent the issuer anticipates the members in those policies will be enrolled in fully ACA-compliant plans during the projection period.
- The Index Rate is defined as the EHB portion of projected allowed claims divided by all projected single risk pool lives. As a result, the Index Rate should be the **same** value for ALL non-grandfathered plans for an issuer in a state and market. This includes claims and enrollment in transitional products/plans in the experience period and to the extent an issuer anticipates the members in those policies will be enrolled in fully ACA-compliant plans during the projection period. Note that if an issuer opted to continue policies under the President's transitional memorandum, experience for these policies should be included in the issuer's 2013 experience for developing rates for the 2015 year. Appropriate adjustments should be made in Worksheet 1 – Section II of the Unified Rate Review Template to bring these policies in line with all requirements of non-grandfathered policies projected in the Single Risk Pool in 2015. For example, in the projection period, include projected experience and membership at the point when these products become ACA-compliant and membership renews to the ACA-compliant plan, or at a point when the members in these plans move to an ACA-compliant plan, if the plans are closed to new membership in 2015.
- The Market Adjusted Index Rate is the Index Rate adjusted for Risk Adjustment, Reinsurance and Exchange Fees (with impacts and costs spread across the whole risk pool). As a result, the Market Adjusted Index Rate should be the **same** value for ALL non-grandfathered plans for an issuer in a state and market.
- The Plan Adjusted Index Rate is the Market Adjusted Index Rate further adjusted for plan specific factors allowed by 45 CFR Part 156.80(d)(2) such as provider network, utilization management, benefits in addition to Essential Health Benefits (EHBs), actuarial value and cost sharing, distribution and administrative costs (less Exchange fees) and catastrophic plan eligibility variation.
- Note, fees and costs are included in the premium and applied at the plan level as part of the distribution and administrative costs adjustment. The only exception is the application of the Exchange User fees, which are applied at the market level to the Index Rate. All other fees must be included in the development of the Plan Adjusted Index Rate, prior to the application of member level rating factors, such as age factors. No

additional fees may be charged outside of the development of the Plan Adjusted Index Rate. For example, if it costs an issuer \$35 to process an application, that cost must be included in the premium rate development of all policies (new issues and renewals) and subject to the member level rating factors such as age and geographic region factors. The issuer may not, in that example, charge a \$35 fee per policy for submission of the application.

- A calibration may be required to allow the rating factors to be directly applied in order to generate the Consumer Adjusted Premium Rates.

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

The calibration with respect to the age curve is allowed and identifies the value on the age curve associated with the weighted average age on the standard age curve. The Plan Adjusted Index Rate and the age curve can then be used to generate the schedule of premium rates for all ages for each plan. Calibration may be required for the geographic factors and tobacco factors. More detailed instructions are provided later in this document regarding the requirements for the calibration.

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

The result of this calibration process should be that the Plan Adjusted Index Rate calibrated for geography and tobacco (but not age), multiplied by the geographic factor for a given region should be similar to Premium Rate for that particular plan for a non-tobacco user in the given geographic region for the weighted average age (rounded to a whole number) of the projected single risk pool.

- The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual, family, or small employer group utilizing the rating and premium adjustments as articulated in the applicable Market Reform Rating Rules. The Consumer Adjusted Premium Rate is developed by calibrating the Plan Adjusted Index Rate to the age curve as described above, calibrating for geography and tobacco if necessary, and applying the allowable rating factors. Allowable rating factors are Age

(3:1 standard age curve or state specific age curve), Tobacco, Geography and Family tiering/structure, unless otherwise prohibited by state law.

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

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

Family structure takes into account family composition and the maximum of 3 child dependents. This is further clarified in regulation that the premium for family coverage is determined by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account; this adjustment does not result in a separate rating factor. Family tiering only occurs in states that use pure community rating and are uniformly applied to all plans in the risk pool (and published to the ccio.cms.gov website).

The following graphic depicts the flow of the rate development:



General Information

This section of the actuarial memorandum should include general information about the issuer and the policies which are the subject of the submission. The information provided in this section should include at least the following:

Company Identifying Information: State the following information that uniquely identifies the issuer submitting the memorandum. The information must be the same as the entries in the general information section of Worksheet 1 of the Part I Unified Rate Review Template (see the instructions for the Part I Unified Rate Review Template for additional definition of these fields):

- **Company Legal Name:** the organization's legal entity name associated with the HIOS Issuer ID
- **State:** the state that has regulatory authority over the policies
- **HIOS Issuer ID:** the HIOS ID assigned to the legal entity
- **Market:** the market in which the products and plans are offered
- **Effective Date:** the effective date of the change of the Index Rate

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

- **Primary Contact Name:** Provide the name of the person at the company who will serve as the primary contact for the submission. The regulator will contact this person if there are questions related to the information submitted, or if additional information is needed.
- **Primary Contact Telephone Number:** Provide the phone number for the primary contact
- **Primary Contact Email Address:** Provide the email address for the primary contact

Proposed Rate Increase(s)

In this section the actuary must provide information related to the proposed rate increase(s). If the proposed rate adjustment varies by product, the information provided should clearly identify which proposed adjustments apply to which products. Include all products which are part of the single risk pool, as defined by 45 CFR Part 156, §156.80, including those products for which no rate adjustment is being proposed. The information that must be provided includes the following items:

Reason for Rate Increase(s): Provide a narrative description of all significant factors driving a proposed rate increase. As an example, these factors could include but are not limited to:

- Single risk pool experience which is more adverse than that assumed in the current rates
- Medical inflation
- Increased utilization
- Prospective changes to benefits covered by the product or successor products
- New taxes and fees imposed on the issuer

- Anticipated changes in the average morbidity of the covered population that is market wide, as opposed to issuer specific morbidity that is reflected in risk adjustment
- Anticipated changes in payments from and contributions to the Federal Transitional Reinsurance Program

If the requested rate increase is not the same across all products and plans, provide a narrative discussion as to why the rate changes vary by product or plan given they are based on the same single risk pool of experience for the market.

Experience Period Premium and Claims

This section of the actuarial memorandum should include information related to the actuary's best estimate of premium and claims for the single risk pool during the experience period reported in Worksheet 1, Section I of the Part I Unified Rate Review Template.

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

Premiums (net of MLR Rebate) in Experience Period: Provide support for how the amount of premium earned during the experience period, net of MLR rebates to policyholders, was developed.

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

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

- Worksheet 1, Section I shows the actuary's best estimate of the amount of claims that were incurred during the 12-month experience period. Separately indicate the amount of claims which were processed through the issuer's claim system, processed outside of the issuer's claims system, and the amount that represents the actuary's best estimate of claims incurred but not paid as of the Paid Through Date stated above. This should be provided separately for Incurred Claims in Experience Period and Allowed Claims, as defined and reported on Worksheet 1, Section I.

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

Benefit Categories

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

Projection Factors

This section should include a description of each factor used to project the experience period allowed claims to the projection period, and supporting information related to the development of those factors. For each factor, the actuary should include a description of the source data or assumptions used, why they are appropriate for the single risk pool, and any applicable adjustments made to the data, such as considerations for issuer specific experience, industry or internal studies, benefit design and credibility of the source data. At a minimum, include support for the following factors:

Changes in the Morbidity of the Population Insured: Describe any adjustment factors applied to the experience period claims to account for anticipated differences in the average morbidity of the pooled population underlying the experience period and the issuer’s population anticipated to be insured in the projection period. These adjustments are shown in the “Pop’s risk Morbidity” column on Worksheet 1, Section II, and are in addition to the anticipated change in claims cost as a result of changes in the average mix by age and gender of the

covered population (which are shown in the “Other” adjustment column). The morbidity of the population could be impacted by items such as guarantee issue, an individual mandate to maintain coverage, expansion of Medicaid programs, and the introduction of a Basic Health Program.

Changes in Benefits: Describe the development of factors used to adjust the experience period claims to reflect the average benefits that will be covered during the projection period, including any newly mandated benefits. These changes are reflected in the “Other” adjustments column on Worksheet 1, Section II. The factors could adjust for items including but not limited to the following:

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

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

Other Adjustments: Describe any other adjustments, in addition to benefits and demographics which are specifically addressed above, that are reflected in the “Other” adjustments column on Worksheet 1, Section II. Also describe how these factors were developed.

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

- Normalization for changes in age
- Normalization for benefit changes that occurred during the period (Even if allowed claims are used to project trend a normalization adjustment may be warranted to account for the influence that changes in benefits have on utilization.)

- Adjustments for seasonality patterns underlying the claims that may skew calculated trends
- Normalization for any one-time events which are not anticipated to reoccur during the projection period
- Adjustments for anticipated changes in provider contracts that differ from those underlying the experience used
- For prescription drugs, any adjustments made to account for changes in the formulary, expiration of patents, or introduction of new drugs

Credibility Manual Rate Development

For issuers with experience period claims that are not determined to be fully credible, the use of other credible claims experience must be employed in developing a credibility manual rate for blending with the experience period claims. The actuary must provide information related to the other experience and general methodology used in developing the manual rate.

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

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

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

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

Credibility of Experience

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

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

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

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."*

Paid to Allowed Ratio

Provide support for the Paid to Allowed Average Factor in Projection Period for the market, shown in Worksheet 1, Section III. Demonstrate that the ratio is consistent with membership projections by plan included in Worksheet 2. The ratio for each plan should be relatively consistent with the metallic actuarial value for the plan to which the actuary is attesting, however it is recognized that they may not be exactly the same due to differences between the issuer's experience and the experience underlying the AV Calculator.

Risk Adjustment and Reinsurance

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

Projected Risk Adjustments PMPM:

Under the single risk pool pricing requirements issuers are required to make a market wide adjustment to the pooled market level Index Rate to account for federal risk adjustment and reinsurance payments. Consistent with this adjustment, anticipated risk adjustment revenue must be allocated proportionally based on plan premiums for all plans within a risk pool by

applying the risk adjustment transfer adjustment factor as a constant multiplicative factor across all plans. The risk adjustment transfer amount should be net of the risk adjustment fees.

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

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

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market and Combined Markets Only):

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

The Part I Unified Rate Review template requires issuers to report reinsurance payments net of reinsurance contributions. Issuers must describe the underlying experience data and assumptions that they used to develop their estimates of both reinsurance contributions and payments. In particular, issuers should provide an explanation of how they developed an estimate of their claims liability between the reinsurance attachment point and cap. Issuers should describe any key aspects of their enrolled population that significantly impacted their claims assumptions.

Issuers must also describe how they allocated their anticipated reinsurance payments net of reinsurance contributions across the plans in their risk pool (as noted above reinsurance revenue should be allocated proportionally based on premium). Issuers may provide supplemental exhibits that demonstrate how they estimated plan level reinsurance payments in order to demonstrate that they appropriately track with the Federal methodology for calculating reinsurance payments.

As only non-grandfathered policies in the individual market are eligible for payments under the transitional reinsurance program, in a combined market, the pooled reinsurance adjustment should be based only on the portion of the issuer's combined market business eligible for

reinsurance payments. Further, the transitional reinsurance program does not apply to policies renewed under the special transition policy.

State the assumed amount of the assessment as a PMPM amount.

Non-Benefit Expenses and Profit & Risk

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

For reporting purposes, the Administrative Expense Load should not include the Profit & Risk Load or the Taxes & Fees load, both described below, even though they are considered administrative expenses for the purposes of adjusting the Index Rate to arrive at premium in the pricing process.

It is suggested that the issuer 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.

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

Note that for pricing purposes, Profit & Risk Load is considered part of administrative expenses, per 45 CFR Part 156, §156.80(d). It is described separately in the actuarial memorandum to facilitate rate review.

Taxes and Fees: Describe each tax and/or fee and indicate the amount for each, either as a percent of premium or a per member per month amount. Describe only the taxes and fees that may be subtracted from premiums for purposes of calculating MLR. However, do not include any contributions to the Federal transitional reinsurance program or risk adjustment user fees in this amount despite their treatment in MLR calculations, since Federal reinsurance and risk adjustment are expressed in the template net of reinsurance premium and risk adjustment user fees. Any additional taxes and fees should be reflected in the Administrative Expense Load.

Note that for pricing purposes, Taxes & Fees (including Exchange user fees) are considered part of administrative expenses, per 45 CFR Part 156, §156.80(d). It is described separately in the actuarial memorandum to facilitate rate review.

Exchange user fees should be included in the template in Taxes and Fees. The issuer should provide a narrative verifying the exchange user fees are applied as an adjustment to the Index

Rate at the market level. A description of the process the issuer used to calculate the adjustment should be included. The value should reflect the expected mix of exchange and non-exchange enrollees.

Projected Loss Ratio

Indicate the projected loss ratio using the Federally prescribed MLR methodology. If the projected loss ratio is less than 80%, explain your plan to comply with the Federal MLR requirement found in PHSA 2718.

If the state requires a projected loss ratio demonstration, then such a demonstration should also be included.

Single Risk Pool

The issuer is required to provide support that the Single Risk Pool for in a particular state and market is established according to the requirements in 45 CFR part 156, §156.80(d). The Single Risk Pool reflects all covered lives for every non-grandfathered product/plan combination for an issuer in a state and market. The Single Risk Pool is specific to the legal entity for the state and market for which it is submitted.

The Single Risk Pool should include transitional products/plans for purposes of base rate experience used to demonstrate the single risk pool. The projection period should reflect experience of transitional policies to the extent the issuer anticipates the members in those policies will be enrolled in fully ACA-compliant plans during the projection period.

Index Rate

The issuer is required to provide support for the development of the Index Rate in both the experience period and the projection period. The Index Rate is specific to the legal entity for the state and market for which it is submitted. The Index Rate represents the estimated total combined allowed claims experience PMPM in the Single Risk Pool, and should not be adjusted for payments and charges under the risk adjustment and reinsurance programs, or for Exchange user fees.

The Index Rate is to be developed following the specifications of 45 CFR part 156.80(d)(1). The Index Rate is based on the total combined claim costs for providing the EHBs for the Single Risk Pool of that state market. The Index Rate is derived by dividing the total combined EHB allowed claims for the Single Risk Pool by all covered lives in the Single Risk Pool of that state market. Issuers must establish a single Index Rate for all product/plan combinations in the Single Risk Pool.

Issuers are required to provide detailed documentation of the development of the Index Rate in the Actuarial Memorandum.

Describe the difference between the total allowed claims PMPM and the Index Rate. For example, describe any covered benefits in excess of essential health benefits that are included in allowed claims but excluded from the Index Rate.

For Part I Unified Rate Review Template submissions with an Experience Period Start Date of January 1, 2014 or later, it is expected that the Index Rate of the Experience Period reported in Worksheet 1 be consistent with the Experience Period Allowed Claims PMPM. While these two amounts may not be identical due to the inclusion of non-EHB services in the Experience Period Allowed Claims PMPM, which would not be included in the Index Rate of the Experience Period, it is anticipated that these amounts would be developed on a consistent basis.

For Part I Unified Rate Review Template submissions with an Experience Period Start Date prior to January 1, 2014, provide the methodology used to develop the reported Index Rate of Experience Period. Describe how claims for benefits which were covered during the experience period but are not essential health benefits were identified and removed.

If the submission is for the individual or combined market, the Index Rate for Projection Period should reflect the twelve month projection period shown on Worksheet 1, Section II. If the submission is for the small group market and includes prospective trend adjustments (only if permitted by the state), then the Index Rate for Projection Period should reflect the member weighted average of the projected Index Rates applicable for each effective date in the submission. Show the projected trended Index Rate for each effective date in the submission.

The projected Index Rate must reflect the anticipated claim level of the projection period with respect to trend, benefit and demographics. It must reflect the experience of all policies expected to be in the single risk pool (with all necessary adjustments to reflect the benefits, market rules, etc. applicable to policies upon issue or renewal during the projection period). For transitional policies, the issuer should include those policies anticipated to be enrolled in a fully ACA-compliant during the projection period at a point when the members in these plans move to an ACA-compliant plan. If an issuer wants the renewal rates to increase with trend in the small group market as allowed by the state regulatory authority, the issuer may file the quarterly trend amounts for the twelve month period at one time. The quarterly trend factors applied to the issuer's rates should be included in the Part III Actuarial Memorandum. The Appendix to the Instructions for the Part I Unified Rate Review Template provides further guidance.

The Index Rate may only change at uniform intervals. All issuers are required to set the Index Rate for an effective date of January 1 of each year, and file the Index Rate with the applicable regulatory authority. Subject to state requirements, small group issuers are allowed to file subsequent submissions that reset the Index Rate for the remaining quarters of the calendar year.

For individual and combined market exchanges this will be annually. It is anticipated that Issuers in the small group market will be able to file for quarterly Index Rate changes starting with the third quarter of 2014.

While rate adjustments for the small group market may be filed on a quarterly basis (if permitted by the state), these interim filings could include adjustments for other items, such as new products, more recent experience period claims, etc. However, the rate development for these interim filings must be based on the single risk pool. For example, take an issuer with two cohorts of small employers that files on an interim quarterly basis. The small employers with young enrollees renew in January, while the small employers with older enrollees renew in April. The issuer's Index Rate in the applicable submissions would be derived as follows (assuming the same experience period is used for the two submissions with no projected changes to the population between the experience period and the projection period):

	January effective date	April effective date	Total Single Risk Pool
Member Months (2012)	1000	1000	2000
Base Allowed Claims (2012) PMPM	\$250	\$400	\$325
Months of Trend	24	27	
Annual Trend Rate	5%	5%	
Single Risk Pool Projected Allowed Claims (= $\$325 \times (1 + \text{Annual Trend})^{(\text{Months of Trend}/12)}$)	\$358.31	\$362.71	
Index Rate	\$358.31	\$362.71	

As shown in the table above, the projected Index Rate is based on the weighted average claims, benefit mix, demographic mix, etc. of the entire single risk pool, even if it is only submitted to be effective for a portion of the single risk pool (e.g., one quarter of renewals).

As described above, small group issuers may have the ability to file Part I Unified Rate Review Templates subsequent to the annual filing that resets the Index Rate for the remaining quarters of the calendar year. However, the change in the Index Rate is only allowed to occur for the remainder of the calendar year and subsequent submission is required at the beginning of the next calendar year.

For example, if a small group issuer submits the Part I Unified Rate Review Template for January 1, they may submit a subsequent Part I Unified Rate Review Template that resets the Index Rate effective July 1 of that same year. The Part I Unified Rate Review Template effective July 1 in this example is only allowed to contain a trend increase for

October 1 of that same year. Quarters after October 1 would be included in the next annual submission effective January 1 of the next calendar year.

Market Adjusted Index Rate

Issuers are required to include the Market Adjusted Index Rate.

The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(1). The following market-wide adjustments to the Index Rate are allowable under these rules:

- Federal reinsurance program adjustment (market-wide adjustment)
- Risk adjustment (market-wide adjustment)
- Exchange user fee adjustment (market-wide adjustment)

The issuer is required to provide an explanation of how these modifiers are developed and applied to the Index Rate to develop the Market Adjusted Index Rate. Similar to the Index Rate, the Market Adjusted Index Rate reflects the average demographic characteristics of the single risk pool. In other words, the Market Adjusted Index Rate is not calibrated.

However, the Market Adjusted Index Rate is not included in the Part I Unified Rate Review Template in 2015.

Plan Adjusted Index Rates

The Plan Adjusted Index Rates are included in Worksheet 2, Section IV of the Part I Unified Rate Review Template in 2015.

The Plan Adjusted Index Rate is calculated as the issuer Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(2). The following adjustments are allowable under these rules:

- Actuarial value and cost sharing adjustment (plan adjustment)
- Provider network, delivery system and utilization management adjustment (plan adjustment)
- Adjustment for benefits in addition to the EHBs (plan adjustment)

- Impact of specific eligibility categories for the catastrophic plan (plan adjustment)
- Adjustment for distribution and administrative costs (plan adjustment)

The issuer is required to provide an explanation of how these modifiers are developed and applied to the Market Adjusted Index Rate to derive the Plan Adjusted Index Rate. Note, fees and costs are included in the premium and applied at the plan level as part of the distribution and administrative costs adjustment. The only exception is the application of the Exchange User fees, which are applied at the market level to the Index Rate. All other fees must be included in the development of the Plan Adjusted Index Rate, prior to the application of member level rating factors, such as age factors. No additional fees may be charged outside of the development of the Plan Adjusted Index Rate. For example, if it costs an issuer \$35 to process an application, that cost must be included in the premium rate development of all policies (new issues and renewals) and subject to the member level rating factors such as age and geographic region factors. The issuer may not, in that example, charge a \$35 fee per policy for submission of the application.

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

Similar to the Index Rate and Market Adjusted Index Rate, the Plan Adjusted Index Rates reflect the average demographic characteristics of the single risk pool. In other words, the Plan Adjusted Index Rate is not calibrated.

Calibration

Issuers may need to calibrate the Plan Adjusted Index Rates (which are based on the single risk pool) to apply the allowable rating factors (i.e. age, geography, and tobacco) in order to calculate Consumer Adjusted Premium Rates. The calibration for each allowable rating factor is described below. It is important to note that there is ONLY ONE calibration value which is applied to all Plan Adjusted Index Rates. That is, the calibration may not vary by plan; it must be a common value to all plans in a state and market. Each calibration should be performed using a unique weighting; i.e., the geographic weighting will differ from the age weighting for determining the calibration factor. Once the calibration factor is determined it must be applied uniformly to all plans in a market and state.

Age Curve Calibration

Issuers must provide the approximate weighted average age, rounded to a whole number, associated with the projected single risk pool in the Actuarial Memorandum.

Issuers must provide a detailed explanation of the methodology used in the calibration to the age curve. Specifically, issuers should describe the factors used in the determination of the risk pool weighted average age, a description of data used to weight the factors and a description of the exact calculation. Issuers will need to provide actuarial justification that the methodology employed in the calculation of the average age and the calibration to the age curve complies with the standard age curve methodology and that it conforms with the rating rules specified in 45 CFR 147.102.

A demonstration of how the the Plan Adjusted Index Rate and the age curve are used to generate the schedule of premium rates for each plan should be included in the Actuarial Memorandum. Note, the age curve calibration adjustment is not plan specific. In other words, the same age curve calibration must be applied to all plans in the projected single risk pool.

Geographic Factor Calibration

The issuer is required to include a listing of all geographic rating factors applied to the Plan Adjusted Index Rate in the Actuarial Memorandum.

The issuer must provide the geographic factor calibration that is applied to the projected single risk pool if one is necessary. For example, if the weighted average of the geographic factors does not equal 1.0, calibration may be required.

A detailed description of the development of the geographic rating factors and a demonstration of how these factors are applied to the Plan Adjusted Index Rate is to be included in the Actuarial Memorandum. For example, if the weighted average of the geographic factors does not equal 1.0, the calibration adjustment that is applied should be included in the Actuarial Memorandum along with documentation of the calculation of the calibration adjustment. Note, the geographic calibration adjustment is not plan specific. In other words, the same geographic calibration would be applied to all plans in the projected single risk pool. If an issuer has multiple networks within a given rating area and wants to develop premiums specific for each network, the issuer must have a separate plan for each network with the rating area.

Tobacco Calibration

The issuer is required to include a listing of all tobacco rating factors applied to the Plan Adjusted Index Rate in the Actuarial Memorandum.

If the issuer uses tobacco factors, as allowed, the issuer must provide the tobacco calibration that is applied to the projected single risk pool.

A detailed description of the development of the tobacco rating factors and a demonstration of how these factors are applied to the Plan Adjusted Index Rate should be included in the Actuarial Memorandum. Note, the tobacco calibration adjustment is not plan specific. In other

words, the same tobacco calibration would be applied to all plans in the projected single risk pool.

The calibration adjustments are to be applied uniformly to all plans; plan specific calibration is not allowed.

Calibration adjustments are not found in the Part I Unified Rate Review Template in 2015.

Once the Plan Adjusted Index Rate is calibrated to the age curve using the weighted average age, the entire set of age rates is determined using the standard age factor of each age relative to the standard age factor for the rounded weighted average age. The age factors must be the standard age curve set by HHS or a state specific age curve (if the state requires different age factors than the standard federal age curve).

Issuers that calibrate the Plan Adjusted Index Rate as described in the previous section must calibrate the plans to in the Single Risk Pool consistently; **in other words the calibration cannot vary by plan.**

Issuers must apply these consumer level adjustments as described in §147.102 uniformly to all plans in the Single Risk Pool; **these adjustments cannot vary by plan.**

Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual, family, or small employer group utilizing the rating and premium adjustments as articulated in the applicable Market Reform Rating Rules. The Consumer Adjusted Premium Rate is developed by calibrating the Plan Adjusted Index Rate to the age curve as described above, calibrating for geography and tobacco if necessary, and applying the rating factors specified by 45 CFR Part 147, §147.102. The following adjustments are allowable under this rule:

- Whether the plan coverage covers an individual or family (issuers must cover any eligible individual and/or eligible family that requests coverage per the guaranteed issue requirement of the ACA); this is further clarified in regulation that the premium for family coverage is determined by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account; this adjustment does not result in a separate rating factor
- Rating area
- Age – reflecting the applicable age curve
- Tobacco status

The Actuarial Memorandum should describe how each allowable consumer level adjustment is applied to the Plan Adjusted Index Rate so that the reviewing actuary can readily use the information to approximate Consumer Adjusted Premium Rates filed by the issuer.

The Consumer Adjusted Premium Rates are not included in the Part I Unified Rate Review Template in 2015.

Small Group Plan Premium Rates

If an issuer files small group rates with trend, the Index Rate, the Market Adjusted Index Rate and the Plan Adjusted Index Rate reflect the member weighted average premium over the calendar year (see example in the Appendix of the instructions to the Part I Unified Rate Review Template). As such, in the development of the Consumer Adjusted Premium Rates for small group plans in this case, the Plan Adjusted Index Rate must be adjusted to reflect the appropriate quarter when the consumer level modifiers are applied. Issuers should provide the trend factors that apply to the weighted average Plan Adjusted Index Rates to develop the rates for each effective date included in the submission.

AV Metal Values

The issuer must describe whether the AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were entirely based on the AV Calculator, or whether an acceptable alternative methodology was used to generate the AV Metal Value of one or more plans. If an alternate methodology was employed to develop the AV Metal Value(s), the actuary must provide a copy of the actuarial certification required by 45 CFR Part 156, §156.135. The certification must be signed by a member of the American Academy of Actuaries, and must indicate that the values were developed in accordance with generally accepted actuarial principles and methodologies.

The actuary must indicate the reason an alternate methodology was used, explain why the benefits for those plans for which an acceptable alternative methodology was used are not compatible with the AV Calculator, and state the chosen alternate methodology that was used for each applicable plan. The actuary must describe the process that was used to develop the AV Metal Value.

Actuaries are encouraged to refer to applicable practice note(s) for guidance on alternate methods of calculating actuarial value.

AV Pricing Values

For each plan, indicate the portion of the AV Pricing Value that is attributable to each of the allowable modifiers to the Index Rate, as described in 45 CFR Part 156, §156.80(d)(2). If the adjustment for plan cost-sharing includes any expected differences in utilization due to these differences in cost sharing, describe in detail how the difference was estimated and how the methodology ensures that differences due to health status are not included in the adjustment.

Membership Projections

Describe how the membership projections found in Worksheet 2 of the Part I Unified Rate Review Template were developed. Items impacting these projections could include but are not limited to changes in the size of the market due to introduction of guarantee issue requirements (individual market), the individual mandate, expansion of Medicaid, and the introduction of a Basic Health Program.

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

For Silver level plans in the individual or combined markets, describe the methodology used to estimate the portion of projected enrollment that will be eligible for cost sharing reduction subsidies at each subsidy level. State the resulting projected enrollment by plan and subsidy level.

Terminated Products

List the name of each product that will be terminated prior to the effective date. Include both products that have experience included in the single risk pool during the experience period and any products that were not in effect during the experience but were made available thereafter.

Plan Type

In the event that the plan types listed in the drop-down box in Worksheet 2, Section I of the Part I Unified Rate Review Template do not describe an issuer's plan exactly and the issuer has selected the closest plan available, per the instructions, please describe the differences between the issuer's plan and the plan type selected.

Warning Alerts

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

Effective Rate Review Information (optional)

45 CFR Part 154 §154.301 describes the elements of an effective rate review program. There are elements of an effective rate review for which the data needed to perform the review is not explicitly shown on the Part I Unified Rate Review Template, e.g., the health insurance issuer's capital and surplus. Issuers may optionally provide additional information to facilitate an effective review of the submitted rate increase(s). While this information is optional, it is noted that providing the information with the initial submission reduces the likelihood of the reviewer requesting supplemental information during the course of the rate review. In addition, states may have additional data requirements. Additional state-required data may be submitted with the submission, or it may be provided to the state separately.

Reliance

If, in preparing the Part I Unified Rate Review Template submission, the certifying actuary relied on any information or underlying assumptions provided by another individual, the information relied upon and the name of the individual providing that information may be disclosed.

Actuarial Certification

An actuarial certification must be provided for the following:

- the methodology used to calculate the AV Metal Value for each plan,
- the appropriateness of the essential health benefit portion of premium upon which advanced payment of premium tax credits (APTCs) are based, and
- the Index Rate is developed in accordance with federal regulations and the Index Rate along with allowable modifiers are used in the development of plan specific premium rates.

State specific required information or certifications may also be included at the actuary's discretion. If an actuary chooses to exclude this information from the Part III Actuarial Memorandum, this information would need to be provided to the state regulatory agency under separate cover.

The opining actuary must be a member of the American Academy of Actuaries, in good standing, and have the education and experience necessary to perform the work. The actuary must develop rates in accordance with the appropriate Actuarial Standards of Practice (ASOPs) and the profession's Code of Professional Conduct. While other ASOPs apply, particular emphasis is placed on the following:

- ASOP No. 5, *Incurred Health and Disability Claims*
- ASOP No. 8, *Regulatory Filings for Health Plan Entities*
- ASOP No. 12, *Risk Classification*
- ASOP No. 23, *Data Quality*
- ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages*
- ASOP No. 26, *Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans*
- ASOP No. 41, *Actuarial Communications*

At a minimum, the actuarial certification must include the following:

1. Identification of the certifying actuary and a statement that he/she is a member of the American Academy of Actuaries

2. A certification that the projected Index Rate is:
 - a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
 - b. Developed in compliance with the applicable Actuarial Standards of Practice
 - c. Reasonable in relation to the benefits provided and the population anticipated to be covered
 - d. Neither excessive nor deficient
3. A certification that the Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.
4. A certification that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.
5. A certification stating that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans except those specified in the certification. If an alternate methodology was used to calculate the AV Metal Value for at least one plan offered, a copy of the actuarial certification required by 45 CFR Part 156, §156.135 must be included. The certification must be signed by a member of the American Academy of Actuaries, and must indicate that the values were developed in accordance with generally accepted actuarial principles and methodologies.

For purposes of rate review, also include the reason an alternate methodology was used, and the chosen alternate methodology that was used for each applicable plan. Describe the process that was used to develop the AV metal value.

The actuary may qualify the opinion, if desired, to state that the Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally facilitated exchanges and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Benefits Map

INSTRUCTIONS AND NOTES ON BENEFIT DOCUMENTATION

- 1 The purpose of the Benefits Map is to codify the principal elements that define each benefit package offered by the carrier to the Small Group and Individual markets. In most cases, cells have been limited to a pre-determined drop-down menu of selected values to promote uniformity among plan descriptions.

If more than three plans are offered please add additional tabs

- 2 The term *Cost-Sharing* applies to the mechanism by which member out-of-pocket contribution is determined, according to the type of service being rendered. Basic cost-sharing can be in the form of copayments (i.e. fixed dollar amounts), coinsurance (i.e. a fixed percentage of the cost of services), or front-end deductibles where the member covers 100% of the cost of services up to the defined deductible amount, after which point plan coverage begins. More complex cost-sharing can be in the form of mixed coinsurance and copayments, where minimum and maximum dollar amounts are in place around a base coinsurance amount (e.g. 20% coinsurance with a minimum \$15 copayment, or 25% coinsurance with a maximum copayment amount of \$300).
- 3 In some plan designs, reduced cost-sharing is available in the medical coverage if certain preferred facilities are utilized. If this is the case, indicate so by selecting 'Y' (yes) under the column '*Preferred Facility Y or N*' for the specified service category, and then enter the reduced cost-share (\$ or %) in the '*Preferred Facility Copay*' column beside the 'Y.'
- 4 For purposes of the Benefits Map, in order to indicate that a certain benefit is **NOT COVERED**, or that the member is in a *Deductible Phase* (as in the case of Rx Coverage with a front-end deductible), the *Member Cost-Share* should reflect COINSURANCE of 100% (i.e. the member pays 100% of the cost).
- 5 Some plan designs may contain a feature, such as a *Major Medical* rider, which allows the member to submit for reimbursement amounts paid for services rendered by non-participating providers. Some of these riders limit reimbursement to services rendered in Puerto Rico while others include services rendered in the United States. The Benefits Map allows plans to indicate whether they include such a rider, whether or not they cover U.S. services, and whether those services require prior authorization. Typically these riders carry an annual front-end deductible per individual (with a maximum deductible per family covered), followed by cost-sharing based on a defined member coinsurance amount. Often these riders contain a provision which caps member cost-sharing to an annual *Out-of-Pocket Maximum*, defined both at the individual and family contract levels.
- 6 Plans that cover Dental Services may carry Overall Annual Benefit Limits (*General Annual Limits*) and/or specific *Category Lifetime Limits* (such as for Orthodontia). Please indicate such limits as they may apply in the Dental Coverage section.
- 7 In the case of Prescription Drug Coverage, plans should indicate which rule applies to the dispensing of brand drugs which have a generic bioequivalent substitution (i.e. Multi-Source Brand Drugs). Select '*Generics Not Mandatory*' if members are not required to select a generic medication as a first option. Select '*Dispense As Written (D.A.W.)*' if the member is required (via a copay penalty) to select generics as a first option, but where such penalty is waived if the physician indicates "Do Not Substitute" on the prescription. Select '*\$ Penalty + Generic Copay*' if members are required to select generics as a first option (regardless of physician indications) or pay a copay penalty (usually the difference in price between the generic and brand versions), plus the amount of the generic copayment. If instead the amount of the penalty is added to the BRAND copay, then select '*\$ Penalty + Brand Copay*.'
- 8 Indicate other features of the Prescription Drug Coverage such as whether Step Therapy and/or Drug Formularies apply, and whether OTC medications are covered, along with the corresponding copay.
- 9 Since many prescription drug plan designs offer different levels of coverage at different expenditure levels throughout the policy year, the Benefits Map provides for up to three (3) different benefit phases in order to codify such plan designs. For example, a complex plan design may carry a \$500 front-end deductible before benefits kick in, later providing benefits at \$5 for generics and \$15 for brand drugs up until \$2,000 in annual expenditures. After that point, the plan design may only cover 50% of the cost of brand drugs, while covering generics with a flat copay of \$15. The Benefits Map provides the necessary parameters to codify this design by indicating 100% coinsurance (no coverage) in *Phase I* from \$0 to \$500, indicating \$5 Generic and \$15 Brand in *Phase II* from \$500 to \$2,000, and finally indicating \$15 Generic and 50% coinsurance for Brand in *Phase III* from \$2,000 to \$99,999. **Note: The limit of \$99,999 indicates that the given Rx benefit phase has no limit.**

Benefits Map

UNIFORM PLAN DESIGN TEMPLATE

General Info

Carrier Name:
NAIC Company Code:
OCS Contract Name:
Product Name:
Product Type (PPO, POS, HMO):
Product Effective Date:
Termination or Change Date:

Experience

Incurred Experience Period:
Claims Payment Period:
Member Months (Incurred Period):
Earned Premium:
Gross (Allowed) Claims (before Cost-Sharing):
Net Paid Claims (after Member Cost-Sharing):
Member Cost-Share (Gross less Net):

Medical Coverage

OFFICE VISITS

Generalist Copay:
Specialist Copay:
Sub-Specialist Copay:
Chiropractic (first visit):
Chiropractic Manipulation:
Physical Therapy:
Respiratory Therapy:

HOSPITAL / ASC FACILITY

Full Hospital Admission:
Partial Hospital Admission:
Ambulatory Surgical Center (ASC):

EMERGENCY VISITS

Accident / Trauma
w/o Nurse Triage Line:
with Nurse Triage Line:
Sickness & Other Urgency
w/o Nurse Triage Line:
with Nurse Triage Line:

DIAGNOSTIC

Standard Laboratory:
X-Ray:
MRI:
CT Scan:
PET Scan:
PET/CT:
Endoscopic:

SURGICAL (PROFESSIONAL)

Hospital Setting:
ASC Setting:
Office Setting:

Does this plan include Major Medical or other Supplemental Coverage?
If Yes, does the coverage include services rendered in the U.S.?
If U.S. services are covered, is pre-authorization required?

Applicable Member Coinsurance:
Per Individual Front-End Deductible & Max Deductible per Family:
Out-of-Pocket Maximum (Y or N):

Major Medical

Member Cost-Share \$ or %
Standard Copay / Coins
Preferred Facility Y or N
Preferred Facility Copay
Individual
Family

Attachment 4

Prescription Drug Coverage

Rule for Mandatory Generics:
Step Therapy Rule:
Prescription Drug Formulary:
OTC Coverage:

Rx Benefit Phase I

FROM: \$0 TO: \$0

Per Individual Front-End Deductible & Max Deductible per Family:
Out-of-Pocket Maximum (Y or N):

Individual
Family

Generic Not Mandatory
No Step Therapy Rule
No Rx Formulary
If so, OTC Copay:

Type of Rx Cost-Share % Coins Min Copay Max Copay

GENERIC DRUGS
Non-Preferred Generic:
Preferred Generic:

MULTI-SOURCE BRAND DRUGS
Preferred Multi-Source Brand:
Non-Preferred Multi-Source Brand:

SINGLE-SOURCE BRAND DRUGS
Preferred Single-Source Brand:
Non-Preferred Single-Source Brand:
Specialty/Biotechnological:

Rx Benefit Phase II
FROM: TO:

Type of Rx Cost-Share % Coins Min Copay Max Copay

GENERIC DRUGS
Non-Preferred Generic:
Preferred Generic:

MULTI-SOURCE BRAND DRUGS
Preferred Multi-Source Brand:
Non-Preferred Multi-Source Brand:

SINGLE-SOURCE BRAND DRUGS
Preferred Single-Source Brand:
Non-Preferred Single-Source Brand:
Specialty/Biotechnological:

Rx Benefit Phase III
FROM: \$0 TO: \$0

Type of Rx Cost-Share % Coins Min Copay Max Copay

GENERIC DRUGS
Non-Preferred Generic:
Preferred Generic:

MULTI-SOURCE BRAND DRUGS
Preferred Multi-Source Brand:
Non-Preferred Multi-Source Brand:

SINGLE-SOURCE BRAND DRUGS
Preferred Single-Source Brand:
Non-Preferred Single-Source Brand:
Specialty/Biotechnological:

Drop-Down Menu Items

VALUES DESCRIPTION

\$ % Flat Copay Level
Coinsurance Level

Y N Yes No

Flat Copay
Pure Coins
Coins w Min Copay
Coins w Min & Max Copay Only
Coinsurance Only
Coinsurance with a Minimum Copay Amount
Coinsurance with Minimum and Maximum Copay Amounts

No Benefit Limit
General Annual Limit
Category Annual Limit
Category Lifetime Limit No Dental Limit
Overall Benefit Limit per Year
Benefit Limit per Dental Category per Year
Benefit Limit per Dental Category per Lifetime

PPO
POS
HMO
Other Preferred Provider Organization (Free Access)
Point of Service Plan (PPO/HMO Hybrid)
Health Maintenance Organization (Managed Care with Gatekeeper)
Other health care delivery system

Generics Not Mandatory
Dispense As Written (D.A.W.)
\$ Penalty + Generic Copay
\$ Penalty + Brand Copay Generic Dispense is Optional to the Member
Physician May Indicate 'Do Not Substitute' w/o Penalty to Member
Member Pays Difference in Cost (between Gen & Brand) plus Generic Copay
Member Pays Difference in Cost (between Gen & Brand) plus Brand Copay

No Rx Formulary
Formulary Applies No Prescription Drug Formulary Applies to this Plan
Prescription Drug Formulary Applies to this Plan

No Step Therapy Rule
Step Therapy w Waiver
\$ Penalty + Gen Copay Step Therapy Not Required
Step Therapy Waived if Utilization Documented in the Last Six (6) Months
No Exceptions to Step Therapy Rule

List of Optional Benefits Included in the Premium

Benefits Map

UNIFORM PLAN DESIGN TEMPLATE

General Info	Carrier Name:	
	NAIC Company Code:	
	OCS Contract Name:	
	Product Name:	
	Product Type (PPO, POS, HMO):	
	Product Effective Date:	
	Termination or Change Date:	

Experience	Incurred Experience Period:	
	Claims Payment Period:	
	Member Months (Incurred Period):	
	Earned Premium:	
	Gross (Allowed) Claims (before Cost-Sharing):	
	Net Paid Claims (after Member Cost-Sharing):	
	Member Cost-Share (Gross less Net):	

Medical Coverage	Member Cost-Share \$ or %		Standard Copay / Coins		Preferred Facility Y or N		Preferred Facility Copay	
	OFFICE VISITS							
	Generalist Copay:	\$						
	Specialist Copay:	\$						
	Sub-Specialist Copay:	\$						
	Chiropractic (first visit):	\$						
	Chiropractic Manipulation:	\$						
	Physical Therapy:	\$						
	Respiratory Therapy:	\$						
	HOSPITAL / ASC FACILITY							
Full Hospital Admission:	\$							
Partial Hospital Admission:	\$							
Ambulatory Surgical Center (ASC):	\$							
EMERGENCY VISITS								
Accident / Trauma								
w/o Nurse Triage Line:	\$							
with Nurse Triage Line:	\$							
Sickness & Other Urgency								
w/o Nurse Triage Line:	\$							
with Nurse Triage Line:	\$							
DIAGNOSTIC								
Standard Laboratory:	%							
X-Ray:	%							
MRI:	%							
CT Scan:	%							
PET Scan:	%							
PET/CT:	%							
Endoscopic:	%							
SURGICAL (PROFESSIONAL)								
Hospital Setting:	%							
ASC Setting:	%							
Office Setting:	%							
Does this plan include Major Medical or other Supplemental Coverage?								
If Yes, does the coverage include services rendered in the U.S.?								
If U.S. services are covered, is pre-authorization required?								
Applicable Member Coinsurance:								
Individual								
Family								
Per Individual Front-End Deductible & Max Deductible per Family:								
Out-of-Pocket Maximum (Y or N):								
OOP Amounts:								

Major Medical

List of Optional Benefits Included in the Premium

Attachment 4

Prescription Drug Coverage	Rule for Mandatory Generics:	Generics Not Mandatory			
	Step Therapy Rule:	No Step Therapy Rule			
	Prescription Drug Formulary:	No Rx Formulary			
	OTC Coverage:	If so, OTC Copay:			
	Rx Benefit Phase I				
	FROM: \$0 TO: \$0				
	Individual				
	Family				
	Per Individual Front-End Deductible & Max Deductible per Family:				
	Out-of-Pocket Maximum (Y or N):				
OOP Amounts:					
Type of Rx Cost-Share % Coins Min Copay Max Copay					
GENERIC DRUGS					
Non-Preferred Generic:					
Preferred Generic:					
MULTI-SOURCE BRAND DRUGS					
Preferred Multi-Source Brand:					
Non-Preferred Multi-Source Brand:					
SINGLE-SOURCE BRAND DRUGS					
Preferred Single-Source Brand:					
Non-Preferred Single-Source Brand:					
Specialty/Biotechnological:					
Rx Benefit Phase II					
FROM: TO:					
Type of Rx Cost-Share % Coins Min Copay Max Copay					
GENERIC DRUGS					
Non-Preferred Generic:					
Preferred Generic:					
MULTI-SOURCE BRAND DRUGS					
Preferred Multi-Source Brand:					
Non-Preferred Multi-Source Brand:					
SINGLE-SOURCE BRAND DRUGS					
Preferred Single-Source Brand:					
Non-Preferred Single-Source Brand:					
Specialty/Biotechnological:					
Rx Benefit Phase III					
FROM: \$0 TO: \$0					
Type of Rx Cost-Share % Coins Min Copay Max Copay					
GENERIC DRUGS					
Non-Preferred Generic:					
Preferred Generic:					
MULTI-SOURCE BRAND DRUGS					
Preferred Multi-Source Brand:					
Non-Preferred Multi-Source Brand:					
SINGLE-SOURCE BRAND DRUGS					
Preferred Single-Source Brand:					
Non-Preferred Single-Source Brand:					
Specialty/Biotechnological:					

VALUES	DESCRIPTION
\$ %	Flat Copay Level Coinsurance Level
Y N	Yes No
Flat Copay Pure Coins Coins w Min Copay Coins w Min & Max	Copay Only Coinsurance Only Coinsurance with a Minimum Copay Amount Coinsurance with Minimum and Maximum Copay Amounts
No Benefit Limit General Annual Limit Category Annual Limit Category Lifetime Limit	No Dental Limit Overall Benefit Limit per Year Benefit Limit per Dental Category per Year Benefit Limit per Dental Category per Lifetime
PPO POS HMO Other	Preferred Provider Organization (Free Access) Point of Service Plan (PPO/HMO Hybrid) Health Maintenance Organization (Managed Care with Gatekeeper) Other health care delivery system
Generics Not Mandatory Dispense As Written (D.A.W.) \$ Penalty + Generic Copay \$ Penalty + Brand Copay	Generic Dispense is Optional to the Member Physician May Indicate 'Do Not Substitute' w/o Penalty to Member Member Pays Difference in Cost (between Gen & Brand) plus Generic Copay Member Pays Difference in Cost (between Gen & Brand) plus Brand Copay
No Rx Formulary Formulary Applies	No Prescription Drug Formulary Applies to this Plan Prescription Drug Formulary Applies to this Plan
No Step Therapy Rule Step Therapy w Waiver \$ Penalty + Gen Copay	Step Therapy Not Required Step Therapy Waived if Utilization Documented in the Last Six (6) Months No Exceptions to Step Therapy Rule

Plan Cost Summary (All Plan Designs Combined)

DETAIL OF NET COST AND MEMBER COST-SHARE BY SERVICE CATEGORY

Carrier Name:

NAIC Company Code:

	Net Paid Claims	Member Cost-Share	Total Gross Cost	Member Months	Service Count	% Net Claims	% Cost Share	Net Claims PMPM	Cost Share PMPM	Total Cost PMPM	Net Claims Per Serv	Cost Share Per Serv	Total Cost Per Serv
Medical Coverage Experience													
Generalist Office Visits						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Specialist Office Visits						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Sub-Specialist Office Visits						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Chiropractic Services						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Physical Therapy						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Respiratory Therapy						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Hospital Per Diem Expense						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Other Hospital Services						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Ambulatory Surgical						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Emergency - Accident/Trauma						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Emergency - Sickness/Urgency						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Standard Laboratory						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
X-Ray Services						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MRI Services						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
CT Scan Services						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
PET Scan Services						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
PET/CT Services						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Endoscopic Services						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Surgery - Hospital Setting						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Surgery - ASC Setting						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Surgery - Office Setting						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
All Other Medical Services						0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TOTAL MEDICAL SERVICES	\$ -	\$ -	\$ -			0%	0%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Major Medical Experience													
Services Rendered in PR								\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Services Rendered in US								\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TOTAL MAJOR MEDICAL SERVICES								\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Prescription Drug Experience													
Generic (Pref & Non-Pref)								\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Preferred Multi-Source Brand								\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Non-Preferred Multi-Source Brand								\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Preferred Single-Source Brand								\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Non-Preferred Single-Source Brand								\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Specialty/Biotechnological								\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TOTAL Rx DRUG SERVICES								\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Carrier Name:		
Date of Initial Filing:		
Is this Original or Replacement:		
NAIC Company Code:		
SERFF Tracking Number:		
Market:		
Item	File name, page or worksheet and section name	Carrier verified complete filing (initial)
Unified Rate Review Template (Excel and PDF)		
Public Form of the Rate Filing Information to be Placed on the OCI website (As a separated document in PDF)		
Brief description in simple language the reasons why the rate increase is being requested.		
Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in the rate increase summary		
Preliminary Justification Part II Requirements (Only for rate increases greater than 10%) As a separated document in PDF identified as Preliminary Justification Part II		
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 margins: Identify the main drivers of changes in administrative costs. Discuss how changes in anticipated administrative costs and underwriting gain/loss are impacting the rate increase		
Actuarial Memorandum meeting the requirements of Puerto Rico and the Federal 2014 Actuarial Memorandum and Certification Instructions 2.0 (Part III)		
General Information		
Company legal name		
HIOS issuer ID		
Market		
Effective date		
Primary contact name, telephone number, email address		
Item	File name, page or worksheet and section name	Carrier verified complete filing (initial)
Overview of Rate Increase		
Provide a brief explanation of why a rate increase is being requested and on what policy forms including the names of the policy forms affected.		
Describe the scope and driving factors impacting the rate increase including a description of how the rates were determined.		
Overview of products. This should be a description of type of products, benefits, marketing method, premium classifications, renewability, and underwriting method.		
Historical rate increase for last 3 years.		
Rate increase detailed information, including averages, minimum and maximum		

Provide a comparative table that shows the percent increase between the current rate and the proposed age-21 consumer rate per plan and overall, including averages, minimum and maximum (As separated document in Excel and PDF identified as "Comparative Table Rate Increase")		
Provide, in Excel, the procedure with the calculation used to determine the percentage increase in rates by plan and overall (As separated document in Excel and PDF identified as "Calculation demonstration of Rate Increase")		
Effective through date and any rate increase schedule applicable (small group only)		
Include all products which are part of the single risk pool, including those with no proposed rate adjustment		
Base Period Experience		
Explanation of the base period used indicating the basis of the data used, first and last incurred date included.		
Indicate paid through date		
Provide support for the development of the actuary's best estimate of allowed and paid claims incurred during the experience period		
Describe the treatment of large claims and claims pooling, if any.		
Treatment of commercial reinsurance, if any. This is separate from the Transitional Federal Reinsurance program, but is adjustments for commercial reinsurance purchased by the carrier to protect against the risk of large claims.		
Indicate the amount of MLR rebates refunded during experience period. (This must be consistent with the most recent MLR Report submitted to OCS)		
Exhibit showing current age distribution of the population and those anticipated for projection period. (As separated document in Excel and PDF identified as "Current and Proposed Age Distribution")		
Capitation Payments		
Describe what is covered by any capitation payments.		
Projection Factors		
Provide actuarial development of each factor used in the development of the rates, including an explanation of where the data used to determine each factor comes from. (As separated document in Excel and PDF identified as "Quantitative development of Factors for rating")		
Item	File name, page or worksheet and section name	Carrier verified complete filing (initial)
Provide documentation of all assumptions and methodologies used in the development of the impact of morbidity and enrollee mix.		
Provide in Excel, a comparative table of current copayments, coinsurance and deductibles for each submitted plan, versus the proposed copayments, coinsurance and deductibles structure of each plan. The table shall show changes in values for each service category and explain the impact in the proposed rates, including a quantitative demonstration and justification of the changes made. This comparison must be submitted even when no change has been made. (As separated document in Excel and PDF identified as "Comparative Table Cost Sharing Changes")		
If there were changes in the benefits covered, provide a description of all benefit changes and quantitative support of their impact.		
For each Essential Health Benefit (EHB) not covered previously, the additional cost per-member-per-month (PMPM) with an actuarial explanation in the Actuarial Memorandum of how the additional cost was developed. Pursuant to Section 2.050 (D) (1) (k) of the Health Insurance Code of Puerto Rico, any other service or mandatory benefit required by state or federal law or rule is considered a new essential health benefit. (As separated document in Excel and PDF identified as "Quantitative development of New EHB")		
Describe any optional benefit in addition to the basic EHB coverage in the Actuarial Memorandum, including a quantitative demonstration in Excel of the impact in rates, if any. (As separated document in Excel and PDF identified as "Quantitative development of optional additional benefits")		

For adjustment factors related to differences in demographics, if applicable, include a description of the source data or assumptions used, why they are appropriate for the single risk pool, and any applicable adjustments made to the data, such as considerations for issuer specific experience, industry or internal studies, benefit design and credibility.		
If there are other changes impacting rates, provide a description and quantitative documentation of all factors.		
Provide a description of all changes in the rating structure, if any, and provide quantitative support of their impact including all assumptions used.		
Provide quantitative support of the impact due to changes to network, if any.		
Provide quantitative documentation of the trend development including as well as an explanation of the data, assumptions, and periods used.		
Provide a quantitative development of the prescription drug benefit cost sharing design, including, prescription drug coverage experience for each plan design, claims paid by the carrier and cost share paid by the insured by drug type (ie. Generic, preferred brand, non-preferred brand, specialty). In addition, include a projection of the insured and carrier payment with the proposed prescription drug benefit cost sharing design, explaining the impact of the proposed cost sharing design on the final rates. Coinsurance of 90% or over in First level generic or brand names drugs must be actuarially justified for reasonableness. (As separated document in Excel and PDF identified as "Quantitative development of Prescription Drug coverage cost sharing design")		
Changes in medical cost trend by major service categories for the past three years and future projections.		
Item	File name, page or worksheet and section name	Carrier verified complete filing (initial)
Changes in the use of services by major service categories for the past three years and future projections.		
Please explain significant changes from the prior filing assumptions.		
Manual Rate Development, if applicable		
Describe the source data used to develop the manual rate and why such data is appropriate.		
Describe all adjustments made to the data underlying the development of the manual rate to account for differences in demographics, benefits and morbidity/ risk to ensure that that resulting manual rate is appropriate for blending with the adjusted experience period claims.		
Credibility		
Indicate the credibility methodology and credibility level of the base period experience.		
Paid to Allowed Ratio		
Provide a quantitative demonstration of the development of the paid to allowed ratio based on company specific projections. (As separated document in Excel and PDF identified as "Quantitative demonstration of Paid to Allowed")		
Non-Benefit Expense Projections		
Administrative Costs		
The methodology used to project administrative expenses, including gain/loss margins, should be explained.		
Identify the main factors that affect changes in administrative costs. Discuss how changes in projected administrative costs are impacting the rate increase and what is driving these changes.		
Actual administrative expenses PMPM for the last three years and explain any changes in administrative expenses from the prior filings.		
Breakdown of projected administrative expenses with any quality improvement costs separated.		
Discuss how and why the percentage administrative load varies by product or plan, if applicable		
Projected Gain/Loss Margins		
Describe the target underwriting gain/loss margin, and any additional risk margin		

To the extent that the target as a percent of premium has changed from the prior submission, provide additional support for why the change is warranted		
Discuss how the percentage load varies by product or plan, if applicable		
<i>Taxes and Fees</i>		
Describe each tax and/or fee and indicate the amount for each, either as a percent of premium and PMPM amount and a quantitative development.		
Provide an explanation of how taxes and fees were allocated across plans.		
<i>Medical Loss Ratio</i>		
Item	File name, page or worksheet and section name	Carrier verified complete filing (initial)
Provide a demonstration of the projected loss ratio using the federal rebate loss ratio formula including the values used.		
Describe how the credibility adjustment was determined, if applicable.		
If the projected loss ratio is less than federal requirement, explain the plan to comply with the Federal MLR requirement.		
<i>Index Rate</i>		
Provide an example procedure of determining a family rate. Demonstrate that this family rating complies with the federal rating rules of the ACA.		
For the catastrophic plan rate, describe the methodology used to estimate the adjustment reflecting differences in anticipated demographics and morbidity of the catastrophic population as compared to the single risk pool		
<i>AV Metal Values</i>		
The issuer must describe whether the AV Metal Values included were entirely based on the AV Calculator, or whether an acceptable alternative methodology was used to generate the AV Metal Value of one or more plans		
If an alternate methodology was employed to develop the AV Metal Value(s), the actuary must provide a copy of the actuarial certification required by 45 CFR Part 156, §156.135, as well as quantitative documentation of all adjustments and explanation of all differences that could not be accommodated using the AVC (Certification of Unique Plan Design)		
Provide all AVC screen shots		
<i>Plan-Adjusted Index Rate</i>		
Demonstrate in Excel with formulas how the projected market level index rate was adjusted to arrive at each plan level adjusted index rate. (As separated document in Excel and PDF identified as "Quantitative development of plan-adjusted index rate")		
<i>Consumer Adjusted Premium Rate</i>		
Quantitative development in Excel (with working formulas) of the Consumer Adjusted Premium Rate starting with the Plan-adjusted index rate (As separated document in Excel and PDF identified as "Quantitative development of consumer adjusted premium rate")		
<i>Membership Projections</i>		
Describe how the membership projections were developed		
Describe any differences between the distribution of projected member months relative to the current membership distribution		
<i>Company Financial Condition</i>		
Describe the financial situation of the company, including surplus, if any. Provide 5 years of RBC ratio levels.		
Provide historic loss ratios.		
<i>Terminated Products</i>		
Item	File name, page or worksheet and section name	Carrier verified complete filing (initial)
List the name of each product that will be terminated prior to the effective date including other products that have experience included in the single risk pool during the experience period and any products that were not in effect during the experience but were made available thereafter		

<i>Plan Type</i>		
In the event that the plan types listed in the drop-down box in Worksheet 2, Section I of the Part I Unified Rate Review Template do not describe an issuer's plan exactly and the issuer has selected the closest plan available, per the instructions, please describe the differences between the issuer's plan and the plan type selected.		
<i>Warning Alerts</i>		
Describe any difference between the sum of the plan level projections and the total projected amounts		
<i>Reliance</i>		
If 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 may be disclosed.		
<i>For All Small Groups Affected</i>		
Name of group		
Group's average rate increase		
Date of contract renewal		
Effective date of rate increase		
Federal Actuarial Certification		
Puerto Rico Certification Letter (Certification of Data Accuracy)		
SERFF Rates Template (Excel)		
Rating Manual		
Puerto Rico Benefits Maps for each plan		

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ATTACHMENT 6
REVISED 02/2023

COMPANY:
FORM(S) NUMBER:
SERFF TRACKING NUMBER:
MARKET TYPE

- ☐ Individual
☐ Small Group
☐ Large Group

Benefit	Description	Please specify location (Form/Page/Paragraph/ Other) of complying provision/language <u>or, attach explanation for an</u> <u>N/A response</u>	FOR OFFICIAL USE ONLY
Essential Health Benefits			
Air ambulance	Covered, No limits. Out of area air ambulance coverage is not covered.		
Allergy tests	(50) Test per policy year per enrollee ¹ . Vaccines not covered.		
Bariatric Surgery	Subject to preauthorization. It must be covered the payment of (1) of the types of the bariatric surgery per member for life in Puerto Rico, if the services are available. The types of bariatric surgery that may be covered are the following: gastric bypass, adjustable band or sleeve gastrectomy. Coverage is available only to a diagnostic of morbid obesity. Morbid obesity means is the excess fat in the body determined by a body mass index (BMI) greater or equal to 35. The insured and dependents may have to meet a waiting period of 12 months before the benefit is covered, unless the physician certifies that the patient's life is in imminent danger. The facility must have accreditation from the Joint Commission and one of two entities the American College of Surgeon or the American Society for Metabolic and Bariatric Surgery. Surgeries to remove excess skin (commonly known as flaps) are not covered, unless the physician certifies that it is necessary to remove excess skin, since it affects the functionality of a limb or body part.		
Biophysical profile	(1) Procedure per pregnancy.		
Chiropractic Care	(20) Physical therapies or manipulations covered under a combined limit per policy year per enrollee.		
Contraceptive methods	Covered, No limits.		
Cryo-surgery of the uterus	(1) procedures per year per enrollee.		
Delivery and All Inpatient Services for Maternity Care	Delivery of baby (48) hour minimum length for vaginal delivery and (96) for cesarean delivery. Covered for main enrollee, spouse and dependent daughter.		
Dental Check-Up for Children	Dental checkup and cleanings (2) per policy year per member (every (6) months); bitewings and periapicals no more than one set every 3 years.		

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Diagnostic Test (X-Ray and Lab Work)	No Limits. The reproduction of X-Rays must be covered. Laboratories related to infertility problems are covered as long as the same are laboratories covered in the policy.		
Dialysis and hemodialysis	(90) Days. Services related to any type of dialysis or hemodialysis, as well as services for any complication that may arise and their corresponding hospital or medical-surgical services. Will be covered for the first (90) days from: a) the date in which the member became eligible for the policy during the first time or, b) the date in which he/she received the first dialysis and hemodialysis. This will apply when subsequent dialysis or hemodialysis are related to the same clinical conditions. These services must be covered for inpatient and outpatient services.		
Durable Medical Equipment	Covered with a preauthorization from plan rental or purchase or oxygen and necessary equipment for its administration/wheelchair/hospital bed. Mechanical respirators and ventilators are covered without limits as required by Law No. 62 of May 4, 2015 to member's patients under age of (21) and those who have started treatment as minors and meet (21) years and who received medical services or receive home care will continue to receive these services after (21) years of age. Coverage include also the following benefits: technological equipment necessary to enable the insured to stay alive; at least one daily shift of (8) hours of skilled nursing services with expertise in respiratory therapy or respiratory therapy specialists with expertise in nursing; supply that involve the management of the technological equipment; physical and occupational therapy.		
Emergency Room Services	No Limits. No preauthorization or waiting period required. Emergency services for out-network providers cannot be covered through reimbursement. Limitations indicating that the emergency service must be received during the first 24 hours are not accepted. Carrier with emergency telephone lines that offers waiver or a lower copayment or coinsurance if the member calls to such line cannot make any difference between an in-network or out-network provider.		
Emergency Transportation/Ambulance	Services requested through the 9-1-1 Emergency System, covered and paid directly to the provider. Other transportation services (i.e. transportation between institutions) covered by reimbursement up to \$80 per trip.		

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Eye Glasses for Children	(1) pair of glasses (lenses and frames per year per member), supplemented using FEDVIP. Low Vision coverage - Glasses for member until age (21). (1) pair per policy year per member within the contracted collection, including high-powered glasses to policyholders with significant loss of vision, but do not have totally blind. Also covers one item per year per member, visual aids (prescription lenses, telescopes single or double lens) to policyholders up to age (21) with significant loss of vision, but do not have totally blind. Services related to Eye glasses cannot be provided through reimbursement, discounts or allowance.		
Gastrointestinal endoscopies	Covered, No Limits.		
Generic Drugs	Subject to a Drug List, Generics as a first option. Some medications may require preauthorization, age limits, quantity limits, specialty limits and/or step therapy. Drugs related to mental health conditions cannot include limitations indicating that a specific drug must be prescribe by a psychiatrist or neurologist. Not all the drugs related to mental/behavioral health conditions can be manage through a specialty limit.		
Habilitation Services	(20) Physical therapies or manipulations covered under a combined limit per year. Services limited to physical therapies, except for those covered under home health care benefit.		
Home Health Care Services	(40) physical, occupational and speech therapy under a combined limit per policy year per member. Covered only if they begin 14 days after members discharge from hospital of at least (3) days and if they are provided for the same condition by he/she was admitted.		
Imaging (CT/PET Scans, MRIs)	For PET & PET/CT, (1) Per policy year per enrollee. For MRI & CT, (1) per anatomical region per policy year per enrollee.		
Inpatient Hospital Services (e.g., Hospital Stay)	Excludes services for personal comfort and or custodial services. Hospitalizations for services or procedures that may be performed in an outpatient services are not covered.		
Inpatient Physician and Surgical Services	Covered, No Limits.		
Intra-articular injections	(12) Injections per policy year per member, up to (2) daily injections.		
Invasive cardiovascular, non-invasive cardiovascular procedures and tests	Electromyograms covered up to (2) procedures per year per enrollee.		
Lithotripsy	Covered, No limits		

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Mental/Behavioral Health Inpatient Services	Residential treatment outside service area is not covered. No limit in accordance to the Mental Health Parity Act. Limitations indicating that these services must be received or coordinate through an specific company or program are not accepted.		
Mental/Behavioral Health Outpatient Services	No limit in accordance to the Mental Health Parity Act. Limitations indicating that these services must be received or coordinate through an specific company or program are not accepted.		
MRA	Covered, No limits.		
Nerve conduction velocity tests	(2) Procedures per policy year per enrollee.		
Neurological tests and procedures	Covered, No limits.		
Non-Preferred Brand Drugs	Subject to a Drug List, Generics as a first option. Some medications may require preauthorization, age limits, quantity limits, specialty limits and/or step therapy. Drugs related to mental health conditions cannot include limitations indicating that a specific drug must be prescribe by a psychiatrist or neurologist. Not all the drugs related to mental/behavioral health conditions can be manage through a specialty limit.		
Nuclear medicine tests	Covered, No Limits.		
Nutritionist services	(4) Per policy year per enrollee. Limited to morbid, renal and diabetes conditions. Covered by reimbursement up to \$20 per visit.		
Oral, Intravenously, Injectable or Intrathecal chemotherapy	Covered, No Limits. Antineoplastic agents cannot be excluded from the basic coverage. These services must be covered for inpatient and outpatient services.		
Orthognatic surgery	Expenses related for materials are excluded.		
Other Practitioner Office Visit (Nurse, Physician Assistant)	Non physician professionals or doctors in odontology including nurse and physician assistant except those required by local law such as: podiatrist, audiologist, optometrist, clinical psychologists and chiropractors.		
Out of area coverage (US)	Services are covered for emergency cases or cases that required equipment, treatment and facilities not available in Puerto Rico. Services are subject to preauthorization from the plan except for an emergency. Elective treatments, not considered as an emergency, are not covered by this policy. Rates to be paid are the usual and customary (UCR) rate of the geographical area in which the services are provided, would have to be paid directly to the provider.		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Services rendered in an outpatient facility that may be performed in physician's office are not covered.		

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Outpatient Rehabilitation Services	(20) Physical therapies or manipulations covered under a combined limit per policy year per enrollee. Services not covered include occupational, speech and language therapies, prosthetics and implants, orthopedics and orthotic devices, cardiac rehabilitation. Occupational, speech and language therapies must be covered for autism condition and for home health care services. Services limited to physical therapies, except for those covered under home health care benefit.		
Outpatient Surgery Physician/Surgical Services	Excludes: Cosmetic surgery, oral surgery that is dental in origin except those as a result of an accident, mammoplasty (except those required for patients after a breast cancer mastectomy), septoplasty, blepharoplasty, rinoseptoplasty, procedures to re- establish the ability to procreate, organ transplant procedures, other than the specified in the transplant services benefit (other organ transplant may be covered as an optional benefit), induced abortion, experimental procedures, skin tags removal, ptosis repair, nail excisions, scalenotomy, Lasik and other surgical procedures to correct refractive defects, surgical assistance services, intravenous analgesia services or analgesia administered through inhalation at the physician or dentist's office, services for the treatment of the temporomandibular articulation syndrome, excision of granulomas or radicular cysts originated by infection in the tooth pulp; services to correct the vertical dimension or occlusion, removal of exostosis (mandibular or maxillary).		
Polysomnography	(1) Type of test per lifetime per enrollee.		
Preferred Brand Drugs	Subject to a Drug List, Generics as a first option. Some medications may require preauthorization, age limits, quantity limits, specialty limits and/or step therapy. Drugs related to mental health conditions cannot include limitations indicating that a specific drug must be prescribe by a psychiatrist or neurologist. Not all the drugs related to mental/behavioral health conditions can be manage through a specialty limit.		
Prenatal and Postnatal Care	Covered for mainholder, spouse and dependent daughter.		
Preventive Care/Screening/Immunization	Preventive care that meets recommendations described below, as established by the USPSTF.		
Primary Care Visit to Treat an Injury or Illness	Covered, No Limits.		
Radiation therapy	Covered, No Limits. These services must be covered for inpatient and outpatient services.		

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Routine Dental Services (Adult)	Dental checkup and cleaning (2) per policy year per member (every (6) months); bitewings and periapicals no more that one set every (3) years. (Optional coverage; Orthodontic, Periodontics, Endodontic, prosthetic dental services, Full mouth reconstructions, Fluoride treatment covered to members under age (19) and Root canal only to anterior and posterior teeth.)		
Routine Eye Exam (Adult)	Refraction exam is covered (1) per year, per member.		
Routine Eye Exam for Children	(1) Visit per year supplemented using FEDVIP.		
Routine Foot Care	Covered, No Limits.		
Skilled Nursing Facility	Covered only if they begin (14) days after member's discharge from hospital of at least (3) days and if they are provided for the same condition by he/she was admitted. Maximum of (120) days.		
Specialist Visit	Covered, No Limits.		
Specialty Drugs	Subject to a Drug List, Generics as a first option. Some medications may require preauthorization, age limits, quantity limits, specialty limits and/or step therapy. Drugs related to mental health conditions cannot include limitations indicating that a specific drug must be prescribe by a psychiatrist or neurologist. Not all the drugs related to mental/behavioral health conditions can be manage through a specialty limit.		
Sterilization	Covered, No Limits.		
Substance Abuse Disorder Inpatient Services	No limits in accordance to the Mental Health Parity Act. Include Detox and Residential treatment services. Residential treatment outside service area is not covered. Partials are included: (2) partial hospital days equivalent to (1) regular day. Limitations indicating that these services must be received or coordinate through an specific company or program are not accepted. Expenses for services resulting from the administration of an employer drug detection program are not covered. However, after the enrollee's participation in any treatment related to a positive outcome in the employer drug detention program, he/she is eligible for treatment under the contract. Language indicating that the emergency services must be received during the first 24 hours is not accepted. Not all the drugs related to mental/behavioral health conditions can be manage through a specialty limit.		

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Substance Abuse Disorder Outpatient Services	No limits in accordance to the Mental Health Parity Act. Limitations indicating that these services must be received or coordinate through an specific company or program are not accepted. Expenses for services resulting from the administration of an employer drug detection program are not covered. However, after the enrollee's participation in any treatment related to a positive outcome in the employer drug detention program, he/she is eligible for treatment under the contract. Language indicating that the emergency services must be received during the first 24 hours is not accepted. Not all the drugs related to mental/behavioral health conditions can be manage through a specialty limit.		
Transplant Services	Benefit covers skin, bone and corneal transplants. Coverage extends to charges directly related to the transplant service, including care prior to surgery, post-surgery care and treatment in respect of immunosuppressive drugs. Services are covered only through participating providers. Pre authorization is required. This benefit will be covered 100% in Puerto Rico and should not be available through reimbursement.		
Tympanometry	(1) Per policy year per enrollee.		
Urgent Care Centers or Facilities	No Limits. No preauthorization or waiting period required.		
Covered Preventive Services for Adult (NO COST SHARING IS APPLICABLE) **ADULTS PREVENTIVE SERVICES MUST BE INCLUDED IN THE SAME ORDER AND DESCRIPTION ESTABLISHED IN THIS CHECKLIST**			
Abdominal Aortic Aneurysm	(1) time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men aged (65) to (75) who have ever smoked.		
Colorectal Cancer	The USPSTF recommends screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age (45) years and continuing until age (75) years. The risks and benefits of these screening methods vary. Also, USPSTF recommends of a follow-up colonoscopy after a positive result from a non-invasive test. This test is a screening test and so patients will not have any out-of-pocket costs.		

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Depression screening for Adults	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.		
Falls prevention in older adults: Vitamin D	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.		
Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.		
Hepatitis B Virus Infection screening	The USPSTF recommends screening for hepatitis B virus (HBV) infection in adults at increased risk for infection.		
Hepatitis C virus infection screening: Adolescents and Adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years.		
Hypertension Screening in Adults 18 years or older without known hypertension	The USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement. The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.		
HIV preexposure prophylaxis for the prevention of HIV infection	The USPSTF recommends that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.		
HIV screening: nonpregnant adolescents and adults	Clinicians screening for HIV infection in adolescents and adults ages (15) to (65) years. Younger adolescents and older adults who are at increased risk should also be screened. As required by Law 45-2016 one HIV test a year as part of the routine studies for any medical evaluation, except for pregnant women to which apply the requirements of the USPSTF. You should consider the recommendations set out in the Department of Health's HIV regulations.		

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Immunization	Vaccines for adults-doses, recommended ages, and recommended populations vary: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella. Catch ups must be covered. COVID-19 vaccine as part of preventive immunizations for adolescents over 16 years of age and adults, according to the order established by the Puerto Rico Department of Health and the recommendations of the Advisory Committee on Immunization Practices (ACIP), of the Centers for Disease Control and Prevention (CDC), in accordance with Article 2.050 (C) of the Health Insurance Code of Puerto Rico.		
Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults ages (50) to (80) years who have a (20) pack-year smoking history and currently smoke or have quit within the past (15) years. Screening should be discontinued once a person has not smoked for (15) years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.		
Obesity screening and counseling: adults	The USPSTF recommends that clinicians offer or refer adults with a body mass index of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.		
Prediabetes and Type 2 Diabetes Screening in asymptomatic adults aged 35 to 70 years who have overweight or obesity	The USPSTF recommends screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who have overweight or obesity. Clinicians should offer or refer patients with prediabetes to effective preventive interventions.		

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Sexually Transmitted Infections (STI) Counseling	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs).		
Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication	The USPSTF recommends that clinicians prescribe a statin for the primary prevention of CVD for adults aged 40 to 75 years who have 1 or more CVD risk factors (i.e. dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk of a cardiovascular event of 10% or greater.		Updated
Syphilis Infection in Nonpregnant Adolescents and Adults: Screening	The USPSTF recommends screening for syphilis infection in asymptomatic persons, nonpregnant adolescents and adults who are at increased risk for infection.		Updated
Tobacco Smoking cessation and Medication: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to nonpregnant adults who use tobacco. For those who uses tobacco cessation products, this plan cover the dispatch of FDA approved medication for smoke cessation for (90) consecutive days in one intent and until (2) intents per year. The recommendation does not established any difference on the medication for smoke cessation tier. If the formulary include the drug no cost sharing can be applied regardless the specific tier.		
Tuberculosis screening: adults	The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk.		

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Unhealthy alcohol use: adults	The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.		
Unhealthy Drug Use: adults	The USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)		
Covered Preventive Services for Women, Including Pregnant (NO COST SHARING IS APPLICABLE) **WOMENS PREVENTIVE SERVICES MUST BE INCLUDED IN THE SAME ORDER AND DESCRIPTION ESTABLISHED IN THIS CHECKLIST**			
Asymptomatic Bacteriuria Screening: pregnant persons	The USPSTF recommends screening for asymptomatic bacteriuria using urine culture in pregnant persons.		
BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing	The USPSTF recommends that primary care clinicians assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing.		
Breast Cancer Preventive Medication Use to Reduce Risk	The USPSTF recommends that clinicians offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer aged 35 years or older and at low risk for adverse medication effects.		
Breast Cancer Screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older. The USPSTF recommends biennial screening mammography for women aged (50) to (74) years.		

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Breastfeeding	Comprehensive lactation support services (including consultation; counseling; education by clinicians and peer support services; and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods to optimize the successful initiation and maintenance of breastfeeding. Breastfeeding equipment and supplies include, but are not limited to, double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies. Access to double electric pumps should be a priority to optimize breastfeeding and should not be predicated on prior failure of a manual pump. Breastfeeding equipment may also include equipment and supplies as clinically indicated to support dyads with breastfeeding difficulties and those who need additional services. No monetary limits apply. Breastfeeding equipment and supplies cannot be provided through reimbursement or in the optional Major Medical coverage.		
Cervical Cancer Screening	The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).		
Chlamydia Screening in all sexually active women, including pregnant persons	The USPSTF recommends screening for chlamydia in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection.		

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Contraception	All Food and Drug Administration approved, granted or cleared contraceptive methods, sterilization procedures, screening, patient education, counseling and provision of contraceptives (including in the immediate postpartum period) for all women with reproductive capacity as prescribed. Contraceptives care also includes follow-up care. The full range of contraceptives includes those currently listed in the FDA's Birth Control Guide and any additional contraceptives approved, granted or cleared by the FDA. Any device insertion and removal of contraceptive methods is covered. Contraceptives methods cannot be provided through reimbursement. The Health Insurance Code of Puerto Rico, neither the federal applicable law established any difference in contraceptive tiers. If the formulary include the contraceptive no cost sharing can be applied regardless the specific tier.		
Counseling for Healthy Weight and Weight Gain in Pregnancy: Pregnant Persons	The USPSTF recommends that clinicians offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.		
Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening: women of reproductive age	The USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age and provide or refer women who screen positive to ongoing support services.		
Folic Acid	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing (0.4) to (0.8) mg (400 to 800pg) of folic acid.		
Diabetes in Pregnancy	The Women's Preventive Services Initiative (WPSI) recommends screening pregnant women for gestational diabetes mellitus (GDM) after 24 weeks of gestation (preferably between 24 and 28 weeks of gestation) to prevent adverse birth outcomes. The WPSI recommends screening pregnant women with risk factors for type 2 diabetes or GDM before 24 weeks of gestation—ideally at the first prenatal visit.		
Gonorrhea Screening in all sexually active women, including pregnant persons	The USPSTF recommends screening for gonorrhea in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection		

Updated

* Page number range are not accepted (i.e. 28-32)

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GOVERNMENT OF PUERTO RICO
OFFICE OF THE COMMISSIONER OF INSURANCE
ESSENTIAL HEALTH BENEFIT AND PREVENTIVE SERVICES CHECKLIST

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Hepatitis B Screening: Pregnant women	Screening for pregnant women at their first prenatal visit.		
Human Immunodeficiency Virus (HIV) screening: Pregnant persons	The USPSTF recommends that clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown. Regarding pregnant women, all insurers or health services organizations are required to cover and will not impose cost-sharing requirements with regard to the following tests included in the most recent recommendations of the USPSTF: 1) A first HIV test during the first trimester of pregnancy at the first prenatal visit, and 2) A second test during the third trimester of pregnancy (between the (28) and (34) weeks of pregnancy).		
Screening for Human Immunodeficiency Virus Infection (HIV)	All adolescent and adult women, ages 15 and older, receive a screening test for HIV at least once during their lifetime. Earlier or additional screening should be based on risk, and rescreening annually or more often may be appropriate beginning at age 13 for adolescent and adult women with an increased risk of HIV infection. Risk assessment and prevention education for HIV infection beginning at age 13 and continuing as determined by risk. A screening test for HIV is recommended for all pregnant women upon initiation of prenatal care with rescreening during pregnancy based on risk factors. Rapid HIV testing is recommended for pregnant women who present in active labor with an undocumented HIV status. Screening during pregnancy enables prevention of vertical transmission.		
Obesity Prevention in Midlife Women	Counseling midlife women aged 40 to 60 years with normal or overweight body mass index (BMI) (18.5-29.9 kg/m2) to maintain weight or limit weight gain to prevent obesity. Counseling may include individualized discussion of healthy eating and physical activity.		
Osteoporosis screening: postmenopausal women younger than 65 years at increased risk of osteoporosis	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.		
Osteoporosis screening: women 65 years and older	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older.		

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Perinatal depression: counseling and intervention	The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.		
Preeclampsia prevention: aspirin in pregnant persons at high risk for preeclampsia	The USPSTF recommends the use of low-dose aspirin (81 mg/day) as preventive medication after 12 weeks of gestation in persons who are at high risk for preeclampsia.		
Preeclampsia screening	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.		
RH Incompatibility screening	Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy- related care. Also, repeated Rh (D) antibody testing for all unsensitized Rh (D)- negative women at (24)-(28) weeks gestation, unless the biological father is known to be Rh (D)-negative.		
Screening for anxiety	The Women's Preventive Services Initiative recommends screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum. Optimal screening intervals are unknown and clinical judgement should be used to determine screening frequency. Given the high prevalence of anxiety disorders, lack of recognition in clinical practice, and multiple problems associated with untreated anxiety, clinicians should consider screening women who have not been recently screened.		

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Diabetes after pregnancy	The Women's Preventive Services Initiative (WPSI) recommends screening for type 2 diabetes in women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes. Initial testing should ideally occur within the first year postpartum and can be conducted as early as 4–6 weeks postpartum. Women who were not screened in the first year postpartum or those with a negative initial postpartum screening test result should be screened at least every 3 years for a minimum of 10 years after pregnancy. For those with a positive screening test result in the early postpartum period, testing should be repeated at least 6 months postpartum to confirm the diagnosis of diabetes regardless of the type of initial test (eg, fasting plasma glucose, hemoglobin A1C, oral glucose tolerance test). Repeat testing is also indicated for women screened with hemoglobin A1C in the first 6 months postpartum regardless of whether the test results are positive or negative because the hemoglobin A1C test is less accurate during the first 6 months postpartum.. Women who were not screened in the first year postpartum or those with a negative initial postpartum screening test result should be screened at least every 3 years for a minimum of 10 years after pregnancy. For those with a positive screening test result in the early postpartum period, testing should be repeated at least 6 months postpartum to confirm the diagnosis of diabetes regardless of the type of initial test (eg, fasting plasma glucose, hemoglobin A1C, oral glucose tolerance test). Repeat testing is also indicated for women screened with hemoglobin A1C in the first 6 months postpartum regardless of whether the test results are positive or negative because the hemoglobin A1C test is less accurate during the first 6 months postpartum.		
Syphilis screening: pregnant women	Early screening for syphilis infection in all pregnant women.		

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Screening for urinary incontinence in women	The Women's Preventive Services Initiative recommends screening women for urinary incontinence as a preventive service. Factors associated with an increased risk for urinary incontinence include increasing parity, advancing age, and obesity; however, these factors should not be used to limit screening. Several screening tools demonstrate fair to high accuracy in identifying urinary incontinence in women. Although minimum screening intervals are unknown, given the prevalence of urinary incontinence, the fact that many women do not volunteer symptoms, and the multiple, frequently-changing risk factors associated with incontinence, it is reasonable to conduct annually.		
Tobacco Smoking cessation: Pregnant Persons	The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.		
Well-woman visits	Well-woman preventive care visit annually (depending on the woman's health status, health needs and other risk factors) for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care and interpregnancy visits. This well-woman visit should, where appropriate, include other preventive services listed. If the clinician determines that a patient requires additional well-woman visits, the additional visits must be provided without cost sharing. The full range of contraceptives includes those currently listed in the Food and Drug Administration (FDA's) Birth Control Guide- approved, -granted, or -cleared contraceptives, effective family planning practices, and sterilization procedures be available as part of contraceptive care.		

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Covered Preventive Services for Children (NO COST SHARING IS APPLICABLE) **CHILDREN PREVENTIVE SERVICES MUST BE INCLUDED IN THE SAME ORDER AND DESCRIPTION ESTABLISHED IN THIS CHECKLIST**			
Anemia/Iron	Perform risk assessment or screening as appropriate, per recommendations in the current edition of the AAP Pediatric Nutrition: Policy of the American Academy of Pediatrics (Iron chapter).		
Anxiety in Children and Adolescents: Screening: children and adolescents aged 8 to 18 years	The USPSTF recommends screening for anxiety in children and adolescents aged 8 to 18 years.		
Autism Spectrum Disorder Screening	Screening for children at (18) and (24) months.		
Behavioral/Social/Emotional Screening	The American Academy of Pediatrics (AAP) recommends an annual assessment from newborn to 21 years old.		
Bilirubin concentration	Screening for newborns		
Blood Pressure	Screening for Children Ages: (0) to (11) months, (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (17) years.		
Blood screening	Screening for newborns		
Cervical Dysplasia	Screening for sexually active females.		
Depression and Suicide Risk in Children and Adolescents: Screening	The American Academy of Pediatrics (AAP) and the USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 21 years.		
Developmental Screening and Surveillance	Screening for children under age (3), and surveillance throughout childhood.		
Dyslipidemia	Screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years		
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.		

New

Updated

Updated

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Hearing	Screening for hearing loss all newborns infants and for children once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years.		
Height, Weight and Body Mass Index	Measurements for children. Ages: (0) to (11) months, (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (17) years.		
Hematocrit or hemoglobin screening	Screening for all children		
Hemoglobinopathies screening: newborns	Screening for sickle cell disease in newborns.		
Hepatitis B Virus Infection screening	The USPSTF and the American Academy of Pediatrics (AAP) recommends screening for hepatitis B virus (HBV) infection in newborns through young adults (21 years of age) at highest risk of infection.		
Hypothyroidism screening: newborns	Screening for congenital hypothyroidism in newborns.		
Immunization	Vaccines for children from birth to age (18), doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis, Haemophilus influenza type b, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella. Catch ups must be		
Lead screening	For children at risk of lead exposure		
Maternal depression	Screening for mothers of infants at 1, 2, 4, and 6-month visits		
Medical History	For all children throughout development Ages: (0) to (21) years.		

NEW!

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Obesity screening: children and adolescents	The USPSTF recommends that clinicians screen children age (6) years and older for obesity and offer them, or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.		
Oral Health	Risk assessment for young children. Ages: (0) to (11) months, (1) to (4) years, (5) to (10) years.		
Phenylketonuria (PKU) screening: newborns	Screening for phenylketonuria in newborns.		
Prevention of Dental Caries in Children Younger Than 5 Years: Screening and Interventions: children younger than 5 years	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. Also, the American Academy of Pediatrics (AAP) recommends If primary water source is deficient in fluoride, consider oral fluoride supplementation. The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk.		Updated
Skin Cancer behavioral counseling	The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.		
Sudden cardiac arrest and sudden cardiac death	The American Academy of Pediatrics (AAP) recommend assessing risk for sudden cardiac arrest and sudden cardiac death has been added to occur from 11 to 21 years (to account for the range in which the risk assessment can take place) to be consistent with AAP policy ("Sudden Death in the Young: Information for the Primary Care Provider"). Perform a risk assessment, as appropriate		New
Tobacco use: children and adolescents	The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents.		

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Tobacco, Alcohol or Drug Use	Screening children (11) to (21) years of age.		
Tuberculosis	Testing for children at higher risk of tuberculosis. Ages: (0) to (11) months, (1) to (4) years, (5) to (10) years, (11) to (14) years, (15) to (21) years.		
Vision screening: children	The USPSTF recommends vision screening for all children at least once between the ages of (3) and (5) years, to detect the presence of amblyopia or its risk factors.		

References

<https://www.hrsa.gov/womens-guidelines/index.html>
<https://mchb.hrsa.gov/programs-impact/programs/preventive-guidelines-screenings-women-children-youth>
<https://www.womenspreventivehealth.org/recommendations/>
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
<https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf>
<https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf>

CERTIFICATION

I _____ have reviewed or supervised the preparation of the above checklist and certify that the forms(s) and/or drug formulary is (are) in compliance with all of the applicable requirements of the Essential Health Benefit Benchmark for Puerto Rico¹ and the recommendations of the USPSTF. I also acknowledge responsibility for the validity, accuracy and completeness of the contents of this checklist.

Signature: _____

Date: _____

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GOVERNMENT OF PUERTO RICO
OFFICE OF THE COMMISSIONER OF INSURANCE
PUERTO RICO FORM FILING CHECK LIST
INDIVIDUAL MARKET

COMPANY: _____
FORM(S) NUMBER: _____
SERFF TRACKING NUMBER: _____
TYPE OF INSURANCE (TOI) _____

ATTACHMENT 7A
REVISED 02/2023

SUBJECT	REGULATORY REFERENCE	COMMENTS	Please specify location (Form/Page/Paragraph/ Other) of complying provision/language * <u>or attach explanation for a N/A response **</u>	FOR OFFICIAL USE ONLY
Licensing	§ 303	The carrier ¹ is licensed to transact disability insurance business or is authorized as a Health Service Organization in Puerto Rico.	☐ Yes ☐ No	
Final Form	§ 1111	The form(s) is(are) in the final format in which it(they) will be issued. No draft, highlighted, redline or watermark is(are) included in the Form Schedule Tab.	☐ Yes ☐ No	
Filings made on behalf of the carrier by another party	Circular Letter CC-2015-1870-AV/AS	A letter authorizing the third party to act on behalf of the carrier is included in the Supporting Documentation Tab and provides the following information: (a) on carrier's letterhead or include the carrier name in the "Re" line of the authorization; (b) specifically addressed to the Office of the Commissioner of Insurance of Puerto Rico; (c) properly executed by an authorized officer of the carrier; (d) dated; and either (e) specific to the file submitted for approval by including form number(s); or (ii) generally applicable to all contract forms filed on behalf of the carrier as long as a copy of such authorization is included in each submission.	☐ Yes ☐ N/A ☐ Yes ☐ N/A ☐ Yes ☐ N/A ☐ Yes ☐ N/A ☐ Yes ☐ N/A	
Cover Letter	Circular Letter CC-2015-1870-AV/AS	The filing include a cover letter under the Supporting Documentation Tab in SERFF.	☐ Yes ☐ No	
Cover Letter	Circular Letter CC-2015-1870-AV/AS	The cover letter include: a. A detailed explanation as to the purpose of the filing, and the intended use for each submitted form. b. The signature of a representative of the carrier, authorized to submit forms for filing or approval for the carrier. c. A description of any innovative or unique features of each form. d. In the "Re" section, the identification form number of all the forms submitted for approval are displayed with the same form number that appears in the lower left corner of the form. This means that if the word "Form" does not appear in the lower left corner then it should not be part of the Form Number on the cover letter.	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ N/A ☐ Yes ☐ No	
Cover Letter	Rule XXIV	Brief, detailed description of benefits, purpose, and intended market. Disclose if form is new or replacement. If it is an amendment, endorsement or rider, the contract it will go with.	☐ Yes ☐ No	
Cover Letter	Rule XXIV	The cover letter include the name of the carrier presenting the submission and is signed by a representative of the carrier authorized to submit forms for filing or approval.	☐ Yes ☐ No	

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Cover Letter	Rule XXIV	The cover letter advise whether or not the form is replacing a previously submitted form. If there have not been a substantial number of changes, submit a highlighted copy showing the material differences or changes made to the form. If the changes are too extensive, then a highlighted copy is not required, but the changes must be identified in the cover letter. State whether the previously submitted form was approved, disapproved, withdrawn or otherwise disposed or is still pending approval (under review) with the OCI and provide the form number and SERFF tracking number.	☐ Yes ☐ No	
Cover Letter		The cover letter indicate the SERFF tracking number of the filing where the rates applicable to the form(s) were submitted.	☐ Yes ☐ No	
Cover Letter-Resubmissions	Rule XXIV	If the form has been previously submitted to the OCI and the file was closed or withdrawn, any resubmission's cover letter must reference the SERFF tracking number of the previously closed file and address all outstanding issues in the new cover letter. The new cover letter shall include a reference where each objection has been addressed within the forms.	☐ Yes ☐ N/A	
Cover Letter		If the insurer or health services organization intends to subscribe the health plan by electronic means, it must mention it in the cover letter.	☐ Yes ☐ N/A	
Cover Letter		If a form is intended to replace a very recently approved form because of an error found in the approved form, and the approved form has not been issued, the carrier may request to make a substitution of the approved form using the regular prior approval process. The substitution request letter must confirm that the form has not been issued and identify the changes made to the corrected form. The carrier may, under these circumstances, use the same form number on the corrected form being submitted.	☐ Yes ☐ N/A	
Cover Letter		In relation to metallic plans, the cover letter indicate if the carrier will be offering these forms outside the open enrollment period, with or without waiting period.	☐ Yes ☐ No	
Variability (bracketed language)	§ 1111 § 1112	Forms with variable bracketed information must include all the possible language that might be placed within the brackets. The use of too many variables will result in filing disapproval, as OCI staff may not be able to determine whether the filing is compliant with Puerto Rico laws and regulations. The submission must include a separate detailed Memorandum of Variable Material to explain any variable material in the form(s). In order to be approved, any form will need to be furnished accompanied by the intended alternate, replacement, and/or additional language. The use of these brackets, within the approved form, will be limited to the alternatives filed by the carrier.	☐ Yes ☐ N/A ☐ Yes ☐ N/A	
Variable Language Blank pages	§ 1111	Brackets around an entire page constitute a "blank" or generic form – not permitted		

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Red-lined, highlighted, draft or watermark copies		Redline, highlighted, draft or watermark copies are not approvable and must be placed on the SERFF Supporting Documentation Tab.		
Amendments or Endorsements	§ 1118	The contract may not be modified unless the modification is in writing and agreed to by the party against whose interest the modification operates.	☐ Yes ☐ N/A	
Rider a Rider	§ 1112	Companies may not "rider a rider", "endorse and endorsement" or "amend an amendment".		
Form Number		A form identification number (consisting of numerical digits, letters, or both) appears in the lower left-hand corner of the cover page and in all the pages of the form(s). The form identification number is the same in all pages.	☐ Yes ☐ No	
Cover Page		The licensed Puerto Rico carrier's name appears on the cover page of the form(s), as well as the cover page of each rider, amendment, application and endorsement form. Full street address of the carrier's Home Office (bracketed or underlined to reflect possible future changes) for disclosure purposes appears on the cover page or back page of the form. A brief description of the contract (e.g., "individual metallic plan platinum" "small group metallic plan gold") appears on the form cover page. The signature of at least one officer of the carrier appears in the first page, in order to execute the contract. Signatures appearing on contract form(s) can be bracketed to denote variability.	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
Unfair, Misleading, Deceptive Provisions.		Form(s) does(do) not include inequitable, unfairly discriminatory, misleading, deceptive, obscure, unfair, encourage misrepresentation, or not in the public interest provisions. Form(s) does(do) not contain inconsistent, ambiguous or misleading clauses, or contain exceptions and conditions that unreasonably affect the benefits purported to be provided in the coverage.	☐ Yes ☐ No	
CHAPTER 16 OF THE INSURANCE CODE OF PUERTO RICO (Insurance Code)				
Chapter 16 Insurance Code	§ 1602(2)	The style, arrangement and overall appearance of the contract shall give no undue prominence to any portion of the text, and every printed portion of the text of the contract and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower case unspaced alphabet length not less than one hundred and twenty-point.	☐ Yes ☐ No	
Entire Contract	§ 1605	This provision must be included and must be no less favorable to the insured than the statutory provision.		
Grace Period	§ 1607	This provision must be included and must be no less favorable to the insured than the statutory provision.		
Reinstatement Provision	§ 1608	This provision must be included and must be no less favorable to the insured than the statutory provision.		

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Notice of Claim Provision	§ 1609	Only applicable for reimbursement purpose, the language must be adjusted accordingly.		
Claim Forms Provision	§ 1610	Only applicable for reimbursement purpose, the language must be adjusted accordingly.		
Proof of Loss Provision	§ 1611	Only applicable for reimbursement purpose, the language must be adjusted accordingly.		
Time of Payment of Claims Provision	§ 1612	Only applicable for reimbursement purpose, the language must be adjusted accordingly.		
Payment of Claims Provision	§ 1613	Only applicable for reimbursement purpose, the language must be adjusted accordingly.		
Civil Actions Provision	§ 1615	Civil Actions Provision		
Misstatement of Age	§ 1622	The language of the standard provision must be adjusted accordingly. The provision may read as follows: "If a subscriber's/insured's age has been misstated or incorrectly expressed, the premium will be adjusted to the correct age."		
Order of Certain contract Provisions	§ 1629	The provisions which are the subject of §§ 1605-1628 of the Insurance Code, inclusive, or any corresponding provisions which are used in lieu thereof in accordance with such sections, shall be printed in the consecutive order of the provisions in such sections or, at the carrier option, any such provision may appear as a unit in any part of the contract, with other provisions to which it may be logically related, provided the resulting contract shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the contract is offered, delivered or issued.		
Foster child definition	§ 1633	Family expenses disability - <i>Foster child definition</i> . The definition should not include any reference to lived under the same roof (residency) or be dependent to receive support (financial dependency).		
HEALTH INSURANCE CODE OF PUERTO RICO (Health Code)				
Definitions	§ 2.030 § 4.030 § 10.030 § 22.030 § 24.030 § 28.030 § 52.030 § 72.030 § 48.020	Definitions included in the policy or contract form must comply with Sections 2.030, 4.030, 10.030, 22.030, 24.030, 28.030, 52.030, 48.020 and 72.030 of the Health Insurance Code. Do not duplicate definitions. Definitions must be included as long as the contract uses the term. Also, if a same definition is included under more than one law, the definition must apply to the specific intention of each law.	☐ Yes ☐ No	

Updated

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PUERTO RICO FORM FILING CHECK LIST
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SUBJECT	REGULATORY REFERENCE	COMMENTS	Please specify location (Form/Page/Paragraph/ Other) of complying provision/language * <u>or attach explanation for a N/A response **</u>	FOR OFFICIAL USE ONLY
Dependent Coverage	§ 2.03(G) § 10.030(G)	If a contract offers dependent coverage, it must include dependent coverage until age 26. Conditions limiting the dependent coverage based upon financial dependency, marital status, enrollment in school, residency or other factors are not applicable. Also, the definition of "Dependent" must comply with Sections 2.030(G) and 10.030(G) of the Health Code.		
Prohibition on Annual and Lifetime Dollar Limits	§ 2.050 (A)(1) § 2.050 (A)(2)	This policy or contract form must not include annual or lifetime limits on essential health benefits.		
Preventive Services	§ 2.050(C)	This policy or contract form provides coverage for the following preventive care and screenings for children and adults with no cost-sharing: (1) Services for adult, women and children with a rating of A or B as recommended by the U.S. Preventive Services Task Force. (2) Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the "Comité Asesor en Prácticas de Inmunización" of the Puerto Rico Health Department. (3) Preventive care and screenings for infants, children and adolescents as established in the guidelines supported by the Health Resources and Services Administration (HRSA). (In Puerto Rico applies until 21 years). (4) Preventive care and screenings for women as established in the guidelines supported by HRSA, including breast cancer screening, mammography and prevention. Such coverage shall not be subject to deductibles, copayments, and/or coinsurance. The contract also include the link to access the current preventive services list.		
Emergency Services	§ 2.050(F)	This policy or contract form provides coverage for the treatment of an emergency condition in a hospital: *Without the need for any prior authorization; * Regardless of whether the provider is a participating provider; * Without imposing any administrative requirement or limitation that is more restrictive than that required for participating provider services, and at the in-network cost-sharing level.		
Designation of Primary Care Provider and access to pediatricians	Chapter 2 / Health Insurance Code § 2.050(G)	If the policy or contract form requires the designation of a primary care provider, the form permits the designation of a physician who specializes in pediatrics, when the enrollee is eighteen (18) years old or less, as the child's primary care provider, provided that such provider participates in the network of participating providers of the health plan. <i>(Only applicable to coverage managed through referrals and the designation of primary care provider is required)</i>		

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Designation of Primary Care Provider and Direct Access to OB/GYN Services	§ 2.050(H)	If this policy or contract form requires the designation of a primary care provider, it must not require prior authorization or referral to obtain obstetrical and gynecological care provided by participating providers. <i>(Only applicable to coverage managed through referrals and the designation of primary care provider is applicable)</i>		
Pre-existing Conditions	§ 2.050(I) § 10.050(M)	No individual health plan shall deny, exclude or limit the benefits of an enrollee based on preexisting conditions, regardless of the age of the enrollee.		
Rescission	Chapter 2 / Health Insurance Code § 2.050(J)	Coverage may only be rescinded or cancelled for fraud or intentional misrepresentation of material fact. Notification must be given to the insured (30) calendar days prior to cancellation. Recovery of the provided services cost is not allowed.		
Prescription drugs	§ 4.060(A)(1)(b)	Information indicating which prescription drugs, if any, are subject to a management procedure that has been developed and maintained is disclosed in the contract.	☐ Yes ☐ No	
Changes to the formulary	Chapter 4 / Health Insurance Code § 4.060(A)(2)	The contract shall establish that changes in the formulary or other prescription drug management process during the term of the contract shall only be made if such change is being made for safety reasons, because the prescription drug cannot be supplied or has been withdrawn from the market by the drug's manufacturer, or if such change entails the inclusion of prescription drugs in the formulary. To such effects, the carrier shall provide or entrust a third party to provide notice of that change to all enrollees and pharmacies not later than the effective date of the change.		
Formulary Exceptions	Chapter 4 / Health Insurance Code § 4.070	This policy or contract form must provide for a formulary exception process for prescription drugs not on the insurer's formulary. The contract must include the Medical Exceptions Approval Process Requirements and Procedures in accordance to Section 4.070. The language of this section must be included in the contract in the same format and order established in Section 4.070.		
Disclosure	Chapter 4 / Health Insurance Code § 4.100	The contract, certificate, membership booklet, outline of coverage, evidence of coverage, or any other document provided to an enrollee shall include the disclosures required in Section 4.100.		
Maintenance medications	Chapter 4 / Health Insurance Code § 4.120	The policy or contract form shall establish that for insured's that so require, insofar as it does not jeopardize his or her health, and at the discretion of the healthcare provider, the healthcare provider may prescribe refills for maintenance drugs up to a term that shall not exceed one hundred eighty (180) days, subject to the limitations of the health plan's coverage.		

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Guaranteed renewability	Chapter 10 / Health Insurance Code § 10.060	An individual health plan shall be renewable or shall continue in force the coverage for the enrollee and his/her dependent, at the option of the enrollee. Guaranteed renewability. A carrier must renew or continue in force the coverage at the option of the individual, except for nonpayment of premium, fraud, termination of product and movement outside the service area.		
Availability of coverage	Chapter 10 / Health Insurance Code § 10.080	The contract must include a clause establishing the availability of coverage in the Individual Market in compliance with Section 10.080.		
Qualifying events	Chapter 10 / Health Insurance Code § § 10.150(C) and (D)	The contract must establish the events in which an individual can obtain coverage due to a qualified event as describe in Section 10.150 of the Health Code and Ruling Letter CN-201-156-AS of September 30, 2013.		
Prohibition of Discretionary clauses	Chapter 12 / Health Insurance Code § 12.040(A)	No contract, certificate or agreement offered or issued in Puerto Rico by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of healthcare services may contain a provision purporting to reserve discretion to carrier to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of Puerto Rico. An adverse determination by a carrier, as well as disputes or controversies that may arise between a carrier and an enrollee, shall be subject to the internal and external review procedures established in the Health Code.		
First Level Reviews of Grievances Involving an Adverse Determination	Chapter 22 / Health Insurance Code § 22.070	All carriers must include in the contracts a First Level Revision of Complaints related to an Adverse Determination in compliance with Section 22.070. The title and language of this section must be included in the contract in the same format and order established in the Section 22.070.		
Standard Reviews of Grievances Not Involving an Adverse Determination	Chapter 22 / Health Insurance Code § 22.080	All carriers must include in the contracts an Ordinary Revision of Complaints not related to an Adverse Determination in compliance with Section 22.080. The title and language of this section must be included in the contract in the same format and order established in the Section 22.080.		
Voluntary Level of Reviews of Grievances	Chapter 22 / Health Insurance Code § 22.090	All carriers must include in the contract a Voluntary Level of Revision of Grievances in compliance with Section 22.090. <i>(Only applicable to manage care plans)</i> The title and language of this section must be included in the contract in the same format and order established in the Section 22.090.		
Expedited Reviews of Grievances Involving an Adverse Determination	Chapter 22 / Health Insurance Code § 22.100	All carriers must include in the contract an Expedite Review of Grievances involving an Adverse Determination in compliance with Section 22.100. The title and language of this section must be included in the contract in the same format and order established in the Section 22.100.		

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Urgent care	Chapter 24 / Health Insurance Code § 24.030 (Q)(2)	The contract include the following language, or a different wording with the same meaning, in compliance with this Section: "Any request that a physician with knowledge of the enrollee's medical condition determines is an urgent care request, shall be treated by the carrier as an urgent care request."		
Procedures for Standard Utilization Review and Benefit Determinations	Chapter 24 / Health Insurance Code § 24.090	The policy or contract form includes a description of the utilization review policies and procedures, The title and language of the provision must be included in the form in the same format and order established in Section 24.090.		
Procedures for Expedited Utilization Review and Benefit Determinations	Chapter 24 / Health Insurance Code § 24.100	All carriers who perform utilization review procedures must include in its contracts the Procedures for Expedited Utilization Review and Benefit Determinations in compliance with Section 24.100. The title and language of the provision must be included in the form in the same format and order established in Section 24.100.		
Utilization review or benefit determinations for emergency services	Chapter 24 / Health Insurance Code § 24.110	All carriers who perform utilization review procedures must include in its contracts the Procedures for an Utilization Review and Determination of Benefits in respect to Emergency Services in compliance with Section 24.110. The title and language of the provision must be included in the form in the same format and order established in Section 24.110.		
Creation of Adequate network	Chapter 26 / Health Insurance Code § 26.050	health insurance organizations or insurers shall file with the Commissioner an access plan that meets the requirements set forth in this Chapter for each of the coordinated care plans offered in P.R.		NEW!
Requirements for health insurance organizations, insurers and in-network providers	Chapter 26 / Health Insurance Code § 26.060	Provide evidence of compliance with this chapter and of the provisions of the contract between issuer and in-network provider.		NEW!
Filing Requirements	Chapter 26 / Health Insurance Code § 26.080	The health insurance organizations or insurers will file with the Commissioner the model contracts that they will use with their participating providers and intermediaries, so that the Commissioner can verify compliance with the provisions of this Chapter.		NEW!

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Notice of Right to External Review	Chapter 28 / Health Insurance Code § 28.050	All carriers must include in the contracts a Notification of the Right to Request an External Review in compliance with Section 28.050. The title and language of the provision must be included in the form in the same format and order established in Section 28.050.		
Request for External Review	Chapter 28 / Health Insurance Code § 28.060	This policy or contract form includes the instructions on how to request an external external review appeal. The title and language of the provision must be included in the form in the same format and order established in Section 28.060.		
Exhaustion of Internal Grievance Process	Chapter 28 / Health Insurance Code § 28.070	All carriers must include in the contracts information about the Exhaustion of Internal Grievance Process in compliance with Section 28.070. The title and language of the provision must be included in the form in the same format and order established in Section 28.070.		
Standard External Review	Chapter 28 / Health Insurance Code § 28.080	All carriers must include in the contracts information about the Standard External Review in compliance with Section 28.080. The title and language of the provision must be included in the form in the same format and order established in Section 28.080.		
Expedited External Review	Chapter 28 / Health Insurance Code § 28.090	All carriers must include in the contracts information about the Expedite External Review in compliance with Section 28.090. The title and language of the provision must be included in the form in the same format and order established in Section 28.090.		
External Review of Experimental or Investigational Treatment Adverse Determinations	Chapter 28 / Health Insurance Code § 28.100	All carriers must include in the contracts information about the External Review of Experimental or Investigational Treatment Adverse Determinations in compliance with Section 28.100. The title and language of the provision must be included in the form in the same format and order established in Section 28.100.		
Binding Nature of External Review Decision	Chapter 28 / Health Insurance Code § 28.110	All carriers must include in the contracts language in compliance with Section 28.110.		
Funding of External Review	Chapter 28 / Health Insurance Code § 28.170	All carriers must include in the contracts information about the Funding of External Review in compliance with Section 28.170. The title and language of the provision must be included in the form in the same format and order established in Section 28.170.		

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Off-label Use	Chapter 52/ Health Insurance Code § 52.040(A)	A health plan that provides coverage for drugs shall provide for the dispensation of any drug covered, regardless of the disorder, injury, illness, condition, or disease for which they were prescribed, provided, that (1) the drug has been approved by the FDA for at least one indication, and (2) the drug is recognized for treatment of the disorder, injury, illness, condition, or disease in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.		
Off-label Use	Chapter 52 / Health Insurance Code § 52.040(B)	Coverage of a drug shall also include medically necessary services associated with the administration of the drug.		
Newborn and Newly Adopted Children and Children Placed for Adoption	Chapter 54 / Health Insurance Code § 54.050(A) § 54.050(B)	For parent and child/children and/or family coverage, the policy or contract form provides coverage for: (1) A newborn child of a enrollee from the moment of birth; or (2) A newly adopted child of a enrollee from the earlier of: (a) The date of placement in the home of the enrollee for the purpose of adoption and continues in the same manner as other dependents of the enrollee unless the placement is disrupted prior to legal adoption and the child is removed from placement; (b) The date of entry of an order granting the enrollee custody of the child for purposes of adoption; or (c) The effective date of adoption. The coverage shall include coverage of injury or sickness healthcare services including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and is NOT subject to any preexisting condition exclusion. The language of this section must be included in the contract in the same format and order established in Section 54.050(A) and (B).		

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Newborn notice	Chapter 54 / Health Insurance Code § 54.060(A)	For a newborn child, the carrier shall provide covered enrollees with reasonable notice of the following: (1) If payment of a specific premium or subscription fee is required to provide coverage for a newborn child, the health plan may require the enrollee to notify the carrier of the birth of the child and furnish payment of the required premium or fees within thirty (30) days after the date of birth. (2) If notice and the payment described above are not provided, the carrier may refuse to continue coverage for the child under the health plan beyond the thirty (30)-day period. However, if within four (4) months after the birth of the child the enrollee makes all past-due payments, coverage shall be restored. (3) If payment of a specific premium or subscription fee is not required to provide coverage for a newborn child, the carrier may request notification of the birth of the child, but shall not deny or refuse to continue coverage if the enrollee does not furnish the notice. The language of this section must be included in the contract in the same format and order established in Section 54.060(A).		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(A)	Every insurer must update its website within twenty (20) days after adding or excluding a provider to its network or making any change in the affiliation of a doctor to a facility, provided that, in the case of a change in enrollment, the insurer has received notice of such change.		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B1)	Every insurer must, in accordance with state or federal law in force, provide the covered person: 1. A clear and understandable description of the plan's out-of-network health benefits, including the methodology used by the entity to determine the allowed amount for out of network services;.		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B2)	2. the allowed amount that the plan will reimburse under that methodology and, in cases where a covered person requests the allowable amounts associated with a specific procedure code, the portion of the allowed amount that the plan will reimburse and the portion of the allowed amount to be paid by the covered person, including an explanation that the covered person will be required to pay the difference between the allowed amount as defined by the insurer's plan and charges billed by an out-of-network provider;		

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No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B3)	3. examples of anticipated costs for services out-of-network frequently billed		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B4)	4. information, in writing and via the website, that reasonably allows a covered person or potential covered person calculate the anticipated cost for out-of-network services, based on the difference between the amount the insurer reimburse for out-of-network services and the usual and customary cost of out-of-network services;		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B5)	5. when requested by a covered person, information about whether a health or medical service provider is a member of the network;		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B7)	7. access to a direct telephone line that will operate no less than sixteen (16) hours a day, seven (7) days a week, to so consumers can call to find out about network status and costs.		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(C)	C. If an insurer authorizes an in-network health or medical service provider to perform a covered service under any health plan, and the provider's or facility's status changes to out-of-network before it is performed authorized service, the insurer will notify the covered person as soon as possible. If the insurer does not provide notice at least thirty (30) days before the authorized service is performed, the financial responsibility of the covered person will be limited to the financial responsibility that would have been incurred if the provider had been in-network. of the person's health plan.		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(D)	D. Every insurer will add to your Benefits Information, to all reimbursement correspondence to the covered person, and to the provider, a clear and concise notice that inadvertent and involuntary out-of-network charges are not subject to collection or billing beyond the financial responsibility incurred under the terms of the contract of service within of the network. Any attempt by the provider to charge or bill must be reported immediately to the insurer's customer service department, at the telephone number that the insurer will provide in the Benefits Information and all correspondence regarding reimbursement to the covered person.		

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No Surprised Bills	Chapter 48 / Health Insurance Code § 48.120	A. Every insurer shall provide each covered person with written notice, in the form and manner prescribed by the Commissioner of Insurance, regarding the protections provided to covered persons pursuant to this Chapter. The notice will include information about how a consumer may contact the Office of the Commissioner of Insurance to report or dispute an out-of-network charge. This notice will also be published on the insurer's website.		
Newly adopted child or child placed for adoption notice	Chapter 54 / Health Insurance Code § 54.060(B)	For a newly adopted child or child placed for adoption, the carrier shall provide enrollees with reasonable notice of the following: (1) If payment of a specific premium or subscription fee is required to provide coverage for a newly adopted child or child placed for adoption, the health plan may require the enrollee to notify the carrier of the adoption or placement for adoption and furnish payment of the required premium or fees within thirty (30) days after coverage is required to begin under Section 54.050A(2). (2) If the enrollee fails to provide the notice or make the payment described in the preceding paragraph within the thirty (30)-day period, the carrier shall treat the adopted child or child placed for adoption no less favorably than it treats other dependents, other than newborn children, who seek coverage at a time other than when the dependent was first eligible to apply for coverage. The language of this section must be included in the contract in the same format and order established in Section 54.050(B).		
Unfair Discrimination against Victims of Abuse	Chapter 72 / Health Insurance Code § 72.040(A)	The following language in compliance with Section 72.040 must be included in the contract. It is unfairly discriminatory to: (1) Deny, refuse to issue, renew or reissue, cancel or otherwise terminate a health plan, or restrict a health plan coverage or add a premium differential or surcharge to any health plan on the basis of the enrollee's abuse status; or (2) Exclude, limit coverage, or deny a claim on the basis of the enrollee's abuse status. The language of this section must be included in the contract in the same format and order established in the Section 72.040(A).		
OTHER REQUIREMENTS FOR HEALTH SERVICES ORGANIZATIONS				
Evidence of Coverage	Chapter 19/ Insurance Code § 1908	Evidence of coverage must be submitted in compliance with this section. If the contract will be use as the evidence of coverage, the carrier disclosed this information in the cover letter.	☐ Yes ☐ No	

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Prohibited words	Chapter 19/ Insurance Code § 1915(4)	No health service organization may use in its name, contract or literature, any of the words "insurance", "contingency", "guaranty", "mutual", or any other word describing insurance, contingency or guaranty business, deceitfully similar to the name or description of any insurance or guaranty corporation doing business in Puerto Rico. The terms "insurer"," insured", "insurance", "insurance company", "policy", "insure" cannot be use.	☐ Yes ☐ No	

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Puerto Rico Laws				
Coverage for Albinism and Hermansky-Pudlak Syndrome	Act No. 109 December 22, 2022	Private health plans must include in their special coverage the condition of albinism and the genetic disorders that can cause it. Provide for direct access to providers and specialist doctors, as well as those medications, treatments, therapies and tests that are not experimental or genetically modified, scientifically validated as effective and recommended to diagnose and treat the condition, without the need for a referral. Coverage must include the cost of HPS type 1 genetic testing.		NEW!
Down Syndrome amendment	Act No. 13 March 25, 2022	Clarify its scope. The cover must be from birth. Therapeutic services with a remedial approach shall include, but shall not be limited to, physical therapies, speech therapies, occupational therapies, and any other necessary therapy recommended by a health professional authorized to practice such profession in Puerto Rico or the United States, in the quantities and frequency prescribed by the professional or specialist.		NEW!
Psicologist uniform definition	Act No. 79 December 30, 2021	Establish the definition of the term “Psychologist” or “Psychologist” established by Law 194, supra, and Law 296, supra, are uniform with the definition of said term established by Law 408-2000, as amended, known as the “Law of Puerto Rico Mental Health. Also amends Law 220-2012 and Law 239-2012		
Psicologist uniform definition	Act No. 79 December 30, 2021 Section 1	Subsections (n) and (q) of Section 2 of Act 194-2000, as amended, are amended to read as follows: (n) "Health Professional" – shall mean any practitioner duly admitted to practice in Puerto Rico, in accordance with applicable laws and regulations, any of the health and medical care professions, such as, but not limited to, physicians, surgeons, podiatrists, naturopathic doctors, chiropractors, optometrists, psychologists, dentists, pharmacists , nurses, audiologists and medical technologists, as authorized by the corresponding laws of Puerto Rico.		
Psicologist uniform definition	Act No. 79 December 30, 2021 Section 1	q) “Psychologist” - means the professional licensed by the Board Examiner of Psychologists of the Commonwealth of Puerto Rico, as defined in Act No. 96 of June 4, 1983, as amended, known as the "Act to Regulate the Practice of the Profession of Psychology in Puerto Rico", which has training, knowledge, skills, and experience in providing services including, but not limited to: prevention, description or diagnosis of behavior, psychological evaluation, therapeutic intervention with psychological problems of various levels of severity and consulting concerning the intellectual, emotional, behavioral, interpersonal, family, social and occupational functioning of individuals and groups. The license conferred by the Board explicitly requires all professional psychologist to practice according to their training and competencies under the legal provisions and the ethical norms that regulate this practice in Puerto Rico.		

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Medical Emergency Technicians- paramedics	Act No. 69 December 27, 2021	Item 5 of Article 19.030 of the Insurance Code is amended to read as follows: (5) Every health service organization that provides health services must include, as part of its coverage, if there is medical justification according to the criteria established in the protocols created by the Department of Health and according to the home care plan. , to people who require a ventilator to stay alive, a minimum of one daily shift of eight (8) hours of nurses or nurses; or paramedical emergency medical technicians (TEM-P), duly licensed. In addition, duly licensed emergency medical technicians-paramedics (TEM-P) must have approved and validated courses, certifications and training or the skills and knowledge requirements established by regulation by their respective Examining Board related to the care and management of said patients. and its medical equipment as authorized in this Law.”		
Protection against surprised medical bills - New Chapter 48 Health Insurance Code of Puerto Rico	Act No. 134 September 1, 2020	The purposes of stopping the so-called "surprise bills" in the billing of health plans, establish consumer protections, transparency, cost control and responsibility, out of network providers; and for other related purposes.		
Braille system (Blind) evidence of cover and ID card	Act No. 162 December 30, 2020	Article 19.080 of the Insurance Code is amended to read as follows: (1) (a) Each subscriber is entitled to evidence of coverage. If the subscriber obtains coverage through an insurance policy, the insurer will issue the evidence of coverage. Otherwise, the health service organization will issue the evidence of coverage. In the case of blind subscribers the evidence of coverage and the identification card will be issued in the Braille system		
Clinical Review Criteria	Act No. 142 October 9, 2020 Amends Section 2.030 (E) of the Health Insurance Code	E. "Clinical Review Criteria" means the written screening procedures, decision summaries, clinical protocols, and practice guidelines used by the health insurance organization or insurer to determine the medical necessity and appropriateness of the medical service. health care. These practice guides are not mandatory for the Health Professional in the exercise of their functions when providing any health care service in accordance with state and federal laws and corresponding regulations; and as long as the service provided is recognized by the generally accepted standards of health and medical practice, in the light of modern means of communication and teaching. The professional diagnosis will be the guiding and exclusive criterion to determine the treatment to be followed in a patient. Therefore, professional judgment cannot be altered by the insurer. Notwithstanding the foregoing, the provisions of this subsection must comply with federal laws and regulations on the matter.		

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Requirements and Procedures for Approval of Medical Exceptions.	Act No. 142 October 9, 2020 Amends Section 4.070 (B) 1st paragraph of the Health Insurance Code	B. The health insurance organization or insurer that provides prescription drug benefits, the PBM or any other entity to which the administration of pharmacy services has been delegated, will have the obligation to offer immediate temporary coverage for an initial prescription. of the prescription drug during the medical exception request process and until you notify your final determination in writing, when the physician or health care professional who issued the prescription establishes in writing that the requested prescription drug is medically necessary for the treatment of the illness or condition of the covered or insured person; even when said prescription drug is one of which is excluded from the drug formulary of the covered or insured person's medical plan or is subject to a prescription drug management procedure established in this Article. The health insurance organization or insurer that provides prescription drug benefits, the PBM or any other entity to which the administration of pharmacy services has been delegated, must pay the pharmacy the initial prescription of the dispensed medication, in what the insurer awards the prescription drug coverage. The pharmacy may submit an electronic invoice to the insurer for the payment of the initial prescription for dispensed drugs and the insurer will be required to accept electronic invoicing and may not require a physical or paper invoice as a condition for payment. Thus, under no circumstances will the covered or insured person be deprived of their prescription drug while they are in the process of requesting medical exceptions as established in this Article, or the presentation of a complaint in accordance with the Chapter on Internal Complaint Procedures of Health Insurance Organizations or Insurers of this Code. This rule for temporary coverage of initial prescription drug prescriptions will not affect existing regulations on transitional drugs. Notwithstanding the foregoing, the provisions of this subsection must comply with federal laws and regulations on the matter.		

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Requirements and Procedures for Approval of Medical Exceptions.	Act No. 142 October 9, 2020 Amends Section 4.070 (B) 2nd paragraph of the Health Insurance Code	Any health insurance organization or insurer that provides prescription drug benefits, pharmacy benefits manager or administrator or any entity to which the administration or management of pharmacy services or benefits has been delegated, will include in the calculation or in the requirement of contribution or cost sharing (“cost sharing, out-of-pocket maximum”), any payment, discount or item that is part of a financial assistance program, discount plan, coupons, or any contribution offered to the insured by the manufacturer. These items will be considered for the exclusive benefit of the patient in the calculation of their contribution, out-of-pocket expenses, co-payments, co-insurance, deductible or in compliance with shared contribution requirements. These contributions, discounts and coupons from the manufacturer will be available and may be used in all health providers, according to the requirements of the program, regardless of the place of acquisition of the discount or coupon. The use of the accumulator of benefits, maximizer or any other similar program that has the effect of implementing a restriction on liability established in this subsection is prohibited.		
Requirements and Procedures for Approval of Medical Exceptions.	Act No. 142 October 9, 2020 Amends Section 4.070 (E) (1) of the Health Insurance Code	1) The procedure for requesting medical exceptions provided in this Article shall require that the health insurance organization or insurer that provides prescription drug benefits, the PBM or any other entity to which the administration of the pharmacy services, make the determination regarding a request submitted and notify said determination to the covered person or insured, or his personal representative, with the urgency required by the medical condition of the covered person or insured, but in no case may the notification Exceed forty-eight (48) hours from the date of receipt of the request, or the date of receipt of the certification, in the event that the health insurance organization or insurer requests it in accordance with section B (2) , whichever is later of the dates. In the case of controlled medications, this term should not exceed twenty-four (24) hours.		

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Special Law to Ensure Access to Treatment and Diagnosis of Cancer Patients in Puerto Rico.	Act No. 79 August 1, 2020 Section 5	Every insurer or health insurance organization that provides individual or group medical plans must have coverage available that includes mandatory treatments, medications and diagnostic tests, included in the guidelines of the National Comprehensive Cancer Network ("NCCN Guideliness") and / or approved by the Food and Drug Administration (FDA, for its acronym in English), as well as those necessary to attend and minimize its adverse effects, subject to the provisions of this Law. The "Local Coverage Determinations-LCD from First Coast Service Options, INC "; " Medicare Approved Compendia List "; " National Coverage Determinations Alphabetical Index "; " Milliman Care Guidelines "and ASES Internal Guidelines. Nothing provided in this Article shall be understood as prohibiting an insurer or health insurance organization from providing services, or including coverage of drugs or tests that are broader than those described herein.		
Special Law to Ensure Access to Treatment and Diagnosis of Cancer Patients in Puerto Rico.	Act No. 79 August 1, 2020 Section 6	Any individual or group medical plan that includes the prescription or coverage of medications, treatments and diagnostic tests must submit approval or denial of medications, treatments and diagnostic tests listed in the guidelines of the National Comprehensive Cancer Network ("NCCN Guideliness") Or those approved by the Food and Drug Administration (FDA), within a term of 24 to 72 hours of receipt of the request or within a term of 24 hours, if it is a case marked urgent or expedited. Provided that, of the individual or group medical plan, not issuing its determination within said term, it will be understood that the medications, treatments and / or diagnostic tests were approved by the same.		
Special Law to Ensure Access to Treatment and Diagnosis of Cancer Patients in Puerto Rico.	Act No. 79 August 1, 2020 Section 7	Any medical plan, individual or group, that requires the appointment of a primary care provider, may allow the appointment, in cancer patients, of a doctor specialized in oncology, as primary care provider; as long as that health professional consents to such designation.		

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Special Law to Ensure Access to Treatment and Diagnosis of Cancer Patients in Puerto Rico.	Act No. 79 August 1, 2020 Section 8	The rights established in this Act will be additional to those provided by Act 275-2012, as amended, known as the "Bill of Rights of Cancer Patients and Survivors", and will have the scope and will be governed in accordance with the requirements and procedures provided by Public Law 111-148, known as the "Patient Protection and Affordable Care Act", Public Law 111-152, known as the "Health Care and Education Reconciliation Act" and the federal and local regulations adopted under this and any other law or regulation that is successor or applicable at the federal or local level. Every patient will have the right to receive the treatment that his doctor recommends, without limitations by the insurers, that the patient receives a more effective and cutting-edge treatment, available in the market, in accordance with the coverage and protocols designed to the protection of Articles 5 and 9 of this Law. The policies, contracts, certificates or agreements offered or issued in Puerto Rico by a health insurance organization or insurer to provide, deliver, process, pay or reimburse the cost of health care services, treatments, medications or diagnostic tests included as mandatory and uniform, they will not provide that the final interpretation of the terms of the contract will be subject to the discretion of the health insurance organization or insurer, nor will they contain interpretation or review rules that contravene the provisions of this Law.		
To amend Law No. 168 of 2018, Law for the use of Telemedicine in Puerto Rico.	Act No. 68 July 16, 2020 Amends Act No. 168 August 1, 2018 Section 13 (1), (2)	The provisions included below regarding the practice of telemedicine and telehealth will apply as a result of the emergency declaration promulgated by the Governor of Puerto Rico through Administrative Bulletin No. OE-2020-020 as a consequence of the SARS-CoV-2 coronavirus, known as COVID-19. (1) Physicians and health professionals covered by this Act may use their own telemedicine or telehealth technology to care for their patients, without the need to have the corresponding Certification from the Licensing Board or their respective Examining Board. u Governing Body. (2) The Examining Board or Governing Body of each health profession covered by this Law, must immediately establish the basic guidelines to be able to attend patients using telehealth technology and notify the corresponding group of health professionals so that they can begin to use such mechanisms. No health professional authorized to practice in Puerto Rico may begin to care for patients using telehealth's own technology, until their respective board or governing body issues the corresponding guidelines according to the nature of the declared emergency. This subsection will not apply to doctors authorized to practice telemedicine as established in Joint Resolution 19-2020.		

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To amend Law No. 168 of 2018, Law for the use of Telemedicine in Puerto Rico.	Act No. 68 July 16, 2020 Amends Act No. 168 August 1, 2018 Section 13 (3), (4)	(3) All the services offered in accordance with the provisions of this Article will be subject to and will respond to the same standards of care, competence and professional conduct applicable to the offering of said services in person. Recording of therapeutic consultations, sessions or conversations is prohibited. (4) The authorization outlined in this Article does not exempt doctors and health professionals, with the fulfillment of the requirements of their respective licenses and / or ethical standards, for which they will be subject to the corresponding sanctions.		
To amend Law No. 168 of 2018, Law for the use of Telemedicine in Puerto Rico.	Act No. 68 July 16, 2020 Amends Act No. 168 August 1, 2018 Section 13 (5), (6), (7)	(5) Regardless of what is established in this Article, patient privacy will always be respected in accordance with the provisions of the Health Insurance Portability Accountability Act of 1996 or any other applicable state or federal statute or regulation. Both the Licensing Board and the Examining Board or Governing Body may adopt all the measures they deem necessary to ensure that the health providers they regulate protect the privacy of their patients; These measures must be in accordance with any applicable federal law or regulation. (6) Health insurance companies, insurers, health service organizations, pharmacy benefit managers or managers, the Health Insurance Administration (ASES) and related entities contracted by them, will be required to include within the coverage basic and pay from state or federal funds those diagnostic tests and / or medical treatment present or future to treat COVID-19, according to the prices established by the Center for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services from the United States. Likewise, the ASES will temper its requirements to eliminate the signature of the primary physician on a prescription, referral and medical order. (7) As a measure to reduce personal contact, contagion and discourage citizens from going to doctors' offices, pharmacies are ordered to dispatch refills of those chronic medications even if the patient does not have available refills or a new prescription . For this, the patient must show the empty medicine bottle in which the dose and the identity of the patient are specified. Medicines classified as controlled in classifications II, III, IV or V by federal or state laws or regulations, as well as narcotics regardless of their classification, are excepted from the foregoing.		

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To amend Law No. 168 of 2018, Law for the use of Telemedicine in Puerto Rico.	Act No. 68 July 16, 2020 Amends Act No. 168 August 1, 2018 Section 13 (8), (9), (10), (11)	(8) Any permanent or temporary building that is enabled in a service facility to attend in isolation to patients with symptoms of this virus, will be considered for all relevant legal purposes as an extension of health services in which it is located. (9) As long as this COVID-19 emergency persists, any doctor or health professional who is authorized by law to prepare prescriptions, referrals, medical order or order treatments, tests or examinations to the patient, may send the prescription, referral or order by photography or any other electronic method and the service provider that receives it will be obliged to accept it. The prescription must be sent directly by the doctor or health professional, for which reason prescriptions sent by photographs to the patient directly will not be accepted. (10) The doctors and health professionals authorized here will keep all the information necessary to document the services provided. In order to avoid insurance fraud, insurance companies, health service organizations and ASES may carry out the pertinent verifications to corroborate that, in effect, the services have been provided by the telemedicine or telehealth means themselves. (11) The doctors and health professionals authorized here must comply with the informed consent provisions established in this Law.		

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To amend Law No. 168 of 2018, Law for the use of Telemedicine in Puerto Rico.	Act No. 68 July 16, 2020 Amends Act No. 168 August 1, 2018 Section 13 (12)	(12) Billing: (a) Any doctor or health professional authorized to practice in Puerto Rico may bill the services provided using telemedicine or telehealth technology and health insurance companies, insurers, health service organizations, administrators or managers of pharmacy benefits , the ASES and related entities hired by them, will be obliged to pay it as if it were a face-to-face consultation. For these purposes, they will have to provide physicians and health professionals who so request with the corresponding codes for billing for health services provided using the technology of telemedicine or telehealth. No health insurance company, insurers, health service organizations, pharmacy benefit administrators or managers, the ASES or related entities, may refuse to pay for a service provided that is not properly codified, if its rules and procedures allow it. create the codes and / or procedures to conform to the provisions of this Law. In the case of doctors or health professionals who provide their services in accordance with this Law, but whose services are not duly codified by the ASES or a health insurance company and there is a statutory, normative, procedural or regulatory impediment to codify it, they may bill for the services provided as they normally do for a face-to-face consultation, but they must deduct ten percent (10%) from the billing of the total cost. (b) When the doctor or health professional authorized by this Article, provides their services through medical plans or health insurance, and the patient receives the services, he or she will be exempt from paying the fixed amount paid for these services or the copayment that would ordinarily pay in a face-to-face consultation, during the term of the emergency declared by the Governor as a result of COVID-19.		
Law to Regulate Cyber Therapy in Puerto Rico	Act No. 48 April 29, 2020	"Cyber therapy" is the distance practice of the professions described in the preceding paragraph, in which the individual-therapist interaction is mediated by technological communication and information tools. They should include, but are not limited to, diagnostic services, evaluation, analysis, consultation, supervision, information, education, interpretation and intervention with the needs and expectations of the individual who receives them. The practice of cyber therapy must take into consideration those aspects as defined by the "Center for Medicare Services" (CMS, for its acronym in English), so that the consultations made may be considered for reimbursement by "Medicare" or " Medicaid "		
Law to combat Covid-19	Act No. 43 April 16, 2020	All medical care, study, analysis, diagnosis and treatment of COVID-19, including hospitalization, will be free of charge for all citizens, regardless of whether they have health insurance or not. *No health insurance organization, insurer, PBM or third-party administrators may require any copayment, deductible, pre-authorization or referral to the patient, for medical care, studies, analysis, diagnosis and treatment of COVID-19, including hospitalization, as long as these services are provided in Puerto Rico.		

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Diabetes Equipment and Supplies Coverage	Act No. 19 January 12, 2020 Amends Act No. 177 of August 13, 2016 Ruling Letter No. CN-2016-209-AS	Health Plans should include, as part of their basic coverage the supply of a glucose monitor every three (3) years with replacement of damaged equipment, the supply of one (1) glucagon injection and replacement of it in case of use or expiration, and a minimum of one hundred and fifty (150) strips and one hundred and fifty (150) lancets each month for patients diagnosed with type I diabetes mellitus by a specialist in pediatric endocrinology or endocrinology. The coverage should also include the portable insulin infusion pump or microinfuser, as therapy for patients diagnosed with Type I Diabetes Mellitus. Section 4 of Law 177-2016, as amended, is amended to read as follows: “Once the patient has been diagnosed with the condition of type I diabetes mellitus, for the patient to receive the benefit established under this Law, they must submit a prescription properly Issued by a medical practitioner duly authorized to practice the profession within the jurisdiction of Puerto Rico so that a pharmacist will dispense in his original box duly sealed the authorized monthly strips and lancets under this Act.” Ruling Letter No. CN-2016-209-AS: Coverage must clearly indicate that the carrier will cover the glucometer brand ordered by the endocrinologist whenever there is a justification submitted. With regard to coverage for the insulin infusion pump, the selection of the brand of this device will be determined by the endocrinologist based on the age of the enrollee, the level of physical activity of the enrollee, and the enrollee's and/or the caregiver's knowledge regarding the condition.		
Law on the Right to Effective Detection of Breast Cancer	Act No. 10 January 3, 2020	Every insurer or health services organization will provide, as part of the benefits of preventive care of its basic coverage, mammograms and other breast cancer diagnosis and detection tests, according to acceptable practices, in accordance with the following: - a.a baseline mammogram, for women between thirty-five (35) and thirty-nine (39) years, - b.an annual mammogram for women forty (40) years of age or older - c.an annual mammogram, follow-up treatment or supplementary diagnostic tests: i. to women of forty (40) years of age or older, who have breasts of tissue classified as heterogeneously dense or extremely dense, as determined by mammography by a radiologist, based on the breast density scale of the Image and System Projection Report Breast Imaging Reporting and Data System, BI-RADS, promulgated by the American College of Radiology - ii.to women at high risk of developing breast cancer because: 1.to your family history 2.to his own history as a cancer patient 3.presence of high-risk markers in your genetic profile or 4.Some other factor determined by your doctor. Follow-up treatment or supplementary diagnostic tests for the detection of breast cancer in women aged forty (40) or older, who have breasts of tissue classified as heterogeneously dense or extremely dense, may include, but is not limited to the list of content criteria established in this law.		

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Ambulance ground transportation coverage for medical emergencies	Act No. 129 August 1, 2019	Every insurer, health service organization or other health plan provider authorized to operate in Puerto Rico must include in its basic plan or insurance, the ambulance ground transportation cover for medical emergencies. Transportation service through the 9-1-1 Emergency System, due to a medical emergency, must be paid to the ambulance provider directly for the cost of transportation. Any entity responsible for the health of a patient shall be obliged to honor, at a minimum, the rates established by Regulation of the Bureau of Transportation and other Public Services (Negociado de Transporte y otros Servicios Públicos), attached to the Puerto Rico Public Service Regulatory Board (Junta Reglamentadora de Servicio Público de Puerto Rico). Law 383-2000, known as the "Law to Prohibit Health Plans, Nonprofit Organizations Offering Health Services," is repealed, for being in conflict with the provisions contained in this Law.		

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Treatment of hyperbaric oxygenation to people diagnosed with Autism	Act No. 63 July 19, 2019	Health plans must include, as part of their coverage, the treatment of hyperbaric oxygenation to people diagnosed with Autism Spectrum Disorder, provided that it is recommended by a certified medical or healthcare professional and the treatment is allowed by law and federal regulations.		
Telemedicine	Act No. 168 August 1, 2018	The policy or contract form may, if applicable, provide coverage for a telemedicine program. In such case, the policy or contract form should include: 1. The definition of telemedicine in compliance with Act No. 168 -2018, and 2. A description of the telemedicine program, including how the covered persons can access the program. 3. If the coverage is subject to deductibles, copayments, and/or coinsurance, the same shall be disclosed.		
Down syndrome	Act No. 97 May 15, 2018	The policy or contract form shall cover tests, not limited to, genetics, neurology, immunology, gastroenterology and nutrition. Also, shall cover visits and tests referred by a physician, and therapeutic services with a remediative approach to independent living or assisted living for adults over 21 years of age. The carrier will not rescind, refuse, deny coverage or services if an insured is diagnosed with Down Syndrome. The carrier will not cancel an existing health policy if one of the beneficiaries is diagnosed with Down Syndrome and it was unknown at the time of obtaining the policy.		
Phenylketonuria (PKU)	Act No. 139 August 8, 2016	Health plans must include as part of the basic coverage, the "Phenylalanine Free Amino Acids Preparation " for enrollees diagnosed with the genetic disorder called phenylketonuria (PKU), with no enrollee age exclusions. This mandatory coverage is in addition to the recommended preventive service of screening for the genetic disorder (PKU) in newborns.		
Human Immunodeficiency Virus (HIV)	Act No. 45 May 16, 2016	Health plans must include, as part of the basic coverage, an HIV test a year as part of the routine studies for any medical evaluation, except for pregnant women to which apply the following requirements as established by the USPSTF: 1) A first HIV test during the first trimester of pregnancy at the first prenatal visit, and 2) A second test during the third trimester of pregnancy (between the (28) and (34) weeks of pregnancy.		

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Technological equipment	Act No. 62 May 4, 2015 Amends Act No. 125 of September 21, 2007	Health plans must include, as part of the coverage, the technological equipment whose use may be necessary to maintain the user alive, a minimum of one (1) daily eight (8) hour shift of nursing services provided by skilled nurses knowledgeable in respiratory therapy or specialists in respiratory therapy with nursing skills, the supplies needed to operate technological equipment and the physical and occupational therapy needed to develop the motor skills of these enrollees. For the purposes of this law, a user shall be understood to be those who use medical technology as well as children with tracheotomy to breath, and whose operation depends on medical equipment, ventilator or supplemental oxygen and those who have started treatment as minors and meet twenty (21) years and who received medical services or receive home care, continue to receive these services after serving twenty (21) years of age.		
Cancer	Act No. 275 September 27, 2012 Section 3(A)(g)	No carrier shall reject or deny any treatment agreed upon and/or included as part of the terms and conditions of the contract signed by the parties when a medical recommendation to such purposes so require. Physicians, carriers and providers shall not reject or deny treatment such as hospitalization, diagnosis, and medication to any cancer patient enrollee. With regard to cancer survivors, carriers and healthcare plans providers shall not deny coverage for the treatment and frequent and permanent monitoring of the physical health and emotional wellbeing of the enrollee.		
Cervical cancer	Act No. 275 September 27, 2012 Section 3(E)(c)	Coverage shall include pelvic exams and all types of vaginal cytology that may be required by a physician to detect, diagnose, and treat early stages of abnormalities that may lead to Cervical Cancer.		
Breast cancer	Act No. 275 September 27, 2012 Section 3(E)(d)	Every health plan shall provide extended coverage for the payment of breast cancer screening and testing such as visits to specialists, clinical breast exams, mammograms, digital mammograms, magnetic resonance mammography and breast ultrasounds, and treatment including, but not limited to, mastectomy (including males), breast reconstruction after mastectomy, reconstructive surgery of the other breast to achieve symmetry, breast prosthesis, treatment for physical complications at all stages of mastectomy, including lymphedema (swelling that sometimes occurs after breast cancer treatment), any reconstructive surgery after mastectomy that may be needed for the physical and emotional recovery of the enrollee.		
Human papilloma virus (HPV) vaccine	Act No. 255 September 15, 2012	Health plan shall cover the vaccine against the human papilloma virus (HPV) for males and females; according to the recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC). HPV vaccination beginning at age 9 years for children and youth with any history of sexual abuse or assault who have not initiated or complete the 3 doses series (ACIP recommendation). No cost sharing is applicable.		

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Psychology professionals services	Act No. 239 September 13, 2012	Health plans shall include services provided by psychology professionals trained by education with a master degree or PhD, trainings and experience to provide health care services, duly licensed by the Puerto Rico Board of Psychologist Examiners.		
Autism Spectrum Disorder	Act No. 220 September 4, 2012 Section 15	Every health plan shall provide coverage for the treatment of autism. This coverage should include, but not limited to, genetics, neurology, immunology, gastroenterology and nutrition; speech, language, psychological, occupational, and physical therapies; and will include physician office visit and the medical tests referred by them.		
Screening tests	Act No. 218 August 30, 2012 Sections 2 and 3	As part of their coverage carriers shall include, without this constituting a limitation, access to tests of: cancer, high blood pressure and cholesterol, diabetes, osteoporosis, and sexually transmitted diseases.		
Chemotherapy	Act No. 107 June 5, 2012 Section 1	A health plan that provides coverage for treatment of chemotherapy against cancer must also provide coverage of the chemotherapy against cancer in their various methods of administration of the drug, such as intravenous, oral, injectable track or intrathecal route; according to the order of the specialist doctor or oncologist.		
Designation of Primary Care Provider and Direct Access to OB/GYN Services	Act No. 161 November 1, 2010 Section 6(i)	A health plan must cover direct access to gynecology and obstetrics care services without requiring referrals or previous authorization, insofar as such physician participates in the network of the healthcare providers.		
Designation of Primary Care Provider and access to pediatricians	Act No. 161 November 1, 2010 Section 6(j)	A health plan providing coverage for a minor as an enrollee must allow the parent or tutor to select a pediatrician as his/her primary care provider, insofar as such pediatrician participates in the network of healthcare providers.		
Prescription Opioid Drugs	Act No. 140 September 22, 2010	A health plan shall include, as part of the coverage, the medication known as buprenorphine for treatment of opioid dependence in the "Medicaid Preferred Drug List," or the preferred drug list.		
Bariatric surgery	Act No. 212 August 9, 2008	All carriers shall provide, subject to preauthorization, coverage for one (1) bariatric surgery per lifetime for the treatment of morbid obesity using one of the following techniques: gastric bypass, adjustable gastric band or sleeve gastrectomy. The intragastric balloon technique is excluded from the law. The carrier may require a waiting period that shall not exceed twelve (12) months, before cover for the benefits stipulated in this act. For the preauthorization of these services, the first treatment for the morbid obesity should be dietetic and in changes in the life style. The physician must document the unsuccessful attempt(s) with nonoperative medically supervised weight reduction program(s). For purposes of this act, morbid obesity means a body mass index of at least thirty-five (35) kilograms per meter squared, or greater. Bariatric surgery refers to the various surgical procedures performed to treat obesity, which can be practice by the following four techniques: gastric bypass, adjustable gastric band or sleeve gastrectomy or intragastric balloon.		

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GOVERNMENT OF PUERTO RICO
OFFICE OF THE COMMISSIONER OF INSURANCE
PUERTO RICO FORM FILING CHECK LIST
INDIVIDUAL MARKET

SUBJECT	REGULATORY REFERENCE	COMMENTS	Please specify location (Form/Page/Paragraph/ Other) of complying provision/language * <u>or attach explanation for a N/A response **</u>	FOR OFFICIAL USE ONLY
Dependents	Act No. 116 July 17, 2008	Amends Act No. 15 of February 27, 2007, in order to correct the scope of the measure and to extend the term of effectiveness of said act. Provides that the underwriters of the carriers in Puerto Rico shall accept, in a family coverage, the inclusion as enrollees of minors whose custody or guardianship has been granted to the grandparents or other participating family members, and those of legal age who have been declared disabled, whose guardianship has been granted, when the person to whom custody or guardianship has been granted is the primary enrollee of the health plan.		
Naturopathic Physician	Act No. 210 December 14, 2007	A health plan shall provide access to the health services and treatment by a <i>naturopathic physician</i> , if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed naturopathic physician, authorized by the Commonwealth of Puerto Rico. Also, the contract must disclose the applicable copayment or coinsurance.		
Audiology	Act No. 127 September 27, 2007	A health plan shall provide access to the health services and treatment by an audiologist, if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed audiologist physician, authorized by the Commonwealth of Puerto Rico. Also, the contract must disclose the applicable copayment or coinsurance.		
Respiratory syncytial virus (RSV)	Act No. 165 August 30, 2006	All carriers are required to include in the contract the vaccine against respiratory syncytial virus as part of their pediatrics coverage.		
Chiropractor	Act No. 150 August 8, 2006	A health plan shall provide access to the health services and treatment by a chiropractor, if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed chiropractor, authorized by the Commonwealth of Puerto Rico. Also, the contract must disclose the applicable copayment or coinsurance.		
Universal Neonatal Hearing Screening Test	Act No. 311 December 19, 2003	A contract which is available or may be available, renewed, extended, or modified in Puerto Rico by any carrier with benefits applicable within the contract, shall include coverage for initial hearing screening and for any other hearing evaluation within the follow-up care related to the hearing screening described in this act. As provided by the act, the service shall be rendered in Puerto Rico even though the carrier is located outside of Puerto Rico. The benefits of the Universal Neonatal Hearing Screening Test to newborn babies, as well as the follow-up care shall be subject to the same co-payment and co-insurance provisions applicable to any other medical service. With the exception that the benefit of neonatal hearing screening shall be exempted from co-payments/coinsurance or provisions that limit the maximum amount to be paid by the carrier.		
Health Professionals definition	Act No. 148 August 9, 2002 Section 6(d)	A health plan shall provide access to the health services and treatment by a podiatrist, optometrist or psychologist, if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed podiatrist, optometrist and clinical psychologist, authorized by the Commonwealth of Puerto Rico. Also, the contract must disclose the applicable copayment or coinsurance.	AMENDED BY LAW 79-2021	

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Health Professionals definition	Act No. 194 August 25, 2000 Section 6	Defines “Health Professional” as any practitioner duly allowed to practice in Puerto Rico, according to the applicable act and regulations, any of the health and medical care health professions including but not limited to, physicians, surgeons, dentists, pharmacists, nurses and medical technologists, as authorized by the corresponding act of Puerto Rico.	AMENDED BY LAW 79-2021	
Termination	Act No. 194 August 25, 2000 Section 7(a)	A contract shall contain a clause providing that in cases in which health plan coverage is terminated or cancelled, or coverage by a provider is terminated or cancelled, the carrier shall notify the enrollee of such termination or cancellation thirty (30) calendar days before the date such termination or cancellation becomes effective.		
Extension of Benefits	Act No. 194 August 25, 2000 Section 7(b)	The contract shall contain a clause providing that subject to payment of premium as required, should the health plan or the provider terminate coverage, the enrollee may continue receiving the benefits thereof for a transitional period of ninety (90) days as of the date the health plan or the provider terminates coverage. 1. In those cases in which the enrollee is hospitalized at the time of the date of said termination of coverage, and the release of the enrollee from the hospital has been scheduled for a date preceding the date of termination of coverage, the transition period shall be extended from said date to ninety (90) days after the date the enrollee is released. 2. In those cases in which the enrollee is in her second trimester of pregnancy as of the date of termination of coverage and the provider has been offering medical treatment pertinent to the pregnancy before the date of termination of coverage, the transitional period concerning pregnancy-related health care shall be extended to the date the mother is released from hospital after childbirth, or the date the newborn is released from the hospital, or both, whichever occurs later. 3. In those cases in which the enrollee is diagnosed a terminal condition before the date of termination of coverage and the provider has been offering medical treatment pertinent to the condition before said date, the transitional period shall be extended for the remainder of the enrollee’s life. Providers that continue the treatment of the enrollees during said period must accept the payments and rates fixed by the health plan as full payment for services rendered, as well as continue providing the plan with all the necessary information required for purposes of quality control, and surrender or transfer the medical records corresponding to the enrollees upon termination of said transitional period.		

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Emergency services	Act No. 194 August 25, 2000 Section 8(c)	A health plan shall provide emergency service benefits with no waiting period. The previous authorization of the carrier shall not be required when providing these emergency services. Furthermore, these services shall be provided regardless of whether the provider of such emergency services is a participating provider. In the event that an enrollee is provided services by a provider not contracted by the carrier, the enrollee shall not be held liable for the payment of services in an amount exceeding the amount applicable if the enrollee had received such services from a provider contracted by the carrier. The carrier shall compensate the provider offering the services, and the provider shall be under the obligation to accept said compensation, for an amount not to be less than the agreed with the providers contracted by the carrier to offer the very same services. Moreover, under these circumstances, such emergency services shall be provided regardless of the conditions set forth by the corresponding health plan.		
Experimental or Investigational Treatment	Act No. 194 August 25, 2000 Section 9(g)	A health plan shall contain a provision setting forth that the carrier shall pay the routine medical expenses of any enrollee suffering from a life-threatening condition for which there is no effective treatment, when the enrollee is eligible for participating in an authorized clinical treatment study pursuant to the study protocol provisions concerning said treatment, provided the participation of the enrollee offers a potential benefit to he/she and the physician referring the enrollee believes that participation in said study is pertinent, or the enrollee presents evidence of the fact that participation in said study is pertinent. Routine medical expenses of the enrollee shall not be construed to be expenses related to the study, or tests administered to be used as part of the study, or expenses the entity conducting the study is likely to pay.		
HIV/AIDS Virus	Act No. 349 September 1, 2000	Bill of Rights for carriers of the HIV/AIDS Virus in Puerto Rico. Right to the best assistance and treatment, without any restriction , to guarantee a better quality of life.		

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Maternity Care	Act No. 248 August 15, 1999	Any carrier that provides maternity benefits shall provide a minimum coverage of forty eight (48) hours of care in the hospital facilities in benefit of the mother and her newborn child (or children) if it is a natural birth without complications, and a minimum of ninety-six (96) hours if she required a caesarean section. Any decision that has the effect of shortening the period of time provided above shall have to be determined by the attending purveyor with the acceptance of the enrollee. If the mother and the newborn are released within a period that is less than what is provided in this section, but in accordance with the second paragraph, the coverage shall provide for a follow-up visit within the next forty-eight (48) hours. The services shall include, but shall not be limited to the attention and physical care of the child, instruction on the care of the child for both parents, help and training on breast feeding, information regarding home care, and the provision of any treatment, and medical tests for the infant as well as for the mother. The language of the contract include the act number and its date of approval.	☐ Yes ☐ No	
General anesthesia	Act. No. 352 December 22, 1999	A health plan that provides coverage for general anesthesia services, hospitalization services and dental services in the contract, shall not be able to exclude or deny coverage for general anesthesia to be administered by an anesthesiologist and hospitalization services when: (1) when a pediatric dentist, an oral or maxillofacial surgeon who is a member of the medical faculty of a hospital determines that the condition or ailment of the enrollee is significantly complex according to the criteria established by the American Academy of Pediatric Dentistry, (2) when the enrollee, because of his/her age, impediment, or disability, is unable to resist or tolerate pain, or cooperate with the treatment indicated in the dental procedures, (3) when the infant, boy, girl, adolescent, or person with a physical or mental impediment has a medical condition in which it is indispensable to carry out dental treatment under general anesthesia in an ambulatory surgical center or in a hospital, and that otherwise could pose a significant threat to the enrollee's health, (4) when local anesthesia is ineffective or contraindicated because of an acute infection, anatomic variation, or allergic condition, (5) when the enrollee is an infant, a boy, a girl, an adolescent, or a person with physical or mental disability, and is in a state of fear or anxiety that prevents performing the dental treatment under the procedure traditionally used in dental treatments and the condition is so critical that postponing or deferring treatment would result in pain, infection, loss of teeth, or dental morbidity, (6) when an enrollee has received an extensive and severe dental trauma where the use of local anesthesia would jeopardize the quality of the services or would be ineffective to handle the pain and apprehension. Preauthorization. Every carrier that requires preauthorization to provide the general anesthesia and hospitalization services coverage, as determined by a pediatric dentist, oral or maxillofacial surgeon, shall approve or deny it within two (2) days from the date the enrollee submits all the documents required by the carrier. The required documents shall be: (a) the enrollee's diagnosis; (b) the enrollee's medical condition; and (c) the reasons that justify for the enrollee to receive general anesthesia to perform the dental treatment.		

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Federal Laws				
Mental Health Parity Act		The services provided under the contract regarding mental conditions must comply with the "Mental Health Parity Act". There shall be no distinction between a mental disorder and any other medical condition in terms of the access to the services that persons shall need. In addition, the contract may not include any limitations on visits to a psychiatrist, collateral visits, group therapy and residential treatments.		

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Circular and Rulings Letters				
Obligation to provide Influenza treatments and tests; Mandatory immunization coverage	CN-2022-325-D November 18, 2022	Administrative Order No. 554 - establish the obligation of all health services organization that administers a plan of public or private health, to provide treatments, medicines and diagnostic tests to the patients with influenza symptoms.		
Test rates for the detection of Covid-19	CN-2022-315-AS May 10, 2022	Insurers and health insurance organizations should not amend through circular letters or other documents the fees they pay to their providers for COVID-19 screening tests, or group codes.		
OCS postal address	CC-2021-1979-D January 25, 2021	Direccion postal OCS Oficina del Comisionado de Seguros 361 Calle Calaf PO Box 195415 San Juan, PR 00919 Edificio World Plaza 268 Ave. Munoz Rivera San Juan, PR 00918		
SELECTION OF INDEPENDENT REVIEW ORGANIZATION	CC-2020-1977-D November 18, 2020	Independent External Reviews will be conducted through the independent review body "Maximus Federal Services, Inc".		
Billing Codes for diagnostic services, sampling and treatment of covid-19	CN-2021-292-D January 28, 2021	Billing Codes for diagnostic services, sampling and treatment of covid-19		
CODES AND FEES OF TESTING FOR THE DETECTION OF COVID-19	CN-2020-289-D December 11, 2020	Insurers and organizations are required to provide the health service providers and / or laboratories that administer tests for the diagnosis of COVID-19 within a term of five (5) days from the date of this Normative Letter. , the corresponding billing codes, sample collection codes, and fees for the molecular test, antigen test, and serological test, respectively.		
Personal Protective Equipment Cover for Dental Services	CN-2020-279-D June 16, 2020	Insurers and health care organizations are required to include the D1999 code on dental coverage for commercial health plans. The D1999 code must be billed by a dentist, under a current contract with an insurer or health services organization, accompanied by the dental procedure (s) performed per day and which are part of the patient's coverage, after their in-person visit to the dental office the rate corresponding to this code, which should not be less than \$ 35.00 per face-to-face visit to the dental office		

NEW!

NEW!

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AMENDMENT TO REGULATORY LETTER NO. 2020-274-D	CN-2020-278-D May 14, 2020	For the purpose of expanding its scope in accordance with the provisions of Joint Resolution 32-2020 and Law No. 48-2020. The provisions of Normative Letter CN-2020-274-D remain in force, as amended by what is established herein. the patient who receives medical or psychological attention through the use of telemedicine or telephone, will be exempted from paying shared costs for these services during the term of the Joint Resolution.		
PAYMENT TO HEALTH SERVICE PROVIDERS USE OF TELEMEDICINE	CN-2020-274-D April 8, 2020	All health services organizations and insurers that underwrite commercial health plans and Medicare Advantage honor the payment of services provided by health service providers, whether physical or mental health, through the use of telemedicine based on the same rate as if the service was provided in person face to face.		
AMENDMENT TO REGULATORY LETTER NO. CN- 2020-265-D	CN-2020-269-D March 20, 2020	Availability of coverage for the COVID-19 diagnostic test will be provided by insurers and health service organizations that subscribe to group and individual medical plans in the private sector “free of cost sharing” (including deductibles, copays and coinsurance) to the insured, in cases where the test is ordered to be performed in accordance with medical criteria. Neither may it establish prior authorization requirements or other service utilization management requirements.		
Access to Health Services	CN-2020-268-D March 16, 2020	Grace Period for Premium Payment, Medication Dispatch, Out-of-Network Providers, Pre-authorizations and Referrals, Telemedicine, Term for the presentation of claims		
GUIDELINES ON CARE FOR CORONA VIRUS (COVID-19)	CN-2020-265-D March 11, 2020	• Inform their insured on their internet portals and customer service telephone lines about the providers available to go to receive medical care services. • Allow free access to providers outside the network, in case of insufficient or unavailable providers • Provide coverage for emergency health services without prior authorization, regardless of whether the provider is a participant in your network. • Provide coverage, free of out-of-pocket cost to the insured (copayments, deductibles or coinsurance), for immunization services against COVID-19 • Rescind the requirement of pre-authorizations or step treatment, when for reasons of medical criteria a drug is recommended outside the formulary to treat any health condition associated with COVID-19		
Maximum Out of Pocket	Ruling Letter No. CN-2013-159-AS October 22, 2013	The Maximum Out of Pocket Limit (MOOP) that carriers should apply in their coverages, as established by the Commissioner, is \$6,350 individual coverage and \$12,700 family coverage.		

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Meningitis vaccine	Ruling Letter No. 2011-131-AV September 1, 2011	Require that health plans must include the meningitis vaccine as part of the basic coverage.		
Preventive Services	Ruling Letter No. N-AV-7-8- 2001 July 6, 2001	Requires every carrier to offer, as part of basic coverage, an annual medical evaluation that includes preventive services required by Act No. 296 of September 1, 2000 without any cost sharing beyond the premium originally established for said plans. The mentioned act imposes to the Puerto Rico Department of Education the responsibility to ensure that each child received an annual medical evaluation at the beginning of the school year. Said medical evaluation must include physical and mental evaluation, oral hygiene, hearing and visual tests, as well as periodic tests recommended by the American Academy of Pediatrics.		
Hospital services	Ruling Letter No. N-AV-12-111- 99 December 20, 1999	Requires that all carriers shall stipulate that in such cases in which an enrollee decides to use a private hospital room, instead of a semi-private room, he or she will be responsible for the difference in cost that this utilization represents. In addition, all health plans shall stipulate that unless in the cases of differences in the cost of the hospital rooms, the providers cannot charge to enrollees in a private rooms different quantities to those that have the rights to charge if said enrollee was confined in a semi-private room.		
HIPAA	Ruling Letter No. N-AV-10-90- 97 November 24, 1997	Establishes that the Health Insurance Portability and Accountability Act (HIPAA) is applicable in our jurisdiction and preempts the Insurance Code, with regard to the provisions required in the act, which are not provided in said Code or which are less stringent than the federal requirements.		
Ambulance services	Ruling Letter No. N-C-8-71-95 October 13, 1995	Requires that all carriers that provides ambulance services in their coverage must stipulate that the ambulance companies that will render the services must be authorized by the Puerto Rico Commission of Public Services.		

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HIV Screening	Circular Letter No. CC-2014-1848-AS January 22, 2014	Regarding pregnant women, all carriers are required to cover and will not impose cost-sharing requirements with regard to the following tests included in the most recent recommendations of the "United States Preventive Services Task Force (USPSTF): 1) A first HIV test during the first trimester of pregnancy at the first prenatal visit, and 2) A second test during the third trimester of pregnancy (between the 28th and 34th week of pregnancy).		
Essential Health Benefits	Circular Letter No. 2013-1825-D March 1, 2013 and Section 2.050(D)(1) Health Code	All carriers that provide health plans to individuals and small groups, with the exception of grandfathered plans, large groups and large groups for Bona Fide Associations, will have to include in such plans at a minimum essential health services known as Essential Health Benefits (EHB). EHB include benefits and services in at least the following ten categories: 1. Out-patient (ambulatory) services and medical-surgical services 2. Emergency services 3. Hospitalization 4. Maternity and newborn care services 5. Mental health and substance use disorder services 6. Laboratories, X-Rays and diagnostic testing services 7. Pediatric services including the respiratory syncytial virus vaccine, the cervical cancer vaccine, the vision and dental care 8. Prescribed medication 9. Rehabilitation and habilitation services and equipment 10. Preventive, wellness, and management of chronic disease services 11. Any other mandatory service or benefit required by Commonwealth or Federal laws or regulations The EHB Benchmark Plan selected for Puerto Rico was Optimo Plus PPO. Exclusively with regard to pediatric vision services, the rule provides for using the coverage of the Federal Employees Dental and Vision Insurance Program (FEDVIP) to define the EHB that must be included in health plans.		
ADDITIONAL REQUIREMENTS				
Coordination of Benefit	Chapter 11 / Insurance Code § 11.110(1)	The contract shall include a coordination of benefit provision in compliance with the Coordination of Benefit Model Regulation of the NAIC.		
Medicare Supplement Policies disclosure notice	Rule L Regulation of the Insurance Code § 17(D)(1) Appendix C	Notice related to contracts or certificates which are not Medicare Supplement Policies. Disclosure Statements. Instructions for use of the disclosure statements for health plans sold to Medicare beneficiaries that duplicate Medicare.		

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Definitions		The contract has been revised to verify that all terms define in the same are actually being use.	☐ Yes ☐ No	
Table of Copayment, Coinsurance and Deductibles (Contract)		The Table of Copayment, Coinsurance and Deductibles of the contract include the cost sharing for all the covered services. This verification has been performed by the carrier.	☐ Yes ☐ No	
Providers Directory		The submission include the provided directory in the supporting documentation tab.	☐ Yes ☐ No	
Drug Formulary		The submission include the drug formulary by therapeutic category in the supporting documentation tab. The drug formulary include contraceptives for each of the types as approved by the FDA.	☐ Yes ☐ No ☐ Yes ☐ No	
Crime or Felony		Exclusions or limitations related to the commission or the attempt to commit a crime or felony clearly indicate that apply, except if any injury results from domestic violence or a medical condition.	☐ Yes ☐ No	
Service connected		Exclusions or limitations related to service connected injuries or conditions are not included. Language related to service connected injuries or conditions can be included in a Subrogation clause.	☐ Yes ☐ No	
Application Forms	Section 14.100 of the health insurance code Section 27.50 of the Insurance Code Rule 102 of the Regulations of the Insurance Code	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months. The application contains the prescribed fraud warning statement above the insured's signature. The application contains a question requiring information with respect to other health insurance, for the Coordination of Benefits. If the health plan will be marketed by electronic means, the application must contain the required disclosures regarding the delivery of all policy documents, the right to obtain a paper copy free of charge and other applicable disclosures.	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

CERTIFICATION

I _____ have reviewed or supervised the preparation of the above checklist and certify that the form(s) and/or drug formulary is (are) in compliance with all of the applicable requirements of the Insurance Code of Puerto Rico, Health Insurance Code of Puerto Rico, Federal and State Laws, Ruling and Circular Letters related to the Individual Market and that the form(s) and/or drug formulary does (do) not contain dispositions previously disapproved or required to be corrected by the Office of the Commissioner of Insurance of Puerto Rico. I also acknowledge responsibility for the validity, accuracy and completeness of the contents of this checklist, the transmittal letter and enclosures with the filing.

Signature: _____

Date: _____

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SMALL GROUP MARKET

COMPANY: _____
FORM NUMBER: _____
SERFF TRACKING NUMBER: _____
TYPE OF INSURANCE (TOI) _____

ATTACHMENT 7B
REVISED 02/2023

SUBJECT	REGULATORY REFERENCE	COMMENTS	Please specify location (Form/Page/Paragraph/ Other) of complying provision/language * <u>or attach explanation for a N/A response **</u>	FOR OFFICIAL USE ONLY
Licensing	§ 303	The carrier ¹ is licensed to transact disability insurance business or is authorized as a Health Service Organization in Puerto Rico.		
Final Form	§ 1111	The form(s) is(are) in the final format in which it(they) will be issued. No draft, highlighted, redline or watermark is(are) included in the Form Schedule Tab.	☐ Yes ☐ No	
Filings made on behalf of the carrier by another party	Circular Letter CC-2015-1870-AV/AS	A letter authorizing the third party to act on behalf of the carrier is included in the Supporting Documentation Tab and provides the following information: (a) on carrier's letterhead or include the carrier name in the "Re" line of the authorization; (b) specifically addressed to the Office of the Commissioner of Insurance of Puerto Rico; (c) properly executed by an authorized officer of the carrier; (d) dated; and either (e) specific to the file submitted for approval by including form number(s); or (ii) generally applicable to all contract forms filed on behalf of the carrier as long as a copy of such authorization is included in each submission.		
Cover Letter-Resubmissions	Rule XXIV	If the form has been previously submitted to the OCI and the file was closed or withdrawn, any resubmission's cover letter must reference the SERFF tracking number of the previously closed file and address all outstanding issues in the new cover letter. The new cover letter shall include a reference where each objection has been addressed within the forms.	☐ Yes ☐ No	
Cover Letter		If the insurer or health services organization intends to subscribe the health plan by electronic means, it must mention it in the cover letter.	☐ Yes ☐ N/A	
Cover Letter		In relation to metallic plans, the cover letter indicate if the carrier will be offering these forms outside the open enrollment period, with or without waiting period.	☐ Yes ☐ No	

Updated

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SMALL GROUP MARKET

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Cover Letter	Circular Letter CC-2015-1870-AV/AS Rule XXIV	The filing include a cover letter under the Supporting Documentation Tab in SERFF, which includes: a. A detailed explanation as to the purpose of the filing, and the intended use for each submitted form. b. Disclose if form is new or replacement. If it is an amendment, endorsement or rider, the contract it will go with. c. The signature of a representative of the carrier, authorized to submit forms for filing or approval for the carrier. d. A description of any innovative or unique features of each form. e. In the "Re" section, the identification form number of all the forms submitted for approval are displayed with the same form number that appears in the lower left corner of the form. This means that if the word "Form" does not appear in the lower left corner then it should not be part of the Form Number on the cover letter. f. The name of the carrier presenting the submission and is signed by a representative of the carrier authorized to submit forms for filing or approval. g. Explanation on whether or not the form is replacing a previously submitted form. h. If the form replaces a previously approved form, the cover letter identify and explain the material differences or changes made to the form. i. indicate the SERFF tracking number of the filing where the rates applicable to the form(s) were submitted.	☐ Yes ☐ No	
Variability (bracketed language)	§ 1111 § 1112	Forms with variable bracketed information must include all the possible language that might be placed within the brackets. The use of too many variables will result in filing disapproval, as OCI staff may not be able to determine whether the filing is compliant with Puerto Rico laws and regulations. The submission must include a separate detailed Memorandum of Variable Material to explain any variable material in the form(s). In order to be approved, any form will need to be furnished accompanied by the intended alternate, replacement, and/or additional language. The use of these brackets, within the approved form, will be limited to the alternatives filed by the carrier.	☐ Yes ☐ N/A	

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Variable Language Blank pages	§ 1111	Brackets around an entire page constitute a "blank" or generic form – not permitted		
Red-lined, highlighted, draft or watermark copies		Redline, highlighted, draft or watermark copies are not approvable and must be placed on the SERFF Supporting Documentation Tab.	☐ Yes ☐ N/A	
Amendments or Endorsements	§ 1118	The contract may not be modified unless the modification is in writing and agreed to by the party against whose interest the modification operates.		
Rider a Rider	§ 1112	Companies may not "rider a rider", "endorse and endorsement" or "amend an amendment".	☐ Yes ☐ N/A	
Form Number		A form identification number (consisting of numerical digits, letters, or both) appears in the lower left-hand corner of the cover page and in all the pages of the form(s). The form identification number is the same in all pages.	☐ Yes ☐ No	
Cover Page		The licensed Puerto Rico carrier's name appears on the cover page of the form(s), as well as the cover page of each rider, amendment, application and endorsement form. Full street address of the carrier's Home Office (bracketed or underlined to reflect possible future changes) for disclosure purposes appears on the cover page or back page of the form. A brief description of the contract (e.g., "individual metallic plan platinum" "small group metallic plan gold") appears on the form cover page. The signature of at least one officer of the carrier appears in the first page, in order to execute the contract. Signatures appearing on contract form(s) can be bracketed to denote variability.	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
Unfair, Misleading, Deceptive Provisions.		Form(s) does(do) not include inequitable, unfairly discriminatory, misleading, deceptive, obscure, unfair, encourage misrepresentation, or not in the public interest provisions. Form(s) does(do) not contain inconsistent, ambiguous or misleading clauses, or contain exceptions and conditions that unreasonably affect the benefits purported to be provided in the coverage.	☐ Yes ☐ No	
CHAPTER 17 OF THE INSURANCE CODE OF PUERTO RICO (Insurance Code)				
Group Status	§ 1701(3)	No group disability insurance policy shall be issued for delivery in Puerto Rico, unless it is in agreement with one of the descriptions contained in Section 14.010. The Ssubmission letter should include a statement that the policy or contract form will be sold to a group specified in the Insurance Code.	☐ Yes ☐ No	
Grace Period Provision	§ 1703	This provision must be included and must be no less favorable to the insured than the statutory provision.		
Certificates	§ 1706	The insurer shall issue to the policyholder, for delivery to each insured person, an individual certificate stating the protection which the insured person, who will be paid the insurance benefits and the rights and conditions established in subsections (1), (2), (3) and (4) of § 1707 of this title.		

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Conversion – Right to a New Contract After Termination	§ 1707	This provision must be included and must be no less favorable to the insured than the statutory provision.		
HEALTH INSURANCE CODE OF PUERTO RICO (Health Code)				
Definitions	§ 2.030 § 4.030 §10.030 § 22.030 § 24.030 § 28.030 § 52.030 § 72.030 § 48.020	Definitions included in the policy or contract form must comply with Sections 2.030, 4.030, 8.030, 22.030, 24.030, 28.030, 52.030 and 72.030 of the Health Insurance Code. Do not duplicate definitions. Definitions must be included as long as the contract uses the term. Also, if a same definition is included under more than one law, the definition must apply to the specific intention of each law.	☐ Yes ☐ No	
Dependents coverage	Sections 2.03(G)	If dependent coverage is selected by the group, this policy or contract form provides coverage of children until the age of 26. Conditions limiting the dependent coverage based upon financial dependency, marital status, enrollment in school, residency or other factors are not applicable. Also, the definition of "Dependent" must comply with Sections 2.030(G) of the Health Code.		
Prohibition on Annual and Lifetime Dollar Limits	§ 2.050 (A)(1) § 2.050 (A)(2)	This policy or contract form must not include annual or lifetime limits on essential health benefits.		
Preventive Services	§ 2.050(C)	This policy or contract form provides coverage for the following preventive care and screenings for children and adults with no cost-sharing:		
Emergency Services	§ 2.050(F)	This policy or contract form provides coverage for the treatment of an emergency condition in a hospital: *Without the need for any prior authorization; * Regardless of whether the provider is a participating provider; * Without imposing any administrative requirement or limitation that is more restrictive than that required for participating provider services, and at the in-network cost-sharing level.		
Designation of Primary Care Provider and access to pediatricians	Chapter 2 / Health Insurance Code § 2.050(G)	If the policy or contract form requires the designation of a primary care provider, the form permits the designation of a physician who specializes in pediatrics, when the enrollee is eighteen (18) years old or less, as the child's primary care provider, provided that such provider participates in the network of participating providers of the health plan. (Only applicable to coverage managed through referrals and the designation of primary care provider is required)		
Designation of Primary Care Provider and Direct Access to OB/GYN Services	§ 2.050(H)	If this policy or contract form requires the designation of a primary care provider, it must not require prior authorization or referral to obtain obstetrical and gynecological care provided by participating providers. (Only applicable to coverage managed through referrals and the designation of primary care provider is applicable)		
Pre-existing Conditions	§ 2.050 (I) § 8.070(C)(1)	No group health plan shall deny, exclude or limit the benefits of an enrollee based on preexisting conditions, regardless of the age of the enrollee.		

Updated

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Rescission	§ 2.050(J)	Coverage may only be rescinded or cancelled for fraud or intentional misrepresentation of material fact. Notification must be given to the insured (30) calendar days prior to cancellation. Recovery of the provided services cost is not allowed.		
Prescription drugs	§ 4.060(A)(1)(b)	Information indicating which prescription drugs, if any, are subject to a management procedure that has been developed and maintained is disclosed in the contract.		
Changes to the formulary	§ 4.060(A)(2)	The contract shall establish that changes in the formulary or other prescription drug management process during the term of the contract shall only be made if such change is being made for safety reasons, because the prescription drug cannot be supplied or has been withdrawn from the market by the drug's manufacturer, or if such change entails the inclusion of prescription drugs in the formulary. To such effects, the carrier shall provide or entrust a third party to provide notice of that change to all enrollees and pharmacies not later than the effective date of the change.		
Formulary Exceptions	§ 4.070	This policy or contract form must provide for a formulary exception process for prescription drugs not on the insurer's formulary. The contract must include the Medical Exceptions Approval Process Requirements and Procedures in accordance to Section 4.070. The language of this section must be included in the contract in the same format and order established in Section 4.070.		
Disclosure	§ 4.100	The contract, certificate, membership booklet, outline of coverage, evidence of coverage, or any other document provided to an enrollee shall include the disclosures required in Section 4.100.		
Maintenance medications	§ 4.120	The policy or contract form shall establish that for insured's that so require, insofar as it does not jeopardize his or her health, and at the discretion of the healthcare provider, the healthcare provider may prescribe refills for maintenance drugs up to a term that shall not exceed one hundred eighty (180) days, subject to the limitations of the health plan's coverage.		
Waiting period	§ 8.030(O)	Health plans with waiting periods must define the term 'Waiting Period' as the period of time that must pass before coverage for a covered person or enrollee who is otherwise eligible to enroll under the terms of a health plan can become effective. However, emergency room services will not have a waiting period and the waiting period for preventive services may not exceed thirty (30) days.		
Waiting period	§ 8.070(C)(3)	Health plans of small groups and small group health plans for bona fide associations may not have a waiting period that exceeds (90) days. However, emergency room services will not have a waiting period and the waiting period for preventive services may not exceed (30) days. In the case of a health plan that contains a waiting period, the carrier must reduce it if the enrollee has a creditable coverage, and it has ended on a date not before (90) days prior to the date of enrollment to the new health plan. The reduction provided shall be for the entire period of creditable coverage.		
Renewal	§ 8.060	The policy or contract form provides that except as specified in § 8.060, the insurer must renew or continue in force such coverage at the option of the group.	☐ Yes ☐ No	

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Eligibility	§ 8.070(C)(2)	A carrier may not establish eligibility or renewal rules in a health plan through which it is discriminated by reason of a factor related to the health of the enrollee. Eligibility rules will be understood as those related to the following: the subscription in a health plan, the rate, the effective date of the coverage, waiting periods, late enrollees, special subscription periods, election of benefits, inclusion of dependents or cover termination, among others.	☐ Yes ☐ No	
Pregnancy	§ 8.070(C)(4)	Health plans for small groups or bona fides associations will not impose any exclusion due to pregnancy.		
Enrollment Period	§ 8.070(C)(5)	Carriers will allow late enrollees to subscribe according to the terms of the health plan during a special subscription period if: (a) The late enrollee was covered by another health plan when the health plan for PYMES or small groups of bona fide associations was offered, including a health plan in accordance with the provisions of COBRA; (b) The other health plan held by the late enrollee was terminated in accordance with the eligibility requirements of said health plan, which include separation, divorce, death, termination of employment, or reduction in the number of hours of employment or employer contributions to the other coverage have been terminated; and (c) The late enrollee requests to take advantage of the health plan of employers of PYMES or small groups of the bona fide association, no later than (30) days from the expiration date of the other health plan.		
Enrollment Period	§ 8.070(C)(6)	Any carrier providing a health plan to employers of PYMES or small groups of the bona fides associations will establish a special period for the enrollment of dependents, during which the dependent and the eligible employee or member of the bona fide association, if not subscribed by another way, can enroll to the health plan, in the case of birth, adoption of a child, adjudication of custody or guardianship, or in the case of marriage. The special enrollment period shall be a period of no less than (30) days and shall begin on the later date of the following: (a) The date on which the health plan for dependents becomes available; or (b) The date of marriage, birth, adoption or adjudication of custody or guardianship. If the eligible employee or member of the bona fide association enrolls the dependent during the first (30) days of the special enrollment period, the effective date of the health plan shall be as follows: (i) In the case of marriage, the first day of the month beginning after the date on which the request for enrollment was received; (ii) In the case of a dependent's birth, as of the date of birth; and (iii) In the case of a dependent's adoption award of custody or guardianship, the date of the adoption or award.		

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Minimum participation requirements - PYMES	§ 8.070(C)(7)	PYMES employer carriers shall not require a minimum participation level greater than: (a) (100%) of eligible employees working for employers of three (3) or less employees; and (b) (75%) of eligible employees working for employers with more than four (4) employees. In applying minimum participation requirements with respect to a PYMES employer, an issuer shall not consider employees or dependents who have creditable coverage in determining whether the applicable percentage of participation is met. Individuals covered under a health plan pursuant to continuation provisions of COBRA shall not be considered. Issuers shall not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a PYMES employer at any time after such employer has been accepted for the health plan. <i>(Only applicable to PYMES)</i>		
Minimum participation requirements - Bonafide Associations	§ 8.070(C)(8)	The small group health plans of the bona fide associations will be subscribed through a group health plan issued by carrier, in favor of the bona fide association, subject to compliance with each of the following requirements: (a) All members of the bona fide association, employees of the member employer and their dependents shall be eligible for health plan, regardless of the existence of any factor related to the state of health; (b) The premium to be charged shall be paid by the members of the enrolled bona fide association; (c) In order to issue the coverage, the carrier will not require a level of participation that is greater than a minimum of (25) members of the bona fide association's health plan; (d) A bona fide association may negotiate and contract the group health plan for the benefit of the members of said association with one or more carriers. For the bona fide association to contract with more than one carrier, each member of the bona fide association shall have the right to select, among the available group health plans, the one that offers the premiums, coverage and benefits that best fit their needs. (e) Two or more small groups of bona fide associations may be grouped for purposes of negotiating services for their members. If the grouping exceeds the number of (50) members, the grouped bona fide associations will be considered as a large group. (f) No carrier may enroll to health plans for small groups or large groups of bona fide associations that do not meet all the criteria established in the definition of the Bona Fide Association. Nor can any entity that does not meet the criteria established in the definition of bona fide association be able to process in any way health plans of groups of bona fide associations to its members. <i>(Only applicable to small group health plans for bonafide associations)</i>		
Eligibility	§ 8.070(C)(9)	The carrier offering a health plan to an employer of PYMES or small groups of bona fide associations will offer it to all eligible employees of said employer, members of said association and their dependents. The carrier will not limit the health plan only to certain eligible employees, members of the bona fide association or dependents of the group.		
Enrollment	§ 8.070(C)(10)	Carriers of employers of PYMES or of the bona fide associations will not establish any restriction regarding the enrollment in the health plan of the eligible employees or their dependents that is related to their health condition.		
Certification of Creditable Coverage	§ 8.080	The policy shall include information about the Certification of Creditable Coverage in compliance with Section 8.080.		

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Required Disclosures	§ 8.170	Provide free of charge to insureds, within a period not to exceed seven (7) business days after receipt of the request or the date of enrollment of the insured, whichever occurs first, a written summary of benefits and coverage, known by its acronym in English as “SBC”. In case of renewal or change in coverage, the SBC will be provided thirty (30) days prior to the date of renewal or change in coverage.”		
Prohibition of Discretionary clauses	Chapter 12 / Health Insurance Code § 12.040(A)	No contract, certificate or agreement offered or issued in Puerto Rico by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of healthcare services may contain a provision purporting to reserve discretion to carrier to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of Puerto Rico. An adverse determination by a carrier, as well as disputes or controversies that may arise between a carrier and an enrollee, shall be subject to the internal and external review procedures established in the Health Code.	☐ Yes ☐ No	
First Level Reviews of Grievances Involving an Adverse Determination	Chapter 22 / Health Insurance Code § 22.070	All carriers must include in the contracts a First Level Revision of Complaints related to an Adverse Determination in compliance with Section 22.070. The title and language of this section must be included in the contract in the same format and order established in the Section 22.070.	☐ Yes ☐ No	
Standard Reviews of Grievances Not Involving an Adverse Determination	Chapter 22 / Health Insurance Code § 22.080	All carriers must include in the contracts an Ordinary Revision of Complaints not related to an Adverse Determination in compliance with Section 22.080. The title and language of this section must be included in the contract in the same format and order established in the Section 22.080.		
Voluntary Level of Reviews of Grievances	Chapter 22 / Health Insurance Code § 22.090	All carriers must include in the contract a Voluntary Level of Revision of Grievances in compliance with Section 22.090. <i>(Only applicable to manage care plans)</i> The title and language of this section must be included in the contract in the same format and order established in the Section 22.090.		
Expedited Reviews of Grievances Involving an Adverse Determination	Chapter 22 / Health Insurance Code § 22.100	All carriers must include in the contract an Expedite Review of Grievances involving an Adverse Determination in compliance with Section 22.100. The title and language of this section must be included in the contract in the same format and order established in the Section 22.100.		
Urgent care	Chapter 24 / Health Insurance Code § 24.030 (Q)(2)	The contract include the following language, or a different wording with the same meaning, in compliance with this Section: "Any request that a physician with knowledge of the enrollee's medical condition determines is an urgent care request, shall be treated by the carrier as an urgent care request."		
Procedures for Standard Utilization Review and Benefit Determinations	Chapter 24 / Health Insurance Code § 24.090	The policy or contract form includes a description of the utilization review policies and procedures, The title and language of the provision must be included in the form in the same format and order established in Section 24.090.		

NEW!

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Procedures for Expedited Utilization Review and Benefit Determinations	Chapter 24 / Health Insurance Code § 24.100	All carriers who perform utilization review procedures must include in its contracts the Procedures for Expedited Utilization Review and Benefit Determinations in compliance with Section 24.100. The title and language of the provision must be included in the form in the same format and order established in Section 24.100.		
Utilization review or benefit determinations for emergency services	Chapter 24 / Health Insurance Code § 24.110	All carriers who perform utilization review procedures must include in its contracts the Procedures for an Utilization Review and Determination of Benefits in respect to Emergency Services in compliance with Section 24.110. The title and language of the provision must be included in the form in the same format and order established in Section 24.110.		
Creation of Adequate network	Chapter 26 / Health Insurance Code § 26.050	health insurance organizations or insurers shall file with the Commissioner an access plan that meets the requirements set forth in this Chapter for each of the coordinated care plans offered in P.R.		NEW!
Requirements for health insurance organizations, insurers and in-network providers	Chapter 26 / Health Insurance Code § 26.060	Provide evidence of compliance with this chapter and of the provisions of the contract between issuer and in-network provider.		NEW!
Filing Requirements	Chapter 26 / Health Insurance Code § 26.080	The health insurance organizations or insurers will file with the Commissioner the model contracts that they will use with their participating providers and intermediaries, so that the Commissioner can verify compliance with the provisions of this Chapter.		NEW!
Notice of Right to External Review	Chapter 28 / Health Insurance Code § 28.050	All carriers must include in the contracts a Notification of the Right to Request an External Review in compliance with Section 28.050. The title and language of the provision must be included in the form in the same format and order established in Section 28.050.		
Request for External Review	Chapter 28 / Health Insurance Code § 28.060	This policy or contract form includes the instructions on how to request an external external review appeal. The title and language of the provision must be included in the form in the same format and order established in Section 28.060.		
Exhaustion of Internal Grievance Process	Chapter 28 / Health Insurance Code § 28.070	All carriers must include in the contracts information about the Exhaustion of Internal Grievance Process in compliance with Section 28.070. The title and language of the provision must be included in the form in the same format and order established in Section 28.070.		
Standard External Review	Chapter 28 / Health Insurance Code § 28.080	All carriers must include in the contracts information about the Standard External Review in compliance with Section 28.080. The title and language of the provision must be included in the form in the same format and order established in Section 28.080.		
Expedited External Review	Chapter 28 / Health Insurance Code § 28.090	All carriers must include in the contracts information about the Expedite External Review in compliance with Section 28.090. The title and language of the provision must be included in the form in the same format and order established in Section 28.090.		

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External Review of Experimental or Investigational Treatment Adverse Determinations	Chapter 28 / Health Insurance Code § 28.100	All carriers must include in the contracts information about the External Review of Experimental or Investigational Treatment Adverse Determinations in compliance with Section 28.100. The title and language of the provision must be included in the form in the same format and order established in Section 28.100.		
Binding Nature of External Review Decision	Chapter 28 / Health Insurance Code § 28.110	All carriers must include in the contracts language in compliance with Section 28.110.		
Funding of External Review	Chapter 28 / Health Insurance Code § 28.170	All carriers must include in the contracts information about the Funding of External Review in compliance with Section 28.170. The title and language of the provision must be included in the form in the same format and order established in Section 28.170.		
Off-label Use	Chapter 52/ Health Insurance Code § 52.040(A)	A health plan that provides coverage for drugs shall provide for the dispensation of any drug covered, regardless of the disorder, injury, illness, condition, or disease for which they were prescribed, provided, that (1) the drug has been approved by the FDA for at least one indication, and (2) the drug is recognized for treatment of the disorder, injury, illness, condition, or disease in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.		
Off-label Use	Chapter 52 / Health Insurance Code § 52.040(B)	Coverage of a drug shall also include medically necessary services associated with the administration of the drug.		
Newborn and Newly Adopted Children and Children Placed for Adoption	Chapter 54 / Health Insurance Code § 54.050(A) § 54.050(B)	For parent and child/children and/or family coverage, the policy or contract form provides coverage for: (1) A newborn child of a enrollee from the moment of birth; or (2) A newly adopted child of a enrollee from the earlier of: (a) The date of placement in the home of the enrollee for the purpose of adoption and continues in the same manner as other dependents of the enrollee unless the placement is disrupted prior to legal adoption and the child is removed from placement; (b) The date of entry of an order granting the enrollee custody of the child for purposes of adoption; or (c) The effective date of adoption. The coverage shall include coverage of injury or sickness healthcare services including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and is NOT subject to any preexisting condition exclusion. The language of this section must be included in the contract in the same format and order established in Section 54.050(A) and (B).		

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Newborn notice	Chapter 54 / Health Insurance Code § 54.060(A)	For a newborn child, the carrier shall provide covered enrollees with reasonable notice of the following: (1) If payment of a specific premium or subscription fee is required to provide coverage for a newborn child, the health plan may require the enrollee to notify the carrier of the birth of the child and furnish payment of the required premium or fees within thirty (30) days after the date of birth. (2) If notice and the payment described above are not provided, the carrier may refuse to continue coverage for the child under the health plan beyond the thirty (30)-day period. However, if within four (4) months after the birth of the child the enrollee makes all past-due payments, coverage shall be restored. (3) If payment of a specific premium or subscription fee is not required to provide coverage for a newborn child, the carrier may request notification of the birth of the child, but shall not deny or refuse to continue coverage if the enrollee does not furnish the notice. The language of this section must be included in the contract in the same format and order established in Section 54.060(A).		
Newly adopted child or child placed for adoption notice	Chapter 54 / Health Insurance Code § 54.060(B)	For a newly adopted child or child placed for adoption, the carrier shall provide enrollees with reasonable notice of the following: (1) If payment of a specific premium or subscription fee is required to provide coverage for a newly adopted child or child placed for adoption, the health plan may require the enrollee to notify the carrier of the adoption or placement for adoption and furnish payment of the required premium or fees within thirty (30) days after coverage is required to begin under Section 54.050A(2). (2) If the enrollee fails to provide the notice or make the payment described in the preceding paragraph within the thirty (30)-day period, the carrier shall treat the adopted child or child placed for adoption no less favorably than it treats other dependents, other than newborn children, who seek coverage at a time other than when the dependent was first eligible to apply for coverage. The language of this section must be included in the contract in the same format and order established in Section 54.050(B).		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(A)	Every insurer must update its website within twenty (20) days after adding or excluding a provider to its network or making any change in the affiliation of a doctor to a facility, provided that, in the case of a change in enrollment, the insurer has received notice of such change.		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B1)	Every insurer must, in accordance with state or federal law in force, provide the covered person: 1. A clear and understandable description of the plan's out-of-network health benefits, including the methodology used by the entity to determine the allowed amount for out of network services;.		

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No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B2)	2. the allowed amount that the plan will reimburse under that methodology and, in cases where a covered person requests the allowable amounts associated with a specific procedure code, the portion of the allowed amount that the plan will reimburse and the portion of the allowed amount to be paid by the covered person, including an explanation that the covered person will be required to pay the difference between the allowed amount as defined by the insurer's plan and charges billed by an out-of-network provider;		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B3)	3. examples of anticipated costs for services out-of-network frequently billed		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B4)	4. information, in writing and via the website, that reasonably allows a covered person or potential covered person calculate the anticipated cost for out-of-network services, based on the difference between the amount the insurer reimburse for out-of-network services and the usual and customary cost of out-of-network services;		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B5)	5. when requested by a covered person, information about whether a health or medical service provider is a member of the network;		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B7)	7. access to a direct telephone line that will operate no less than sixteen (16) hours a day, seven (7) days a week, to so consumers can call to find out about network status and costs.		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(C)	C. If an insurer authorizes an in-network health or medical service provider to perform a covered service under any health plan, and the provider's or facility's status changes to out-of-network before it is performed authorized service, the insurer will notify the covered person as soon as possible. If the insurer does not provide notice at least thirty (30) days before the authorized service is performed, the financial responsibility of the covered person will be limited to the financial responsibility that would have been incurred if the provider had been in-network. of the person's health plan.		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(D)	D. Every insurer will add to your Benefits Information, to all reimbursement correspondence to the covered person, and to the provider, a clear and concise notice that inadvertent and involuntary out-of-network charges are not subject to collection or billing beyond the financial responsibility incurred under the terms of the contract of service within of the network. Any attempt by the provider to charge or bill must be reported immediately to the insurer's customer service department, at the telephone number that the insurer will provide in the Benefits Information and all correspondence regarding reimbursement to the covered person.		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.120	A. Every insurer shall provide each covered person with written notice, in the form and manner prescribed by the Commissioner of Insurance, regarding the protections provided to covered persons pursuant to this Chapter. The notice will include information about how a consumer may contact the Office of the Commissioner of Insurance to report or dispute an out-of-network charge. This notice will also be published on the insurer's website.		

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Unfair Discrimination against Victims of Abuse	Chapter 72 / Health Insurance Code § 72.040(A)	The following language in compliance with Section 72.040 must be included in the contract. It is unfairly discriminatory to: (1) Deny, refuse to issue, renew or reissue, cancel or otherwise terminate a health plan, or restrict a health plan coverage or add a premium differential or surcharge to any health plan on the basis of the enrollee's abuse status; or (2) Exclude, limit coverage, or deny a claim on the basis of the enrollee's abuse status. The language of this section must be included in the contract in the same format and order established in the Section 72.040(A).		
OTHER REQUIREMENTS FOR HEALTH SERVICES ORGANIZATIONS				
Evidence of Coverage	Chapter 19/ Insurance Code § 1908	Evidence of coverage must be submitted in compliance with this section. If the contract will be use as the evidence of coverage, the carrier disclosed this information in the cover letter.	☐ Yes ☐ No	
Prohibited words	Chapter 19/ Insurance Code § 1915(4)	No health service organization may use in its name, contract or literature, any of the words "insurance", "contingency", "guaranty", "mutual", or any other word describing insurance, contingency or guaranty business, deceitfully similar to the name or description of any insurance or guaranty corporation doing business in Puerto Rico. The terms "insurer"," insured", "insurance", "insurance company", "policy", "insure" cannot be use.	☐ Yes ☐ No	
Puerto Rico Laws				
Coverage for Albinism and Hermansky-Pudlak Syndrome	Act No. 109 December 22, 2022	Private health plans must include in their special coverage the condition of albinism and the genetic disorders that can cause it. Provide for direct access to providers and specialist doctors, as well as those medications, treatments, therapies and tests that are not experimental or genetically modified, scientifically validated as effective and recommended to diagnose and treat the condition, without the need for a referral. Coverage must include the cost of HPS type 1 genetic testing.		NEW!
Down Syndrome amendment	Act No. 13 March 25, 2022	Clarify its scope. The cover must be from birth. Therapeutic services with a remedial approach shall include, but shall not be limited to, physical therapies, speech therapies, occupational therapies, and any other necessary therapy recommended by a health professional authorized to practice such profession in Puerto Rico or the United States, in the quantities and frequency prescribed by the professional or specialist.		NEW!
Psicologist uniform definition	Act No. 79 December 30, 2021	Establish the definition of the term "Psychologist" or "Psychologist" established by Law 194, supra, and Law 296, supra, are uniform with the definition of said term established by Law 408-2000, as amended, known as the "Law of Puerto Rico Mental Health. Also amends Law 220-2012 and Law 239-2012		

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Psicologist uniform definition	Act No. 79 December 30, 2021 Section 1	Subsections (n) and (q) of Section 2 of Act 194-2000, as amended, are amended to read as follows: (n) "Health Professional" – shall mean any practitioner duly admitted to practice in Puerto Rico, in accordance with applicable laws and regulations, any of the health and medical care professions, such as, but not limited to, physicians, surgeons, podiatrists, naturopathic doctors, chiropractors, optometrists, psychologists, dentists, pharmacists , nurses, audiologists and medical technologists, as authorized by the corresponding laws of Puerto Rico.		
Psicologist uniform definition	Act No. 79 December 30, 2021 Section 1	q) "Psychologist" - means the professional licensed by the Board Examiner of Psychologists of the Commonwealth of Puerto Rico, as defined in Act No. 96 of June 4, 1983, as amended, known as the "Act to Regulate the Practice of the Profession of Psychology in Puerto Rico", which has training, knowledge, skills, and experience in providing services including, but not limited to: prevention, description or diagnosis of behavior, psychological evaluation, therapeutic intervention with psychological problems of various levels of severity and consulting concerning the intellectual, emotional, behavioral, interpersonal, family, social and occupational functioning of individuals and groups. The license conferred by the Board explicitly requires all professional psychologist to practice according to their training and competencies under the legal provisions and the ethical norms that regulate this practice in Puerto Rico.		
Medical Emergency Technicians- paramedics	Act No. 69 December 27, 2021	Item 5 of Article 19.030 of the Insurance Code is amended to read as follows: (5) Every health service organization that provides health services must include, as part of its coverage, if there is medical justification according to the criteria established in the protocols created by the Department of Health and according to the home care plan. , to people who require a ventilator to stay alive, a minimum of one daily shift of eight (8) hours of nurses or nurses; or paramedical emergency medical technicians (TEM-P), duly licensed. In addition, duly licensed emergency medical technicians-paramedics (TEM-P) must have approved and validated courses, certifications and training or the skills and knowledge requirements established by regulation by their respective Examining Board related to the care and management of said patients. and its medical equipment as authorized in this Law."		
Protection against surprised medical bills - New Chapter 48 Health Insurance Code of Puerto Rico	Act No. 134 September 1, 2020	The purposes of stopping the so-called "surprise bills" in the billing of health plans, establish consumer protections, transparency, cost control and responsibility, out of network providers; and for other related purposes.		
Braille system (Blind) evidence of cover and ID card	Act No. 162 December 30, 2020	Article 19.080 of the Insurance Code is amended to read as follows: (1) (a) Each subscriber is entitled to evidence of coverage. If the subscriber obtains coverage through an insurance policy, the insurer will issue the evidence of coverage. Otherwise, the health service organization will issue the evidence of coverage. In the case of blind subscribers the evidence of coverage and the identification card will be issued in the Braille system		

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Clinical Review Criteria	Act No. 142 October 9, 2020 Amends Section 2.030 (E) of the Health Insurance Code	E. "Clinical Review Criteria" means the written screening procedures, decision summaries, clinical protocols, and practice guidelines used by the health insurance organization or insurer to determine the medical necessity and appropriateness of the medical service. health care. These practice guides are not mandatory for the Health Professional in the exercise of their functions when providing any health care service in accordance with state and federal laws and corresponding regulations; and as long as the service provided is recognized by the generally accepted standards of health and medical practice, in the light of modern means of communication and teaching. The professional diagnosis will be the guiding and exclusive criterion to determine the treatment to be followed in a patient. Therefore, professional judgment cannot be altered by the insurer. Notwithstanding the foregoing, the provisions of this subsection must comply with federal laws and regulations on the matter.		
Requirements and Procedures for Approval of Medical Exceptions.	Act No. 142 October 9, 2020 Amends Section 4.070 (B) 1st paragraph of the Health Insurance Code	B. The health insurance organization or insurer that provides prescription drug benefits, the PBM or any other entity to which the administration of pharmacy services has been delegated, will have the obligation to offer immediate temporary coverage for an initial prescription. of the prescription drug during the medical exception request process and until you notify your final determination in writing, when the physician or health care professional who issued the prescription establishes in writing that the requested prescription drug is medically necessary for the treatment of the illness or condition of the covered or insured person; even when said prescription drug is one of which is excluded from the drug formulary of the covered or insured person's medical plan or is subject to a prescription drug management procedure established in this Article. The health insurance organization or insurer that provides prescription drug benefits, the PBM or any other entity to which the administration of pharmacy services has been delegated, must pay the pharmacy the initial prescription of the dispensed medication, in what the insurer awards the prescription drug coverage. The pharmacy may submit an electronic invoice to the insurer for the payment of the initial prescription for dispensed drugs and the insurer will be required to accept electronic invoicing and may not require a physical or paper invoice as a condition for payment. Thus, under no circumstances will the covered or insured person be deprived of their prescription drug while they are in the process of requesting medical exceptions as established in this Article, or the presentation of a complaint in accordance with the Chapter on Internal Complaint Procedures of Health Insurance Organizations or Insurers of this Code. This rule for temporary coverage of initial prescription drug prescriptions will not affect existing regulations on transitional drugs. Notwithstanding the foregoing, the provisions of this subsection must comply with federal laws and regulations on the matter.		

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Requirements and Procedures for Approval of Medical Exceptions.	Act No. 142 October 9, 2020 Amends Section 4.070 (B) 2nd paragraph of the Health Insurance Code	Any health insurance organization or insurer that provides prescription drug benefits, pharmacy benefits manager or administrator or any entity to which the administration or management of pharmacy services or benefits has been delegated, will include in the calculation or in the requirement of contribution or cost sharing ("cost sharing, out-of-pocket maximum"), any payment, discount or item that is part of a financial assistance program, discount plan, coupons, or any contribution offered to the insured by the manufacturer. These items will be considered for the exclusive benefit of the patient in the calculation of their contribution, out-of-pocket expenses, co-payments, co-insurance, deductible or in compliance with shared contribution requirements. These contributions, discounts and coupons from the manufacturer will be available and may be used in all health providers, according to the requirements of the program, regardless of the place of acquisition of the discount or coupon. The use of the accumulator of benefits, maximizer or any other similar program that has the effect of implementing a restriction on liability established in this subsection is prohibited.		
Requirements and Procedures for Approval of Medical Exceptions.	Act No. 142 October 9, 2020 Amends Section 4.070 (E) (1) of the Health Insurance Code	1) The procedure for requesting medical exceptions provided in this Article shall require that the health insurance organization or insurer that provides prescription drug benefits, the PBM or any other entity to which the administration of the pharmacy services, make the determination regarding a request submitted and notify said determination to the covered person or insured, or his personal representative, with the urgency required by the medical condition of the covered person or insured, but in no case may the notification Exceed forty-eight (48) hours from the date of receipt of the request, or the date of receipt of the certification, in the event that the health insurance organization or insurer requests it in accordance with section B (2) , whichever is later of the dates. In the case of controlled medications, this term should not exceed twenty-four (24) hours.		
Special Law to Ensure Access to Treatment and Diagnosis of Cancer Patients in Puerto Rico.	Act No. 79 August 1, 2020 Section 5	Every insurer or health insurance organization that provides individual or group medical plans must have coverage available that includes mandatory treatments, medications and diagnostic tests, included in the guidelines of the National Comprehensive Cancer Network ("NCCN Guidelines") and / or approved by the Food and Drug Administration (FDA, for its acronym in English), as well as those necessary to attend and minimize its adverse effects, subject to the provisions of this Law. The "Local Coverage Determinations-LCD from First Coast Service Options, INC "; " Medicare Approved Compendia List "; " National Coverage Determinations Alphabetical Index "; " Milliman Care Guidelines " and ASES Internal Guidelines. Nothing provided in this Article shall be understood as prohibiting an insurer or health insurance organization from providing services, or including coverage of drugs or tests that are broader than those described herein.		

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Special Law to Ensure Access to Treatment and Diagnosis of Cancer Patients in Puerto Rico.	Act No. 79 August 1, 2020 Section 6	Any individual or group medical plan that includes the prescription or coverage of medications, treatments and diagnostic tests must submit approval or denial of medications, treatments and diagnostic tests listed in the guidelines of the National Comprehensive Cancer Network (“NCCN Guidelines”) Or those approved by the Food and Drug Administration (FDA), within a term of 24 to 72 hours of receipt of the request or within a term of 24 hours, if it is a case marked urgent or expedited. Provided that, of the individual or group medical plan, not issuing its determination within said term, it will be understood that the medications, treatments and / or diagnostic tests were approved by the same.		
Special Law to Ensure Access to Treatment and Diagnosis of Cancer Patients in Puerto Rico.	Act No. 79 August 1, 2020 Section 7	Any medical plan, individual or group, that requires the appointment of a primary care provider, may allow the appointment, in cancer patients, of a doctor specialized in oncology, as primary care provider; as long as that health professional consents to such designation.		
Special Law to Ensure Access to Treatment and Diagnosis of Cancer Patients in Puerto Rico.	Act No. 79 August 1, 2020 Section 8	The rights established in this Act will be additional to those provided by Act 275-2012, as amended, known as the "Bill of Rights of Cancer Patients and Survivors", and will have the scope and will be governed in accordance with the requirements and procedures provided by Public Law 111-148, known as the “Patient Protection and Affordable Care Act”, Public Law 111-152, known as the “Health Care and Education Reconciliation Act” and the federal and local regulations adopted under this and any other law or regulation that is successor or applicable at the federal or local level. Every patient will have the right to receive the treatment that his doctor recommends, without limitations by the insurers, that the patient receives a more effective and cutting-edge treatment, available in the market, in accordance with the coverage and protocols designed to the protection of Articles 5 and 9 of this Law. The policies, contracts, certificates or agreements offered or issued in Puerto Rico by a health insurance organization or insurer to provide, deliver, process, pay or reimburse the cost of health care services, treatments, medications or diagnostic tests included as mandatory and uniform, they will not provide that the final interpretation of the terms of the contract will be subject to the discretion of the health insurance organization or insurer, nor will they contain interpretation or review rules that contravene the provisions of this Law.		

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To amend Law No. 168 of 2018, Law for the use of Telemedicine in Puerto Rico.	Act No. 68 July 16, 2020 Amends Act No. 168 August 1, 2018 Section 13 (1), (2)	The provisions included below regarding the practice of telemedicine and telehealth will apply as a result of the emergency declaration promulgated by the Governor of Puerto Rico through Administrative Bulletin No. OE-2020-020 as a consequence of the SARS-CoV-2 coronavirus, known as COVID-19. (1) Physicians and health professionals covered by this Act may use their own telemedicine or telehealth technology to care for their patients, without the need to have the corresponding Certification from the Licensing Board or their respective Examining Board. u Governing Body. (2) The Examining Board or Governing Body of each health profession covered by this Law, must immediately establish the basic guidelines to be able to attend patients using telehealth technology and notify the corresponding group of health professionals so that they can begin to use such mechanisms. No health professional authorized to practice in Puerto Rico may begin to care for patients using telehealth's own technology, until their respective board or governing body issues the corresponding guidelines according to the nature of the declared emergency. This subsection will not apply to doctors authorized to practice telemedicine as established in Joint Resolution 19-2020.		
To amend Law No. 168 of 2018, Law for the use of Telemedicine in Puerto Rico.	Act No. 68 July 16, 2020 Amends Act No. 168 August 1, 2018 Section 13 (3), (4)	(3) All the services offered in accordance with the provisions of this Article will be subject to and will respond to the same standards of care, competence and professional conduct applicable to the offering of said services in person. Recording of therapeutic consultations, sessions or conversations is prohibited. (4) The authorization outlined in this Article does not exempt doctors and health professionals, with the fulfillment of the requirements of their respective licenses and / or ethical standards, for which they will be subject to the corresponding sanctions.		

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To amend Law No. 168 of 2018, Law for the use of Telemedicine in Puerto Rico.	Act No. 68 July 16, 2020 Amends Act No. 168 August 1, 2018 Section 13 (5), (6), (7)	(5) Regardless of what is established in this Article, patient privacy will always be respected in accordance with the provisions of the Health Insurance Portability Accountability Act of 1996 or any other applicable state or federal statute or regulation. Both the Licensing Board and the Examining Board or Governing Body may adopt all the measures they deem necessary to ensure that the health providers they regulate protect the privacy of their patients; These measures must be in accordance with any applicable federal law or regulation. (6) Health insurance companies, insurers, health service organizations, pharmacy benefit managers or managers, the Health Insurance Administration (ASES) and related entities contracted by them, will be required to include within the coverage basic and pay from state or federal funds those diagnostic tests and / or medical treatment present or future to treat COVID-19, according to the prices established by the Center for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services from the United States. Likewise, the ASES will temper its requirements to eliminate the signature of the primary physician on a prescription, referral and medical order. (7) As a measure to reduce personal contact, contagion and discourage citizens from going to doctors' offices, pharmacies are ordered to dispatch refills of those chronic medications even if the patient does not have available refills or a new prescription . For this, the patient must show the empty medicine bottle in which the dose and the identity of the patient are specified. Medicines classified as controlled in classifications II, III, IV or V by federal or state laws or regulations, as well as narcotics regardless of their classification, are excepted from the foregoing.		
To amend Law No. 168 of 2018, Law for the use of Telemedicine in Puerto Rico.	Act No. 68 July 16, 2020 Amends Act No. 168 August 1, 2018 Section 13 (8), (9), (10), (11)	(8) Any permanent or temporary building that is enabled in a service facility to attend in isolation to patients with symptoms of this virus, will be considered for all relevant legal purposes as an extension of health services in which it is located. (9) As long as this COVID-19 emergency persists, any doctor or health professional who is authorized by law to prepare prescriptions, referrals, medical order or order treatments, tests or examinations to the patient, may send the prescription, referral or order by photography or any other electronic method and the service provider that receives it will be obliged to accept it. The prescription must be sent directly by the doctor or health professional, for which reason prescriptions sent by photographs to the patient directly will not be accepted. (10) The doctors and health professionals authorized here will keep all the information necessary to document the services provided. In order to avoid insurance fraud, insurance companies, health service organizations and ASES may carry out the pertinent verifications to corroborate that, in effect, the services have been provided by the telemedicine or telehealth means themselves. (11) The doctors and health professionals authorized here must comply with the informed consent provisions established in this Law.		

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To amend Law No. 168 of 2018, Law for the use of Telemedicine in Puerto Rico.	Act No. 68 July 16, 2020 Amends Act No. 168 August 1, 2018 Section 13 (12)	(12) Billing: (a) Any doctor or health professional authorized to practice in Puerto Rico may bill the services provided using telemedicine or telehealth technology and health insurance companies, insurers, health service organizations, administrators or managers of pharmacy benefits , the ASES and related entities hired by them, will be obliged to pay it as if it were a face-to-face consultation. For these purposes, they will have to provide physicians and health professionals who so request with the corresponding codes for billing for health services provided using the technology of telemedicine or telehealth. No health insurance company, insurers, health service organizations, pharmacy benefit administrators or managers, the ASES or related entities, may refuse to pay for a service provided that is not properly codified, if its rules and procedures allow it. create the codes and / or procedures to conform to the provisions of this Law. In the case of doctors or health professionals who provide their services in accordance with this Law, but whose services are not duly codified by the ASES or a health insurance company and there is a statutory, normative, procedural or regulatory impediment to codify it, they may bill for the services provided as they normally do for a face-to-face consultation, but they must deduct ten percent (10%) from the billing of the total cost. (b) When the doctor or health professional authorized by this Article, provides their services through medical plans or health insurance, and the patient receives the services, he or she will be exempt from paying the fixed amount paid for these services or the copayment that would ordinarily pay in a face-to-face consultation, during the term of the emergency declared by the Governor as a result of COVID-19.		
Law to Regulate Cyber Therapy in Puerto Rico	Act No. 48 April 29, 2020	"Cyber therapy" is the distance practice of the professions described in the preceding paragraph, in which the individual-therapist interaction is mediated by technological communication and information tools. They should include, but are not limited to, diagnostic services, evaluation, analysis, consultation, supervision, information, education, interpretation and intervention with the needs and expectations of the individual who receives them. The practice of cyber therapy must take into consideration those aspects as defined by the "Center for Medicare Services" (CMS, for its acronym in English), so that the consultations made may be considered for reimbursement by "Medicare" or " Medicaid "		
Law to combat Covid-19	Act No. 43 April 16, 2020	All medical care, study, analysis, diagnosis and treatment of COVID-19, including hospitalization, will be free of charge for all citizens, regardless of whether they have health insurance or not. *No health insurance organization, insurer, PBM or third-party administrators may require any copayment, deductible, pre-authorization or referral to the patient, for medical care, studies, analysis, diagnosis and treatment of COVID-19, including hospitalization, as long as these services are provided in Puerto Rico.		

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Diabetes Equipment and Supplies Coverage	Act No. 19 January 12, 2020 Amends Act No. 177 of August 13, 2016 Ruling Letter No. CN-2016-209-AS	Health Plans should include, as part of their basic coverage the supply of a glucose monitor every three (3) years with replacement of damaged equipment, the supply of one (1) glucagon injection and replacement of it in case of use or expiration, and a minimum of one hundred and fifty (150) strips and one hundred and fifty (150) lancets each month for patients diagnosed with type I diabetes mellitus by a specialist in pediatric endocrinology or endocrinology. The coverage should also include the portable insulin infusion pump or microinfuser, as therapy for patients diagnosed with Type I Diabetes Mellitus. Section 4 of Law 177-2016, as amended, is amended to read as follows: “Once the patient has been diagnosed with the condition of type I diabetes mellitus, for the patient to receive the benefit established under this Law, they must submit a prescription properly Issued by a medical practitioner duly authorized to practice the profession within the jurisdiction of Puerto Rico so that a pharmacist will dispense in his original box duly sealed the authorized monthly strips and lancets under this Act.” Ruling Letter No. CN-2016-209-AS: Coverage must clearly indicate that the carrier will cover the glucometer brand ordered by the endocrinologist whenever there is a justification submitted. With regard to coverage for the insulin infusion pump, the selection of the brand of this device will be determined by the endocrinologist based on the age of the enrollee, the level of physical activity of the enrollee, and the enrollee's and/or the caregiver's knowledge regarding the condition.		
Law on the Right to Effective Detection of Breast Cancer	Act No. 10 January 3, 2020	Every insurer or health services organization will provide, as part of the benefits of preventive care of its basic coverage, mammograms and other breast cancer diagnosis and detection tests, according to acceptable practices, in accordance with the following: a.a baseline mammogram, for women between thirty-five (35) and thirty-nine (39) years, b.an annual mammogram for women forty (40) years of age or older c.an annual mammogram, follow-up treatment or supplementary diagnostic tests: i. to women of forty (40) years of age or older, who have breasts of tissue classified as heterogeneously dense or extremely dense, as determined by mammography by a radiologist, based on the breast density scale of the Image and System Projection Report Breast Imaging Reporting and Data System, BI-RADS, promulgated by the American College of Radiology ii.to women at high risk of developing breast cancer because: 1.to your family history 2.to his own history as a cancer patient 3.presence of high-risk markers in your genetic profile or 4.Some other factor determined by your doctor. Follow-up treatment or supplementary diagnostic tests for the detection of breast cancer in women aged forty (40) or older, who have breasts of tissue classified as heterogeneously dense or extremely dense, may include, but is not limited to the list of content criteria established in this law.		

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Ambulance ground transportation coverage for medical emergencies	Act No. 129 August 1, 2019	Every insurer, health service organization or other health plan provider authorized to operate in Puerto Rico must include in its basic plan or insurance, the ambulance ground transportation cover for medical emergencies. Transportation service through the 9-1-1 Emergency System, due to a medical emergency, must be paid to the ambulance provider directly for the cost of transportation. Any entity responsible for the health of a patient shall be obliged to honor, at a minimum, the rates established by Regulation of the Bureau of Transportation and other Public Services (Negociado de Transporte y otros Servicios Públicos), attached to the Puerto Rico Public Service Regulatory Board (Junta Reglamentadora de Servicio Público de Puerto Rico). Act No. 383-2000, known as the "Law to Prohibit Health Plans, Nonprofit Organizations Offering Health Services," is repealed, for being in conflict with the provisions contained in this Law.		

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Treatment of hyperbaric oxygenation to people diagnosed with Autism	Act No. 63 July 19, 2019	Health plans must include, as part of their coverage, the treatment of hyperbaric oxygenation to people diagnosed with Autism Spectrum Disorder, provided that it is recommended by a certified medical or healthcare professional and the treatment is allowed by law and federal regulations.		
Telemedicine	Act No. 168 August 1, 2018	The policy or contract form may, if applicable, provide coverage for a telemedicine program. In such case, the policy or contract form should include: 1. The definition of telemedicine in compliance with Act No. 168 -2018, and 2. A description of the telemedicine program, including how the covered persons can access the program. 3. If the coverage is subject to deductibles, copayments, and/or coinsurance, the same shall be disclosed.		
Down syndrome	Act No. 97 May 15, 2018	The policy or contract form shall cover tests, not limited to, genetics, neurology, immunology, gastroenterology and nutrition. Also, shall cover visits and tests referred by a physician, and therapeutic services with a remediative approach to independent living or assisted living for adults over 21 years of age. The carrier will not rescind, refuse, deny coverage or services if an insured is diagnosed with Down Syndrome. The carrier will not cancel an existing health policy if one of the beneficiaries is diagnosed with Down Syndrome and it was unknown at the time of obtaining the policy.		
Phenylketonuria (PKU)	Act No. 139 August 8, 2016	Health plans must include as part of the basic coverage, the "Phenylalanine Free Amino Acids Preparation " for enrollees diagnosed with the genetic disorder called phenylketonuria (PKU), with no enrollee age exclusions. This mandatory coverage is in addition to the recommended preventive service of screening for the genetic disorder (PKU) in newborns.		
Human Immunodeficiency Virus (HIV)	Act No. 45 May 16, 2016	Health plans must include, as part of the basic coverage, an HIV test a year as part of the routine studies for any medical evaluation, except for pregnant women to which apply the following requirements as established by the USPSTF: 1) A first HIV test during the first trimester of pregnancy at the first prenatal visit, and 2) A second test during the third trimester of pregnancy (between the (28) and (34) weeks of pregnancy.		

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SUBJECT	REGULATORY REFERENCE	COMMENTS	Please specify location (Form/Page/Paragraph/ Other) of complying provision/language * <u>or attach explanation for a N/A response **</u>	FOR OFFICIAL USE ONLY
Technological equipment	Act No. 62 May 4, 2015 Amends Act No. 125 of September 21, 2007	Health plans must include, as part of the coverage, the technological equipment whose use may be necessary to maintain the user alive, a minimum of one (1) daily eight (8) hour shift of nursing services provided by skilled nurses knowledgeable in respiratory therapy or specialists in respiratory therapy with nursing skills, the supplies needed to operate technological equipment and the physical and occupational therapy needed to develop the motor skills of these enrollees. For the purposes of this law, a user shall be understood to be those who use medical technology as well as children with tracheotomy to breath, and whose operation depends on medical equipment, ventilator or supplemental oxygen and those who have started treatment as minors and meet twenty (21) years and who received medical services or receive home care, continue to receive these services after serving twenty (21) years of age.		
Cancer	Act No. 275 September 27, 2012 Section 3(A)(g)	No carrier shall reject or deny any treatment agreed upon and/or included as part of the terms and conditions of the contract signed by the parties when a medical recommendation to such purposes so require. Physicians, carriers and providers shall not reject or deny treatment such as hospitalization, diagnosis, and medication to any cancer patient enrollee. With regard to cancer survivors, carriers and healthcare plans providers shall not deny coverage for the treatment and frequent and permanent monitoring of the physical health and emotional wellbeing of the enrollee.		
Cervical cancer	Act No. 275 September 27, 2012 Section 3(E)(c)	Coverage shall include pelvic exams and all types of vaginal cytology that may be required by a physician to detect, diagnose, and treat early stages of abnormalities that may lead to Cervical Cancer.		
Breast cancer	Act No. 275 September 27, 2012 Section 3(E)(d)	Every health plan shall provide extended coverage for the payment of breast cancer screening and testing such as visits to specialists, clinical breast exams, mammograms, digital mammograms, magnetic resonance mammography and breast ultrasounds, and treatment including, but not limited to, mastectomy (including males), breast reconstruction after mastectomy, reconstructive surgery of the other breast to achieve symmetry, breast prosthesis, treatment for physical complications at all stages of mastectomy, including lymphedema (swelling that sometimes occurs after breast cancer treatment), any reconstructive surgery after mastectomy that may be needed for the physical and emotional recovery of the enrollee.		
Human papilloma virus (HPV) vaccine	Act No. 255 September 15, 2012	Health plan shall cover the vaccine against the human papilloma virus (HPV) for males and females; according to the recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC). HPV vaccination beginning at age 9 years for children and youth with any history of sexual abuse or assault who have not initiated or complete the 3 doses series (ACIP recommendation). No cost sharing is applicable.		
Psychology professionals services	Act No. 239 September 13, 2012	Health plans shall include services provided by psychology professionals trained by education with a master degree or PhD, trainings and experience to provide health care services, duly licensed by the Puerto Rico Board of Psychologist Examiners.		

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Autism Spectrum Disorder	Act No. 220 September 4, 2012 Section 15	Every health plan shall provide coverage for the treatment of autism. This coverage should include, but not limited to, genetics, neurology, immunology, gastroenterology and nutrition; speech, language, psychological, occupational, and physical therapies; and will include physician office visit and the medical tests referred by them.		
Screening tests	Act No. 218 August 30, 2012 Sections 2 and 3	As part of their coverage carriers shall include, without this constituting a limitation, access to tests of: cancer, high blood pressure and cholesterol, diabetes, osteoporosis, and sexually transmitted diseases.		
Chemotherapy	Act No. 107 June 5, 2012 Section 1	A health plan that provides coverage for treatment of chemotherapy against cancer must also provide coverage of the chemotherapy against cancer in their various methods of administration of the drug, such as intravenous, oral, injectable track or intrathecal route; according to the order of the specialist doctor or oncologist.		
Designation of Primary Care Provider and Direct Access to OB/GYN Services	Act No. 161 November 1, 2010 Section 6(i)	A health plan must cover direct access to gynecology and obstetrics care services without requiring referrals or previous authorization, insofar as such physician participates in the network of the healthcare providers.		
Designation of Primary Care Provider and access to pediatricians	Act No. 161 November 1, 2010 Section 6(j)	A health plan providing coverage for a minor as an enrollee must allow the parent or tutor to select a pediatrician as his/her primary care provider, insofar as such pediatrician participates in the network of healthcare providers.		
Prescription Opioid Drugs	Act No. 140 September 22, 2010	A health plan shall include, as part of the coverage, the medication known as buprenorphine for treatment of opioid dependence in the "Medicaid Preferred Drug List," or the preferred drug list.		
Bariatric surgery	Act No. 212 August 9, 2008	All carriers shall provide, subject to preauthorization, coverage for one (1) bariatric surgery per lifetime for the treatment of morbid obesity using one of the following techniques: gastric bypass, adjustable gastric band or sleeve gastrectomy. The intragastric balloon technique is excluded from the law. The carrier may require a waiting period that shall not exceed twelve (12) months, before cover for the benefits stipulated in this act. For the preauthorization of these services, the first treatment for the morbid obesity should be dietetic and in changes in the life style. The physician must document the unsuccessful attempt(s) with nonoperative medically supervised weight reduction program(s). For purposes of this act, morbid obesity means a body mass index of at least thirty-five (35) kilograms per meter squared, or greater. Bariatric surgery refers to the various surgical procedures performed to treat obesity, which can be practice by the following four techniques: gastric bypass, adjustable gastric band or sleeve gastrectomy or intragastric balloon.		

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Dependents	Act No. 116 July 17, 2008	Amends Act No. 15 of February 27, 2007, in order to correct the scope of the measure and to extend the term of effectiveness of said act. Provides that the underwriters of the carriers in Puerto Rico shall accept, in a family coverage, the inclusion as enrollees of minors whose custody or guardianship has been granted to the grandparents or other participating family members, and those of legal age who have been declared disabled, whose guardianship has been granted, when the person to whom custody or guardianship has been granted is the primary enrollee of the health plan.		
Naturopathic Physician	Act No. 210 December 14, 2007	A health plan shall provide access to the health services and treatment by a <i>naturopathic physician</i> , if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed naturopathic physician, authorized by the Commonwealth of Puerto Rico. Also, the contract must disclose the applicable copayment or coinsurance.		
Audiology	Act No. 127 September 27, 2007	A health plan shall provide access to the health services and treatment by an audiologist, if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed audiologist physician, authorized by the Commonwealth of Puerto Rico. Also, the contract must disclose the applicable copayment or coinsurance.		
Respiratory syncytial virus (RSV)	Act No. 165 August 30, 2006	All carriers are required to include in the contract the vaccine against respiratory syncytial virus as part of their pediatrics coverage.		
Chiropractor	Act No. 150 August 8, 2006	A health plan shall provide access to the health services and treatment by a chiropractor, if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed chiropractor, authorized by the Commonwealth of Puerto Rico. Also, the contract must disclose the applicable copayment or coinsurance.		
Universal Neonatal Hearing Screening Test	Act No. 311 December 19, 2003	A contract which is available or may be available, renewed, extended, or modified in Puerto Rico by any carrier with benefits applicable within the contract, shall include coverage for initial hearing screening and for any other hearing evaluation within the follow-up care related to the hearing screening described in this act. As provided by the act, the service shall be rendered in Puerto Rico even though the carrier is located outside of Puerto Rico. The benefits of the Universal Neonatal Hearing Screening Test to newborn babies, as well as the follow-up care shall be subject to the same co-payment and co-insurance provisions applicable to any other medical service. With the exception that the benefit of neonatal hearing screening shall be exempted from co-payments/coinsurance or provisions that limit the maximum amount to be paid by the carrier.		

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Health Professionals definition	Act No. 148 August 9, 2002 Section 6(d)	A health plan shall provide access to the health services and treatment by a podiatrist, optometrist or psychologist, if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed podiatrist, optometrist and clinical psychologist, authorized by the Commonwealth of Puerto Rico. Also, the contract must disclose the applicable copayment or coinsurance.	AMENDED BY LAW 79-2021	
Health Professionals definition	Act No. 194 August 25, 2000 Section 6	Defines "Health Professional" as any practitioner duly allowed to practice in Puerto Rico, according to the applicable act and regulations, any of the health and medical care health professions including but not limited to, physicians, surgeons, dentists, pharmacists, nurses and medical technologists, as authorized by the corresponding act of Puerto Rico.	AMENDED BY LAW 79-2021	
Termination	Act No. 194 August 25, 2000 Section 7(a)	A contract shall contain a clause providing that in cases in which health plan coverage is terminated or cancelled, or coverage by a provider is terminated or cancelled, the carrier shall notify the enrollee of such termination or cancellation thirty (30) calendar days before the date such termination or cancellation becomes effective.		
Extension of Benefits	Act No. 194 August 25, 2000 Section 7(b)	The contract shall contain a clause providing that subject to payment of premium as required, should the health plan or the provider terminate coverage, the enrollee may continue receiving the benefits thereof for a transitional period of ninety (90) days as of the date the health plan or the provider terminates coverage. 1. In those cases in which the enrollee is hospitalized at the time of the date of said termination of coverage, and the release of the enrollee from the hospital has been scheduled for a date preceding the date of termination of coverage, the transition period shall be extended from said date to ninety (90) days after the date the enrollee is released. 2. In those cases in which the enrollee is in her second trimester of pregnancy as of the date of termination of coverage and the provider has been offering medical treatment pertinent to the pregnancy before the date of termination of coverage, the transitional period concerning pregnancy-related health care shall be extended to the date the mother is released from hospital after childbirth, or the date the newborn is released from the hospital, or both, whichever occurs later. 3. In those cases in which the enrollee is diagnosed a terminal condition before the date of termination of coverage and the provider has been offering medical treatment pertinent to the condition before said date, the transitional period shall be extended for the remainder of the enrollee's life. Providers that continue the treatment of the enrollees during said period must accept the payments and rates fixed by the health plan as full payment for services rendered, as well as continue providing the plan with all the necessary information required for purposes of quality control, and surrender or transfer the medical records corresponding to the enrollees upon termination of said transitional period.		

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Emergency services	Act No. 194 August 25, 2000 Section 8(c)	A health plan shall provide emergency service benefits with no waiting period. The previous authorization of the carrier shall not be required when providing these emergency services. Furthermore, these services shall be provided regardless of whether the provider of such emergency services is a participating provider. In the event that an enrollee is provided services by a provider not contracted by the carrier, the enrollee shall not be held liable for the payment of services in an amount exceeding the amount applicable if the enrollee had received such services from a provider contracted by the carrier. The carrier shall compensate the provider offering the services, and the provider shall be under the obligation to accept said compensation, for an amount not to be less than the agreed with the providers contracted by the carrier to offer the very same services. Moreover, under these circumstances, such emergency services shall be provided regardless of the conditions set forth by the corresponding health plan.		
Experimental or Investigational Treatment	Act No. 194 August 25, 2000 Section 9(g)	A health plan shall contain a provision setting forth that the carrier shall pay the routine medical expenses of any enrollee suffering from a life-threatening condition for which there is no effective treatment, when the enrollee is eligible for participating in an authorized clinical treatment study pursuant to the study protocol provisions concerning said treatment, provided the participation of the enrollee offers a potential benefit to he/she and the physician referring the enrollee believes that participation in said study is pertinent, or the enrollee presents evidence of the fact that participation in said study is pertinent. Routine medical expenses of the enrollee shall not be construed to be expenses related to the study, or tests administered to be used as part of the study, or expenses the entity conducting the study is likely to pay.		
HIV/AIDS Virus	Act No. 349 September 1, 2000	Bill of Rights for carriers of the HIV/AIDS Virus in Puerto Rico. Right to the best assistance and treatment, without any restriction , to guarantee a better quality of life.		
Maternity Care	Act No. 248 August 15, 1999	Any carrier that provides maternity benefits shall provide a minimum coverage of forty eight (48) hours of care in the hospital facilities in benefit of the mother and her newborn child (or children) if it is a natural birth without complications, and a minimum of ninety-six (96) hours if she required a caesarean section. Any decision that has the effect of shortening the period of time provided above shall have to be determined by the attending purveyor with the acceptance of the enrollee. If the mother and the newborn are released within a period that is less than what is provided in this section, but in accordance with the second paragraph, the coverage shall provide for a follow-up visit within the next forty-eight (48) hours. The services shall include, but shall not be limited to the attention and physical care of the child, instruction on the care of the child for both parents, help and training on breast feeding, information regarding home care, and the provision of any treatment, and medical tests for the infant as well as for the mother. The language of the contract include the act number and its date of approval.	☐ Yes ☐ No	

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General anesthesia	Act. No. 352 December 22, 1999	A health plan that provides coverage for general anesthesia services, hospitalization services and dental services in the contract, shall not be able to exclude or deny coverage for general anesthesia to be administered by an anesthesiologist and hospitalization services when: (1) when a pediatric dentist, an oral or maxillofacial surgeon who is a member of the medical faculty of a hospital determines that the condition or ailment of the enrollee is significantly complex according to the criteria established by the American Academy of Pediatric Dentistry, (2) when the enrollee, because of his/her age, impediment, or disability, is unable to resist or tolerate pain, or cooperate with the treatment indicated in the dental procedures, (3) when the infant, boy, girl, adolescent, or person with a physical or mental impediment has a medical condition in which it is indispensable to carry out dental treatment under general anesthesia in an ambulatory surgical center or in a hospital, and that otherwise could pose a significant threat to the enrollee's health, (4) when local anesthesia is ineffective or contraindicated because of an acute infection, anatomic variation, or allergic condition, (5) when the enrollee is an infant, a boy, a girl, an adolescent, or a person with physical or mental disability, and is in a state of fear or anxiety that prevents performing the dental treatment under the procedure traditionally used in dental treatments and the condition is so critical that postponing or deferring treatment would result in pain, infection, loss of teeth, or dental morbidity, (6) when an enrollee has received an extensive and severe dental trauma where the use of local anesthesia would jeopardize the quality of the services or would be ineffective to handle the pain and apprehension. Preauthorization. Every carrier that requires preauthorization to provide the general anesthesia and hospitalization services coverage, as determined by a pediatric dentist, oral or maxillofacial surgeon, shall approve or deny it within two (2) days from the date the enrollee submits all the documents required by the carrier. The required documents shall be: (a) the enrollee's diagnosis; (b) the enrollee's medical condition; and (c) the reasons that justify for the enrollee to receive general anesthesia to perform the dental treatment.		
Federal Laws				
Mental Health Parity Act		The services provided under the contract regarding mental conditions must comply with the "Mental Health Parity Act". There shall be no distinction between a mental disorder and any other medical condition in terms of the access to the services that persons shall need. In addition, the contract may not include any limitations on visits to a psychiatrist, collateral visits, group therapy and residential treatments.		
Circular and Rulings Letters				
Obligation to provide Influenza treatments and tests; Mandatory immunization coverage	CN-2022-325-D November 18, 2022	Administrative Order No. 554 - establish the obligation of all health services organization that administers a plan of public or private health, to provide treatments, medicines and diagnostic tests to the patients with influenza symptoms.		

NEW!

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Test rates for the detection of Covid-19	CN-2022-315-AS May 10, 2022	Insurers and health insurance organizations should not amend through circular letters or other documents the fees they pay to their providers for COVID-19 screening tests, or group codes.		
OCS postal address	CC-2021-1979-D January 25, 2021	Direccion postal OCS Oficina del Comisionado de Seguros 361 Calle Calaf PO Box 195415 San Juan, PR 00919 Edificio World Plaza 268 Ave. Munoz Rivera San Juan, PR 00918		
SELECTION OF INDEPENDENT REVIEW ORGANIZATION	CC-2020-1977-D November 18, 2020	Independent External Reviews will be conducted through the independent review body "Maximus Federal Services, Inc".		
Billing Codes for diagnostic services, sampling and treatment of covid-19	CN-2021-292-D January 28, 2021	Billing Codes for diagnostic services, sampling and treatment of covid-19		
CODES AND FEES OF TESTING FOR THE DETECTION OF COVID-19	CN-2020-289-D December 11, 2020	Insurers and organizations are required to provide the health service providers and / or laboratories that administer tests for the diagnosis of COVID-19 within a term of five (5) days from the date of this Normative Letter. , the corresponding billing codes, sample collection codes, and fees for the molecular test, antigen test, and serological test, respectively.		
Personal Protective Equipment Cover for Dental Services	CN-2020-279-D June 16, 2020	Insurers and health care organizations are required to include the D1999 code on dental coverage for commercial health plans. The D1999 code must be billed by a dentist, under a current contract with an insurer or health services organization, accompanied by the dental procedure (s) performed per day and which are part of the patient's coverage, after their in-person visit to the dental office the rate corresponding to this code, which should not be less than \$ 35.00 per face-to-face visit to the dental office		
AMENDMENT TO REGULATORY LETTER NO. 2020-274-D	CN-2020-278-D May 14, 2020	For the purpose of expanding its scope in accordance with the provisions of Joint Resolution 32-2020 and Law No. 48-2020. The provisions of Normative Letter CN-2020-274-D remain in force, as amended by what is established herein. the patient who receives medical or psychological attention through the use of telemedicine or telephone, will be exempted from paying shared costs for these services during the term of the Joint Resolution.		
PAYMENT TO HEALTH SERVICE PROVIDERS USE OF TELEMEDICINE	CN-2020-274-D April 8, 2020	All health services organizations and insurers that underwrite commercial health plans and Medicare Advantage honor the payment of services provided by health service providers, whether physical or mental health, through the use of telemedicine based on the same rate as if the service was provided in person face to face.		
AMENDMENT TO REGULATORY LETTER NO. CN- 2020-265-D	CN-2020-269-D March 20, 2020	Availability of coverage for the COVID-19 diagnostic test will be provided by insurers and health service organizations that subscribe to group and individual medical plans in the private sector "free of cost sharing" (including deductibles, copays and coinsurance) to the insured, in cases where the test is ordered to be performed in accordance with medical criteria. Neither may it establish prior authorization requirements or other service utilization management requirements.		
Access to Health Services	CN-2020-268-D March 16, 2020	Grace Period for Premium Payment, Medication Dispatch, Out-of-Network Providers, Pre-authorizations and Referrals, Telemedicine, Term for the presentation of claims		

NEW!

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GUIDELINES ON CARE FOR CORONA VIRUS (COVID-19)	CN-2020-265-D March 11, 2020	• Inform their insured on their internet portals and customer service telephone lines about the providers available to go to receive medical care services. • Allow free access to providers outside the network, in case of insufficient or unavailable providers • Provide coverage for emergency health services without prior authorization, regardless of whether the provider is a participant in your network. • Provide coverage, free of out-of-pocket cost to the insured (copayments, deductibles or coinsurance), for immunization services against COVID-19 • Rescind the requirement of pre-authorizations or step treatment, when for reasons of medical criteria a drug is recommended outside the formulary to treat any health condition associated with COVID-19		
Maximum Out of Pocket	Ruling Letter No. CN-2013-159-AS October 22, 2013	The Maximum Out of Pocket Limit (MOOP) that carriers should apply in their coverages, as established by the Commissioner, is \$6,350 individual coverage and \$12,700 family coverage.		
Meningitis vaccine	Ruling Letter No. 2011-131-AV September 1, 2011	Require that health plans must include the meningitis vaccine as part of the basic coverage.		
Preventive Services	Ruling Letter No. N-AV-7-8-2001 July 6, 2001	Requires every carrier to offer, as part of basic coverage, an annual medical evaluation that includes preventive services required by Act No. 296 of September 1, 2000 without any cost sharing beyond the premium originally established for said plans. The mentioned act imposes to the Puerto Rico Department of Education the responsibility to ensure that each child received an annual medical evaluation at the beginning of the school year. Said medical evaluation must include physical and mental evaluation, oral hygiene, hearing and visual tests, as well as periodic tests recommended by the American Academy of Pediatrics.		
Hospital services	Ruling Letter No. N-AV-12-111-99 December 20, 1999	Requires that all carriers shall stipulate that in such cases in which an enrollee decides to use a private hospital room, instead of a semi-private room, he or she will be responsible for the difference in cost that this utilization represents. In addition, all health plans shall stipulate that unless in the cases of differences in the cost of the hospital rooms, the providers cannot charge to enrollees in a private rooms different quantities to those that have the rights to charge if said enrollee was confined in a semi-private room.		
HIPAA	Ruling Letter No. N-AV-10-90-97 November 24, 1997	Establishes that the Health Insurance Portability and Accountability Act (HIPAA) is applicable in our jurisdiction and preempts the Insurance Code, with regard to the provisions required in the act, which are not provided in said Code or which are less stringent than the federal requirements.		
Ambulance services	Ruling Letter No. N-C-8-71-95 October 13, 1995	Requires that all carriers that provides ambulance services in their coverage must stipulate that the ambulance companies that will render the services must be authorized by the Puerto Rico Commission of Public Services.		

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HIV Screening	Circular Letter No. CC-2014-1848-AS January 22, 2014	Regarding pregnant women, all carriers are required to cover and will not impose cost-sharing requirements with regard to the following tests included in the most recent recommendations of the "United States Preventive Services Task Force (USPSTF): 1) A first HIV test during the first trimester of pregnancy at the first prenatal visit, and 2) A second test during the third trimester of pregnancy (between the 28th and 34th week of pregnancy).		
Essential Health Benefits	Circular Letter No. 2013-1825-D March 1, 2013 and Section 2.050(D)(1) Health Code	All carriers that provide health plans to individuals and small groups, with the exception of grandfathered plans, large groups and large groups for Bona Fide Associations, will have to include in such plans at a minimum essential health services known as Essential Health Benefits (EHB). EHB include benefits and services in at least the following ten categories: 1. Out-patient (ambulatory) services and medical-surgical services 2. Emergency services 3. Hospitalization 4. Maternity and newborn care services 5. Mental health and substance use disorder services 6. Laboratories, X-Rays and diagnostic testing services 7. Pediatric services including the respiratory syncytial virus vaccine, the cervical cancer vaccine, the vision and dental care 8. Prescribed medication 9. Rehabilitation and habilitation services and equipment 10. Preventive, wellness, and management of chronic disease services 11. Any other mandatory service or benefit required by Commonwealth or Federal laws or regulations The EHB Benchmark Plan selected for Puerto Rico was Optimo Plus PPO. Exclusively with regard to pediatric vision services, the rule provides for using the coverage of the Federal Employees Dental and Vision Insurance Program (FEDVIP) to define the EHB that must be included in health plans.		
ADDITIONAL REQUIREMENTS				
Coordination of Benefit	Chapter 11 / Insurance Code § 11.110(1)	The contract shall include a coordination of benefit provision in compliance with the Coordination of Benefit Model Regulation of the NAIC.		
Medicare Supplement Policies disclosure notice	Rule L Regulation of the Insurance Code § 17(D)(1) Appendix C	Notice related to contracts or certificates which are not Medicare Supplement Policies. Disclosure Statements. Instructions for use of the disclosure statements for health plans sold to Medicare beneficiaries that duplicate Medicare.		

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Definitions		The contract has been revised to verify that all terms define in the same are actually being use.	☐ Yes ☐ No	
Table of Copayment, Coinsurance and Deductibles (Contract)		The Table of Copayment, Coinsurance and Deductibles of the contract include the cost sharing for all the covered services. This verification has been performed by the carrier.	☐ Yes ☐ No	
Providers Directory		The submission include the provided directory in the supporting documentation tab.	☐ Yes ☐ No	
Drug Formulary		The submission include the drug formulary by therapeutic category in the supporting documentation tab. The drug formulary include contraceptives for each of the types as approved by the FDA.	☐ Yes ☐ No	
Crime or Felony		Exclusions or limitations related to the commission or the attempt to commit a crime or felony clearly indicate that apply, except if any injury results from domestic violence or a medical condition.	☐ Yes ☐ No	
Service connected		Exclusions or limitations related to service connected injuries or conditions are not included. Language related to service connected injuries or conditions can be included in a Subrogation clause.	☐ Yes ☐ No	
Application Forms	Section 14.100 of the health insurance code Section 27.50 of the Insurance Code Rule 102 of the Regulations of the Insurance Code	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months. The application contains the prescribed fraud warning statement above the insured's signature. The application contains a question requiring information with respect to other health insurance, for the Coordination of Benefits. If the health plan will be marketed by electronic means, the application must contain the required disclosures regarding the delivery of all policy documents, the right to obtain a paper copy free of charge and other applicable disclosures.	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

I, _____ have reviewed or supervised the preparation of the above checklist and certify that the form(s) and/or drug formulary is (are) in compliance with all of the applicable requirements of the Insurance Code of Puerto Rico, Health Insurance Code of Puerto Rico, Federal and State Laws, Ruling and Circular Letters related to the Small Group Market, including Small Groups for Bonafide Associations, and that the form(s) and/or drug formulary does (do) not contain dispositions previously disapproved or required to be corrected by the Office of the Commissioner of Insurance of Puerto Rico. I also acknowledge responsibility for the validity, accuracy and completeness of the contents of this checklist, the transmittal letter and enclosures with the filing.

Date: _____

Carrier Name

ATTACHMENT 8

Rev. 02/2023

	Cubierta Metálica	Cubierta Metálica	Cubierta Metálica
	Nombre del Plan	Nombre del Plan	Nombre del Plan
Deducible y Máximo de Bolsillo (MOOP)			
Deducible Anual para Beneficios Médicos			
-Individual			
-Familiar			
Deducible Anual para Medicamentos			
-Individual			
-Familiar			
Gasto Maximo de Bolsillo (MOOP) para Beneficios Medicos y Medicamentos Recetados (Combinados)			
-Individual			
-Familiar			
Beneficios Esenciales de Salud			
Servicios de Emergencia			
-Accidente			
-Enfermedad			
Hospitalización			
-Parcial incluyendo Salud Mental			
-Completa con Pre-Autorización (incluyendo Salud Mental)			
-Completa sin Pre-Autorización (incluyendo Salud Mental)			
-Facilidad de Enfermería Especializada (Skilled Nursing Facility)			
-Asistencia Quirúrgica			
Servicios Ambulatorios			
-Generalista			
-Especialista			
-Sub-Especialista			
-Siquiatría			
-Sicólogo			
-Podiatría			
-Quiropráctico			
-Audiólogo			
-Optómetra			
Centro de Cirugía Ambulatoria			
Procedimientos Diagnósticos y Quirúrgicos ambulatorios en Oficina Médica			
-Procedimientos Endoscópicos			
Servicios de Rehabilitación, Habilitación, y Equipo Médico Duradero			
-Terapia Física			
-Terapia Respiratoria			
Cuidado de Salud en el Hogar (incluye, entre otros, Terapia del Habla y Ocupacional)			
-Equipo Médico Duradero			
-Manipulaciones de Quiropráctico			
Salud Mental			
-Terapia de Grupo			
-Visitas Colaterales			
Farmacia			
-Generico Bioequivalente			
-Marca Preferida			
-Marca No Preferida			
-Productos Especializados			
-Medicamentos Fuera del Recetario (OTC)			

Programa de Medicamentos Por Correo (si aplica)			
-Generico Bioequivalente			
-Marca Preferida			
-Marca No Preferida			
-Productos Especializados			
Servicios de Laboratorios y Rayos X			
-Laboratorio			
-Rayos X			
PET Scan, CT Scan, MRI o PET CT (1 por año)			
Servicios Preventivos, Bienestar y Manejo de Enfermedades Crónicas			
-Servicios Preventivos (incluyendo las de mujer)			
-Inmunizaciones (Vacunas) Preventivas			
-Inmunización (Vacuna) para Virus Respiratorio Sincitial			
Servicios de Visión Pediátrica			
Examen de la vista (Refracción)			
Visión Pediátrica (Lentes de Corrección Visual o marcos (frames) para Lentes de Corrección Visual)			
Otros Servicios Cubiertos			
Examen de Refracción (adultos)			
Ambulancia Aerea en Puerto Rico			
Servicios de Emergencia en EU			
Servicios en los Estados Unidos de América de casos donde se requiera equipo, tratamiento y facilidades no disponibles en Puerto Rico			
Beneficio de Cirugía Bariátrica para el Tratamiento de Obesidad Mórbida			
Procedimiento de Cirugía Bariátrica			
Programas Incluidos como Parte de sus Beneficios			
Nutricionista			
Cubierta Dental			
-Diagnostico y Preventivo			
-Mantenedores de Espacio			

GOVERNMENT OF PUERTO RICO
OFFICE OF THE COMMISSIONER OF INSURANCE
PUERTO RICO CONTRACEPTIVES METHODS CHECK LIST

COMPANY:

ATTACHMENT 9

FORM(S) NUMBER:

Rev 02/2023

SERFF TRACKING NUMBER:

TYPE OF INSURANCE (TOI):

FDA Contraception Method	Please specify location (Page number/Row/Column) in the Drug Formulary or Contract	Please specify the commercial brand or generic name as included in the drug formulary	FOR OFFICIAL USE ONLY
Sterilization Surgery for Women			
Sterilization Implant for Women			
IUD Copper			
IUD Progestin			
Implantable Rod			
Shot/Injection			
Oral Contraceptives (Combined Pill)			
Oral Contraceptives (Extended/Continuous Use Combined Pill)			
Oral Contraceptives "the Mini Pill" (Progestin Only)			
Patch			
Vaginal Contraceptive Ring			
Diaphragm with Spermicide			
Sponge with Spermicide			
Cervical Cap with Spermicide			
Female Condom			
Spermicide Alone			
Levonorgestrel 1.5 mg / .75 mg			
Ulipristal Acetate			

CERTIFICATION

I _____ have reviewed or supervised the preparation of the above list and certify that the forms(s) and/or drug formulary is(are) in compliance with all of the applicable requirements of the USPSTF in relation to contraceptives methods. I also acknowledge responsibility for the validity, accuracy and completeness of the contents of this checklist.

Signature: _____

Date: _____

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	BENCHMARK COUNT	COVERED COUNT	CLASS PAGE REFERENCE
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	19		
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	6		
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	7		
ANESTHETICS	LOCAL ANESTHETICS	2		
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	1		
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	2		
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	0		
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1		
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	19		
ANTIBACTERIALS	AMINOGLYCOSIDES	5		
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	13		
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	11		
ANTIBACTERIALS	BETA-LACTAM, OTHER	0		
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	7		
ANTIBACTERIALS	MACROLIDES	3		
ANTIBACTERIALS	QUINOLONES	5		
ANTIBACTERIALS	SULFONAMIDES	4		
ANTIBACTERIALS	TETRACYCLINES	4		
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	2		
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4		
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	4		
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3		
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	6		
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1		
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3		
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1		
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	7		
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	3		

CATEGORY	CLASS	BENCHMARK COUNT	COVERED COUNT	CLASS PAGE REFERENCE
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	8		
ANTIDEPRESSANTS	TRICYCLICS	9		
ANTIEMETICS	ANTIEMETICS, OTHER	10		
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	5		
ANTIFUNGALS	NO USP CLASS	24		
ANTIGOUT AGENTS	NO USP CLASS	4		
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2		
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3		
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7		
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	2		
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2		
ANTIMYCOBACTERIALS	ANTITUBERCULARS	9		
ANTINEOPLASTICS	ALKYLATING AGENTS	6		
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2		
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3		
ANTINEOPLASTICS	ANTIMETABOLITES	1		
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	2		
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3		
ANTINEOPLASTICS	ENZYME INHIBITORS	0		
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	11		
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0		
ANTINEOPLASTICS	RETINOIDS	2		
ANTIPARASITICS	ANTHELMINTICS	3		
ANTIPARASITICS	ANTIPROTOZOALS	11		
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	2		
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	3		
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	2		
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	3		
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	2		
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	1		
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	10		
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	5		
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1		
ANTISPASTICITY AGENTS	NO USP CLASS	3		
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	0		

CATEGORY	CLASS	BENCHMARK COUNT	COVERED COUNT	CLASS PAGE REFERENCE
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	5		
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	11		
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	3		
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9		
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4		
ANTIVIRALS	ANTIHEPATITIS AGENTS	9		
ANTIVIRALS	ANTIHERPETIC AGENTS	5		
ANXIOLYTICS	ANXIOLYTICS, OTHER	4		
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5		
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	5		
BIPOLAR AGENTS	MOOD STABILIZERS	5		
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	17		
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2		
BLOOD GLUCOSE REGULATORS	INSULINS	10		
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	7		
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	5		
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0		
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	6		
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4		
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4		
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	7		
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10		
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	7		
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	12		
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9		
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	3		
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2		
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	4		
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	4		
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	6		
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2		
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	6		

CATEGORY	CLASS	BENCHMARK COUNT	COVERED COUNT	CLASS PAGE REFERENCE
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	6		
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	2		
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3		
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	3		
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	3		
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	1		
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	2		
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	7		
DENTAL AND ORAL AGENTS	NO USP CLASS	5		
DERMATOLOGICAL AGENTS	NO USP CLASS	24		
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	6		
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	5		
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	5		
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4		
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2		
GASTROINTESTINAL AGENTS	LAXATIVES	1		
GASTROINTESTINAL AGENTS	PROTECTANTS	2		
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	4		
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	3		
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	7		
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	3		
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3		
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	23		
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	2		
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1		

CATEGORY	CLASS	BENCHMARK COUNT	COVERED COUNT	CLASS PAGE REFERENCE
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	0		
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4		
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	6		
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	4		
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1		
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	NO USP CLASS	2		
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1		
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1		
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	6		
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5		
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2		
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	8		
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0		
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	7		
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3		
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5		
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1		
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	14		
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3		
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	3		
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	6		
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	9		
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	13		
OTIC AGENTS	NO USP CLASS	6		

CATEGORY	CLASS	BENCHMARK COUNT	COVERED COUNT	CLASS PAGE REFERENCE
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	5		
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	10		
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	2		
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2		
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	2		
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	7		
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1		
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	5		
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	3		
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6		
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	2		
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	3		
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	5		
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	7		

CERTIFICATION

I _____ have reviewed or supervised the preparation of the above checklist and certify that the drug formulary is (are) in compliance with all of the applicable requirements of the Insurance Code of Puerto Rico, Health Insurance Code of Puerto Rico, Federal and State Laws, Ruling and Circular Letters related to the Individual and Small Group Market and that the drug formulary does (do) not contain dispositions previously disapproved or required to be corrected by the Office of the Commissioner of Insurance of Puerto Rico. I also acknowledge responsibility for the validity, accuracy and completeness of the contents of this checklist, the transmittal letter and enclosures with the filing.

Signature: _____

Date: _____