2017 ACA-Compliant Small Group Quarterly Rate Filing Guidance

Pennsylvania Insurance Department
December 2016

This document is subject to change based on changes in federal guidance for the 2017 plan year.
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A. General Instructions

This document outlines the requirements for quarterly rate filings for ACA-compliant small group plans offered in Pennsylvania. The term “ACA-compliant small group plans” refers to those small group plans that are regulated under the single risk pool requirements in the ACA, and which must follow all ACA health reform rating rules. This term excludes grandfathered and transitional plans. The standardization of rate submissions will provide consistent reporting processes between issuers and will enable the Department to expedite its review and approval process.

1. Timeline

In accordance with federal Unified Rate Review (URR) instructions, all quarterly small group rate filings on and off Exchange must be submitted no later than 105 days prior to the effective date. If the date is not a business day, the due date is the first business day before the due date. Although all insurers should be aware of the URR instructions requiring filing submission no later than 105 days prior to the effective date, which equates to December 15, 2016, for a 2/3/4 quarter filing, in recognition of the fact that this state-specific guidance is being released after December 15, the Department will make a one-time allowance to permit submission of a 2/3/4 quarter filing by January 13. The Department will accept a 3/4 quarter or 4th quarter only filing no later than March 15, 2017. The rate change request summaries (see Appendix 1) will be made public after they are reviewed for completeness. Rate filings will be published no later than 15 days after receipt, according to the PA Bulletin schedule, and posted on the Department’s website. Filings will be open for a 30-day public comment period. Approved rates will be made public uniformly at each quarterly interval. In addition, correspondence and filing revisions will be made public as they occur during review.

2. Pennsylvania Filing Requirements

A. Required Documents

Pennsylvania requires quarterly rate filings to be filed for all ACA-compliant small group plans, whether on or off exchange, if rates will be changed from those filed and approved in the annual filing. All filings must be made in both SERFF and HIOS.

For quarterly filings, only experience, trends, single risk pool adjustment factors (i.e. change in morbidity/demographics/network/benefits/other), and taxes and fees (if appropriate) should be updated. The Department anticipates that changes to the single risk pool adjustment factors would usually be nominal. All other factors must be the same as in the 2017 annual filing.

For quarterly filings, only the items bulleted below may be updated. All other factors must be the same as in the 2017 annual filing.

- Membership (Departmental tables 1, 10, 11)
- Experience (Departmental tables 0, 1, 2, 2b, 4, 4b)
- Trend (Departmental tables 3, 3b)
- Factors related to experience, which the Department anticipates would typically change only nominally (Departmental table 5 and the calibration factors associated with table 10)
- Taxes and fees, if the tax structure in place at the time of the annual filing has changed (tables 6 and 10)
Filings will be considered incomplete and rejected if the items listed in the table below are not included. Every rate filing for ACA-compliant small group plans must include all of the required documents listed in the table below, including all three components of the Rate Filing Justification (RFJ).

The Part III actuarial memorandum should state four rate change amounts:
1. The additional rate change over the 2017 approved quarter rate,
2. The total rate change consumers will see year over year (i.e. updated quarter rate over the same quarter rate in the prior year),
3. The additional rate change over the total average approved annual rate, and
4. The total average rate change that consumers will see year over year.

45 CFR § 154.215(h) specifies that CMS will make available on its website the information contained in Part II, and the information contained in Parts I and III that is not a trade secret or confidential commercial or financial information as defined in HHS’s Freedom of Information Act (FOIA) regulations at 45 CFR § 5.65.

Consistent with the guidance provided during the annual rate review cycle, the Department does not anticipate redactions other than the following items:
1. AV screenshots
2. Statements specifying a company’s anticipated risk level in relation to the state average risk level (e.g., the underlined portion could be redacted in the following statement: “we expect the risk level of membership to be X% higher/lower than the state average risk level“)
3. Opining actuary’s name

If the issuer does not submit any redacted documents, the Department will make public the un-redacted versions.

The Department will only permit revisions to a rate filing to correct clearly inadvertent errors that impact the rates, for unforeseen circumstances that impact the industry, or at the Department’s request.

<table>
<thead>
<tr>
<th>Required Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Federal Documents Required to be Filed with PID</strong></td>
</tr>
<tr>
<td>RFJ Part I – Unified Rate Review Template (URRT)</td>
</tr>
<tr>
<td>RFJ Part II – Consumer Friendly Justification</td>
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<tr>
<td>RFJ Part III – Actuarial Memorandum</td>
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<td>Federal Rates Template</td>
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<tr>
<td>PA Actuarial Memorandum</td>
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<tr>
<td>PA Actuarial Memorandum Rate Exhibits (Excel and PDF)</td>
</tr>
<tr>
<td>PA Plan Design Summary and Rate Tables (Excel and PDF)</td>
</tr>
<tr>
<td>Justification for Confidentiality Requests</td>
</tr>
</tbody>
</table>
B. HIOS Submission
The HIOS submission must include the SERFF Tracking Number. The Department strongly encourages QHP issuers to use the CMS Data Integrity Tool (DIT) to reduce later corrections.

C. SERFF Submission
The following Types of Insurance (TOI), Sub-Types of Insurance (Sub-TOI) and Filing Types must be used for ACA rate filings. Rate and form filings must be submitted as separate filings.

- TOI – Group
  - H15G Group Health – Hospital/Surgical/Medical Expense
  - Sub-TOI – H15G.003 Small Group Only
- Filing Type
  - Rate

D. SERFF Rate/Rule Schedule Tab
The SERFF Rate/Rule Schedule Tab should contain the proposed premium rates for all proposed plans, and Excel and PDF versions of the Federal Rates Template and the PA Plan Design Summary and Rate Tables. No other data or information should be included in this tab.

The Company Rate Information and Rate Review Detail must be complete and accurate. The data presented should be consistent with the data that appears in Table 10 column AC and the PA actuarial memorandum.

The RFJ and all supporting data and documents should be included in the Supporting Documentation Tab.

E. Pennsylvania Insurance Department Contact
Johanna Fabian-Marks, Special Deputy & Director, Bureau of Life, Accident and Health Insurance
Email: jfabianmar@pa.gov. Phone: 717.783.4335.

B. Pennsylvania Bulletin Information

All rate submissions will be published in the Pennsylvania Bulletin. This PDF document must contain the following information. Ensure that the PDF is not locked and is in text rather than image format.

1. Company Name & NAIC #
2. Market (Small Group)
3. Products (Indemnity, HMO, POS (HMOs only), PPO, or EPO)
4. Average rate change (% and $) and range
5. Current number of covered lives and of policyholders (as of May 1, 2016 for 2nd quarter filings and August 1, 2016 for 3rd quarter filings)
6. Experience period revenue
7. Additional revenue from rate increase
C. Cover Letter

This PDF document must contain the following information. Ensure that the PDF is not locked and is in text rather than image format.

1. Company Name & NAIC #
2. Market (Small Group)
3. On or Off Exchange
4. Effective date of coverage
5. Requested rate change (see 2 A. above)
6. Range of rate change requested 12.
7. Product(s) (Indemnity, HMO, POS (HMOs only), PPO, or EPO)
8. Metal Levels and Catastrophic Plans
9. Current number of covered lives and of policyholders (as of May 1, 2016 for 2nd quarter filings and August 1, 2016 for 3rd quarter filings)
10. Number of plans offered in 2017
11. Corresponding contract form #, SERFF and Binder ID#s
12. HIOS Issuer ID # and submission tracking #

D. Rate Change Request Summary

Each issuer must complete a Rate Change Request Summary (see Attachment 1 at the end of this document). Note: the 2015 financial information in Attachment 1 should be consistent with the Supplemental Health Care Exhibit included in the 2015 Annual Financial Statement for the market. If it is not, explain why.

E. Pennsylvania Actuarial Memorandum

The PA Actuarial Memorandum must be provided for all rate submissions. This memorandum must:

- Document and show the development of the proposed per member per month 21-year-old premium rates starting from the experience period allowed claims data for the single risk pool. All adjustments and assumptions must be discussed and supporting documentation and data provided.
  - Index rate development
    - Base period allowed (both experience and manual, if a manual rate is used)
    - Morbidity adjustments (both experience and manual, if a manual rate is used)
    - Other adjustments with detail for all the elements included (both experience and manual, if a manual rate is used)
    - Utilization trends by type of service (both experience and manual, if a manual rate is used)
    - Cost trends by type of service (both experience and manual, if a manual rate is used)
    - Paid to allowed factor
    - Reduction for non-EHB benefits
  - Market Adjusted Index Rate development
- Net risk adjustment on an allowed and paid PMPM basis
- Exchange user fee on an allowed and paid PMPM basis

- Plan Adjusted Index Rate development
  - Please note, the Allowable Factors in Table 10 used in developing the Plan Adjusted Index Rates should be consistent with the annual rate filing, with the possible exception of taxes and fees in Column S.
  - Actuarial value (incurred to allowed factor)
  - Benefit richness factor (induced utilization) (before and after normalization)
  - Catastrophic plan factor
  - Network and managed care factor
  - Tobacco surcharge factor
  - Non-benefit factor

- Age 21 premium rate development
  - Age calibration
  - Geographic calibration
  - Provide each plan’s corresponding policy form numbers. For any new plans, provide AV screenshots. The HIOS Plan ID and contract form numbers must be included on the screenshot.
  - Demonstrate that the proposed rates are based on the entire single risk pool and are developed in a manner consistent with applicable state and federal guidance.
  - Demonstrate that the rates are commensurate to the benefits offered and further that the rates are not excessive, inadequate or unfairly discriminatory.

The guidance that follows describes minimum requirements. Issuers are encouraged to provide as much detail, supporting documentation and data as possible to support the proposed rates.

Templates for the tables described throughout the guidance that follows are provided in the Excel workbook titled PA Actuarial Memorandum Rate Exhibits. The Excel workbook should be completed in conjunction with the PA Actuarial Memorandum. Cells in the workbook shaded yellow require that the filer enter information. Cells shaded blue contain formulas that calculate the required information.

1. Basic Information and Data

A. Company Information
Same information identified in the cover letter. Also complete column D of Table 0. Note that the experience period start date calculated in cell D10 can be overwritten with a more recent date, but an earlier date is not permitted. Consistent with the federal URR Instructions, the first date of the experience period must be the first date of a calendar quarter, i.e., April 1, July 1, or October 1.

B. Rate History and Proposed Variations in Rate Changes
Document the most recent 3 years of historical rate changes in Pennsylvania, including any quarterly trend update submissions for small group filings. The history should include the amount of the rate change and the SERFF ID# for the filing. Note and discuss if the 3 prior years’ rate revisions were not applied uniformly across all rating areas and plans.
Clearly state whether the proposed rate revision applies uniformly or varies by plan or area. If there are variations, provide an exhibit showing the variation and explain the reason for the variation.

C. Average Rate Change
The calculation of the average rate change entered as the “percent rate change requested” should be consistent with Table 10 cell AC15. Also list the change in 21-year-old non-tobacco premium pmpm calculated in table 11, cell AZ13, for comparison purposes.

D. Membership Count
Provide the age breakdown and total number of members for the periods shown in Table 1.

E. Benefit Changes
Identify any benefit or cost sharing changes and the corresponding HIOS Plan IDs for the impacted plans. Provide a discussion of the pricing assumptions used in the development of the cost for the benefit changes. Discuss the impact of the 2017 Essential Health Benefit (EHB) Benchmark Plan change and changes to the AV calculator, if applicable. Note: The 2017 EHB Benchmark Plan for Pennsylvania is the Keystone HMO Gold Preferred $30/$60/$600 small group plan offered by Keystone Health Plan East, Inc.

F. Experience Period Claims and Premium
In Table 2, provide experience period data. For quarterly rate filings, issuers must file updated data and documentation to support the rate request. The beginning of the 12-month experience period should be no more than 24 months before the requested quarterly effective date with at least two months of run-out for the entire single risk pool. So the 12-month experience period for a 4/1/17 update should reflect a 12-month experience period no earlier than from 4/1/15 through 3/31/16; for a 7/1/17 update the 12-month experience period would be no earlier than 7/1/15 through 6/30/16. Consistent with the federal URR Instructions, 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.

The experience period paid claims data must represent all non-grandfathered policies in the single risk pool, with at least two months of run-out, for the named entity and market. (Point-of-service data may be based on multiple companies.)

If this data is not consistent with the data reported in Section I of Worksheet I of the URRT, discuss why and provide the actual data used in developing the rates, including all assumptions and adjustments. Note that claims for transitional policies must be included. The narrative must discuss any adjustments to the data, the basis for the adjustments and provide supporting data.

Additionally, the narrative must:

• Discuss the development of the premium data.
• Discuss the development of the allowed claims.
  o If the issuer has private reinsurance, discuss the experience period reinsurance expenses and recoveries and how they are reflected in the allowed claims.
• Separately identify non-EHB benefits and the experience period cost.
• Discuss capitated services, the capitation amount and if the capitation is uniform or varies by age, for the experience period.
• Identify and discuss the impact of pharmacy rebates on the incurred claims.
• Discuss the development of the estimated risk adjustment and estimated reinsurance recoveries.
• The loss ratio is auto-calculated.

G. Credibility of Data
Provide a narrative regarding the credibility of the data and provide the credibility formula and methodology.

If the experience data is not 100% credible, discuss and provide the manual data (as tables 2b, 3b, and 4b) and source used for the manual rate. All adjustments and assumptions must be shown and data provided to support all adjustments and assumptions. If the experience and manual rate are blended, show and justify the method used to blend the two rates. The blended rate should be presented in table 2c.

H. Trend Identification
In Table 3, identify the proposed annual medical and prescription drug allowed claims cost and utilization trends. For an explanation of how the service categories, cost, and utilization in table 3 are defined, reference the URRT instructions. If the numbers entered in the Cost and Utilization columns do not match those entered in Worksheet I, Section 2 of the URRT, please explain why. The Composite number entered for Capitation should match the product of the Cost and Utilization entries for Capitation in Worksheet I, Section 2 of the URRT.

Discuss the basis for the trend, provide justification for each service category and show the weights used in the development of the total composite trend. Disclose the data source and all assumptions and adjustments.

Additionally, for a small group filing, the actuarial memorandum must specify whether quarterly rates are proposed and if this is consistent with what was proposed in the annual filing.

I. Historical Experience
Provide the data in Table 4, using the most recent 36 months (the experience period and the previous 24 months) of data with at least two month of run-out. Disclose the method used to develop the allowed claims. Discuss how the monthly data was used and adjusted to develop the total proposed annual trend identified in Table 3. If this data was not used to develop the trend, explain why and provide the data (as table 4b) and analysis used in the development of the proposed trend.

2. Rate Development & Change

A. Development of Projected Index Rate, Market-Adjusted Index Rate, & Total Allowed Claims
The first three paragraphs below describe the completion of the top half of Table 5 for three alternative situations. The remaining paragraphs apply in all three situations.

 Rates based entirely on the issuer’s experience
When no manual experience is used, the “Experience Period Total Allowed EHB Claims PMPM + EHB Capitation PMPM (net of prescription drug rebates)” (Table 5, cell C6) should be the value from Table 2. If this is not the
same as Index Rate of Experience Period from the URRT, provide an explanation. The “Total Applied Trend Projection Factor” (cell C7) should be the value from Table 3. The “Change in Morbidity” (cell C10) should be the Population Risk Morbidity factor used in the URRT. The four components comprising the “Other” adjustment from the URRT should be entered in cells C12 through C15.

Rates based entirely on the manual experience
If rates are based entirely on manual experience, the “Experience Period Total Allowed EHB Claims PMPM + EHB Capitation PMPM (net of prescription drug rebates)” (Table 5, cell C6) should be the value from Table 2b. The “Total Applied Trend Projection Factor” (cell C7) should be the value from Table 3b. The “Change in Morbidity” (cell C10) and the four components comprising the “Other” adjustment (cells C12 through C15) should be the adjustments applicable to the manual experience.

Rates based entirely on a blend of actual and manual experience
If rates are based on a blend of actual and manual experience, the “Experience Period Total Allowed EHB Claims PMPM + EHB Capitation PMPM (net of prescription drug rebates)” (Table 5, cell C6) should be the value from Table 2c. The “Total Applied Trend Projection Factor” (cell C7) should be the value from Table 3b. The “Change in Morbidity” (cell C10) and the four components comprising the “Other” adjustment (cells C12 through C15) should reflect a blend of the adjustments applicable to the actual experience and the adjustments applicable to the manual experience.

Provide a detailed narrative of the development of the Projected Index Rate, Projected Market-Adjusted Index Rate, and Projected Total Allowed Claims. All rating period adjustments must be shown and supporting data and narrative provided.

Discuss the calculation of each of the Single Risk Pool Adjustment Factors. Detail the contributing factors to the “Change in Benefits” factor, including the effect of changes in the EHB benchmark plan and adjustments to bring transitional experience to the EHB benefit level. Adjustments captured in cell C15, the “Other - Change in Other” category, must be identified. Such adjustments may include the impact of the change in induced utilization.

Discuss the non-EHBs and the development of the associated costs.

To the extent that the calculation of the items in Table 5 is modified to adjust the treatment of capitation, demonstrate and explain those modifications in the narrative.

Note that, in table 5, after the paid to allowed ratio is applied to the index rate, the result is named the Projected Paid EHB Claims PMPM. In fact, this is the projected incurred PMPM, but the term “paid” is used to remain consistent with the URRT spreadsheet 1.

Small group market filings using quarterly trended rates should complete Table 5A. For these filings, enter the number of member months renewing by quarter in cells I9 through L9. Enter the corresponding value from the first-quarter (annual) filing in cell I14 (January Single Risk Pool Projected Allowed Claims). For second-quarter filings, overwrite the formula in cell J14 (April Single Risk Pool Projected Allowed Claims) and enter the corresponding value from the second-quarter filing or, if there was no second-quarter filing, enter the corresponding value from the first-quarter (annual) filing. For third-quarter and fourth-quarter filings, respectively, delete the contents of cells J11:J13 and K11:K13. Enter the appropriate number of Months of Trend
on line 12. Typically this will be 0, 3, and 6 for second-quarter filings, 0 and 3 for third-quarter filings and 0 for fourth-quarter filings.

B. Retention Items
Complete Table 6 and, in the narrative, separately identify all retention items and show the proposed percent of premium for the rating period. The values in Table 6 for total Administrative Expenses, total Taxes and Fees, and Profit/Contingency are imported from Table 10. Table 6 provides a breakdown of the administrative expenses and taxes and fees, and the broken out elements should sum to the total administrative expenses and taxes and fees. If they do not, explain why in the narrative. Please note the following:

• Administrative expenses should be the same dollar amount or percent of premium as in the 2017 annual filing.
• Profit, contribution to surplus or risk margins should be the same as in the 2017 annual filing.
• For calendar year 2017, the federal government will not collect the Health Insurance Provider Fee imposed by the Affordable Care Act Provision 9010. The fee should be included for plans that provide coverage in 2018, and the amount of the fee included should be prorated to account only for coverage provided in 2018 and should be the same as the 2017 annual filing.
• Provide documentation and supporting data for any changes in taxes and fees.

C. Normalized Market-Adjusted Projected Allowed Total Claims
The projected data is on an average basis. To more appropriately compare the average year-over-year rate change, as is done in Table 8, a normalization process is performed in Table 7. To normalize, the Market Adjusted Projected Allowed Total Claims PMPM are normalized using the projected average factors for age, geography, tobacco, benefit richness (induced demand), and network. The Market Adjusted Projected Allowed Total Claims PMPM should be calculated based on the approved amount for the quarter or quarters prior to the effective date of the current filing and the proposed amount for the remaining quarters of 2017 as shown in cell C32.

Provide the 2016 Market-Adjusted Projected Allowed Total Claims PMPM and the 2016 normalization factors as reported in the 2016 column of Table 7 of the 2017 annual filing. The 2016 Normalized Market-Adjusted Projected Allowed Total Claims PMPM is auto-calculated based on the 2016 input data.

Show the development of each normalization factor and explain changes between 2016 and 2017 factors. Normalization factors should be based on the projection period member population. The average age factor may include a factor of 0 for non-billable members, i.e., dependents in excess of the 3 child max.

D. Components of Rate Change
Document the components of change in the proposed 2017 Calibrated Plan Adjusted Index Rate (PMPM).

Table 8 requires at most four data entries. First, enter the 2016 and 2017 base period allowed claims in cells C62 and D62. The 2016 value should be the same as reported in the 2016 column of table 8 of the 2017 annual filing. The 2017 value should be calculated based on the approved amount for the quarter or quarters prior to the effective date of the current filing and the proposed amount for the remaining quarters of 2017. If necessary, complete “Change in Miscellaneous Items” for 2016 and 2017 in cells C85 and D85. The narrative must detail
any miscellaneous items and describe how the values for cells C85 and D85 were calculated. The rest of the table will calculate based on entries elsewhere in the excel workbook.

Row H of Table 8 should approximate Row A of Table 8. If Row H is substantially different from Row A, explain why in the narrative.

Table 9 collects data elements for 2016 and 2017 to support the calculations in Table 8. 2016 amounts should be the amounts reported in the 2016 column of table 9 of the 2017 annual filing. The 2017 amounts should be calculated based on the approved amounts for the quarter or quarters prior to the effective date of the current filing and the proposed amounts for the remaining quarters of 2017. If the amounts shown for 2016 Paid-to-Allowed, URRT Trend, URRT Morbidity, URRT “Other”, Risk Adjustment, Reinsurance, Exchange User Fee, and Capitation differ from those on the 2016 URRT, explain why.

3. Plan Rate Development

Instructions for Completing Table 10 of the PA Rate Template

The Department notes that the only expected changes to Table 10, relative to the annual rate filing, are cells C8-C11, column S (if appropriate), cells T4-T6, cell V15 and column W, unless an issuer is adding new plan, in which case a corresponding form filing is required and a network filing with the Department of Health may be required.

The instructions included between the dotted lines below are only relevant if a new plan is added. Otherwise, the data described in the instructions below should be the same as the data in the 2017 annual filing, with the possible exception of column S for taxes and fees, which may be updated if appropriate.

Beginning in Column B, row 17, the template requests the HIOS Plan ID number for all plans that will be offered in 2017, and for all plans offered in 2016 that will not be offered in 2017. Column C requires plan type for each plan, consistent with the URRT. Column D requires the plan marketing name for each plan. This naming convention will be specific to each issuer but there should be consistency from filing to filing each year. Since plan offerings will need to conform to metallic tier offerings, and HHS has issued a new 2017 actuarial value calculator, some plans may be discontinued, others may be new, and others may be modified. Column E requires the issuer to indicate whether a plan will be discontinued (D), new (N), modified (M) or remain as is, existing (E). Plans must be discontinued if they exceed the federal uniform modification standards in 45 CFR 147.106.

The issuer is expected to map plans being discontinued to plans that will be in existence in 2017. In column F, for a plan that is being discontinued, please provide the January 1, 2017 plan marketing name for the plan to which the discontinued plan is being mapped. For plans that are not being discontinued, Column F may be left blank. For discontinued plans, the information entered in columns F through T should pertain to the mapped 2017 plan, while Information in columns V through Z should pertain to the 2016 plan.

Column G requests the metallic tier (Platinum, Gold, Silver, Bronze, and Catastrophic) and column H requires the metallic tier actuarial value. This is the actuarial value that the issuer calculates using the HHS Actuarial Value
Calculator. If the HHS Actuarial Value Calculator does not accommodate an issuer’s benefit designs, the issuer has one of two options:

**Approach 1** (45 CFR § 156.135(b)(2)): The issuer may adjust the plan benefit design (for calculation purposes only) to fit the parameters of the calculator and have a member of the American Academy of Actuaries certify the methodology.

**Approach 2** (45 CFR § 156.135(b)(3)): The issuer may use the calculator for the plan design provisions that correspond to the parameters of the calculator and then have a member of the American Academy of Actuaries make appropriate adjustments to the actuarial value.

In Column I, please indicate whether the metallic tier actuarial value was calculated using the HHS Actuarial Value Calculator (“Standard AV”), or whether it was calculated using “Approach 1” or “Approach 2.” For those metallic tier actuarial values for new plans calculated with the AV calculator, provide screenshots of the calculations. The policy form number should be included on the screenshot. Within the PA Actuarial Memorandum, please include the actuarial certifications for those metallic tier actuarial values calculated under Approach 1. The actuarial certification can be found in the federal form, Unique Plan Design Supporting Documentation and Justification. For those metallic tier actuarial values calculated under Approach 2, please provide supporting calculations within the PA Actuarial Memorandum.

In Column J, please indicate whether the plan offering will be through the federally-facilitated Exchange.

Columns K through P and R through T require issuers to report the allowable factors to adjust the 2017 market adjusted index rate to calculate the plan adjusted index rate. The numbers entered in columns K through P should be reported as a multiplier. Column Q calculates the pure premium by multiplying the market-adjusted index rate by the factors in columns K through P. The numbers in columns R through T should be reported as a percent of gross premium. The issuer should provide supporting information for these allowable plan level adjustments within the PA Actuarial Memorandum. For further information on these allowable plan level adjustments, please refer to the URRT instructions and the instructions for the Federal Part III Actuarial Memorandum.

In cells T4 and T5, the issuer should enter the age and geographic calibration factors.

Columns V and W require total covered lives and total policyholders by plan as of the date entered in C10. Do not enter data in column V – it will autofill using the numbers from Table 11, column R.

The 2016 Calibrated Plan Adjusted Index Rate in column Z, row 17 and following should be the amounts reported in the 2016 column of table 10 of the 2017 annual filing. The 2017 amounts should be calculated based on the approved amounts for the quarter or quarters prior to the effective date of the current filing and the proposed amounts for the remaining quarters of 2017. Weighted average rates for 2016 and 2017 are calculated using the most recent membership distribution by plan offering (as of 5/1/16 for second-quarter filings or 8/1/16 for third-quarter filings) and average rate changes are calculated.
4. Plan Premium Development for 21-Year-Old Non-Tobacco User
The projected calibrated plan-adjusted index rate is used to develop the average premium weighted for quarterly trend in the small group market. 2016 and 2017 premiums are compared to calculate the average 21-year-old premium increase.

Instructions for Completing Table 11 of the PA Rate Template
Columns B through G will auto-fill with data from Table 10. Starting in cell I15, enter the most recent enrollment as of 5/1/16 for 2nd quarter filings, as of 8/1/16 for 3rd quarter filings, and as of 11/1/16 for 4th quarter filings, by rating area for each plan listed. Column R automatically sums the numbers entered in columns I through Q to calculate each plan’s total enrollment. If a plan is not offered in a rating area, leave the cell blank.

The rest of the worksheet will automatically calculate based on: the entries in columns I through Q; the plan adjusted index rates for 2016 and 2017 in table -10, columns Z and AA; and the current and proposed geographic factors entered in table 13, columns M and N.

5. Plan Factors
A. Age and Tobacco Factors
Complete Table 12 by entering in the tobacco factor used for each age band. Pennsylvania uses the default federal standard age curve. These factors should be the same as the annual factors.

Note: The member-level rate build-up is capped such that no more than the three oldest covered children under age 21 can be taken into account when determining the total family premium.

B. Geographic Factors
Complete Table 13. If the proposed geographic factors are not consistent with the current approved factors, data and narrative must be provided indicating the development of each factor. These factors should be the same as the annual factors.

C. Network Factors
Complete Table 14. For each network, only one network rating factor per state per market may be used. That factor is applied to all plans the carrier has in all applicable rating areas uniformly. If multiple networks exist within a given rating area, a separate plan ID# for each network within the rating area must be used. These factors should be the same as the annual factors, unless a new network is proposed for the remainder of the rating quarters. Please be mindful that all networks must be approved by the Pennsylvania Department of Health, before the Insurance Department approves the rate filing.

D. Service Area Composition
If multiple service areas exist, show the counties that comprise each service area.

E. Composite Rating
CMS cannot support composite rating in SHOP for 2017; however, Pennsylvania will allow composite rating as described in 45 C.F.R. § 147.102(c)(3)(ii) for off-SHOP plans. If the issuer plans to use composite rating, indicate this in the narrative.
6. Actuarial Certifications
At a minimum, the actuarial certification must include certifications that:

• All factor, benefit and other changes from the prior approved filing have been disclosed in the actuarial memorandum.
• New plans are not considered modifications of existing plans under the uniform modification standards in 45 CFR 147.106.
• The information presented in the PA Actuarial Memorandum and PA Actuarial Memorandum Rate Exhibits is consistent with the information presented in the 2017 Rate Filing Justification.

F. PA Actuarial Memorandum Rate Exhibits

All data exhibits must be provided in Excel and PDF.

G. Additional Rate Exhibits

The Federal Rates Template and the Department Plan Design Summary and Rate Tables must be included in the Rate/Rule Schedule Tab in SERFF. Submit in both Excel and pdf. Issuers should complete only one Federal Rates Template per company, and should use separate tabs for each market.