



# 2018 ACA-Compliant Health Insurance Rate Filing Guidance

Pennsylvania Insurance Department

March 14, 2017

This document is subject to change based on the  
release of final federal guidance for the 2018 plan year.

# Contents

- Revisions.....1
- A. General Instructions.....3
  - 1. Timeline.....3
  - 2. Pennsylvania Filing Requirements .....3
    - A. Required Documents and Redactions 3
    - B. HIOS Submission 4
    - C. SERFF Submission 5
    - D. SERFF Rate/Rule Schedule Tab 5
    - E. Pennsylvania Insurance Department Contact 5
- B. Cover Letter and PA Bulletin Information.....5
- C. Rate Change Request Summary .....6
- D. Pennsylvania Actuarial Memorandum & Rate Exhibits .....6
  - 1. Basic Information and Data.....7
    - A. Company Information (Table 0) 7
    - B. Rate History and Proposed Variations in Rate Changes 8
    - C. Average Rate Change 8
    - D. Membership Count (Table 1) 8
    - E. Benefit Changes 8
    - F. Experience Period Claims and Premium (Table 2) 8
    - G. Credibility of Data (Tables 2b, 3b, 4b) 9
    - H. Trend Identification (Table 3) 9
    - I. Historical Experience (Table 4) 10
  - 2. Rate Development & Change..... 10
    - A. Projected Index Rate, Market-Adjusted Index Rate, & Total Allowed Claims (Table 5) 10
    - B. Retention Items (Table 6) 11
    - C. Normalized Market-Adjusted Projected Allowed Total Claims (Table 7) 11
    - D. Components of Rate Change (Tables 8 and 9) 12
  - 3. Plan Rate Development (Table 10) ..... 12
    - A. Instructions for Completing Table 10 of the PA Rate Exhibits 12
    - B. Mapping Scenarios – Individual Market 12
    - C. Mapping Scenarios – Small Group Market 13
    - D. General Instructions – Individual and Small Group Market 13
  - 4. Plan Premium Development for 21-Year-Old Non-Tobacco User (Table 11) ..... 15
  - 5. Plan Factors ..... 15
    - A. Age and Tobacco Factors (Table 12) 15
    - B. Geographic Factors (Table 13) 15
    - C. Network Factors (Table 14) 16
    - D. Service Area Composition 16
    - E. Composite Rating 16
  - 6. Actuarial Certifications..... 16
- E. Additional Exhibits ..... 16
  - 1. Department Plan Design Summary ..... 16
  - 2. Service Area Map ..... 16
- Common Data Call Questions Related to 2017 ACA-Compliant Rate Submissions ..... 17

# Revisions

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Throughout this document you will see numerous revisions from the 2017 Guidance. Based on feedback from issuers, revisions have been made, in some cases, to be consistent with federal guidance, and in other cases to clarify the Department guidance. While the following identifies the revised tables and the rationale, detailed information is provided in the body of the guidance in the appropriate section.

In addition, the Department has provided a list of common questions asked during last year’s review cycle for consideration when preparing a filing – see the end of this document.

Table #	Explanation
General	<ul style="list-style-type: none"> <li>a. Merged cover letter and PA Bulletin summary documents into single cover letter submission.</li> <li>b. The 2016 Financial Experience data in the Rate Change Request Summary template should now be populated with data from Table 2. Administrative expenses and after tax profit must be reported for the subject market for the 2016 rating period.</li> <li>c. We have added a request that each filing include a map demonstrating the issuer’s service area (distinguishing between on- and off-exchange, if applicable).</li> <li>d. The completeness and redaction checklist is now in Excel rather than a PDF.</li> <li>e. Rather than requesting a PDF version of each submitted document for public posting, as we did last year, we are requesting a single PDF of the entire filing for public posting. If the issuers chooses to make the limited redactions anticipated by the Department, those redactions should be made only in this document.</li> </ul>
0.	<p>Added new Table 0, above Table 1</p> <ul style="list-style-type: none"> <li>a. Requires company inputs, e.g. company name, product information. <ul style="list-style-type: none"> <li>i. The effective date is a list.</li> </ul> </li> <li>b. Base Period Start Date <ul style="list-style-type: none"> <li>i. This is a calculated field which enters 24 months prior to the effective date chosen.</li> </ul> </li> <li>c. Date of Most Recent Membership <ul style="list-style-type: none"> <li>i. This is a calculated field which enters 11 months prior to the effective date, i.e. 2/1/17 for annual small group filings.</li> </ul> </li> <li>d. Rate Effective Date Through <ul style="list-style-type: none"> <li>i. This is a calculated field which calculates the end of the 12-month effective period.</li> </ul> </li> <li>e. Base Period Date Through <ul style="list-style-type: none"> <li>i. This is a calculated field which calculates the end of the 12-month base period.</li> </ul> </li> </ul>
1.	<ul style="list-style-type: none"> <li>a. Entry required for the average age for each recording period.</li> </ul>
2.	<ul style="list-style-type: none"> <li>a. Member months (cell E36) were changed to calculated cell referencing Table 1 experience member months.</li> </ul>

3.	<ul style="list-style-type: none"> <li>a. Changed cell G54 to reference the months of trend cell G53.</li> <li>b. Added Months of Trend on row 52. <ul style="list-style-type: none"> <li>i. This is a calculated field which calculates the months of trend from midpoint of experience period to midpoint of rating period from Table 0.</li> </ul> </li> <li>c. Changed “2 Year Trend Projection Factor” in B54 to “Total Applied Trend Projection Factor.”</li> <li>d. Added “Induced Demand” column to separately capture the change in induced demand related to product shifts.</li> <li>e. Added “Composite URRT Trend,” which includes the utilization impact of the change in induced demand. This trend should match what is reported in Section II of the URRT and is used to project the experience data to the rating period.</li> </ul>
5.	<ul style="list-style-type: none"> <li>a. Split table into ‘Actual Experience Data’ and ‘Manual Data’ for the calculation of the Projected Index Rate.</li> <li>b. The formula for the Market-Adjusted Projected Paid EHB Claims PMPM has been changed so that the sign (+ or -) of the Projected Risk Adjustment PMPM is the same as the sign on URRT.</li> </ul>
5.A.	<ul style="list-style-type: none"> <li>a. Changed labels in row 28</li> <li>b. Cell J32 is unprotected in the event an issuer uses an annual trend that differs from Table 3 in small group filings. Detailed justification will be required in the Actuarial Memorandum if different trends are used in Tables 3 and 5A.</li> <li>c. Added row 34 “Quarterly Trend Factor”</li> <li>d. Added row 35 “2018 Trend Factors by Quarter” to be used in Table 11 to calculate the first quarter small group consumer adjusted premium rates.</li> </ul>
6.	<ul style="list-style-type: none"> <li>a. Cell B54 now accepts a dollar amount for PCORI Fees.</li> </ul>
10.	<ul style="list-style-type: none"> <li>a. Changed column F from “2018 Plan Marketing Name” to “2018 HIOS Plan ID.”</li> <li>b. Moved the “Number of Covered Lives by Rating Area” from Table 11 to the end of Table 10.</li> <li>c. Provided more detailed instructions on mapping plans in this guidance.</li> <li>d. Added instructions for additional “Induced Utilization Exhibit” to this guidance. No table is provided for this purpose in the Departmental Rate Exhibits, so the insurer should separately create and submit this table.</li> </ul>
11.	<p>Instead of using a single table for both individual and small group filings, we have split table 11 into two tables, each on its own tab: “PA Plan Premiums Individual” and “Plan Premiums SG Annual”. Based on the market segment selected, the unused tab for Table 11 must be deleted or hidden.</p> <ul style="list-style-type: none"> <li>a. If Market segment is Individual, the Annual Rates for by Rating Area are auto-calculated and no data entry is required.</li> <li>b. If Market segment is Small Group Annual, the rates for all the four quarters of 2018 are auto-calculated. However, the first quarter 2017 approved rates must be entered in the yellow section.</li> </ul>
12.	Updated child age bands and now allow for the tobacco surcharge to apply to age 18+.
PA Plan Design Summary and Rate Tables	<ul style="list-style-type: none"> <li>a. Deleted the “On-Exchange Silver Plan Premium” and “Off-Exchange Silver Plan Premium” tabs.</li> <li>b. Changed column I on the Plan Design Summary tab to require “Counties Covered” instead of “Counties Excluded.”</li> <li>c. Added a “Rates by County” tab.</li> </ul>

# A. General Instructions

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This document outlines the rate filing requirements for all ACA-compliant plans offered in Pennsylvania. The term “ACA-compliant plans” refers to those 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, transitional, and student health plans. Student health guidance is posted on the Department’s website at <http://www.insurance.pa.gov/Companies/ProductAndRateRequire/Pages/default.aspx>. The standardization of rate submissions provides consistent reporting processes between issuers and will enable the Department to expedite our review and approval process.

Please note, this guidance references the 2017 URRT and Instructions. If substantive changes are made to the 2018 URRT and Instructions, changes to this guidance may be required.

## 1. Timeline

All rate filings, for both individual and small group plans, on and off Exchange, must be submitted by May 22, 2017. Filings revised only to reflect updated risk adjustment projections will be accepted between July 1-July 14 and all required documents, including the rate change request summaries (see Attachment 1) will be made public July 21, as well as correspondence and filing revisions made up to that point. After July 21, correspondence and filing revisions will be made public as they occur during review. Redactions will be permitted as described in the following section. Final filings will be made public the week of October 16, 2017.

## 2. Pennsylvania Filing Requirements

### A. Required Documents and Redactions

Pennsylvania requires annual rate filings for all ACA-compliant individual and small group plans, whether on or off exchange. All filings must be made in both SERFF and HIOS.

Filings will be considered incomplete and rejected if the items listed in the table on the following page are not included. Note that Pennsylvania requires that all issuers submit annual rate filings for all ACA-compliant plans, including those with rate decreases or unchanged rates. This aligns with the federal requirements in 45 C.F.R 154.215(a). Every rate filing for ACA-compliant plans must include all of the required documents listed in the table on the following page, including all three components of the Rate Filing Justification (RFJ).

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 2017 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
4. Specific provider contracting information (note: such information was not submitted in plan year 2017 rate filings and the department does not anticipate receiving such information in plan year 2018 rate filings)
5. Commission schedules

Please note, one complete PDF file for public review (the “public rate filing PDF”) must be submitted. The PDF document must contain all required documents, tables and exhibits. If the issuers chooses to make the limited redactions anticipated by the Department, those redactions should be made only in this document. In this manner, the Department will not have to select the component documents in making redacted items available for public inspection, but will instead have one complete document for public review.

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, for risk adjustment after the CMS Risk Adjustment Report, or at the Department’s request. Please be reminded that 2017 quarterly updates for small group rates may not be made after noon on March 15, 2017 and that the 2018 URRT must be used in reporting the updated 2017 information.

<b>Required Documents</b>
<b><i>Federal Documents Required to be Filed with PID</i></b>
RFJ Part I – Unified Rate Review Template (URRT)
RFJ Part II – Consumer Friendly Justification
RFJ Part III – Actuarial Memorandum*
Federal Rates Template
<b><i>Pennsylvania Documents Required to be Filed with PID</i></b>
Cover Letter
Rate Change Request Summary (Attachment 1)
PA Actuarial Memorandum*
PA Actuarial Memorandum Rate Exhibits (Excel)
PA Plan Design Summary and Rate Tables (Excel)
Service Area Map
Public Rate Filing PDF
Completeness and Redaction Checklist, and, if applicable, Redaction Justification

\*The Department strongly prefers that the RRJ and PA actuarial memorandums be submitted separately, with the RRJ memorandum addressing the specific requirements of the URR instructions, and the PA memorandum addressing the specific instructions laid out in this guidance. If the insurer chooses to submit a single consolidated actuarial memorandum, the memorandum must clearly and fully meet ALL the standards of BOTH the URR instructions and the instructions in this guidance. Where URR and PA guidance instructions differ, the insurer must clearly identify those differences and provide all data and documentation necessary to meet both sets of instructions.

## 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 – Individual
  - H15I Individual Health – Hospital/Surgical/Medical Expense
  - Sub-TOI –H15I.001 Health – Hospital/Surgical/Medical Expense
- 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 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. Issuers should complete only one Federal Rates Template per company, and should use separate tabs for each market.

The Company Rate Information and Rate Review Detail must be complete and accurate. The rate change data presented should be consistent with Table 10 and the number of policyholders affected should be populated using the total covered lives as of 2/1/17 in Table 2. The total requested rate change entered should be consistent with column AC of Table 10.

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 & Acting Director, Bureau of Life, Accident and Health Insurance  
Email: [jfabianmar@pa.gov](mailto:jfabianmar@pa.gov). Phone: 717.783.4335.

## B. Cover Letter and PA Bulletin Information

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The cover letter must be a Microsoft Word file and must contain the following information in the numbered sequence as shown below. Notice of all rate submissions will be published in the Pennsylvania Bulletin. The published information will be extracted from the Cover Letter.

1. Company Name & NAIC number
2. Market (Individual or Small Group)
3. On or Off Exchange
4. Effective date of coverage
5. Average rate change requested
6. Range of rate change requested
7. Product(s) (Indemnity, HMO, POS (HMOs only), PPO, or EPO)
8. Rating Areas and the change from 2017

9. Metal Levels and Catastrophic Plans
10. Current number of covered lives and of policyholders as of February 1, 2017
11. Number of plans offered in 2018 and the change this represents from 2017
12. Corresponding contract form number, SERFF and Binder ID numbers
13. HIOS Issuer ID # and submission tracking number

## C. Rate Change Request Summary

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Each issuer must complete a separate Rate Change Request Summary (see Attachment 1) for each market (individual and/or small group) in which it offers plans. The 2016 Financial Experience data in the Rate Change Request Summary template should be populated with data from Table 2. For this attachment, premium is the sum of earned premium in cell B36 and the estimated risk adjustment in cell L36. Claims is the sum of the ultimate incurred claims in cell D36, pharmacy rebates in cell I36 and EHB and non-EHB capitation in cells J36 and K36, less the estimated reinsurance recoveries in cell M36. Since administrative expenses and after tax profit are not captured in Table 2, the issuer must calculate these amounts, using a reasonable method, and report these amounts for the subject market for the 2016 rating period.

## D. Pennsylvania Actuarial Memorandum & Rate Exhibits

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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. Data elements include:
  - Index rate development
    - Base period allowed claims (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 a paid PMPM basis
    - Exchange user fee on a paid PMPM basis
  - Plan Adjusted Index Rate development
    - 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 (show in Excel and discuss development)
  - Non-benefit factor (such as admin, taxes and fees and profit)
- Age 21 premium rate development
  - Age calibration (show in Excel and discuss development)
  - Geographic calibration (show in Excel and discuss development)
- Provide each plan's corresponding policy form numbers and 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 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
- Disclose all factor and benefit changes from the prior approved rate filing, as appropriate, and provide supporting documentation and data.

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.

Additionally we have attached, at the end of this guidance, questions the Department asked issuers during the 2017 rate review cycle. Please consider these questions as you prepare your Pennsylvania Actuarial Memorandum.

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.

#### Individual vs. Small Group Tabs in the PA Actuarial Memorandum Rate Exhibits

Consistent with the 2017 Guidance, the Department has one Excel workbook that contains the Actuarial Memorandum Exhibits for both the Individual and Small Group Market. New this year, tab IV/table 11, which develops premiums by rating area, has been broken into two tabs, tab IV-A for individual market filings and tab IV-B for small group market annual filings.

The filer must delete the tab IV versions that are not relevant to the filing. That is, for individual market filings, please delete the blue tab labeled *IV B Plan Premium SG Annual*; for small group market annual filings, please delete the tab labeled *IV A Plan Premium Individual*.

## 1. Basic Information and Data

### A. Company Information (Table 0)

Complete table 0 in tab I Data. Cells D6 and D7 require entry of issuer name and product type. Select the input from cells D8 and D9 from the drop down menu. Note that individual rate filings and small group market annual rate filings must have a rate effective date of January 1, 2018. Consistent with the federal URR Instructions, the first date of the experience period in cell D10 is automatically calculated to be two years before the rate effective date, and the end date of the experience period calculated in cell F10 is 364 days later.

## 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

List the average rate change from Table 10, column AC. For comparison purposes, also list the change in 21-year-old non-tobacco premium pmpm calculated in table 11, cell AN13; and the two rate increase amounts calculated on the URRT worksheet 1 - the percent increase over Experience Period in cell V45, and the percent increase, annualized, in cell V46.

## D. Membership Count (Table 1)

Provide the average age, age breakdown, and total number of members or member months, as indicated, for the periods shown in Table 1.

For small group market filings, include all members as of 2/1/17, regardless of whether they are in plan year 2016 or plan year 2017 plans.

## 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 changes to the AV calculator and the expanded de minimis ranges, if applicable. Note: The current 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 (Table 2)

In Table 2, provide experience period data for the most recent calendar year. Although CMS does not require calendar year data for small groups in Section I of Worksheet I of the URRT, the Department requests that issuers complete this section using calendar year data.

The experience period paid claims data must represent the most recent calendar year for all non-grandfathered policies in the single risk pool, with at least one month 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. Note that claims and premiums for transitional policies must be included; if the issuer has transitional business, provide the dollar amount of claims, premium and the number of transitional member months in the actuarial memorandum. 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.

- Refer to the URR instructions for the definition of allowed claims. Note that the URR instructions state that “By definition, “Allowed Claims” do not include: [...] 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.” Additionally, please note that quality incentive payments should not be included in allowed claims as they are part of the administrative expenses.
- 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. Estimated payments into the risk adjustment program should be entered as a negative number and estimated recoveries from the risk adjustment program should be entered as a positive number.
- The loss ratio is auto-calculated.

### G. Credibility of Data (Tables 2b, 3b, 4b)

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. Provide a justification as to why the experience period data is not fully credible. All adjustments and assumptions must be shown and data provided to support all adjustments and assumptions. Table 5 has been revised to better accommodate the development of the credibility weighted Projected PMPM in cell D24 of Table 5. See section 4.A. below for instructions.

### H. Trend Identification (Table 3)

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.

Table 3 has been revised to include a column for induced demand and the “Composite” column has been renamed “Composite URRT Trend”. The 2017 URR Instructions indicate that the utilization trend should include the impact of the change in induced demand related to product shifts. The Department has separated the induced demand trend from the utilization trend because it may not be appropriate to include induced demand changes when projecting the experience period utilization to the rate effective period, particularly in small group rating with quarterly trends. If the issuer does not project any changes in induced demand related to product shifts, you may enter “1.00” in the Induced Demand column for each benefit category.

The Composite URR Trend is used in Table 5 to project the experience period data to the rating period. . The aggregate URR Trend reported in Worksheet I, Section 2 of the URRT should match the Composite URR Trend in Table 3 of the Department’s Guidance. 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.

- Show quantitatively the derivation of the trend assumptions for each benefit category in Table 3.
- Provide a detailed narrative that explains how this data was used in developing the trend, including all assumptions and adjustments.

- Discuss the impact of provider contracting and leveraging on trend. The specific provider contracting agreement and amount may be redacted, but not aggregate amounts.

Additionally, for a small group filing, the actuarial memorandum must specify whether quarterly rates are proposed.

### I. Historical Experience (Table 4)

Provide the data in Table 4, using the most recent 36 months (3 calendar years) of data with at least one 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 Composite URR 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. If premium for transitional policies is included in table 4, provide the annual dollar amount of premium, claims, and the number of transitional member months for each year in the actuarial memorandum.

## 2. Rate Development & Change

### A. Projected Index Rate, Market-Adjusted Index Rate, & Total Allowed Claims (Table 5)

Starting with the 2016 index rate, complete Table 5 and provide a detailed narrative of the development of the Projected Index Rate, Projected Market-Adjusted Index Rate, and Projected Total Allowed Claims. Table 5 has been revised to show the development of the credibility weighted Projected Index Rate using parallel actual experience and/or manual data inputs. Issuers are now required to input in row 23 the credibility weights associated with the actual experience data and the manual data. Provide the credibility factors used and support these factors by providing a narrative including the credibility formula and methodology. All rating period adjustments must be shown and supporting data and narrative provided.

Discuss the calculation, and show quantitatively, in an Excel spreadsheet with formulas, the derivation and justification of each of the Single Risk Pool Adjustment Factors (Change in Morbidity, Change in Demographics, Change in Network, Change in Benefits, Change in Other) for actual and manual data and explain the variation (if any) between the two. Detail the contributing factors to the “Change in Benefits” factor, including adjustments to bring transitional experience to the EHB benefit level. The “Change in Morbidity” and the total of the “Change in Other” adjustments should equal those entered in Worksheet I, Section 2 of the URRT. Adjustments captured in cells C20 and D20, the “Other - Change in Other” category, must be identified. Adjustments such as private reinsurance should be included in these cells. See the URR Instructions for additional items that may be reported in this section.

Discuss the non-EHBs, included in cell C38, 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.

Show quantitatively, including an Excel spreadsheet with formulas, the derivation of the Projected Risk Adjustments PMPM amount. Provide a detailed narrative that describes the development of the estimated risk adjustment transfer payment. In demonstrating the development of the transfer payment, please show all risk transfer formula components, the estimated market-wide average risk assumptions, and support for those assumptions. Also show the development of the Exchange user fee.

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 Only

Only 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 J29 through M29. The template includes default months of trend (0, 3, 6 and 9) in cells J31 through M31. Previously, average small group rates were developed in Table 11 based on inputs from Table 5A. The 2018 Department Guidance revises Table 5A in that an average trend factor is developed and used to backtrend the quarterly trend factors. The 2018 Trend Factors by Quarter can now be used in Table 11 to develop the 1<sup>st</sup> quarter 2018 Consumer Adjusted Index Rate for a 21 year old consumer in a given rating area.

### B. Retention Items (Table 6)

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. Provide documentation and supporting data for all changes in administrative expenses including agent/broker fees and commissions and quality improvement initiatives, and taxes and fees, separately identified. Please note the following:

- The narrative should discuss the development of the average commission and circumstances in which broker commissions will be paid and if they will vary based on geographic location, metal level, plan, open enrollment vs SEP enrollment, etc. Additionally, the current and 2018 broker agreements should be included.
- If profit, contribution to surplus or risk margins is included in the rate development, the Department expects a consistent percent of premium load for all plans. If the profit, contribution to surplus, or risk margin does vary by plan, explain why the variation is not discriminatory.
- If the administrative expenses vary by plan, explain why in the narrative.
- Cell B54 is now unprotected to allow for the entry of the PCORI dollar amount, whereas cell C54 requires a percentage entry.

### C. Normalized Market-Adjusted Projected Allowed Total Claims (Table 7)

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 from table 5, cell I57 is normalized using the projected average factors for age, geography, tobacco, benefit richness (induced demand), and network.

Provide the 2017 Market-Adjusted Projected Allowed Total Claims PMPM and the 2017 normalization factors. These numbers should match the numbers provided in the plan year 2017 rate filing. The 2017 Normalized Market-Adjusted Projected Allowed Total Claims PMPM is auto-calculated based on the 2017 input data.

Show the development of each normalization factor and explain changes between 2017 and 2018 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 (Tables 8 and 9)

Document the components of change in the proposed 2018 Calibrated Plan Adjusted Index Rate (PMPM).

Table 8 requires at most three data entries. First, enter the 2017 base period allowed claims in cell C72. If necessary, complete "Change in Miscellaneous Items" for 2017 and 2018 in cells C95 and D95. The narrative must detail any miscellaneous items and describe how the values for cells C95 and D95 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 2017 and 2018 to support the calculations in Table 8. The amounts shown in the 2017 column should match those entered in the 2017 column in the plan year 2017 rate filing. If the amounts shown differ from those in the 2017 rate filing, explain why.

## 3. Plan Rate Development (Table 10)

The projected market-adjusted index rate is used to develop the calibrated plan adjusted index rates in columns Z and AA of Table 10. Each plan's rate is developed as the product of the market-adjusted index rate, the allowable factors, and calibration for age and geography.

### A. Instructions for Completing Table 10 of the PA Rate Exhibits

Beginning in Column B, row 17, the template requests the HIOS Plan ID number for all plans that will be offered in 2018, and for all plans offered in 2017 that will not be offered in 2018. 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 2018 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 existing (E) - i.e., no changes to the plan; modified (M); new (N); discontinued and mapped to a 2018 plan (DM); or discontinued and not mapped to a 2018 plan (DNM). Plans must be discontinued if they exceed the federal uniform modification standards in 45 CFR 147.106.

### B. Mapping Scenarios – Individual Market

The issuer is expected to account for all enrollment as of 2/1/17 on table 10. This means that the number in table 10, cell AP15 should equal the number in table 1, cell D17. Plans may fall into several categories, which will necessitate different treatment in table 10:

- The 2017 plan will continue to be available to all current enrollees in 2018 – in this case, all 2017 enrollees should be mapped into the continued 2018 plan. Input 2017 plan information in columns B-D, W, Z, and AG-AO. Input "E" or "M" in column E, as appropriate. Input 2018 plan information in all other input columns.
- The 2017 plan will be discontinued in 2018 – in this case, information for the 2017 plan should be entered in columns B-D, W, Z, and AG-AO.
  - If enrollees will be mapped into a 2018 plan, input "DM" in column E and input the information for the 2018 plan in all other input cells starting at column F.
  - If enrollees will not be mapped into a 2018 plan, input "DNM" in column E and leave all other input cells blank.

- The 2017 plan will be available to some, but not all, enrollees in 2018 due to reductions in service area or change in exchange participation from on-exchange to off-exchange – in this case, multiple rows should be used to account for all 2017 enrollees. Edit the plan numbers in column A as follows – if the 2017 plan with enrollment being split into multiple paths in 2018 is, for example, plan 4 according to table 10, input Plan 4a, Plan 4b, Plan 4c, etc., into column A, and then renumber subsequent rows so that they continue with Plan 5, Plan 6, etc.
  - The first row (“Plan 4a” in this example) should include information on the 2017 enrollees who will be mapped into the continued 2018 plan. Input “M” in column E. Columns W and AG-AO should show numbers for the 2017 enrollees who will be mapped into the continued 2018 plan.
  - The next row(s) (“Plan 4b” in this example) should be used to show information for any 2017 enrollees who will be mapped into a different 2018 plan. Input “DM” in column E. If 2017 enrollees will be mapped into multiple 2018 plans, use a separate row for each 2018 plan. Columns A-D, and Z should show information pertaining to the 2017 plan. Columns F-T should show information pertaining to the 2018 plan. Columns W and AG-AO should show numbers for the 2017 enrollees who will be mapped to that plan.
  - The last row (“Plan 4c” in this example) should be used to show information for any 2017 enrollees who will not be mapped into a 2018 plan. Input “DNM” in column E. Columns A-D and Z should show information on the 2017 plan. Columns G-T should be blank. Columns W and AG-AO should show the number of 2017 enrollees who will not be mapped to a 2018 plan.
- The plan is new in 2018 – in this case, Columns W, Z, and AG-AO should be left blank.

### C. Mapping Scenarios – Small Group Market

The instructions presented above for how to present enrollment in Table 10 for an individual market filing should also be followed for a small group market filing. The Department recognizes that many small group market enrollees as of 2/1/17 will still be in plan year 2016 plans. The filer should map enrollees in plan year 2016 plans to the plan year 2017 plan that the filer anticipates the 2016 enrollees will move into when they renew in 2017. If the 2016 plan has continued in 2017, then the 2016 enrollees should be mapped to the 2017 plan. If the 2016 plan has not been continued in 2017, then the 2016 enrollees should be mapped to the 2017 plan that will be offered to them for renewal.

### D. General Instructions – Individual and Small Group Market

The 2017 Calibrated Plan Adjusted Index Rate in column Z should reflect the 2017 plan and the 2018 Calibrated Plan Adjusted Index Rate in column AA should reflect the 2018 plan. For new plans, we do not expect to see a 2017 rate.

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 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 2018 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. Please note, only columns L, N and P should be normalized using the 2/1/17 or the projected member distribution. Whichever distribution is used, the methodology must be internally consistent and described in the PA Actuarial Memorandum.

Using the results in column 9 from the matrix below, populate Table 10 Column L to support the induced utilization included in the AV Pricing inputs. The actuarial memorandum should include this exhibit, completed, and provide supporting narrative by responding to the direction following the table.

Induced Utilization Exhibit								
Plan ID	Metal Level	Projected Membership	Projected Allowed Claims	Projected Paid Claims	Paid To Allowed Factor	Average Tobacco Factor	AV & Cost Sharing Factor	(8)/(6*7)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
xxxxxx								
xxxxxx								
Total								

- Please confirm that the ratio in column (9) represents the pure induced utilization for each plan.
- Please show quantitatively, including an Excel spreadsheet with formulas, the derivation of the AV and cost sharing factors for each plan. Please note that it is assumed that the AV and cost sharing factor includes the average tobacco factor.
- Please provide any additional justification for induced utilization assumptions in the Company’s pricing.
- Please confirm that each plan’s induced utilization factor was normalized by an aggregate factor, and that the resulting sumproduct (against 2/1/17 membership or the projected membership distribution) produces a factor of 1.000. Please show the steps that demonstrate this

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. Please note, the profit reported in column T should be on an after-tax basis.

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. The age calibration may include an adjustment to account for the 3 child cap. The development of all factors must be quantitatively shown in an Excel spreadsheet.

Columns V and W require total covered lives and total policyholders by plan as of February 1, 2017. Do not enter data in column V – it will autofill using the numbers entered in columns AG – AO and totaled in cell AP15 of this Table.

In Column Z, row 17 and following, the issuer is expected to fill in the annual individual or average small group 2017 approved calibrated plan adjusted index rates by plan offering. Starting in row 17, Column AA, each 2018 calibrated plan adjusted index rate is calculated by applying the proposed 2018 plan adjustments in columns K through P and R through T, and the calibration factor in cell T6, to the market-adjusted index rate in cell C11. Weighted average rates for 2017 and 2018 are calculated using the 2/1/17 membership distribution by plan offering and average rate changes are calculated.

## 4. Plan Premium Development for 21-Year-Old Non-Tobacco User (Table 11)

The projected calibrated plan-adjusted index rate is used to develop the 21-year-old non-tobacco premium in the individual market on Tab IV A, and the 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> quarter 21-year-old non-tobacco premium in the small group market on Tab IV B. For individual market filings, 2017 and 2018 premiums are compared to calculate the average 21-year-old premium increase. For small group market filings, 1<sup>st</sup> quarter 2017 and 2018 rates are compared to calculate the average 21-year-old premium increase in the 1<sup>st</sup> quarter. Rates for 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> quarters may be changed through quarterly filings.

### *Instructions for Completing Table 11 of the PA Rate Template*

In Table 11 Tab IV A (individual market filing), no inputs are needed. In Table 11 Tab IV B, columns I through Q, issuers are required to enter the 1<sup>st</sup> quarter non-tobacco premium rate for each rating area. All other cells will automatically calculate.

## 5. Plan Factors

### A. Age and Tobacco Factors (Table 12)

Complete Table 12 by entering in the tobacco factor used for each age band. Pennsylvania uses the default federal standard age curve. Consistent with CMS, the 2018 age bands have been updated to parse the former 0 to 20 age band as shown in Tab V Table 12. Note with this change, the tobacco factor may now be applied to age bands 18, 19 and 20.

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 (Table 13)

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.

### C. Network Factors (Table 14)

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.

### D. Service Area Composition

If multiple service areas exist, show the counties that comprise each service area. If this filing proposes Service Area changes relative to the last approved filing, detail the changes and their cause.

### E. Composite Rating

Pennsylvania will allow composite rating as described in 45 C.F.R. § 147.102(c)(3)(ii). 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 cannot be 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.

## E. Additional Exhibits

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### 1. Department Plan Design Summary

Submit the Department Plan Design Summary in Excel in the Rate/Rule Schedule Tab in SERFF. Please note the change in the Plan Design Summary which now requires issuers to show counties where plans are offered instead of counties where plans are not offered.

### 2. Service Area Map

Submit a map of the current 2017 service area and the proposed 2018 service area. Distinguish, if appropriate, between on-exchange and off-exchange service area by using the formatting indicated on the template to indicate the off-exchange service area and the on-exchange service area. If necessary, the 2017 and the 2018 service areas may be depicted on different maps. The Department has provided a template in a PowerPoint slide that issuers may use to submit this information, but issuers are also welcome to use their own software to generate the map(s). To use the formatting indicated in the template, you can either right click on a county and select "fill" to change the color and/or select "format shape/pattern fill" to add the pattern overlay, or you can click the desired format in the key, select "Format Painter" on the Home tab, and then click on the county you want to format. .

## Common Data Call Questions Related to 2017 ACA-Compliant Rate Submissions

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An italicized question indicates that the Departmental guidance has been updated to explicitly include the request/direction. Questions that are not italicized should still be considered when preparing the filing; they were not directly incorporated into this guidance either because the Department feels they were already addressed in the guidance, because they pertain to specific circumstances that may not be applicable to all issuers, or because they pertain to the URRT and are already addressed in the URR instructions.

### Other

1. Please provide all tables, exhibits, etc. supporting the actuarial memorandum in Excel format with formulas for each entry.
2. Please be advised that each time the URRT is changed in SERFF, the URRT in HIOS must also be updated. Please acknowledge your understanding and certify that you are in compliance.
3. Does this filing propose any changes in your pricing model? If so, please discuss. This response may be redacted since it may contain confidential information.
4. Please discuss the impact SEP enrollees have had on your company's claims experience. If possible, provide the 2015 loss ratio for SEP enrollees and non-SEP enrollees.

### Tables 1-4

5. Please provide the January 1, 2016 through April 30, 2016 emerging experience in an Excel worksheet formatted similar to Table 2.
6. *In Tables 2 and 4, does the premium include revenue generated from transitional business? If so, please provide the dollar amount of premium and the number of transitional members.*
7. *Please show quantitatively the derivation of the trend assumptions for each benefit category as shown in Table 3. Please include the sources and source claims data. Also provide a detailed narrative that explains how this data was used in developing the trend, including all assumptions and adjustments. Also discuss the impact of provider contracting and leveraging on trend. The specific provider contracting agreement and amount may be redacted, but not aggregate amounts.*
8. *If manual data was used in developing the trend, provide a detailed narrative that explains how this data was used in developing the trend, the data source and all assumptions and adjustments. Also discuss the impact of provider contracting and leveraging on trend.*

### Table 5 / Related URRT components

9. *Please show quantitatively including an Excel spreadsheet with formulas the derivation and justification of each of the "Change in Morbidity" (.xxx), "Change in Demographics" (.xxx), "Change in Network" (X.xxx), and "Change in Other" (.xxx) Single Risk Pool Adjustment Factors, shown in Table 5 of the Actuarial Memorandum Rate Exhibits.*
10. Please describe quantitatively, including an Excel spreadsheet with formulas, the derivation of the population risk morbidity and the "Other" factor as found in Worksheet 1, Section II of the URRT.

11. *Please show quantitatively, including an Excel spreadsheet with formulas, the derivation of the -\$XX.xx Projected Risk Adjustments PMPM amount found in Section III, Worksheet 1 of the URRT. Please provide a detailed narrative that describes the development of the estimated risk adjustment transfer payment. In demonstrating the development of the transfer payment, please show all risk transfer formula components, the estimated market-wide average risk assumptions as well as support for those assumptions. When responding to this data call, you may redact this response as it will contain proprietary information. Since this response should include detailed insight into the risk adjustment transfer methodology, you may redact this response.*
12. 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 AV 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.
13. *Please show the development of the Exchange user fee.*

#### Table 6

14. Table 6 requests separate reporting of general and claims administrative expenses and agent/broker commissions. Company has combined these expenses. Please provide separately.
15. Expenses for Quality Improvement Initiatives are included in the general and claims administrative percentage and were not broken out separately. Please modify Table 6 to separately identify, as requested in the Table.
16. Please provide the actual and projected (according to the approved rate filing) general administrative expense, claims expense, agent/broker fees and commissions, and Quality Improvement Initiatives for calendar years 2014 and 2015 and the year to date 2016. If aggregate numbers were provided and approved in prior year filings, show the allocated amount of each.
17. 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.
18. *Regarding broker commissions:*
  - *Under what circumstances and in what geographic locations will commissions be paid?*
  - *Are commissions paid for SEP?*
  - *Provide a copy of the broker agreement - current and 2017.*
  - *Show the calculation of the average commission - current and 2017.*

*Since this response should include detailed insight into the broker commission, you may redact this response.*

#### Table 10

19. *Please show quantitatively, including an Excel spreadsheet with formulas, the derivation of the Age, Geographic and Tobacco Calibration Factor.*
20. *Please show quantitatively that plan premiums are in proportion to the plan AV Pricing Values.*
21. Quantitatively show how the average factors in Table 10 row 13 have been normalized.

22. Induced Utilization

a. Please complete the table below for all plans, and confirm that the ratio in column (9) represents the induced utilization for each plan.

Plan ID	Metal Level	Projected Membership	Projected Allowed Claims	Projected Paid Claims	Paid-to-Allowed Factor	Average Tobacco Factor	AV & Cost Sharing Factor	(8)/(6)*(7)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
xxxxxx								
xxxxxx								
Total								

- b. Please confirm that the ratio in column (9) represents the pure induced utilization for each plan.
- c. Please show quantitatively, including an Excel spreadsheet with formulas, the derivation of the AV and cost sharing factors for each plan. Please note that it is assumed that the AV and cost sharing factor includes the average tobacco factor.
- d. Please provide any additional justification for induced utilization assumptions in the Company's pricing.

Please confirm that each plan's induced utilization factor was normalized by an aggregate factor, and that the resulting sumproduct (against 2/1/17 membership or the projected membership distribution) produces a factor of 1.000. Please show the steps that

23. Please indicate if the Company included an adjustment to account for the regulation that prohibits charging for more than three children per family, and, if applicable, demonstrate how the adjustment was derived and where it is included in the filing.

Table 11

24. Please show quantitatively with an Excel spreadsheet with formulas that the Consumer Adjusted Premium Rates match the rates shown in the Rates Table template.

Tables 13-14

25. Does this filing propose Service Area changes relative to the last approved filing? If so, please discuss.

26. Please provide an explanation for revising the Geographic Area Factors and describe quantitatively, including an Excel spreadsheet with formulas, the derivation of the revised factors.