



2019 ACA-Compliant Health Insurance Rate Filing Guidance

Pennsylvania Insurance Department

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This document is subject to change based on the
release of final federal guidance for the 2019 plan year.

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Revisions

In response to comments from carriers requesting to deviate from the standard factors referenced surrounding the draft guidance, the Department requests that all issuers file the uniform adjustments - Individual Adjustment of 1.06 and the CSR Defunding Adjustment of 1.28 - in their initial rate submission. As the rate review process moves forward and federal healthcare reform efforts are clarified, the Department will consider issuer specific requests.

Throughout this document you will see numerous revisions from the 2018 Guidance and the 2019 Draft Guidance.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’s 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 an attachment – Attachment II – which lists topics that must be addressed, in detail, in the Pennsylvania Actuarial Memorandum to facilitate timely review and approval – see the end of this document.

Table	Explanation
General	<ul style="list-style-type: none"> a. The subcategories within the SERFF “Supporting Documentation” Tab have been updated to standardize the filing requirement(s) under each category. In this manner, all issuers will file the required information in a consistent location as required by the category heading. b. The naming conventions for the following requirements have been standardized: <ul style="list-style-type: none"> 1. Under the “Supporting Documentation” Tab - The Pennsylvania Actuarial Memorandum Rate Exhibits = 2019_Market (SmGrp or Indiv)_Company Name_PAAMExhibits_Date (mmddyy).xlsm 2. Under the “Rate/Rule Schedule” Tab - The Plan Design Summary and Rate Tables = 2019_Market (SmGrp or Indiv_Company Name_PDSRateTable_Date (mmddyy).xlsm c. The Department will no longer accept generic actuarial memorandums. Within the memorandum, a discussion of a particular item must contain the specific proposed PMPM, percent of premium, etc. as shown in the corresponding Pennsylvania Actuarial Memorandum Exhibit. d. Some highlighted fields in the PA Actuarial Memorandum Exhibits will require a formula input, instead of a hard-coded number. This should eliminate a question from the Department regarding the development of the input. e. Each response to a Department data call must contain a cover letter that details the changes made to the PA Actuarial Memorandum Exhibits and the reasons why the changes were made, e.g., in response to Department question number 5. f. An exhibit is required to reconcile the PA rate increase and the URR rate increase. g. We are now requesting a single PDF of the entire filing for public posting with the initial filing and one additional Public PDF with the final submission. Intermediate Public PDFs are no longer required. If an issuer chooses to make the limited redactions anticipated by the Department, those redactions should be made only in the Public PDF. All PDF documents must be properly displayed – set print range, pagination, etc.

2. and 2b.	<ul style="list-style-type: none"> a. The run out for the experience period data is now two months, instead of one. b. Removed the experience period reinsurance input as the benefit year underlying the experience was beyond the coverage period for this temporary reinsurance program.
3. and 3b.	<ul style="list-style-type: none"> a. The formula to calculate the annual trend in cell G52 of Table 3 and cell G25 of Table 3b was modified to calculate the annual trend in the same manner as the URRT.
4. and 4b.	<ul style="list-style-type: none"> a. Added an additional 12 months of Historical Data – Monthly data for 2014-2017 is now required.
5.	<ul style="list-style-type: none"> a. Cells C15 and D15 require a formula input. The formula should multiply the Individual-adjustment of 1.06 times the issuer assumption for the change in morbidity. b. The note in cell D27 (Index Rate for Projection Period on URRT - Small Group) was deleted.
5.A.	<ul style="list-style-type: none"> a. 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. b. Cells K32:M32 are unprotected and highlighted orange to indicate these cells may be overwritten. For small group filings, issuers may include the pro-rated HIT (Health Insurance Provider Fee), due to the 2019 moratorium, in the formula that shows the annual trend.
6.	<ul style="list-style-type: none"> a. Removed the PCORI PMPM input from Cell B54. b. Added Column D for Retention Item PMPMs. These Cells are auto-calculated. c. The yellow highlighted fields now require formula inputs. d. The input in Cell C57 for the Health Insurance Tax should be pro-rated for small groups only, if not included in Table 5A, as discussed above.
10.	<ul style="list-style-type: none"> a. Column A, Rows 18-117 were unlocked to allow the user to edit the plan names. b. Column AA, Rows 18-117 were changed to reference T7 instead of T6. c. Removed the Tobacco Surcharge Column. d. Added Tobacco Surcharge to calibration Table. e. Added Column “P” for CSR adjustment for On Exchange Silver plans. f. Added Row 17 to capture Transitional Enrollment. g. Columns E, G, I, and J, starting in Row 18, were changed to dropdowns for consistency purposes. h. Row 15 was adjusted to use a straight average if there are no enrollment inputs (to avoid errors downstream).
11.	<ul style="list-style-type: none"> a. In tab IV A, Column A, Rows 18-117 were changed to reference tab ‘III Plan Rates’. b. In tab IV B, Column A, Rows 18-117 were changed to reference tab ‘III Plan Rates’.

PA Plan Design Summary and Rate Tables	<p>a. The following changes were made:</p> <ul style="list-style-type: none">i. "Rate Pages" Tab<ul style="list-style-type: none">1. A macro/button has been added which will add additional plan Columns if they are needed by the issuer in order to achieve consistency in added Columns across all issuers.2. Company/market/product/effective date inputs have been added in rows 1-4.ii. "Plan Design Summary" Tab<ul style="list-style-type: none">1. A macro/button has been added which will validate the template by checking that all information was entered for each plan and that the information entered corresponds to what is possible from the drop-downs.2. Columns D-F were changed to dropdowns for consistency purposes.iii. "Rates by County" Tab<ul style="list-style-type: none">1. Columns B-F were changed to formulas to match the inputs on the "Plan Design Summary" Tab.2. Row 5 was added to capture membership inputs by county.
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A. General Instructions

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 among issuers and will enable the Department to expedite our review and approval process.

Please note, this guidance references the 2018 URRT and Instructions. If the federal government makes substantive changes to the 2018 URRT and Instructions for Plan Year 2019, 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 21, 2018. Filings revised only to reflect updated risk adjustment projections will be accepted between July 6-July 13. All required documents, including the Rate Change Request Summaries (see Attachment I) will be made public July 23, as well as correspondence and filing revisions made up to that point. After July 23, other correspondence and filing revisions will be made public once the rates are finalized. Redactions will be permitted as described in the following section. Final approved filings will be made public the week of October 15, 2018.

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 rate filings must be submitted in both SERFF and HIOS.

Filings will be considered incomplete and rejected if the items listed in Table A: Required Documents 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 Table A: Required Documents on the following page, including all three components of the Rate Filing Justification (RFJ).

45 C.F.R. § 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 trade secret or confidential commercial or financial information as defined in HHS’s Freedom of Information Act (FOIA) regulations at 45 C.F.R. § 5.65.

Consistent with the guidance provided during the 2018 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 (such information was not submitted in plan year 2018 rate filings and the Department does not anticipate receiving such information in plan year 2019 rate filings).
5. Commission schedules.

Please note, one complete PDF file for public review (the "public rate filing PDF") must be submitted with the initial submission and the final submission. The PDF document must contain all required documents, tables and exhibits. If an issuer chooses to make the limited redactions anticipated by the Department, those redactions should be made only in these documents. 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 2018 quarterly updates for small group rates may not be made after noon on March 15, 2018 and that the 2019 URRT, if available, must be used in reporting the updated 2018 information.

Table A: Required Documents
<i>Federal Documents Required to be Filed with PID</i>
RFJ Part I – Unified Rate Review Template (URRT)
RFJ Part II – Consumer Friendly Justification
RFJ Part III – Actuarial Memorandum*
Federal Rates Template (QHP & non-QHP filed in both rate and binder filings)
<i>Pennsylvania Documents Required to be Filed with PID</i>
Cover Letter
Rate Change Request Summary (Attachment I)
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 an issuer 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 issuer must clearly identify those differences and provide all data and documentation necessary to meet both sets of instructions.

B. HIOSSubmission

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. SERFFSubmission

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. An issuer 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 shown in Table 10 cell V15. 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, under the appropriate category.

E. Pennsylvania Insurance Department Contact

Tracie Gray, Director, Bureau of Life, Accident and Health Insurance
 Email: tgray@pa.gov. Phone: 717.705.7257.

B. Cover Letter

The cover letter must be a Microsoft Word file and must contain the following information in the numbered sequence as shown below.

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. Total additional annual revenue generated from the proposed rate change
8. Product(s) (Indemnity, HMO, POS (HMOs only), PPO, or EPO)
9. Rating Areas and any changes from 2018
10. Metal Levels and Catastrophic Plans
11. Current number of covered lives and of policyholders as of February 1, 2018 as shown in Cell V15 of Table 10
12. Number of plans offered in 2019 and the change this represents from 2018
13. Corresponding contract form number, SERFF and Binder ID numbers
14. HIOS Issuer ID number and submission tracking number

C. Rate Change Request Summary

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 2017 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. 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 2017 rating period.

D. Pennsylvania Actuarial Memorandum & Rate Exhibits

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
 - 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)
- Tobacco 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 as possible, supporting documentation and data, to support the proposed rates.

Additionally, we have attached, at the end of this guidance, Attachment II which lists topics that must be addressed in the Actuarial Memorandum. Please ensure these issues are addressed in your Pennsylvania Actuarial Memorandum. Further, we note the change that requires issuers to personalize the Pennsylvania Actuarial Memorandum. That is, the memorandum must incorporate the PMPM, percent of premium, factor adjustments, etc. into the Pennsylvania Actuarial Memorandum. For example, when the issuer discusses the development of the risk adjustment transfer amount, the calculated amount must be stated.

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. Cells shaded orange may be overwritten with justification.

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

Consistent with the 2018 Guidance, the Department has one Excel workbook that contains the Actuarial Memorandum Exhibits for both the Individual and Small Group Market. As with last 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 market rate filings and small group market annual rate filings must have a rate effective date of January 1, 2019. 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 three 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 number for the filing. Note and discuss if the three 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 2/1/18, regardless of whether they are in plan year 2017 or plan year 2018 plans.

E. Benefit Changes

Provide an exhibit that identifies 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 minimus ranges, if applicable. Note: The current EHB Benchmark Plan for Pennsylvania continues to be 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 in the annual rate filings.

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 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. 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, or similar provider 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. 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.
- State the loss ratio. This 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 or if credible, discuss the reasons why the experience data was not used as the rate basis. All adjustments and assumptions must be shown and data provided to support all adjustments and assumptions. Table 5 accommodates 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 as well as the induced demand adjustments. 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 2018 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, Cell C12, 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 rate exhibits. If the Composite number entered for Capitation does not match the product of the Cost and Utilization entries for Capitation in Worksheet I, Section 2 of the URRT, please explain and

provide an exhibit that reconciles the trend assumptions.

State the proposed trend and 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 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)

The 2019 guidance increases the number of historical data months required in Table 4 and 4b.

Provide the data in Table 4, using the most recent 48 months (four calendar years) of data with at least two months 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 2017 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. Cells C15 and D15 require a formula input. The formula should multiply the Individual Adjustment of 1.06 times the issuer assumption for the change in morbidity. The formula input should show the issuer change in morbidity assumption times the Individual Adjustment of 1.06. Table 5 shows the development of the credibility weighted Projected Index Rate using parallel actual experience and/or manual data inputs. Issuers are 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, if not, discuss in the actuarial memorandum. 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 for 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 by inputting the formula in the highlighted area in Cell C32.

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. Cells J32 through M32 are highlighted in orange to indicate that the formulas in these cells may be overwritten to reflect trend changes, relative to Table 3, and/or the proration of the Health Insurance Provider Fee (HIT) due to the 2019 moratorium on this fee. Additionally, an Excel exhibit must be provided to show the development of the quarterly trend and the HIT in Table 5A.

Previously, average small group rates were developed in Table 11 based on inputs from Table 5A. The 2019 Department Guidance develops an average trend factor that is used to backtrend the quarterly trend factors. The 2019 Trend Factors by Quarter are used in Table 11 to develop the 1st quarter 2019 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. If the sum of the administrative expenses or the sum of taxes and fees is inconsistent with the average amount in Column Q of Table 10 an error will present in Cell C49 or Cell C53 in Table 6. Table 6 provides a breakdown of the administrative expenses and taxes and fees, and the broken-out elements sums to the total administrative expenses and taxes and fees. Provide documentation and supporting data for all inputs -- administrative expenses including agent/broker fees and commissions and quality improvement initiatives, and taxes and fees, separately identified. Please note the following:

- If the administrative expenses vary by plan, explain why in the narrative.
- 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 2019 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.
 - The Department notes the federal change in the corporate income tax. The Tax Cuts and Jobs Act of 2017 (Pub. L. No. 115-97) lowered the federal corporate tax rate from 35% to 21%, applicable to taxable years beginning after December 31, 2017. The Department expects that rate filings will, if applicable, reflect the revised federal corporate tax rate.

- The Senate Amendment to Extension of Continuing Appropriations Act (HR 195) of January 2018 suspends for calendar year 2019 (but not 2018) the annual fee imposed by the Affordable Care Act on health issuers. As discussed in the “Small Group Market Filings Only” section on the prior page, the impact of the moratorium on small groups may be reflected in Table 5A, or in Cell C57 of Table 6. For Individual Market filings, the HIT should be shown in Cell C57.

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 K57 is normalized using the projected average factors for age, geography, tobacco, benefit richness (induced demand), and network.

Provide the 2018 Market-Adjusted Projected Allowed Total Claims PMPM and the 2018 normalization factors. These numbers should match the numbers provided in the plan year 2018 rate filing. The 2018 Normalized Market-Adjusted Projected Allowed Total Claims PMPM is auto-calculated based on the 2018 input data.

Normalization factors should be based on the projection period member population. An Excel exhibit must be provided to show the development of the normalization factors, the experience period and the projected period distributions. Additionally, the narrative must discuss any differences between the experience period and projected period distributions. The average age factor may include a factor of 0 for non-billable members, i.e., dependents in excess of the three-child max under the age of 21.

D. Components of Rate Change (Tables 8 and 9)

Document the components of change in the proposed 2019 Calibrated Plan Adjusted Index Rate (PMPM).

Table 8 requires at most three data entries. First, enter the 2019 base period allowed claims in Cell C72. If necessary, complete “Change in Miscellaneous Items” for 2018 and 2019 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 2018 and 2019 to support the calculations in Table 8. The amounts shown in the 2018 Column should match those entered in the 2018 Column in the plan year 2018 rate filing. If the amounts shown differ from those in the 2018 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, geography and tobacco.

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

This guidance and accompanying exhibits revise Table 10 in that it removes the tobacco surcharge column and added a row to the calibration Table to include the tobacco calibration factor. Further, Column P has been added to capture the CSR defunding adjustment for On Exchange Silver Plans. For On Exchange Silver Plans, issuers should populate

Column P with 1.28 such that CSR Defunding Adjustment can be applied in the development of the Calibrated Plan Adjustment Index Rate in Column AA.

Column A, Rows 18-117 have been unlocked to allow issuers to edit the Plan numbers, if needed, in accordance with the mapping instructions on Page 15 of the guidance.

Beginning in Column B, Row 18, the template requests the HIOS Plan ID number for all plans that will be offered in 2019, and for all plans offered in 2018 that will not be offered in 2019. 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 2019 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 2019 plan (DM); or discontinued and not mapped to a 2019 plan (DNM).

Plans must be discontinued if they exceed the federal uniform modification standards in 45 C.F.R. §147.106.

B. Mapping Scenarios – Individual Market

The issuer is expected to account for all enrollment as of 2/1/18 on Table 10. This means that the number in Table 10, Cell AP15 should equal the number in Table 1, Cell D18. Plans may fall into several categories, which will necessitate different treatment in Table 10:

- The 2018 plan will continue to be available to all current enrollees in 2019 – in this case, all 2018 enrollees should be mapped into the continued 2019 plan. Input 2018 plan information in Columns B-D, W, Z, and AG-AO. Input “E” or “M” in Column E, as appropriate. Input 2019 plan information in all other input columns.
- The 2018 plan will be discontinued in 2019 – in this case, information for the 2018 plan should be entered in Columns B-D, W, Z, and AG-AO.
 - If enrollees will be mapped into a 2019 plan, input “DM” in Column E and input the information for the 2019 plan in all other input cells starting at Column F.
 - If enrollees will not be mapped into a 2019 plan, input “DNM” in Column E and leave all other input cells blank.
- The 2018 plan will be available to some, but not all, enrollees in 2019 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 2018 enrollees. Edit the plan numbers in Column A as follows – if the 2018 plan with enrollment being split into multiple paths in 2019 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 2018 enrollees who will be mapped into the continued 2019 plan. Input “M” in Column E. Columns W and AG-AO should show numbers for the 2018 enrollees who will be mapped into the continued 2019 plan.
 - The next row(s) (“Plan 4b” in this example) should be used to show information for any 2018 enrollees who will be mapped into a different 2019 plan. Input “DM” in Column E. If 2018 enrollees will be mapped into multiple 2019 plans, use a separate row for each 2019 plan. Columns A-D, and Z should show information pertaining to the 2018 plan. Columns F-T should show information pertaining to the 2019 plan. Columns W and AG-AO should show numbers for the 2018 enrollees who will be mapped to that plan.
 - The last Row (“Plan 4c” in this example) should be used to show information for any 2018 enrollees who will not be mapped into a 2019 plan. Input “DNM” in Column E. Columns A-D and Z should

show information on the 2018 plan. Columns G-T should be blank. Columns W and AG- AO should show the number of 2018 enrollees who will not be mapped to a 2019 plan.

- The plan is new in 2019 – 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 2/1/18 will still be in plan year 2017 plans. The filer should map enrollees in plan year 2017 plans to the plan year 2018 plan that the filer anticipates the 2017 enrollees will move into when they renew in 2018. If the 2017 plan will be continued in 2018, then the 2017 enrollees should be mapped to the 2018 plan. If the 2017 plan will not be continued in 2018, then the 2017 enrollees should be mapped to the 2018 plan that will be offered to them for renewal.

D. General Instructions – Individual and Small Group Market

The 2018 Calibrated Plan Adjusted Index Rate in Column Z should reflect the 2018 plan and the 2019 Calibrated Plan Adjusted Index Rate in Column AA should reflect the 2019 plan. For new plans, we do not expect to see a 2018 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 C.F.R. § 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 C.F.R. § 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 Columns R through T require issuers to report the allowable factors to adjust the 2019 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 and N should be normalized using the 2/1/18 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 Table B: Induced Utilization Exhibit.

Table B: 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								

- a. Please confirm that the ratio in Column (9) represents the pure induced utilization for each plan.
- b. 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.
- c. Please provide any additional justification for induced utilization assumptions in the Company's pricing.
- d. Please confirm that each plan's induced utilization factor was normalized by an aggregate factor, and that the resulting sum product (against 2/1/18 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 O. 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, T5 and T6, the issuer should enter the age, geographic and tobacco calibration factors. The age calibration may include an adjustment to account for the three-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, 2018. 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 18 and following, the issuer is expected to fill in the annual individual or average small group 2018 approved calibrated plan adjusted index rates by plan offering. Starting in Row 18, Column AA, each 2019 calibrated plan adjusted index rate is calculated by applying the proposed 2019 plan adjustments in Columns K through O and R through T, and the calibration factor in Cell T6, to the market-adjusted index rate in Cell C11. Weighted average rates for 2018 and 2019 are calculated using the 2/1/18 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 1st, 2nd, 3rd and 4th quarter 21-year-old non-tobacco premium in the small group market on Tab IV B. For individual market filings, 2018 and 2019 premiums are compared to calculate the average 21-year-old premium increase. For small group market filings, 1st quarter 2018 and 2019 rates are compared to calculate the average 21-year-old premium increase in the 1st quarter. Rates for 2nd, 3rd and 4th quarters may be changed through quarterly filings.

Instructions for Completing Table 11 of the PA Rate Template

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 other Tab for Table 11 must be deleted or hidden.

- a. If Market segment is Individual, the Annual Rates by Rating Area are auto-calculated and no data entry is required.
- b. If Market segment is Small Group Annual, the rates for all four quarters of 2019 are auto-calculated. However, the first quarter 2018 approved rates must be entered in the yellow section.

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 1st 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.

Note: The member-level rate build-up is capped such that no more than the three oldest covered children under age 21 may 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 issuer has in all applicable rating areas uniformly. If multiple networks exist within a given rating area, a separate plan ID number 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.
- A new plan is not a modification of an existing plan. See the uniform modification standards in 45 C.F.R. § 147.106.
- The information presented in the PA Actuarial Memorandum and PA Actuarial Memorandum Rate Exhibits is consistent with the information presented in the 2019 Rate Filing Justification.

E. Additional Exhibits

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 2018 service area and the proposed 2019 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 2018 and the 2019 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 an issuer is also welcome to use its own software to generate the map(s). To use the formatting indicated in the template, you may 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 may click the desired format in the key, select “Format Painter” on the Home Tab, and then click on the county you want to format.

Attachment I

Rate Change Summary

[Issuer Name] – [Individual/Small Group] Plans

Rate request filing ID # XXXXX - This document is prepared by the insurance company submitting the rate filing as a consumer tool to help explain the rate filing. It is not intended to describe or include all factors or information considered in the review process. For more information, see the filing at <http://www.insurance.pa.gov/Consumers/ACARelatedFilings/>

Overview

Initial requested average rate change: XX%¹ *[Should be consistent with table 10]*
Revised requested average rate change: N/A¹
Range of requested rate change: XX% *[Should be consistent with table 10]*
Effective date: [Insert date]
People impacted: [Insert covered lives] *[Should be consistent with membership in table 1]*
Available in: [List rating areas]

Key information

Jan. 2017-Dec. 2017 financial experience

Premiums	\$XX
Claims	\$XX
Administrative expenses	\$XX
Taxes & fees	\$XX
<hr/>	
Company made (after taxes)	\$XX

[Financial info should be consistent with Table 2 of this guidance. Since administrative expenses and after-tax profit are not captured in Table 2, the issuer must report these amounts for the subject market for the 2017 rating period.]

How it plans to spend your premium

This is how the insurance company plans to spend the premium it collects in 2019:

Claims:	XX%
Administrative:	XX%
Taxes & fees:	XX%
Profit:	XX%

[Should be consistent with tables 5 and 6, except that Taxes & fees should include Exchange user fees.]

The company expects its annual medical costs to increase **X%**.

Explanation of requested rate change

Provide a non-technical description of why the issuer is requesting this rate increase. Identify and explain the key drivers of the increase.

Once the required information has been entered, delete the red text throughout the document.

¹ Note that insurers will have the opportunity to revise their rate change request in July, after they are scheduled to receive updated information about the impact of a federal program called risk adjustment. This document will be updated accordingly at that time.

Attachment II

Inclusion Topics for PA Actuarial Memorandum

Experience Period Allowed Claims

- Does the source data reflect experience from the most recent calendar year for all non-grandfathered policies in the single risk pool, with at least two month of runout, for the named issuer and market?
- Does the source data consist of Pennsylvania experience from the applicable single risk pool, including the experience of any transitional policies?
- Were claim costs associated with non-EHBs identified separately on Table 2 of the PA Actuarial Memorandum Exhibits?
- Were prescription drug rebates adjusted for, and any capitation related amounts accounted for, in the source data?

Incurred But Not Paid Reserve

- Does Part III Actuarial Memorandum provide support to explain why an unexpected IBNP completion factor was observed?

Comparison with Federal Template

- Do the member months reported in Table 2 of the PA Actuarial Memorandum Exhibits reconcile to those reported in Worksheet 1, Section I of the URRT? If not, explain.
- Do the allowed and incurred claims reported in Table 2 of the PA Actuarial Memorandum Exhibits, net of prescription drug rebates, reconcile to the allowed and incurred claims reported in Worksheet 1, Section I of the URRT? If not, explain.
- Does the projected risk adjustment estimate in Table 5 of the PA Actuarial Memorandum Exhibits reconcile to the risk adjustment estimate in Worksheet 1, Section III of the URRT? If not, explain.
- Do the projected administrative expenses (excluding taxes and fees and profit) as a percent of premium in Table 6 of the PA Actuarial Memorandum Exhibits reconcile to the projected administrative expenses in Worksheet 1, Section III of the URRT? If not, explain.
- Do the projected taxes and fees from Table 6 of the PA Actuarial Memorandum Exhibits plus the Exchange User Fees from Table 5 of the PA Actuarial Memorandum Exhibits, as a percent of premium, reconcile to the projected taxes and fees in Worksheet 1, Section III of the URRT? If not, explain.
- Does the projected profit/contribution to surplus as a percent of premium in Table 6 of the PA Actuarial Memorandum Exhibits reconcile to the profit and risk load in Worksheet 1, Section III of the URRT? If not, explain.
- Does the projected Index Rate in Table 5 of the PA Actuarial Memorandum Exhibits reconcile to the projected Index Rate in Worksheet 1, Section III of the URRT? If not, explain.

- Do any warning messages appear in Worksheet 2 of the URRT? If so, explain.

Comparison with Prior Filings

Projection Factors

Trend

Reviewer Summary

- Has adequate support been provided for the proposed trend assumptions being utilized in the rate development process?
- Are the trend assumptions appropriately applied in the development of the Index Rate? Has the correct number of months of trend been applied?

Change in Morbidity

- Has the issuer sufficiently supported any adjustments made to the base period experience to reflect anticipated changes in morbidity?
- Has the issuer provided consideration for potential morbidity/population shifts due to factors that may impact all issuers in the market?
- Has the issuer provided consideration for potential morbidity/population shifts which could occur specific to its own membership (e.g., due to significant rate changes or changes in the competitive landscape)?
- Has the issuer identified the portion of the anticipated change in morbidity, if any, which is expected to occur on a market-wide basis vs. that which is specific to the issuer's own membership?

Changes in Demographics and Geography

- Has the issuer adjusted the underlying base experience for anticipated changes in demographics (age and gender) and geographic region?
- Are there any significantly large adjustment factors? If so, have they been supported?
- Has the issuer utilized the standardized age rating factors in calculating the adjustment due to changes in the average age mix?
- Has the issuer utilized their proposed rating factors by geographic region in calculating the geographic adjustment?

Change in Network

- Has the issuer adjusted the underlying base experience for anticipated changes in networks?
- Are there any significantly large adjustment factors? If so, have they been supported?
- If accounting for a change in the distribution of networks, has the issuer utilized their proposed rating factors in calculating the network adjustment?
- If the issuer has different networks and/or products, have unique Network/product factors been provided?

Change in Benefits

Were there changes to covered EHBs identified in the Actuarial Memorandums and/or was an adjustment for “Changes in Benefits” applied in Table 5 of the PA Rate Template? (Changes in non-EHBs are accounted for separately later in the rate development process)

Other Projected Changes

Has the issuer detailed any other projection factors being incorporated into the Index Rate development? If yes, are they identified and supported?

Changes in Utilization due to Changes in Cost Sharing

Is the utilization impact of projected changes in cost sharing reasonable relative to the HHS Induced Demand factors? If not, explain.

Large Claim Pooling

Did the issuer consider the risk adjustment program in determining whether a large claim pooling adjustment was necessary and/or in developing the large claim pooling adjustment which was applied?

Net Cost of Private Reinsurance

Is the net impact of private reinsurance being accounted for in cells C20 and D20, the “Other Change in Other” category, in Table 5 of the PA Actuarial Memorandum Exhibits and, if so, what is the magnitude of the adjustment being made?

Credibility

- Has the issuer provided a description and support for the credibility method employed?
- Is the credibility methodology employed consistent with ASOP #25, [Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages](#)?
- Has the credibility methodology/formula changed from the prior filing?
- Did the issuer appropriately apply the credibility formula in determining the credibility factor assigned to the base period experience?
- Was the base period experience included in the development of the credibility manual rate?

Credibility Manual Rate Development

- Has the issuer demonstrated that the source data used as a basis for developing the credibility manual rate is reasonably expected to be similar to the projected base period experience?
- Have the appropriate adjustments been made to the source data so that it reflects the same demographics, benefits, geographic mix, and projected cost and utilization as that reflected by the projected base period experience?
- Is the methodology being utilized to develop adjustments to the manual rate consistent with the methodology used to develop the adjustments which were applied to the base experience period data?

Have claims for services that will be capitated during the projection period been removed from the source data and replaced with the same projected capitation rate that is included in the projected base period experience?

Credibility Adjusted Projected Claims PMPM

Is the credibility adjusted projected claims PMPM equal to the following formula?
= Credibility * Projected Experience_PMPM + (1 - Credibility) * Credibility Manual_Rate_PMPM

Projected Index Rate

Market-wide Adjustments to the Index Rate

Federal Risk Adjustment

- Are assumed risk adjustment user fees consistent with amounts published by HHS?
- Is the issuer's risk adjustment assumption consistent with actual transfers for the most recently available period(s)?
- Do projected transfer payments relative to the most recently available actual transfers appropriately consider the impact of premium trend?
- Has the issuer made an adjustment to account for the net cost of the high cost pooling mechanism included in the risk transfer program starting in 2018?
- Has the issuer made an adjustment in projecting risk adjustment payments that is attributable to sequestration?

Exchange User Fees

- Is the Exchange user fee based on fees incurred only for Exchange policies, but spread over all policies?
 - o Does the assumption take into account market-level changes (e.g., issuer exits, large rate increases, changes in APTCs) which may affect the proportion of the issuer's premium which is subject to Exchange fees relative to recent historical experience?

Plan Level Adjustments to the Index Rate

- In the development of the Plan Adjusted Index Rates from the Market Adjusted Index Rate, has the issuer accounted for only the following items?
 - o The actuarial value and cost sharing design of the plan (including induced demand)
 - o The benefits provided under the plan that are in addition to the EHBs
 - o The plan's provider network, delivery system characteristics, and utilization management practices
 - o The expected impact of the specific eligibility categories for catastrophic plans
 - o Non-benefit expenses (including risk and profit margin), excluding user fees for the Exchange and risk adjustment program.

Actuarial Value and Cost Sharing

- Are the issuer's Pricing AVs similar for plans in the same metal level? If not, explain.
- Have the issuer's factors changed since the prior filing? If so, these factors must be identified and explained in the PA actuarial Memorandum.
- Are any plans flagged as a "Unique Plan Design?" As per Federal Guidance, Actuarial Certifications must be provided.

Benefits in Addition to EHBs

- Do the Actuarial Memoranda provide support that demonstrates the reasonableness of the "Benefits in addition to EHB" adjustment factors?
- For each non-EHB benefit, has the pooled experience for the benefit across all plans been used as the basis for developing the rate for each plan?
- Have the issuer's factors changed since the prior filing?

Provider Network, Delivery System, and Utilization Management

- Are the Provider Network factors the same for plans with the same network?
- Have the issuer's Provider Network factors changed since the prior filing? If so, explain why.
- Are the factors consistent with the difference in normalized paid claims by network? If not, explain.

Catastrophic Plans

- Has support for the Catastrophic Eligibility factor in Table 10 of the PA Rate Template been provided?

Non-Benefit Expenses

Non-Benefit Expenses other than Exchange User Fees

- Is the projected Federal MLR at least 80%? If not, explain.
- Are the total projected non-benefit expenses a percent of premium in Table 6 of the PA Rate Template reasonably consistent with amounts reported in the SHCE for the most recent calendar year available? If not, explain.

Risk and Profit Margin

- Does the projected Profit/Contribution to Surplus (as a percent of premium) equal the sum of the projected risk and profit margin identified in the Actuarial Memorandums?
- Is the same level of profit margin projected for each plan? If not, explain.

Adjusted Community Rating Factors

Normalization for Rate Table Development

- Have the Plan Adjusted Index Rates been appropriately normalized for age, geography, and tobacco status to arrive at the rate tables?
- Are the proposed age factors consistent with the HHS standard age curve?

Tobacco Use

- Are the proposed tobacco load factors between 1.00 and 1.50 at all ages?
- Are the proposed tobacco loads changing from the prior filing? If so, explain.

Geography

- Are the geographic rating regions consistent with those defined by the state?
- Are the proposed and current geographic rating region factor relativities the same? If not, explain.
- Are the proposed geographic rating region factors based solely on cost differences by region? due to differences in provider reimbursement and geographic variation in the delivery of medical services, and excluding differences in morbidity?
- Are the proposed geographic factors consistent with the historical claims by region?
- If the proposed geographic factors are not based on issuer experience for the market, has the issuer supported the difference?

Family Composition

Composite Premium Rates

- Does the issuer intend to offer composite premium rates to groups?

Prospective Small Group Premium Trend

- Are rate changes filed to be effective only on the first day of a calendar quarter?
- Is the prospective premium trend reasonable relative to the assumed claims trend and other information provided in the Actuarial Memorandum? If not, explain.

Loss Ratio Tests

Federal Medical Loss Ratio Test

- Has the issuer provided its projected MLR and the detailed calculation underlying its projected MLR?

- Is the projected MLR calculated correctly, applying only permissible adjustments to premium and claims, and not including any credibility adjustment?
- Is the MLR projected to meet or exceed the 80% minimum requirement defined by the ACA for the single risk pool included in the filing? If not, explain.

Federal Rate Review Requirements

Reviewer Summary

- Is the data reported in the R2D2 screen consistent with the information contained in the filing materials?

Review of Actuarial Certifications

- Does the Part III Actuarial Memorandum identify the opining actuary and include all of the required certifications?