2019 ACA-Compliant Small Group Quarterly Update Rate Filing Guidance

Pennsylvania Insurance Department

November 2018

Contents

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INSURANCE DEPARTMENT

Revisions

Throughout this document you will see general clarification of filing requirements and updates from the 2018 quarterly Guidance.

Section	Explanation
1.	a. Clarified the 2/3/4 Quarters Filing implementation.
A.2. A.	b. Clarified the Filing Requirement process. c. No new plans are permissible.
B.	a. Added disclosure of additional revenue generated from the revised rate request.
D.	a. Added tobacco surcharge factor to the Age 21 premium.
D.1.I	a. Added an additional 12 months of Historical Data for Tables 4. And 4b.
2.A; 3.D; 4.	a. Moved instructions for “Second, Third and Fourth Quarter Filings” to a footnote.
2.B	a. Added PMPM column for retention items.

A. General Instructions

This document outlines the rate filing requirements for quarterly updates to the annual small group 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.

1. Timeline

In accordance with federal Unified Rate Review (URR) instructions, all quarterly updates to the annual small group rate filings on and off Exchange must be submitted no later than 105 days prior to the effective date. If the date is not a business day, the due date is the first business day before the due date. To accommodate the federally-directed rate filing cycles, the Department will accept a 3/4 quarter or 4th quarter only filing no later than noon, March 15, 2019. Given federal timing guidelines, the submission date for a 2/3/4 quarter filing would require a filing by December 14, 2018, which would severely truncate the time for publication and review. Moreover, as noted below, the Department anticipates it will be unlikely that an issuer will have new data, that is, data not available to it during the annual filing review period, to actuarially justify changes for a 2/3/4 quarter filing. Thus, the Department views it as extremely unlikely that a 2/3/4 quarter filing could be submitted and approved for implementation on April 1.

The rate change request summaries (see Appendix 1) will be made public after they are reviewed for completeness. Rate filings will be published no later than 15 days after receipt, according to the PA Bulletin schedule, and posted on the Department's website. Filings will be open for a 30-day public comment period. Approved rates will be made public uniformly at each quarterly interval. In addition, correspondence and filing revisions will be made public as they occur during review.

2. Pennsylvania Filing Requirements

A. Required Documents and Redactions

If an issuer seeks to submit a quarterly rate filing to update rates filed and approved in its annual filing, the Department expects the company will submit quarterly filings for all ACA-compliant small group plans, whether on or off exchange. All filings must be made in both SERFF and HIOS. The Department notes that all small group annual filings were created, peer reviewed and certified by actuaries representing the filing issuer and reviewed by Department and consulting actuaries. Therefore, it is the Department's expectation that an update should only reflect material modifications that were unforeseen at the time of, or during the review period of the annual filing submission.

The Department does not expect new plans to be introduced in quarterly filings. Rather the quarterly filings are for updates as may be necessary to account for more recent experience, trends, single risk pool adjustment factors (i.e. change in morbidity/demographics/ network/ benefits/other), and taxes and fees (if appropriate). The Department anticipates that changes to the single risk pool adjustment factors would usually be nominal. All other assumptions and factors should be the same as in the 2019 annual filing.

For quarterly filings, only the items bulleted below may be updated. All other factors should be the same as in the

2019 annual filing.

1. Membership (Departmental tables 1, 10)
2. Experience period – This should move forward by 6 months for a 3/4 quarter or 4th quarter only filing. If an issuer does make a 2/3/4 quarter filing (but see note in Item 1 – Timeline, above), since a 2/3/4 quarter filing could only reflect a 3 month experience period update, for which data would have been available during the review period for the annual filing submission, it is anticipated that experience period will not be an item used to support a 2/3/4 quarter filing. (Departmental tables 0, 1, 2, 2b, 4, 4b)
3. Trend (Departmental tables 3, 3b)
4. Factors related to experience, which the Department anticipates would typically change only nominally (Departmental table 5 and the calibration factors associated with table 10)
5. Taxes and fees, if the tax structure in place at the time of the annual filing has changed (Departmental tables 6 and 10)

Filings will be considered incomplete and rejected if the items listed in the table on the following page are not included. 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).

The Part III actuarial memorandum should state four rate change amounts:

1. The additional rate change over the 2019 approved quarter rate,
2. The total rate change consumers will see year over year (i.e. updated quarter rate over the same quarter rate in the prior year),
3. The additional rate change over the total average approved annual rate, and
4. The total average rate change that consumers will see year over year.

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

Consistent with the guidance provided during the 2019 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
5. Commission schedules (average commissions may not be redacted)

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 issuer 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. Please be reminded, as noted above, that 3/4 quarters and 4th quarter updates for small group rates for 2019 may not be made after noon on March 15, 2019[1]. Also, please note that the 2019 URRT must be used in reporting any updated 2019 information.

[1] 2/3/4 quarter updates for small group rates for 2019 may not be made after December 14, 2018

Required Documents
Federal Documents Required to be Filed with PID
RFJ Part I – Unified Rate Review Template (URRT)
RFJ Part II – Consumer Friendly Justification
RFJ Part III – Actuarial Memorandum*
Federal Rates Template
Pennsylvania Documents Required to be Filed with PID
Cover Letter
Rate Change Request Summary (Attachment 1) in Word and PDF
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 RFJ and PA actuarial memorandums be submitted separately, with the RFJ 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 should 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 – 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. Only Excel versions of the Federal Rates Template and the PA Plan Design Summary and Rate Tables are required in this section. 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 Federal Rates Template must include the approved quarter 1 and the revised quarters 2, 3 and 4 rates, as applicable.

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 the date in Table 1 cell D16. The total requested rate change entered should

be consistent with column BA of Table 10.

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

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 and PA Bulletin Information

The cover letter should be a Microsoft Word file and should 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 - Small Group
3. On or Off SHOP
4. Effective date of coverage
5. Average total rate change requested (identify the quarterly rate change approved in the annual rate filing and the additional rate change requested in the proposed filing)
6. Range of rate change requested
7. Product(s) (Indemnity, HMO, POS (HMOs only), PPO, or EPO)
8. Rating areas and the change from 2018 as well as the proposed changes relative to the approved 2019 annual filing.
9. Metal Levels and Catastrophic Plans
10. Current number of covered lives and of policyholders as of the date identified in Table 1, cell D16
11. Number of plans offered in 2019 and the change this represents from 2018
12. Additional Revenue to be generated due to the rate change
13. Corresponding contract form number, SERFF and Binder ID numbers
14. HIOS Issuer ID # and submission tracking number

C. Rate Change Request Summary

Each issuer requesting a rate change needs to complete a Rate Change Request Summary (see Attachment 1) for the small group market 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, less the estimated reinsurance recoveries in cell M36. For administrative expenses and after-tax profit, use a similar percentage of premium as approved in the annual filing.

D. Pennsylvania Actuarial Memorandum & Rate Exhibits

The PA Actuarial Memorandum must be provided for all rate submissions. This section is a recap from the annual rate filing, so it is expected that these assumptions and factors change nominally, if at all. 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 factors (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 surcharge factor (show in Excel and discuss development)
- 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 changes from the annual 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.

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 in orange contain formulas that may be overwritten as directed in the instructions; supporting documentation should be provided.

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 D9 from the drop-down menu. 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. The Actuarial Memorandum should specify whether quarterly rates were proposed in the annual filing.

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 BA. For comparison purposes, also list the change in 21-year-old non-tobacco premium PMPM calculated in table 11, cells AN13, BU13, DB13, and EI13, where applicable; 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 shown in Table 1, D18, regardless of whether they are in plan year 2018 or plan year 2019 plans.

E. Benefit Changes

This input should be the same as the annual filing, since no benefit changes are expected in quarterly rate filings.

F. Experience Period Claims and Premium (Table 2)

In Table 2, provide experience period data. For quarterly rate filings, issuers must file updated data and documentation to support the rate request. The beginning of the 12-month experience period should be no

more than 24 months before the requested quarterly effective date with at least two months of run-out for the entire single risk pool. Hence, for a 7/1/19 update the 12-month experience period would be no earlier than 7/1/17 through 6/30/18. Consistent with the federal URR Instructions, the first date of the experience period must be the first date of a calendar quarter, i.e., January 1, April 1, July 1 or October 1.

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

If this data is not consistent with the data reported in Section I of Worksheet I of the URRT, discuss why. 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 should discuss any adjustments to the data, the basis for the adjustments and provide supporting data.
Additionally, the narrative should:

- 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 I." 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.
- The estimated risk adjustment and estimated reinsurance recoveries are not expected to change from the annual filing. 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.

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

The credibility formula and methodology should be the same as the annual filing.

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.

H. Trend Identification (Table 3)

In Table 3, identify the total (mid-point to mid-point) 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. Please note, it is not appropriate to include any taxes or fees in trend.

Table 3 includes a column for induced demand. The 2019 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. Please demonstrate compliance.

Discuss the basis for the trend change, if applicable, 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. Also discuss how the annual data provided now contradicts the trend.

- 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 change, if applicable. The specific provider contracting agreement and amount may be redacted, but not aggregate amounts.

I. Historical Experience (Table 4)

Provide the data in Table 4, using the most recent 48 months of data, as described above in Section F 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 (in 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)

The experience period index rate in Table 5 is auto-populated with input data from Table 2. Provide a detailed narrative of the development of the Projected Index Rate, Projected Market-Adjusted Index Rate, and Projected Total Allowed Claims. Table 5 shows 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.

Cells C12 and D12 may be overwritten to the extent the two-year trend projection factor being used to develop the Index Rate is different than is currently included in these cells. If these cells are overwritten, a detailed narrative should be submitted to support the new data.

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.

The Projected Risk Adjustments PMPM amount should be the same as in the approved annual filing. 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 using quarterly trended rates should complete Table 5A. For these filings, enter the data as follows:

- Cells J29 to M29 – Enter the number of member months renewing in the quarters for which rates are being filed, respectively, from the annual filing.
- Cells J32:M32 may be overwritten to the extent the pricing trend being utilized is different than is currently included in these cells.

For Third and Fourth Quarter filings:[2]

- Any values in cells J29, J30, K29, and K30 should be overwritten and left blank
- Cell L31 & M31 – Enter 0 and 3 respectively for the Months of Trend.
- Cell K32 – Overwrite the formula for Annual Trend and enter zero.

For Fourth Quarter filings:

- Any values in cells J29, J30, K29, K30, L29, and L30 should be overwritten and left blank
- Cell M31 – Enter 0 for the Months of Trend.
- Cells K32 & L32 – Overwrite the formulae for Annual Trend and enter zero.

Table 5A develops an average trend factor that is used to back-trend the quarterly trend factors. The back-trended factors by quarter are used in Table 11 to develop the subsequent future quarter(s) 2019 Consumer Adjusted Index Rate for a 21-year old consumer in a given rating area.

[2] If a Second, Third and Fourth Quarter filing is made (see note in Item 1 – Timeline, above):

- Any values in cells J29 and J30 should be overwritten and left blank
- Cells K31 to M31 – Enter 0, 3 and 6 respectively for the Months of Trend.

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, 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 and this should be consistent with the approved 2019 annual filing. 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. Additionally, these expenses should be consistent with the approved 2018 annual filing.
- A column has been added for PMPM dollar amounts. No data entry is required as these cells are auto-calculated.

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 should be provided to show the development of the normalization factors, the experience period and the projected period distributions. Additionally, the narrative should 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 2018 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 should 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 2019 annual filing. The 2019 amounts should be calculated based on the approved amounts for the quarter or quarters prior to the effective date of the current filing and the proposed amounts for the remaining quarter of 2019. If the amounts shown for 2018 Paid-to-Allowed, URRT Trend, URRT Morbidity, URRT "Other", Risk Adjustment, Reinsurance, Exchange User Fee, and Capitation differ from those in the 2018 rate filing, explain why.

3. Plan Rate Development (Table 10)

The Calibration Table (cells R3-T7) has been revised to include the Tobacco Calibration Factor. Column P has been changed to "For Future Use" and hidden. The Department notes that the only expected changes to Table 10, relative to the annual rate filing, are cells C8-C11, Columns R, S and T (if appropriate), cells T4-T6, Column W, and Columns AG-AO, AT and AY.

The projected market-adjusted index rate is used to develop the calibrated plan adjusted index rates for the quarters being filed in column 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

Columns B through O should be the same as the approved Annual filing. If not, please explain in the Actuarial memorandum. Beginning in Column B, row 17, 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 CFR 147.106.

B. Mapping Scenarios – Individual Market (retained due to small group reference in Section 3.C below)

The issuer is expected to account for all enrollment as of the date in Table 1 cell D16. 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, AG-AO, AT-AV and AY. 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, AG-AO, AT-AV and AY.
    - 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 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 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 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 the date identified in Table 1 D16 will still be in plan year 2018 plans. The filer should map enrollees in plan year 2018 plans to the plan year 2019 plan that the filer anticipates the 2018 enrollees will move into when they renew in 2019. If the 2018 plan has continued in 2019, then the 2018 enrollees should be mapped to the 2019 plan. If the 2018 plan has not been continued in 2019, then the 2018 enrollees should be mapped to the 2019 plan that will be offered to them for renewal.

D. General Instructions – Small Group Market

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 O and R through T require issuers to report the allowable factors (if appropriate) to adjust the 2018 market-adjusted index rate to calculate the plan adjusted index rate. The numbers entered in columns K through O should be reported as a multiplier. Please note, only columns L, N and P should be normalized using the most recent 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								

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 membership as of the date identified in Table 1 cell D16 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, 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 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 the date identified in Table 1 cell D16. 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 AY (row 17 and below) the issuer is expected to fill in the annual average small group 2018 approved calibrated plan adjusted index rates by plan offering, consistent with the amount shown for the 2018 column in the approved 2019 annual filing.[3]

For Third and Fourth Quarter filings:

- Any existing formulas in the cells in column AU referenced below should be overwritten with the information described
- Cells AT11 and AU11 should be populated with the number of member months renewing in the corresponding quarter from the annual filing
- In column AT and AU (row 17 and below) the 1Q19 and 2Q19 amounts should be calculated, respectively, based on the most recent approved amounts for each corresponding quarter and entered

For Fourth Quarter filings:

- Any existing formulas in the cells in columns AU and AV referenced below should be overwritten with the information described
- Cells AT11, AU11, and AV11 should be populated with the number of member months renewing in the corresponding quarter from the annual filing
- In columns AT, AU, and AV (row 17 and below) the 1Q19, 2Q19, and 3Q19 amounts should be calculated, respectively, based on the most recent approved amounts for each corresponding quarter and entered

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 subsequent quarterly rates for a 21-year-old non-tobacco user in the small group market on Tab IV B. For small group market filings, subsequent quarterly 2018 and 2019 rates are compared to calculate the average 21-year-old rate increase in the future subsequent quarters depending on the proposed quarter effective date.

Instructions for Completing Table 11 of the PA Rate Template

In Table 11 Tab IV, issuers are required to enter the non-tobacco rates for each rating area.[4]

- For 3/4 quarter updates, BW through CE and DD through DL.
- For 4th quarter updates, DD through DL.

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

[3] If a Second, Third and Fourth Quarter filing is made (see note in item 1 – Timeline, above):

- Cell AT11 should be populated with the number of member months renewing in 1Q19 from the annual filing
- In column AT (row 17 and below) the 1Q19 amounts should be calculated from the previously approved rate filing (e.g. for each plan, multiplying the Calibrated Plan Adjusted Index Rate from column AA of Table 10 by the 1Q19 adjustment from cell J35 of Table 5A) and entered

[4] If a Second, Third and Fourth Quarter filing is made (see note in item 1 – Timeline, above):

- Enter rates in columns AP through AX, BW through CE, and DD through DL.

federal standard age curve. Consistent with CMS, the 2019 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)

The Geographic factors should be consistent with the approved Annual Rate Filing. Complete Table 13 in a consistent manner.

C. Network Factors (Table 14)

No new networks may be added in quarterly filings: the network factors should be consistent with the approved Annual Rate Filing. 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 should 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 2019 Rate Filing Justification.

E. Additional Exhibits

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.