2017 ACA-Compliant Health Insurance Rate Filing Guidance

Pennsylvania Insurance Department

March 11, 2016

This document is subject to change based on release of final federal guidance for the 2017 plan year.

Contents

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. The Department is working on separate guidance for student health plans. The standardization of rate submissions will provide consistent reporting processes between issuers and will enable the Department to expedite our review and approval process.

1. Timeline

All rate filings, for both individual and small group plans, on and off Exchange, must be submitted by May 11, 2016. The rate change request summaries (see Appendix 1) will be made public on May 25, 2016. The rate filings will be made public the week of June 13, 2016. If a filing is revised in the course of review, the revised version will be posted upon receipt. All rate filings will be finalized by August 23, 2016 and final filings will be made public the week of October 17, 2016.

2. Pennsylvania Filing Requirements

A. Required Documents

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

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

The Department will make the rate change request summaries (see Appendix 1) public on May 25th. The Department will make all other required documents public the week of June 13, 2016. In addition, correspondence and filing revisions will be made public as they occur during review.

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.

If the issuer does not submit any redacted documents, the Department will make public the un-redacted versions. If the issuer wishes to redact information from the rate filing or from the correspondence, the issuer must submit a justification detailing each element that has been redacted and separately justifying why the redacted element is confidential. The Department will consider the intended redactions and the justifications, and may work with the issuer to reduce the amount of material redacted.

At this time, the Department would consider specific provider contracting information and commission schedules to be confidential. The Department does not envision that any other elements of the rate filing would be confidential. If information is available through other public sources, it is not confidential.

The Department will only permit revisions to a rate filing to correct clearly inadvertent errors that impact the rates, for unforeseen circumstances that impact the industry, or at the Department's request. Unless requested by the Department, the Department will not permit changes to the 2017 annual filing because an issuer files changes to Q4 2016 rates after submitting the 2017 annual filing.

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
PA Bulletin Summary
Cover Letter
Rate Change Request Summary
PA Actuarial Memorandum
PA Actuarial Memorandum Rate Exhibits (Excel and PDF)
PA Plan Design Summary and Rate Tables (Excel and PDF)
Justification for Confidentiality Requests

B. HIOS Submission

The HIOS submission must include the SERFF Tracking Number. The Department strongly encourages QHP issuers to use the CMS Data Integrity Tool (DIT) to reduce later corrections.

C. SERFF Submission

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

- TOI – Individual
  - H15l 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 and PDF versions of the Federal Rates Template and the PA Plan Design Summary and Rate Tables. No other data or information should be included in this tab.

The Company Rate Information and Rate Review Detail must be complete and accurate. The data presented should be consistent with the data that appears in the URRT and the actuarial memorandum. The total requested rate change entered should be entered according to the instructions in the SERFF Rate Review Detail Screen.

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

E. Pennsylvania Insurance Department Contact

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

B. Pennsylvania Bulletin Information

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

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

C. Cover Letter

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

1. Company Name & NAIC #
2. Market (Individual or Small Group)
3. On or Off Exchange
4. Effective date of coverage
5. Average rate change requested
6. Range of rate change requested
7. Product(s) (Indemnity, HMO, POS (HMOs only), PPO, or EPO)
8. Rating Areas
9. Metal Levels and Catastrophic Plans
10. Current number of covered lives and of policyholders
11. Number of plans offered in 2017
12. Corresponding contract form #, SERFF and Binder ID#s
13. HIOS Issuer ID # and submission tracking #

D. Rate Change Request Summary

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

E. Pennsylvania Actuarial Memorandum

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

- Document and show the development of the proposed per member per month 21-year-old premium rates starting from the experience period allowed claims data for the single risk pool. All adjustments and assumptions must be discussed and supporting documentation and data provided. Data elements include:
    - Index rate development
        - Base period allowed (both experience and manual, if a manual rate is used)
        - Morbidity adjustments (both experience and manual, if a manual rate is used)
        - Other adjustments with detail for all the elements included (both experience and manual, if a manual rate is used)
        - Utilization trends by type of service (both experience and manual, if a manual rate is used)
        - Cost trends by type of service (both experience and manual, if a manual rate is used)
        - Paid to allowed factor
        - Reduction for non-EHB benefits
    - Market Adjusted Index Rate development
        - Net risk adjustment on an allowed and paid PMPM basis
        - Exchange user fee on an allowed and paid PMPM basis
    - Plan Adjusted Index Rate development
        - Actuarial value (incurred to allowed factor)
        - Benefit richness factor (induced utilization) (before and after normalization)
        - Catastrophic plan factor
        - Network and managed care factor
        - Tobacco surcharge factor
        - Non-benefit factor
    - Age 21 premium rate development
        - Age calibration
        - Geographic calibration
- Provide each plan's corresponding policy form numbers 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; and
- Disclose all factor and benefit changes from the prior approved rate filing, as appropriate, and provide supporting documentation and data.

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

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

1. Basic Information and Data

A. Company Information

Same information identified in the cover letter.

B. Rate History and Proposed Variations in Rate Changes

Document the most recent 3 years of historical rate changes in Pennsylvania, including any quarterly trend update submissions for small group filings. The history should include the amount of the rate change and the SERFF ID# for the filing. Note and discuss if the 3 prior years' rate revisions were not applied uniformly across all rating areas and plans.

Clearly state whether the proposed rate revision applies uniformly or varies by plan or area. If there are variations, provide an exhibit showing the variation and explain the reason for the variation.

C. Average Rate Change

Document the calculation of the average rate change entered as the "percent rate change requested" in the SERFF Rate Review Detail Screen. Also list the change in 21-year-old non-tobacco premium pmpm calculated in table 11, cell AZ13, for comparison purposes.

D. Membership Count

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

E. Benefit Changes

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

F. Experience Period Claims and Premium

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

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

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

Additionally, the narrative must:

- Discuss the development of the premium data
- Discuss the development of the allowed claims.

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

G. Credibility of Data

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

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

H. Trend Identification

In Table 3, identify the proposed annual medical and prescription drug allowed claims cost and utilization trends. For an explanation of how the service categories, cost, and utilization in table 3 are defined, reference the URRT instructions. The numbers entered in the Cost and Utilization columns should match those entered in Worksheet I, Section 2 of the URRT. The Composite number entered for Capitation should match the product of the Cost and Utilization entries for Capitation in Worksheet I, Section 2 of the URRT.

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

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

I. Historical Experience

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

2. Rate Development & Change

A. Development of Projected Index Rate, Market-Adjusted Index Rate, & Total Allowed Claims

Starting with the 2015 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. If the 2015 index rate is not the rate developed in Table 2 (if the experience is 100% credible) or Table 2b (if a manual rate is used), explain the variation and disclose and discuss the calculation of the 2015 index rate. All rating period adjustments must be shown and supporting data and narrative provided.

Discuss the calculation of each of the Single Risk Pool Adjustment Factors. Detail the contributing factors to the "Change in Benefits" factor, including the effect of changes in the EHB benchmark plan and adjustments to bring transitional experience to the EHB benefit level. 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 cell C15, the "Other - Change in Other" category, must be identified.

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

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

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

Small Group Market Filings 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 I9 through L9. The template includes default months of trend (0, 3, 6 and 9) in cells I12 through L12. If using different months of trend, delete and replace the default entries, and in the narrative discuss the calculation used to derive the months of trend.

B. Retention Items

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

- 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.
- For calendar year 2017, the federal government will not collect the Health Insurance Provider Fee imposed by the Affordable Care Act Provision 9010. For individual market filings, this fee should not be included in the taxes and fees for 2017 experience. For small group filings, the fee should be included for plans that provide coverage in 2018, and the amount of the fee included should be prorated to account only for coverage provided in 2018.
- If the administrative expenses vary by plan, explain why in the narrative.

C. Normalized Market-Adjusted Projected Allowed Total Claims

The projected data is on an average basis. To more appropriately compare the average year-over-year rate change, as is done in Table 8, a normalization process is performed in Table 7. To normalize, the Market-Adjusted Projected Allowed Total Claims PMPM from table 5, cell C31 is normalized using the projected average factors for age, geography, tobacco, benefit richness (induced demand), and network.

Provide the 2016 Market-Adjusted Projected Allowed Total Claims PMPM and the 2016 normalization factors. The 2016 Normalized Market-Adjusted Projected Allowed Total Claims PMPM is auto-calculated based on the 2016 input data.

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

D. Components of Rate Change

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

Table 8 requires at most three data entries. First, enter the 2016 base period allowed claims in cellC61. If necessary, complete "Change in Miscellaneous Items" for 2016 and 2017 in cells C84 and D84. The narrative must detail any miscellaneous items and describe how the values for cells C84 and D84 were calculated. The rest of the table will calculate based on entries elsewhere in the excel workbook.

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

Table 9 collects data elements for 2016 and 2017 to support the calculations in Table 8. If the amounts shown for 2016 Paid-to-Allowed, URRT Trend, URRT Morbidity, URRT "Other", Risk Adjustment, Reinsurance, Exchange User Fee, and Capitation differ from those on the 2016 URRT, explain why. In cells I75 through I77 enter the 2016 projected retention expenses from the approved 2016 rate filing.

The Department is aware that issuers may not have previously calculated the 2016 values required in cells I70 through I73. To calculate these values, issuers should follow the process used to calculate the 2017 values, that is, calculate the average values for 2016 weighted by enrollment.

3. Plan Rate Development

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

Instructions for Completing Table 10 of the PA Rate Template

Beginning in Column B, row 15, the template requests the HIOS Plan ID number for all plans that will be offered in 2017, and for all plans offered in 2016 that will not be offered in 2017. Column C requires plan type for each plan, consistent with the URRT. Column D requires the plan marketing name for each plan. This naming convention will be specific to each issuer but there should be consistency from filing to filing each year. Since plan offerings will need to conform to metallic tier offerings, and HHS has issued a new 2017 actuarial value calculator, some plans may be discontinued, others may be new, and others may be modified. Column E requires the issuer to indicate whether a plan will be discontinued (D), new (N), modified (M) or remain as is, existing, (E). Plans must be discontinued if they exceed the federal uniform modification standards in 45 CFR 147.106.

The issuer is expected to map plans being discontinued to plans that will be in existence in 2017. In column F, for a plan that is being discontinued, please provide the January 1, 2017 plan marketing name for the plan to which

the discontinued plan is being mapped. For plans that are not being discontinued, Column F may be left blank. For discontinued plans, the information entered in columns F through T should pertain to the mapped 2017 plan, while Information in columns V through Z should pertain to the 2016 plan.

The 2016 Calibrated Plan Adjusted Index Rate in column Z should reflect the 2016 plan and the 2017 Calibrated Plan Adjusted Index Rate in column AA should reflect the 2017 plan. For new plans, we do not expect to see a 2016 rate.

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

> Approach 1 (45 CFR § 156.135(b)(2)): The issuer may adjust the plan benefit design (for calculation purposes only) to fit the parameters of the calculator and have a member of the American Academy of Actuaries certify the methodology.
>
> Approach 2 (45 CFR § 156.135(b)(3)): The issuer may use the calculator for the plan design provisions that correspond to the parameters of the calculator and then have a member of the American Academy of Actuaries make appropriate adjustments to the actuarial value.

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

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

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

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

Columns V and W require total covered lives and total policyholders by plan as of February 1, 2016. Do not enter data in column V – it will autofill using the numbers from Table 11, column R.

In Column Z, row 15 and following, the issuer is expected to fill in the 2016 approved calibrated plan adjusted index rates by plan offering. Starting in row 15, Column AA, each 2017 calibrated plan adjusted index rate is calculated by applying the proposed 2017 plan adjustments in columns K through P and R through T, and the calibration factor in cell T6, to the market-adjusted index rate in cell C9. Weighted average rates for 2016 and 2017 are calculated using the 2/1/16 membership distribution by plan offering and average rate changes are calculated.

4. Plan Premium Development for 21-Year-Old Non-Tobacco User

The projected calibrated plan-adjusted index rate is used to develop the 21-year-old non-tobacco premium in the individual market, and the average premium weighted for quarterly trend in the small group market. 2016 and 2017 premiums are compared to calculate the average 21-year-old premium increase.

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

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

5. Plan Factors

A. Age and Tobacco Factors

Complete Table 12 by entering in the tobacco factor used for each age band. Pennsylvania uses the default federal standard age curve.

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

B. Geographic Factors

Complete Table 13. If the proposed geographic factors are not consistent with the current approved factors, data and narrative must be provided indicating the development of each factor.

C. Network Factors

Complete Table 14. For each network, only one network rating factor per state per market may be used. That factor is applied to all plans the carrier has in all applicable rating areas uniformly. If multiple networks exist within a given rating area, a separate plan ID# for each network within the rating area must be used.

D. Service Area Composition

If multiple service areas exist, show the counties that comprise each service area.

E. Composite Rating

CMS cannot support composite rating in SHOP for 2017; however, Pennsylvania will allow composite rating as described in 45 C.F.R. § 147.102(c)(3)(ii) for off-SHOP plans. If the issuer plans to use composite rating, indicate this in the narrative.

6. Actuarial Certifications

At a minimum, the actuarial certification must include certifications that:

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

F. PA Actuarial Memorandum Rate Exhibits

All data exhibits must be provide in Excel and PDF.

G. Additional Rate Exhibits

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