# 2023 ACA-Compliant Health Insurance Rate Filing Guidance

Pennsylvania Insurance Department

March 18th, 2022

# Contents

# Highlights for PY23 (Including Revisions)

1. The Department requests that all issuers in the Individual market file uniform adjustments as follows in their rate submission:
    a. Individual Adjustment of 1.00 – all individual plans.
    b. CSR Defunding Adjustment of a factor within a range of 1.22 – 1.26 for all individual silver on-exchange plans. The Department will continue to evaluate this flexibility and may narrow the range in response to its review of the rate filings.
    c. User Exchange Fee of 3%.
    d. Reinsurance Morbidity Adjustment of 0.999 (i.e., -0.1%).
    e. For reinsurance parameters in the individual market filings, if the final parameters do not become finalized in time forthe May 18th initial submission, please use a reinsurance attachment point of $60,000, a cap of $100,000,and a coinsurance parameter of 64%. Once the Reinsurance Parameters for 2023 are finalized, the Department will instruct the insurer to input the proper Reinsurance Parameters. The final parameters will need to be submitted in the July 13th revised PAAM Exhibits.

2. For the initial filing, the Department expects the CSR Defunding Adjustment used in the PAAM Exhibits to represent the insurer's estimate based on the assumption that the expanded subsidies are **not extended** for plan year 2023.

3. In the Pennsylvania Actuarial Memorandum, the Department expects each individual market insurer to submit its alternative CSR Defunding Adjustment factor that will be used if theexpanded subsidies are extended for plan year 2023. Note this factor must also fall within the 1.22 – 1.26 range noted above.

4. In Table 5, Cell C33 is now shaded orange and is editable so that issuers can modify the value of their reinsurance recoveries. If the formula in Cell E33 is modified or overwritten, justification should be provided and discussed in the Pennsylvania Actuarial Memorandum

5. In Table 10 of the PAAM Exhibits, the number of rows has been expanded to allow up to 300 plans.

6. To align with federal guidance, the Department is only requiring the submission of the RFJ Part II – Consumer Friendly Justification if any plan has a rate increase equal to or exceeding 15%.

7. The Department is requesting a detailed explanation and support for any adjustments to the experience data, manual data, and/or projected data due to the impact of COVID. This explanation should be included in the Actuarial Memorandum. More detail is provided in Section D, Part 2a of the guidance.

8. Please note that the actual 2021 experience should be in tab “1 Data”, Table 4 to allow it to match the URRT. Adjusted data can be placed in tab “1.b Manual Data”, Table 4a.

9. The Department is requesting an MLR comparison between the actual and pricing values for the most recent three calendar years of complete data (i.e., 2018 through 2020 for plan year2023). Section E, Item #3 describes the requested information that should be included in thePA Actuarial Memorandum.

10. The tobacco factors may only be applied to age 21 and above as per Federal Law. In Table 12. Tobacco Factors, ages 18, 19, 20 have been updated to be not editable.

11. In Table 14 of the PAAM Exhibits, the heading “DOH Approval Date” has been changed to “Approval Date” because networks are now reviewed and approved by the Pennsylvania Insurance Department.

12. Attachment II, Inclusion Topics for the Actuarial Memorandum has been removed.

13. The Rate Change Request Summary should be submitted twice in this rating process. Submit the initial Rate Change Summary after the risk adjustment estimates have been received from CMS and RA changes have been made on the PAAM Exhibits. Submit the final/revised Rate Change Summary after all the changes have been made, with the final submission. The Revised Rate Change on the Summary should be used only if there are changes recommended by PID or to correct inadvertent errors. The Rate Change Request Summary is not requested for small group quarterly filings.

14. The Public Rate Filing PDF files will be available to the public twice in this rating process. Submit the initial one after risk adjustment estimates have been received from CMS and RA changes have been made to all exhibits and documents. Submit the final/revised Public PDF after all the changes have been made, with the final submission.

15. The PA Actuarial Memorandum exhibits for annual and small group quarterly filings have been consolidated into one file. The default option is to display the necessary tabs and information for annual filings. To adjust the file to display the information for small group quarterly filings, the “Adjust PA Act Memo Exhibits...” button in cell G2 of the “I Data” tab must be pressed. Please note that macros must be enabled for the necessary adjustment to occur.

# A. General Instructions

This document outlines the rate filing requirements for all ACA-compliant plans offered in Pennsylvania and should be followed for all Pennsylvania rate submissions. The 2023 Unified Rate Review (URR) Instructions provide guidance for the completion and submission of federal documents. Please follow the PA guidance for the submission of PA rates and Actuarial Memorandum exhibits, and the federal guidance for all three parts of the URR. The term "ACA-compliant plans" refers to those plans that are regulated under the single risk pool requirements in the ACA, and those that 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 https://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. Issuers may not modify Pennsylvania Actuarial Memorandum exhibits; only enter data as prompted.

Please note, this guidance references the 2022 URRT and Instructions. If the federal government makes substantive changes to the URRT and Instructions for Plan Year 2023, changes to this guidance may be required.

## 1. Timeline

PID welcomes new entrants to the individual and small group market for Plan Year 2023, however filing submissions should follow the ACA QHP timelines in accordance with 45 C.F.R. 154.301(b)(3) and 154.220, regarding timelines for filing. Therefore, all health insurers who wish to issue or renew ACA-compliant individual and small group health insurance coverage on or after January 1, 2023 must file their forms, rates and plan binders containing all the required templates via SERFF beginning in May of 2022. Late or mid-year filings will not be accepted.

**Rate Filings for Individual and Small Group Plans (on and off Exchange)**

- **May 18, 2022 – Filings Due**
  - All rate filings, for both individual and small group plans, on and off Exchange must be submitted by this date
- **July 13, 2022 – Revised Filings Due**
  - Revised filings to reflect updated risk adjustment and changes resulting from the second round of response and the Rate Change Request Summary (see Attachment I) are due on this date.
- **July 27, 2022 – Filings Made Public**
  - All required documents, including the Rate Change Request Summaries, as well as correspondence and filing revisions made up to that point, will be made public on this date.
  - All correspondence and filing revisions posted after this date will be made public once the rates are finalized.
  - Redactions will be permitted as described in the following section.

- **October 3, 2022 – Final Approved Filings Made Public**
    - Final approved filings will be made public the week of October 3, 2022.

**Small Group Rate Filings**

- **December 17, 2022**
    - Submission date for a 2nd, 3rd, and 4th quarter filing
- **March 18, 2023**
    - Submission date for a 3rd and 4th quarter or 4th quarter only filings no later than noon.

In accordance with federal 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 3rd and 4th quarter or 4th quarter only filing no later than noon, **March 18, 2023**. Given federal timing guidelines, the submission date for a 2nd, 3rd, and 4th quarter filing would require a filing by **December 17, 2022**, which would severely truncate the time for publication and review. Moreover, 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 2nd, 3rd, and 4th quarter filing. Thus, the Department views it as extremely unlikely that a 2nd, 3rd, and 4th quarter filing could be submitted and approved for implementation on April 1.

Initial proposed small group quarterly updates will be made public uniformly at each quarterly interval. These rate filings will be published no later than 15 days after receipt, according to the PA Bulletin schedule. Filings will be open for a 30-day public comment period. Approved rates will be made public uniformly at each quarterly interval.

# 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, including those with rate decreases or unchanged rates. This aligns with the federal requirements in 45 C.F.R. § 154.215(a). 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, are not included. Pennsylvania requires the inclusion of all three components of the Rate Filing Justification (RFJ), unless the requested rate change is below the "Rate Review" threshold.

| **Table A: Required Documents** |
|---|
| ***Federal Documents Required to be Filed with PID*** |
| RFJ Part I – Unified Rate Review Template (URRT) |
| RFJ Part II – Consumer Friendly Justification (if any plan equals or exceeds 15%) |
| RFJ Part III – Actuarial Memorandum* |
| Federal Rates Template (QHP & non-QHP filed in both rate and binder filings) |
| ***Pennsylvania Documents Required to be Filed with PID*** |
| Cover Letter |

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|---|
| 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 Issuers can choose to submit the RFJ and PA actuarial memorandums 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 an issuer chooses to submit a single consolidated actuarial memorandum, the memorandum is expected to clearly and fully meet ALL the standards of BOTH the URR instructions and the instructions in this guidance. For both options, 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.

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 Plan Year 2022 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.
5. Commission schedules.
6. Column C through E in Tabs "II.a. Reins Table – Exp" and "II.b. Reins Table – Proj"

The "public rate filing PDF" should be submitted twice in the rating process for public review. The initial one should be submitted with the second round of responses due July 13, 2022 and the second one with the final submission. The PDF document must contain all required documents, tables and exhibits. Please do not include redacted pages of the AV screenshots. 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.***

If an issuer seeks to submit a quarterly rate filing to update rates filed and approved in its small group

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 will not accept new plans introduced in quarterly filings. Rather, the quarterly filings are for updates as may be necessary to account for unforeseen material modifications, such as 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 2023 annual filing.

For quarterly filings, only the items listed below may be updated. All other factors should be the same as in the 2023 annual filing.

1. Membership (Departmental tables 1, 10)
2. Experience period should move forward by 6 months for a 3rd and 4th quarter or 4th quarter only filing. The experience period should move forward by 3 months if an issuer makes a 2nd, 3rd, and 4th quarter filing. However, as noted in item "1. Timeline" above, the 3 months of additional data would have been available during the review period for the annual filing submission. Hence, it is anticipated that the experience period will not be an item used to support a 2nd, 3rd, and 4th 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)

For quarterly filings, the Part III actuarial memorandum should state four rate change amounts:

1. The additional rate change over the 2022 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.

## 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 should 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/Supporting Documentation 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 Cell AC15 of Table 10.

The RFJ and all supporting data and documents should be included in the Supporting Documentation Tab, under the appropriate category. The subcategories under each category within the SERFF "Supporting Documentation" Tab are standardized so that all issuers will file the required information in a consistent location as required by the category heading.

The naming conventions for the following requirements have been standardized:

1. Under the "Supporting Documentation" Tab - The Pennsylvania Actuarial Memorandum Rate Exhibits = 2023_Market (SmGrp or Indiv)_Company Name_PAAMExhibits_Date (mmddyy).xlsm
2. Under the "Rate/Rule Schedule" Tab - The Plan Design Summary and Rate Tables = 2023_Market (SmGrp or Indiv_Company Name_PDSRateTable_Date (mmddyy).xlsm

### E. Pennsylvania Insurance Department Contact

Lindsi Swartz, MBA, MCM, Director – Accident and Health Rate and Policy Form Review
Email: linswartz@pa.gov
Phone: 717.265.3123

# B. Cover Letter

The cover letter must be a Microsoft Word file (uploaded as a PDF text on SERFF) 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/Off or Off Exchange
4. Effective date of coverage

5. Average rate change requested
6. Range of rate change requested (from Table 10, column AC for annual filings and column AZ for small group quarterly filings)
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 2022
10. Metal Levels and Catastrophic Plans
11. Current number of covered lives and of policyholders as of February 1, 2022 as shown in Cell V15 of Table 10
12. Number of plans offered in 2023 and the change this represents from 2022
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 should complete a separate Rate Change Request Summary (see Attachment 1) for each market (individual and/or small group) in which it offers plans. The 2021 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 minus reinsurance recoveries (which are input as a positive value) in cell M36. Since administrative expenses and after-tax profit are not captured in Table 2, the issuer must calculate these amounts, using a reasonable method, and report these amounts for the subject market for the 2021 experience period. The Requested Rate Change should be taken from Cell AC15 of Table 10 of PAAM Exhibits for annual filings.

For annual filings, the Rate Change Request Summary should be submitted twice in this rating process. Submit the initial Rate Change Summary after the risk adjustment estimates have been received from CMS. Hence, the initial Rate Change on the Rate Change Summary should be the rate change after RA changes have been made on the PAAM Exhibits. Submit the final/revised Rate Change Summary after all the changes have been made, with the final submission. The "Revised requested average rate change" on the Summary should be used only if there are changes recommended by PID or to correct any inadvertent errors.

For small group quarterly filings, the Rate Change Request Summary is not requested.

# D. Pennsylvania Actuarial Memorandum & Rate Exhibits

The PA Actuarial Memorandum should be provided for all rate submissions. To provide for meaningful review of the rate submissions, 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, adjustment factors etc. as shown in the corresponding Pennsylvania Actuarial Memorandum Exhibit.

This memorandum must minimally:

- 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 excluding transitional policy 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
        - Adjustment for non-EHB benefits
    - Market Adjusted Index Rate Development
        - Net risk adjustment on an incurred PMPM basis
        - Exchange user fee on an incurred PMPM basis
        - Reinsurance recoveries on an incurred PMPM basis
    - Plan Adjust 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.

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 2022 Guidance, the Department has one Excel workbook that contains the Actuarial Memorandum Exhibits for both the Individual and Small Group Market. 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.

For 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 Tab labeled IV B Plan Premium SG Annual; for small group market annual filings, please delete the Tab labeled IV A Plan Premium Individual.

For small group quarterly filings, the "Adjust PA Act Memo Exhibits…" button in cell G2 of the "I Data" tab should be pressed in order for the file to display the appropriate information. Please note that macros must be enabled for the necessary adjustment to occur.

## 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, 2023. 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 (365 days later in leap years).

### 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, Cell AC15 (Cell BZ15 for small group quarterly filings). For comparison purposes, also list the change in 21-year-old non-tobacco premium PMPM calculated in

Table 11, Cell AN13 (Cells AN13, BU13, DB13, and EI13 for small group quarterly filings).

## 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 the specified date, regardless of the plan year.

## 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.

## F. Experience Period Claims and Premium (Table 2)

For annual filing 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.

For small group quarterly filings in Table 2, provide experience period data. This should be updated from the annual filing and include 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 7/1/2023 update the 12-month experience period would be no earlier than 7/1/2021 through 6/30/2022. 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 the change regarding the inclusion of claims and premium for Transitional Policies. CMS has clarified, in its discussion of the single risk pool in the 2020 URR Instructions, that an issuer is not required to include transitional plan experience from the Experience Period. Therefore, the Pennsylvania Guidance no longer requests the inclusion of Transitional Policy information in Tables 2 and 4.

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.
    - The 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. Include all adjustments and assumptions and provide the data to support all adjustments and assumptions. Table 5 accommodates the development of the credibility weighted Projected PMPM in Cell D25 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. Note that Table 3 includes a Column for induced demand. 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 "0%" in the Induced Demand column for each benefit category.

The Composite Trend is used in Table 5, Cell C12, to project the experience period data to the rating period. Please provide a discussion if the trend in Table 3 differs from the aggregate two-year trend in the URRT.

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)

Provide the data in Table 4, using the most recent 48 months (four calendar years for annual filings) 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 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. Projected Index Rate, Market-Adjusted Index Rate, & Total Allowed Claims (Table 5)

Starting with the 2021 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 reflect the morbidity impact of the reinsurance program in the individual market, which is -0.1% as indicated above by the Department. Cells C16 and D16 reflect theissuer change in morbidity assumption. Table 5 shows the development of the credibility weightedProjected Index Rate using parallel actual experience and/or manual data inputs. Issuers are required to input in Row 24 the credibility weights associated with the actual experience data andthe 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.

For small group quarterly filings, 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 – All Other, 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. The "Change in Morbidity" and the "Total Non-Morbidity Changes" adjustments should equal those entered in Worksheet I, Section 2 of the URRT. If not, discuss in the actuarial memorandum. Adjustments captured in Cells C21 and D21, the "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.

Cell C28 no longer requires an input but now is automatically calculated from cell K15 of Table 10. An issuer has observed that the Department's prior method of incorporating the CSR Defunding Adjustment into the rating process creates a disconnect between the projected required revenue in Table 6 cell C64 (and Worksheet 1 of the URRT) and the projected required revenue generated by the plan adjusted rates in Table 10 (and Worksheet 2 of the URRT). The Table 6 revenue did not include the additional revenue attributable to the silver variant plans; to address this discrepancy, the Department has populated the paid-to-allowed factor field in Table 5 Cell C28 with a formula that auto-calculates projected required revenue based upon entries made in the Plan Pricing AVs, Non-Funding of CSR Adjustment and the Total Covered

Mapped Lives as of the specified date (columns, K, P and V, respectively) in Table 10. Although cell C28 of Table 5 auto-calculates, the formula may be overwritten. If an issuer wants to use projected lives instead of mapped lives, the formula in cell C28 should be overwritten by changing cell K15 to cell K16. If overwritten for any other reason, justification should be provided and discussed in the Pennsylvania Actuarial Memorandum.

Tabs II.a. and II.b. have been added to the PAAM Exhibits for the calculation of the impact of the reinsurance program in the individual market. These tabs do not need to be completed for the small group market. On tab II.a., the carrier should input their experience period information by the annual incurred claim ranges specified. Each claim range should include the number of unique members, total member months, and total incurred claims for members which had annual incurred claims within the specified range. This information should tie to the membership and incurred claim information previously provided in the PAAM Exhibits. Tab II.b. will include the same inputs but should contain the information which was utilized in calculating the impact of the reinsurance program in the projection period. Provide a detailed narrative that describes the development of the data which is input into this table. The projected impact of the reinsurance program is calculated in cell E7 of tab II.b. and a PMPM amount based on this impact is calculated in cell C33 of Table 5.

The reinsurance parameters have yet to be finalized for 2023. As a result, the parameter inputs in cells E3:E5 of the "II.a. Reins Table – Exp" tab are shaded orange and are editable such that the carrier can populate these cells for Individual market filings once the reinsurance parameters have been finalized. The projected impact of the reinsurance program is calculated in cell E7 of the "II.b. Reins Table – Proj" tab.

Reinsurance adjustments will be reviewed to determine and assess the overall impact to PA-Re and SLCS within the market. The Department is reviewing applicable information and may state expected limits upon this value. If any such limits are recommended, that information will be communicated to the carriers. Deviations from the average expectations may require additional justification.

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 Adjustment 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 cell C32 (use a factor of 3%).

A section should be included in the Actuarial Memorandum outlining how the carrier will be calculating and applying any adjustments to the experience data, manual data, and/or projected data due to the impact of COVID. All adjustments should be outlined individually within the Actuarial Memorandum with

sufficient quantitative and qualitative support. These adjustments may include, but are not limited to, the following:

- Adjusting 2021 data to remove the effects of COVID
- Projection period adjustments to reflect any COVID-related costs which are expected to occur in 2023 (e.g., vaccine, testing)
- Adjustments to reflect any changes in care delivery which are expected to occur between the experience/manual data and the projected data (e.g., telehealth, urgent care)

*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. If overwritten, justification must be provided and discussed in the Actuarial Memorandum.

Small group rates are developed in Table 11 based on inputs from Table 5A. The 2023 Trend Factors by Quarter in row 34 of Table 5A are used in Table 11 to develop the Consumer Adjusted Index Rates for all four quarters for a 21-year-old consumer in all rating areas as the Market Adjusted Index Rate reflects a January 1 rate to match the URR template.

For small group quarterly filings, enter the data in Table 5A as follows:

- Cells J29 to M29 – Enter the number of member months for each quarter, 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 3rd and 4th Quarter filings:[1]

- Any values in cells J30, J34, K30, and K34 should be overwritten and left blank
- Cell L31 & M31 – Enter 0 and 3 respectively for the Months of Trend.

For Fourth Quarter filings:

- Any values in cells J30, J34, K30, K34, L30, and L34 should be overwritten and left blank
- Cell M31 – Enter 0 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

[1] If a 2nd, 3rd, and 4th Quarter filing is made (see note in item "1 – Timeline" above) any values in cells J30 and J34 should be overwritten and left blank and cells K31 to M31 should be populated with 0, 3, and 6 respectively.

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 sum 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 2023 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 2018 (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.
- A column is included for PMPM dollar amounts. No data entry is required as these cells are auto-calculated.
- The 2022 URRT requires input for the Risk Adjustment User Fee and this input has been added in Table 6.

## 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 2022 Market-Adjusted Projected Allowed Total Claims PMPM, which should reflect a quarter 1 amount for the small group market, and the 2022 normalization factors. These numbers should match the numbers provided in the plan year 2022 rate filing. The 2022 Normalized Market-Adjusted Projected Allowed Total Claims PMPM is auto-calculated based on the 2022 input data.

The 2023 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, 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 maximum under the age of 21.

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

Document the components of change in the proposed 2023 Calibrated Plan Adjusted Index Rate (PMPM). Table 8 requires at most three data entries. First, enter the 2022 base period allowed claims in Cell C73. If necessary, complete "Change in Miscellaneous Items" for 2022 and 2023 in Cells C97 and D97. The narrative should detail any miscellaneous items and describe how the values for Cells C97 and D97 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 the 2022 and 2023 to support the calculations in Table 8. The amounts shown in the 2022 Column should match those entered in the 2022 Column in the plan year 2022 rate filing. If the amounts shown differ from those in the 2022 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.

For small group quarterly filings, 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, AS, and AX.

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

Column A, Rows 18-317 have been unlocked to allow issuers to edit the Plan numbers, if needed, in accordance with the mapping instructions 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 2023, and for all plans offered in 2022 that will not be offered in 2023. 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 2023 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 2023 plan (DM); or discontinued and not mapped to a 2023 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 2/1/2022 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 2022 plan will continue to be available to all current enrollees in 2023 – in this case,

all 2022 enrollees should be mapped into the continued 2023 plan. Input 2022 plan information in Columns B-D, W, Z, and AG-AO. Input "E" or "M" in Column E, as appropriate. Input 2023 plan information in all other input columns.

- The 2022 plan will be discontinued in 2023 – in this case, information for the 2022 plan should be entered in Columns B-D, W, Z, and AG-AO.
    - If enrollees will be mapped into a 2023 plan, input "DM" in Column E and input the information for the 2023 plan in all other input cells starting at Column F.
    - If enrollees will not be mapped into a 2023 plan, input "DNM" in Column E and leave all other input cells blank.
- The 2022 plan will be available to some, but not all, enrollees in 2023 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 2022 enrollees. Edit the plan numbers in Column A as follows – if the 2022 plan with enrollment being split into multiple paths in 2023 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 2022 enrollees who will be mapped into the continued 2023 plan. Input "M" in Column E. Columns W and AG-AO should show numbers for the 2022 enrollees who will be mapped into the continued 2023 plan.
    - The next row(s) ("Plan 4b" in this example) should be used to show information for any 2022 enrollees who will be mapped into a different 2023 plan. Input "DM" in Column E. If 2022 enrollees will be mapped into multiple 2023 plans, use a separate row for each 2023 plan.

      Columns A-D, and Z should show information pertaining to the 2022 plan. Columns F-T should show information pertaining to the 2023 plan. Columns W and AG-AO should show numbers for the 2022 enrollees who will be mapped to that plan.
    - The last Row ("Plan 4c" in this example) should be used to show information for any 2022 enrollees who will not be mapped into a 2023 plan. Input "DNM" in Column E. Columns A-D and Z should show information on the 2022 plan. Columns G-T should be blank. Columns W and AG- AO should show the number of 2022 enrollees who will not be mapped to a 2023 plan.
- The plan is new in 2023 – 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 the specified date will still be in plan year 2021 or 2022 plans. The filer should map enrollees in plan year 2021 or 2022 plans to the plan year 2023 plan that the filer anticipates the enrollees will move into when they renew in 2023. If the plan will be continued in 2023, then the enrollees should be mapped to the 2023 plan. If the plan will not be continued in 2023, then the enrollees should be mapped to the 2023 plan that will be offered to them for renewal.

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

The 2022 Calibrated Plan Adjusted Index Rate in Column Z should reflect the 2022 plan and the 2023

Calibrated Plan Adjusted Index Rate in Column AA should reflect the 2023 plan. For new plans, we do not expect to see a 2022 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 Pennsylvania's state-based exchange, Pennie.

Columns K through P and Columns R through T require issuers to report the allowable factors to adjust the 2023 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 that Columns L and N should be normalized using the membership as of the specified date or the projected member distribution such that the resulting member-weighted average for each is equal to 1.000. Whichever distribution is used, the methodology should be internally consistent and described in the PA Actuarial Memorandum. The induced demand factors which are used in calculating the normalized factors in Column L should be based on the HHS induced demand factors utilized in the risk transfer formula and should use the following formula: (Plan AV)^2 – (Plan AV) + 1.24. This produces the HHS factors by metal level (i.e., a 0.60 pricing AV is a 1.00 factor and a 0.90 pricing AV is a 1.15 factor) but accounts for the fact that not all plans within a metal level will have the same pricing AV. The "Plan AV" should be the product of the "Pricing AV" (column K of Tab III) and "Non-Funding CSR Adjustment" (column P of Tab III).

Column P captures the CSR defunding adjustment for On Exchange Silver Plans. For On-Exchange Silver Plans, issuers should populate Column P with their selected value within the range of 1.22 – 1.26 such that CSR Defunding Adjustment can be applied in the development of the Calibrated Plan Adjusted Index Rate in Column AA. For all other plans, issuers should populate Column P with 1.00 for both Individual and Small Group markets.

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 URR 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.

Column V – it will autofill using the numbers entered in Columns AG – AO and totaled in Cell AP15 of this Table.

Column W requires Total Projected Lives by plan.

For annual filings, in Column Z, Row 18 and following, the issuer is expected to fill in the annual individual or January 1 small group 2021 approved calibrated plan adjusted index rates by plan offering. Starting in Row 18, Column AA, each 2023 calibrated plan adjusted index rate is calculated by applying the proposed 2023 plan adjustments in Columns K through P and R through T, and the calibration factor in Cell T6, to the market-adjusted index rate in Cell C11. Weighted average rates for 2022 and 2023 are calculated using the specified date membership distribution by plan offering and average rate changes are calculated.

For small group quarterly filings, cells AS11, AT11, AU11 and AV11 are auto-calculated. In Column AX, Row 18 and following, the issuer is expected to fill in the annual average small group 2022 approved calibrated plan adjusted index rates by plan offering, consistent with the amount shown for the 2022 column in the approved 2023 annual filing.[2]

For 3rd and 4th Quarter filings:

- Any existing formulas in the cells in column AT referenced below should be overwritten with the information described
- In column AS and AT (row 18 and below) the Q1 2023 and Q2 2023 amounts should be calculated, respectively, based on the most recent approved amounts for each corresponding quarter and entered

For 4th Quarter filings:

- Any existing formulas in the cells in columns AT and AU referenced below should be overwritten with the information described
- In columns AS, AT, and AU (row 18 and below) the Q1 2023, Q2 2023, and Q3 2023 amounts should be calculated, respectively, based on the most recent approved amounts for each corresponding quarter.

[2] If a 2nd, 3rd, and 4th Quarter filing is made (see note in "1 – Timeline"), in column AT (row 18 and below) the 1Q2023 amounts should be calculated from the previously approved rate filing (e.g., for each plan, the 1Q2023 Calibrated Plan Adjusted Index Rate).

## 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, 2022 and 2023 premiums are compared to calculate the average 21-year-old premium increase. For small group market filings, 1st quarter 2022 and 2023 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*

For annual filings, 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 should 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 2023 are auto-calculated. However, the first quarter 2021 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 expected to enter the 1st quarter non-tobacco premium rate for each rating area. All other Cells will automatically calculate.

For small group quarterly filings, 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 C. On this tab, subsequent quarterly 2022 and 2023 rates are compared to calculate the average 21-year-old rate increase in the future subsequent quarters depending on the proposed quarter effective date. In Table 11 Tab IV, issuers are expected to enter the non-tobacco rates for each rating area.[3]

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

All other cells will automatically calculate.

## 5. PlanFactors

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

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

[3] If a 2nd, 3rd, and 4th Quarter filing is made (see note in "1 – Timeline"), enter rates in columns AP through AX, BW through CE, and DD through DL

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.

### F. Connectivity Factors

If the product filing has available connectivity features (broadband, data plans assistance, etc.), please describe in the narrative how the rate filing accounts for those connectivity features. If the rate filing does not account for such connectivity features but such features are available as part of the product, please state this in the response.

## 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 2022 Rate Filing Justification.

# E. Additional Exhibits

## 1. DepartmentPlanDesignSummary and Rate Tables

Submit the Department Plan Design Summary and Rate Tables in Excel in the Rate/Rule Schedule Tab in SERFF. The information provided in all the three tabs of this workbook must be complete and consistent. The "Plan Design Summary" Tab has a macro/button to validate the template by checking if all information was entered for each plan and that the information entered corresponds to what is possible from the drop downs. The "Rate Pages" Tab has a macro/button to add additional plan columns If they are needed by the issuer in order to achieve consistency in added Columns across all issuers

## 2. Service Area Map

Submit a map of the current 2022 service area and the proposed 2023 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 2022 and the 2023 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.

## 3. MLR Exhibit

The table below summarizes the most recent three years of complete MLR information. This table plus any supporting narrative should be provided in the PA Actuarial Memorandum.

- For plan year 2023, this would be information from 2018 through 2020.
- Actual is the final information which was filed for the specified calendar year.
- Pricing is the information which was projected in the final annual filing for the given year (i.e., the 2020 pricing information is from the plan year 2020 annual filing submitted in 2019).

| | MLR | | Member Months | |
|---|---|---|---|---|
| **Calendar Year** | **Actual** | **Pricing** | **Actual** | **Pricing** |
| 2018 | | | | |
| 2019 | | | | |
| 2020 | | | | |

Are the MLRs and Member Months between Actual and Pricing comparable? If not, explain.

# 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
https://www.insurance.pa.gov/Companies/ProductAndRateRequire/Pages/default.aspx

### Overview

| | |
|---|---|
| Initial requested average rate change: | XX.XX% *[Should be consistent with table 10, Cell AC15]* |
| Revised requested average rate change: | N/A[1] |
| Range of requested rate change: | XX.XX% *[Should be consistent with table 10, Column AC]* |
| Effective date: | [Insert date] |
| Mapped Members: | [Insert covered lives] *[Should be consistent with membership in table 10 Cell V15]* |
| Available in: | Rating Areas [List rating areas] |

### Key information

**Jan. 2021-Dec. 2021 financial experience**

| | |
|---|---|
| Premiums | $XX |
| Claims | $XX |
| Administrative expenses | $XX |
| Taxes & fees | $XX |
| Company made (after taxes) | **$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 2020 rating period.*

**How it plans to spend your premium**
This is how the insurance company plans to spend the premium it collects in 2023:

| | |
|---|---|
| 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.XX%**.

### 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] Rates revised to correct any inadvertent errors and/or Department recommended change.