2025 Plan Year Small Group Nongrandfathered Health Plan (Pool) Rate Filing Checklist

## Instructions:

For each item in Section I, provide the response in this document. For each item in Section II, provide the rate filing document name as well as relevant section, page, and/or exhibit numbers.

Any Excel workbook must be submitted with a corresponding PDF that includes all information from the workbook.

* All content in the Excel file and PDF must be visible; hidden cells, hidden worksheets, and non-visible font colors are not allowed, except for functionality that was already included in official templates from the WA OIC or CMS.
* The file names must match except that the Excel workbook name should end with “duplicate.”
* For ease of reference, please add numbering to each spreadsheet tab and to a title line in the exhibits.
* **IMPORTANT: Storing amounts as values rather than linking to the source calculations results in several objections every year.**
* Retain all *internal links and formulas but break all links to external files*. Ensure your rate development exhibits, for example, show how inputs and assumptions flow through the rating methodology to the final projected premium base rates; this is important for review purposes and to ensure appropriate rate development.
* *Be aware that the PDF documents are relied upon as public records. As such, prior to submitting a PDF, please review each PDF for completeness and readability*. Note: the PDF version of the actuarial memorandum exhibits can be submitted on the URRT tab rather than the Supporting Documentation tab in SERFF so that it will be uploaded to CMS. The URRT is the only Excel file that should be submitted on the URRT tab in SERFF; all other Excel files must be submitted on the Supporting Documentation tab.

## Section I – General Information:

##### **Carrier**: **Enter Your Company’s Name**

##### **Market:** Medical – Small Group

##### **Exchange Intentions:** Check only one box.

##### Exchange Only Outside Market Only Exchange and Outside Market

Note: The Exchange Intentions field on the General Information tab in SERFF should match the wording for the item selected above (see the Additional Information section for the Sub-TOI by searching by TOI under Filing Rules/Submission Requirements in SERFF).

1. **We will offer the following:** Check all boxes that apply.

At least one silver plan and one gold plan throughout each service area outside the Exchange whenever we offer a bronze plan outside the Exchange. See RCW 48.43.700.

One or more plans with a unique benefit design. See Section II #9 below.

Pediatric dental embedded.

Non-essential health benefits (Non-EHBs). See Section II #12 below.

New plans have been added, and we confirm that no previously retired Plan IDs have been reused in this rate filing. We are aware that the reuse of retired Plan IDs can cause risk adjustment reconciliation complications.

**List all Plans**

| **HIOS Plan ID** | **Plan Name** | **Unique Benefit Design (UBD)** | | **Pediatric Dental Embedded (Yes/No)** | **Description of Non-Essential Health Benefits (Non-EHBs)** |
| --- | --- | --- | --- | --- | --- |
| **(Yes/No)** | **If yes, briefly explain why. If no, “N/A.”** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

1. **Do you have any expanded bronze plans as described under 45 CFR §156.140(c) in which the variation in AV Metal Value is between +2% and +5% (i.e., the AV is between 62% and 65%)?**

No

Yes, and we confirm each of the following:

1. That the plans’ member cost-shares are equivalent to less than 50% coinsurance and
2. That each plan is either

(1) A High Deductible Health Plan or

(2) Has at least one major service, other than preventive services, covered prior to the deductible.

(c) The expanded bronze plans are summarized in the following table.

Note: Only one major service needs to be listed in the table even if multiple major services are covered prior to the deductible.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HIOS Plan ID** | **Plan Name** | **High Deductible Health Plan (Yes/No)1** | **Major Service covered prior to the deductible2** | |
| **Yes/No** | **Service** |
|  |  |  |  |  |
|  |  |  |  |  |

1The plan meets the requirements to be a high deductible health plan within the meaning of 26 U.S.C.233(c)(2) as established at 45 CFR §156.140(c).

2The following are considered major services. The major service covered before the deductible must apply a reasonable cost-sharing rate to the service to ensure that the service is affordably covered (HHS Notice of Benefit and Payment Parameters for 2018).

1. At least three primary care visits.
2. Specialist office visits.
3. Inpatient hospital services.
4. Emergency room services.
5. Generic drugs.
6. Preferred brand drugs.
7. Specialty drugs.
8. **Is your service area changing from Plan Year 2024?**

No

Yes, we are making the following changes:

|  |  |  |
| --- | --- | --- |
| **Geographic Rating Area** | **Additional Counties Covered** | **Terminated Counties**  **(a.k.a. Exited or No Longer Covered)** |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |
| 6 |  |  |
| 7 |  |  |
| 8 |  |  |
| 9 |  |  |

1. **Network Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Network Name** | **Type (****EPO, HMO, POS, or PPO)** | **Tiered or Single** | **Date Filed** |
|  |  |  |  |
|  |  |  |  |

1. **Rate filing file names for Parts I, II, and III of HHS Forms:** (Requirements per RCW 48.02.120(5) and 45 CFR §154.215.)

Name the Parts I, II, and III according to the instructions provided in Washington State SERFF Life, Health and Disability Rate Filing General Instructions

## Section **II – Experience Data and Projections**

For each item, provide the rate filing document name and section number, page number, and/or exhibit number that addresses the item. For example: (1) “Part III Rate Filing Documentation and Actuarial Memorandum,” Section III or (2) “Supporting Documentation File,” Exhibit 5.

| **Line** | | **Task** | **Issuer Response:** | |
| --- | --- | --- | --- | --- |
| **Document Name** | **Section / Page / Exhibit Number** |
| **EXPERIENCE PERIOD DATA** | | | | |
| **1** |  | Complete experience:  Include the complete experience for all 2023 small group plans.  Net of Rx rebates: Any prescription drug claims should be net of rebates received from drug manufacturers; please document in the Part III Actuarial Memorandum where and how this is addressed. |  | |
| **a** | Consistent financial data:  Demonstrate that the financial data, including the member months, in (i) URRT Worksheet 1, Section I, (ii) URRT Worksheet 2, Section II, (iii) the WAC 284-43-6660 summary, and (iv) the actuarial memorandum exhibits are consistent as of March 2024. If not consistent, explain why the discrepancy is appropriate. |  |  |
| **b** | To support URRT Worksheet 1, Section I Experience Period Data for 2023, provide:   * Allowed Claims and Incurred Claims * By Month of Incurral and Month of Payment, * Separately for Medical and Rx, * Paid through March 2024 * Any estimated payable or recovery (e.g., reserves, reinsurance, overpayments, rebates, and other) amounts as of March 2024 for Medical and Rx (does not need to be by month). * Monthly premium amounts. * Monthly membership. * Justification of risk adjustment amounts (does not need to be by month). |  |  |
| **c** | Consistent with 1.b above, provide the following to support experience period data in URRT Worksheet 1, Section II, and the WAC 284-43-6660 summary:   1. Separately for 2023 Allowed and Incurred Claims:   By Incurred Month and Benefit Category (as defined for URRT Worksheet 1 Section II) including non-EHBs. Add each non-EHB as its own category.   * 1. Calculate the change in reserves between the beginning (i.e., previous year’s 3/31) claim reserves and ending (i.e., current year’s 3/31) claim reserves.   2. Calculate total claims.   3. Use monthly membership from 1b above to calculate claims PMPM.   4. Calculate paid-to-allowed ratios of paid (incurred) claims to allowed claims.  1. Explain if EHB allowed claims were obtained from claims records or imputed from paid claims. |  |  |
| **d** | 2023 Actual and Projected:  Provide analysis of actual experience by metal level and in total versus amounts projected in the plan year 2023 rate filing per 45 CFR §154.301(a)(3)(ii). Show the experience and projections as total dollars, PMPMs, and percents of premium. Include the following:   * Overall Incurred claims * Overall risk adjustment transfers * Administrative expenses * Taxes and fees * Profit margin * Paid-to-allowed claims ratios   Ensure your response identifies material differences in actual and expected experience, the primary source of these deviations, and action taken in your 2025 projections to address the deviations. |  |  |
| **e** | Split up experience if you are terminating any counties:  If you are terminating any counties for plan year 2025, include a table splitting 2023 experience from URRT Worksheet 1, Section I between continuing and terminated counties. If you are not terminating any counties, respond “N/A.” |  |  |
| **2** | | Manual EHB Allowed Claims:   * If credibility is 100%, respond “N/A” for each item. * If you use a credibility-blended estimate, explain the processes in detail (i) per guidance in URR Instructions 4.4.3.3, to establish the Manual EHB Allowed Claims PMPM for WA and (ii) per 4.4.3.4 to establish the credibility percentage for URRT Worksheet 1, Section II. * Note: if the 2023 experience is 0.00% credible, then the trend, morbidity, demographic, plan design, and other factors in URRT Worksheet 1, Section II can be listed as 1.000. In that case, only analyses of the manual trend and adjustment factors are required. |  | |
|  | **a** | Manual Data Relevance:  Explain the relevance of the data used to determine the Manual EHB Allowed Claims PMPM. |  |  |
| **b** | Calculate Manual EHB Allowed Claims PMPM:  Show the detailed calculation of the Manual EHB Allowed Claims PMPM entered in URRT Worksheet 1, Section II. Justify any adjustments made to the data, such as adjustments for trend, morbidity, demographics, plan design, and geographic areas. Your response should clearly identify how your estimate considers the cost and utilization characteristics of your small group health plan market service area in Washington State. Note: the manual rate must be developed in a manner consistent with 100% credibility. |  |  |
| **c** | Credibility of Experience Data:  Describe the credibility methodology and assumptions used per Actuarial Standard of Practice (ASOP) No. 25.   1. Identify the actuarially sound and appropriate credibility procedure used to develop your credibility estimate. 2. At what level is experience determined to be more than 0% credible? 3. How is partial credibility determined? 4. At what level is experience determined to be 100% credible? |  |  |
| **d** | Show how you estimate credibility of your company’s 2023 allowed claims and member months used in your rate development (use the credibility procedure). |  |  |
| **3** | | Experience in WAC 284-43-6660 summary,  Summary of Pooled Experience with Adjustments: |  | |
|  | **a** | WAC 284-43-6660 summary experience:  Complete the WAC 284-43-6660 summary for Individual and Small Group Contract filings. Provide data to support WAC 284-43-6660 without adjustments for Risk Adjustment and High-Cost Risk Pool (HCRP) transfers and assessments. The experience information should be based on the incurred years 2023, 2022, and 2021. |  |  |
| **b** | Summary of Pooled Experience with Adjustments:  Create a document or exhibit called “Summary of Pooled Experience with Adjustments” starting with the “Summary of Pooled Experience” table in the WAC 284-43-6660 summary and adding the following separate rows at the end of the table (address 2023, 2022 and 2021 calendar years):   1. Total credits or charges for Risk Adjustment (the risk transfer amount only). 2. Total transfer amount from the HCRP. 3. Total HCRP Assessment. 4. HHS-RADV adjustments. Indicate the source of each amount (Benefit Year (BY) and HHS report date). List amounts from different reports on separate lines. 5. Total commercial reinsurance reimbursements received and expected. 6. Adjusted Gain/Loss (both as a dollar amount and as a percentage of premium), excluding MLR rebates. 7. Total anticipated MLR rebates (not included in the Adjusted Gain/Loss). 8. If necessary, also list any subsequent adjustments for prior years according to when payments were received. Document the amount and incurred year for each adjustment. For example, if a Risk Adjustment amount was received or paid in 2023 for a prior period at an amount other than the amount in item (i), it should be listed as a separate adjustment to the 2023 experience.   Document and justify all amounts estimated for 2023, 2022, and 2021. Identify the final federal Risk Adjustment Payments Reports used for each year. Identify any interim reports used when final reports are not available for particular periods. Note: Since the Federal Reinsurance and Risk Corridor programs ended in 2016, they should no longer be included in the table of adjustments.  Also include a copy of this table in the Part II Written Description. |  |  |
| **c** | 2022 & 2021 Changes:  If applicable, justify and show line-item differences in 2022 and 2021 experience versus the final version of the “Summary of Pooled Experience with Adjustments” in last year’s filing. Also comment about any changes in the WAC 284-43-6660 summary under General Information #5. Comment on the 2021 risk adjustment transfers due to the CMS January 20, 2024, updated “Summary Report of 2018 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers” and supporting documents and the impact of any changes that were made due to the report. |  |  |
| **4** | | Plan Level Experience and Current Data:  Document and justify URRT Worksheet 2, Section II: Experience Period and Current Plan Level Information. If amounts by plan are allocated rather than based on actual experience, demonstrate, and justify the allocation method. Explain any differences between totals in URRT Worksheet 2, Section II and URRT Worksheet 1, Section I. |  |  |
| **TREND FACTORS** | | | | |
| **5** | | Allowed Claims Trends: |  | |
|  | **a** | Allowed Claims Historical Trend (EHB & non-EHB):  Provide observed annual trends of rolling average six-month and twelve-month allowed claims PMPM for 2021 through 2023 using the experience of all WA members in the market; show utilization and unit cost separately, if available. Separate the information by URRT Worksheet 1, Section II benefit category (or combination of categories) plus a separate category for non-EHB allowed claims, if applicable. |  |  |
| **b** | Allowed Claims Projected Trend (EHB):  Include an exhibit that develops the EHB allowed claims trend factors entered in URRT Worksheet 1, Section II. If a flat trend across all benefit categories is assumed, submit details demonstrating and justifying why this is reasonable.  Provide the following 2023, 2022, and 2021 experience alongside 2025 projections:  Utilization/1,000 and Unit Cost for each benefit category shown on URRT Worksheet 1. |  |  |
| **c** | Explain projected allowed claims trend development:   * Per URR Instructions 4.4.3.1, describe how you arrived at your allowed claims trend assumptions, including the data used, credibility of the data used, and any adjustments made to the data. * Address how your estimates reflect trends specific to Washington State. * Include whether the unit cost projections reflect input on likely network and provider contract term changes for the projection year and comment about how much of the provider contracting is already complete for plan year 2025 as well as how much of the projected reimbursement trend is already locked in for plan year 2025. Explain any significant provider reimbursement terms that remain outstanding. |  |  |
| **d** | Independence of different utilization changes:   * Explain how you separated expected utilization changes due to (i) changes in average health status of the population (a.k.a. morbidity) versus (ii) other projected utilization changes (e.g., change in mix of services). * Clarify how the various utilization and morbidity adjustments in the rate filing are independent (in other words: do not overlap). |  |  |
| **6** | | Incurred Claims Trends: |  | |
|  | **a** | Incurred Claims Historical Trend:  Provide observed annual trends of rolling average six-month and twelve-month incurred claims PMPM for 2021 through 2023 using the experience of all WA members in the market; show utilization and unit cost separately, if available. Separate the information by benefit category shown in WAC 284-43-6660 Trend Factor Summary. If applicable, indicate how the non-EHB benefits are mapped to the WAC 284-43-6660 benefit categories. |  |  |
| **b** | Incurred Claims Projected Trend:  (see also #31c)   1. Include an exhibit that develops the incurred claims trend percentages entered in the WAC 284-43-6660 summary. 2. Show how to calculate the Portion of Claim Dollars for trends in the WAC 284-43-6660 summary. Note: the percentages should be based on the 2023 incurred claims dollars by trend category. The total incurred claims used in the calculation should be consistent with the incurred claims PMPM in URRT Worksheet 2, Section II Experience, Field 2.17. 3. Demonstrate that the overall incurred claims annual trend (EHB and non-EHB) matches (1) the annualized trend from URRT Worksheet 1, Section I to URRT Worksheet 2, Field 4.15 as well as (2) the incurred claims trend listed in Rate Review Details (see also #22b). |  |  |
| **URRT WORKSHEET 1, SECTION II OTHER ADJUSTMENT FACTORS** | | | | |
| **7** | | URRT Worksheet 1, Section II Non-Trend Factors:  Explain and show the detailed calculations for actuarial assumptions underlying each non-trend factor used in URRT Worksheet 1, Section II.   1. Morbidity Adjustment 2. Demographic Shift 3. Plan Design Changes 4. Other   If applicable, provide a detailed breakdown of any adjustments made under the “Other” category such as significant provider network or pharmacy rebate changes from the experience period. |  |  |
| **URRT WORKSHEET 2, SECTION I AV METAL VALUES** | | | | |
| **8** | | AVC Screenshots:  Note: See also #9 below related to unique benefit designs which might impact AVC screenshots and/or otherwise impact AV Metal Value calculations for one or more of your plans.  Provide the Actuarial Value Calculator (AVC) screenshots in PDF format showing “Calculation Successful.” State the corresponding HIOS Plan ID on each AVC Screenshot. For the 2025 AV Calculator and Methodology, see link:  <https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html>  Please reformat the “Coinsurance, if different” cells to display the same 4-decimal place accuracy as the default coinsurance for tiers 1 & 2. Also, reformat the tiered utilization percentages to more accurately indicate the weights used in the calculation.  Metal Levels  Platinum – 90%, range -2/+2%.  Gold – 80%, range -2/+2%.  Silver – 70%, range -2/+2%.  Bronze – 60%, range -2/+2% or Expanded Bronze +2/+5%. |  |  |
| **9** | | Unique Benefit Design for AVC (Actuarial Value Calculator) Purposes:  Note: Address this item in conjunction with item 8 above.  The actuary would be prudent to attempt to use data and assumptions that are consistent with the calculators as much as possible when adjusting for unique plan designs ([https://www.actuary.org/sites/default/files/files/MVPN\_042314.pdf](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.actuary.org%2Fsites%2Fdefault%2Ffiles%2Ffiles%2FMVPN_042314.pdf&data=05%7C01%7CJeff.Oberle%40oic.wa.gov%7Cbdd4d50ce37a44e8329c08dbc10bbae4%7C11d0e217264e400a8ba057dcc127d72d%7C0%7C0%7C638316028341686216%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=LXfhHBUbvHkjLm86NMI09sKg1mhqb%2Ftz7DLRyVLw%2FKk%3D&reserved=0)). The continuance tables in the AVC should be used, if possible, so that the adjustments are consistent with the AVC calculations.  Do any plans have a unique benefit design? If yes, for each such plan, you must:   * Use one of the two methods, 45 CFR §156.135(b)(2) **or** 45 CFR §156.135(b)(3), to certify the Metal Value and provide the exact AV Metal Value for the plan. * You must also provide detailed support for your unique plan design AVs.   Please provide supporting unique AV calculations in your rate filing memorandum and exhibits.   * Include enough detail for the reviewer to determine whether the methods, assumptions, and results are appropriate and reasonable. * You must provide justification for AVs when actual plan designs deviate from the AVC’s functionality, even if your actuary assumes the impact is immaterial.   **Notes About Plan Designs in the AVC:**   * To be consistent with the requirements in the AVC User Guide (see FAQ Q2 & Q3), all plans with a $0 Rx or a $0 medical deductible should indicate an integrated medical and drug deductible when possible. For illustrative purposes, consider a plan with a non-zero medical deductible and a $0 drug deductible, which is equivalent to saying that none of the drug tiers (i.e., benefits) is subject to any kind of deductible:   + Case 1: One or more of the drug tiers are subject to coinsurance (which, from our earlier assumption, apply before any deductible).   + Case 2: Each drug tier is either fully covered or subject to a copay. * For Case 1, using a combined deductible would force the drug coinsurance(s) to apply after the medical deductible (given the limitations of the AVC with regards to entering coinsurance before the deductible). For Case 2, an integrated deductible should be used. * The reverse situation with $0 medical and non-zero Rx deductibles is similar, however, only coinsurance for the medical benefits listed in the AVC are considered. If, for example, a coinsurance is only applied to the ambulance benefit, which is not part of the AVC, a combined deductible should be applied. * *Plans that include Coinsurance During the Deductible Phase or can otherwise be described as having “Services not Subject to Deductible and without a copay”:*   Excel row 76 on the User Guide sheet of the AVC states, “Services not subject to deductible and without a copay are treated as covered at 100 percent by the plan until the deductible is met through enrollee payments for other services.” When this occurs, the AVC output is higher than that of the actual plan design; the difference depends on the size of the deductible and impact of the corresponding benefit on the actuarial value. The exact difference, however, is unknown without using an effective copay, which requires a unique benefit design, to approximate the coinsurance in the deductible range. If your plans include this type of cost-sharing design, you are required to show that their AVs are within the acceptable metal level range using unique benefit designs. See the AVC User Guide sheet Q&A on rows 196 and 197 for additional information.   * *Plans that include “Services not Subject to Deductible and with a copay”:*   Copays paid during the deductible range do not accumulate toward the deductible, regardless of whether the benefit is subject to deductible.   * *Plans that partition benefit categories into subcategories with different cost-share designs:*   If the plan has different cost-sharing for subcategories of benefits included in the AVC but the AVC only accepts one cost-sharing structure, you must (1) enter the cost-share variations in the Benefit Components document and (2) account for the differences between the plan design and the AVC functionality in your AV Metal Value calculations.  For example, the AVC only accepts one MHSUD (mental health/substance use disorder) outpatient cost-share structure, so if a plan design includes different cost-shares for MHSUD outpatient professional (office) visits versus MHSUD outpatient other-than-professional-visits, the plan design does not align with standard use of the AVC. |  | |
|  | **a** | If using the Unique Benefit Design certification method in 45 CFR §156.135(b)(2):   * Provide the required actuarial certification language as well as justification and detailed calculations of how you estimated a fit of the plan design into the parameters of the AVC. * Submit one AVC screenshot for each plan to show that the benefit design after the fit is a legal metal plan. |  |  |
| **b** | If using the Unique Benefit Design certification method in 45 CFR §156.135(b)(3):   * Provide the required actuarial certification language as well as justification and detailed calculations of (i) how the AVC was used to determine the AV Metal Value for the plan provisions that fit within the calculator parameters while (ii) appropriate adjustments were made to the AVC output(s) for plan design features that deviate substantially from AVC parameters. * Submit two or more AVC screenshots including at least one extreme high AV Metal Value and one extreme low AV Metal Value based on features like those of the plan. * Using the filed AVC screenshot results, explain how adjustments are made to develop the EXACT final AV Metal Value entered into the URRT for each plan. |  |  |
| **c** | Include a completed Unique Plan Design Supporting Documentation and Justification form (a blank form can be found on the CMS website). |  |  |
| **d** | Pharmacy Tiers: If your prescription drug tiers do not exactly match those in the AVC and you do not identify the plans as having unique benefits, please add a discussion to the actuarial memorandum. Consider guidance in relevant documents such as the PY2024 QHP Issuer Application Instructions (e.g., 5.8 Suggested Coordination of Drug Data between Templates) and AVC supporting documentation. |  |  |
| **URRT WORKSHEET 2, SECTION III PLAN ADJUSTMENT FACTORS** | | | | |
| **10** | | AV and Cost Sharing Design of Plan (a.k.a. Pricing AV) Factors:  (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.3)  Document and justify the factors including components (a) through (d) below. Then, address related items (e) through (h).  Note the following:   * The Pricing AV will adjust the MAIR for the actuarial value and cost sharing design of each plan. * Include   + Benefit differences related to EHB-only cost sharing. See 10.a below.   + Expected utilization differences due to differences in cost-sharing (i.e., induced demand). See 10.b below. * Do not include adjustments that consider the morbidity of the population expected to enroll in the plan (i.e., differences due to health status). * Adjust for the following:   + If CSR payments are not funded, a CSR load factor should be included for the Exchange silver plans; this is an additional step not covered in the URR Instructions. See 10.c below.   + For all plans offered on the Exchange, include an adjustment to remove the impact of coverage of abortion services for which public funding is prohibited. See 10.d below. * To determine aggregate weighted averages for items covered by this #10, unless otherwise specified, apply each plan’s projected membership as weights. |  | |
|  | **a** | EHB paid-to-allowed factors (PAFs) by plan:  Provide the factor for each plan that shows the impact of benefit differences for EHB-only cost sharing.  Note that if you have a commercial or other (e.g., internal) reinsurance/pooling agreement, consider projected recoverable amounts in the paid-to-allowed factors (PAFs). |  |  |
| **b** | Induced demand factors (IDFs) by plan:   * Clarify how the IDFs by metal level or plan were determined. * Show that the IDFs have no net impact on the pool’s total projected allowed claims and incurred claims. Show that the result is the same for the weighted average PAF as for the weighted average IDF-adjusted PAF.   Note the following reasoning:   * + The MAIR reflects average induced demand for the pool.   + PAFs should have been developed using data at the pool level. The weighted average PAF reflects average induced demand for the pool.   + IDFs essentially scale the average allowed claims for the pool to projected allowed claims amounts for every plan. They reflect the impact of plan design on plan-level utilization (i.e., induced demand or anti-selection) relative to the average induced demand in the pool. They should not change the overall expected allowed claims nor the paid-to-allowed ratio. |  |  |
| **c** | Exchange plan adjustment for coverage of certain abortion services:  (see also #12 & #26)  For Exchange plans only, include an adjustment factor to remove the impact of coverage of abortion services for which public funding is prohibited. Per 45 CFR §156.280(e)(4)(iii), you may not estimate such a cost at less than one dollar per enrollee, per month.  Note that you must include abortion services in URRT Worksheet 1, Section II because Washington considers abortion services to be EHBs.  The impact of coverage of abortion services for which public funding is prohibited should be addressed in URRT Worksheet 2, Section II. For Exchange plans:   * Include the impact as part of URRT Worksheet 2 field 3.5 Benefits in Addition to EHB. * Remove the impact from URRT Worksheet 2 field 3.3 AV and Cost Sharing Design of Plan. The abortion adjustment applied to field 3.3 is the reciprocal of the abortion adjustment applied to field 3.5. (URR Instructions Section 2.2.3).   Explain in the actuarial memorandum that per URR instructions, coverage of abortion services for which public funding is prohibited are included in the URRT Worksheet 2 field 3.5 as a non-EHB. | **N/A** | **Note: Per Washington Health Benefit Exchange (WAHBE), there will be no Exchange SHOP plans for small groups for plan year 2025.** |
| **d** | Pricing AV:  (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.3)  Discuss and demonstrate the calculation of the final plan adjustment factors used in URRT Worksheet 2, Section III, field 3.3, AV and Cost Sharing Design of Plan. |  |  |
| **e** | Compare the AV Metal Value and the Pricing AV (without the CSR load):  Provide a table that lists your proposed plans with the following columns:   1. HIOS Plan ID; 2. Metal level (e.g., “Silver”); 3. AV Metal Value:   From URRT Worksheet 2, Section I, field 1.6.  Sort the table in descending order of AV Metal Value (i.e., highest AV Metal Value plan listed first and lowest last).   1. AV Metal Value Relativity:   Calculate the AV Metal Value Relativity of each plan, with the 1.000 relativity given to the plan (a.k.a. the base plan) that has the highest AV Metal Value.   1. Pricing AV (w/o CSR loading):   State the Pricing AV without the CSR loading (i.e., the AV and Cost Sharing Design of Plan factor with the CSR load factor, if applicable, removed).   1. Pricing AV (w/o CSR loading) Relativity:   Calculate the Pricing AV (w/o CSR loading) Relativity of each plan, with the 1.000 relativity given to the same base plan used for the AV Metal Value Relativity. Note: the same base plan will have a value of 1.000 in this column and in the AV Metal Value Relativity column.   1. Relativity Difference:   Calculate the difference in each plan’s Pricing AV (w/o CSR loading) Relativity and AV Metal Level Value Relativity.  Identify and analyze material Relativity Differences in the table provided. Identify how you validated the differences, considering allowable rating variations, and explain why they are reasonable. |  |  |
| **f** | Base premium rates versus CPAIR:  Calculate the difference between the 1.0000 premium rates (i.e., age factor 1.0000 such as for age 21; area factor 1.0000; tobacco factor 1.0000 (wellness discount) for each plan in the Rate Schedule and the Calibrated Plan Adjusted Index Rate (CPAIR) amounts in URRT Worksheet 2 Plan Adjustment Factors, Field 3.14. The differences should be within a few cents at most. (see also #35 of this checklist) |  |  |
| **g** | 2023 Incurred Claims, Allowed Claims, and Paid-to-Allowed Ratios:  Include a table that shows by metal level the 2023 Paid (Incurred) Claims and Allowed Claims experience and calculates the paid-to-allowed ratios. See also #1c and 1d of this checklist. |  |  |
| **11** | | Provider Network Adjustment Factors:  (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.4)  Demonstrate the build-up of the provider network factors. If you only have one network, please respond “N/A,” and use a factor of 1.0000.  The network factors should be normalized so that there is no change to the overall weighted average of the claim costs after the Provider Network Adjustment factors are applied. Include an exhibit demonstrating the normalization.   * Calculate the average incurred claims (with risk adjustment and exchange fee) as the sum product of the projected membership x MAIR x (AV and Cost Sharing Design of Plan) x (Benefits in Addition to EHB) x (Catastrophic Adjustment) divided by the total projected membership. * Calculate the same average above with the Provider Network Adjustment factors included in the sum product. * Normalize the Network factors such that the calculated averages above match. * If applicable, include a discussion of the network for the public option plans (i.e., Cascade Select plans). |  |  |
| **12** | | Benefits in Addition to EHB Factors:  (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.5)  Document and justify these factors. Note that they should be developed as loads on EHB incurred claims. If plans do not include non-EHBs (non-essential health benefits) and all plans are outside the Exchange, please respond “N/A.”  Notes about abortion services for URRT purposes (see also checklist #10c & #26):   * Exchange plans that include coverage of abortion services for which public funding is prohibited must calculate such abortion services as non-EHBs. * For plans offered Outside Market Only, such abortion services must be calculated as EHBs. * Per Washington Health Benefit Exchange (WAHBE), there will be no Exchange SHOP plans for small groups for plan year 2025, so no 2025 small group plans will need to be adjusted for coverage of abortion services for which public funding is prohibited. Only other non-EHBs will need to be addressed, if applicable. |  |  |
| **13** | | Catastrophic Adjustment Factors:  (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.9)  For the small group market, these Plan Adjustment Factors will all be 1. | **N/A** | **Not offered in the small group market.** |
| **URRT WORKSHEET 2, SECTION III CALIBRATION FACTORS** | | | | |
| **14** | | Age Factors and Age Calibration Factors: |  | |
|  | **a** | Age Calibration Factor Development:  Provide the 2025 age factors and the calculation of the age calibration factor used in URRT Worksheet 2, field 3.11.  Note: each calibration factor (age, geographic, and tobacco) must be calculated independently. |  |  |
| **b** | Age Calibration Factors, 2025 versus Prior:  Compare the 2025 age calibration factor to the 2022, 2023, and 2024 factors. |  |  |
| **c** | Average Age:  Show the average age and provide actuarial justification for the methodology employed to calculate the average age. |  |  |
| **15** | | Area Factors and Geographic Calibration Factors:  See WAC 284-43-6701 for geographic rating areas effective on or after January 1, 2019.  Note, if Area 1 (King County) is in your service area, its factor must be set at 1.0000. If Area 1 (King County) is **not** in your service area, the geographic rating area of the county with the largest enrollment in your service area must be set at 1.0000. If you are an insurer new to the Washington state market, the geographic area with the greatest number of counties must be set at 1.0000. |  | |
|  | **a** | Area Factor Development:  Demonstrate the build-up of the geographic rating area factors.  Note: if your service area is limited to a single area, please respond “N/A,” since the area factor is 1.0000.  Document and justify the 2025 factors including certification that the following items were not used to establish any geographic rating area factor:   1. Health status of enrollees or the population in an area. 2. Medical condition of enrollees or the population in an area, including physical, mental, and behavioral health illnesses. 3. Claims experience. 4. Health services utilization in the area. 5. Medical history of enrollees or the population in an area. 6. Genetic information of enrollees or the population in an area. 7. Disability status of enrollees or the population in an area. 8. Other evidence of insurability applicable in the area. |  |  |
| **b** | Area Factors, Highest versus Lowest:  Demonstrate that your geographic rating area factors comply with WAC 284-43-6681 highest to lowest cost ratio requirements of 1.15.  Note: the higher ratios of 1.22 and 1.40 are limited to companies offering Exchange QHPs, which is not currently available to the Washington small group market. |  |  |
| **c** | Area Factors, 2025 versus Prior:  Compare the 2025 area factors and calibration factor to the 2022, 2023, and 2024 factors. |  |  |
| **d** | URRT Geographic Calibration Factor:  Provide the calculation of the geographic calibration factor used in URRT Worksheet 2, field 3.12. Note: each calibration factor (age, geographic, and tobacco/wellness) must be calculated independently. |  |  |
| **e** | Load area factors into URRT:  Provide the geographic rating areas and rating factors in URRT Worksheet 3. |  |  |
| **16** | | Tobacco (Wellness) Use Factor and Tobacco (Wellness) Calibration Factor: |  | |
|  | **a** | Tobacco (Wellness) Use Factor Development:  Document and justify the 2025 Tobacco Use factor.   * If the factor did not change from the prior filing, indicate when the factor was last evaluated and what data was used in that evaluation. Note: Our opinion is that the factor should be re-evaluated periodically. |  |  |
| **b** | URRT Tobacco (Wellness) Calibration Factor:  Provide the calculation of the tobacco (wellness) calibration factor used in URRT Worksheet 2, field 3.13.  Note: each calibration factor (age, geographic, and tobacco) must be calculated independently. |  |  |
| **c** | Tobacco (Wellness) Factors, 2025 versus Prior:  Compare the 2025 tobacco (wellness) factor and calibration factor to the 2022, 2023 and 2024 factors. |  |  |
| **RISK ADJUSTMENT AND HIGH-COST RISK POOL (HCRP)** | | | | |
| **17** | | 2023 Risk Adjustment & HCRP: |  |  |
|  | **a** | For 2023 risk adjustment data, provide an Excel table showing the HCRP Reimbursement, HCRP Assessment, and the following risk adjustment transfer formula elements for the state and your own risk pool. Include metal (and catastrophic) level details sourced from the HHS interim public summary report in March 2024 or other comparable report:   1. Statewide Average Premium (SWAP), 2. Billable member months, 3. Average plan liability risk score (PLRS), 4. Average allowable rating factor (ARF), 5. Average actuarial value (AV), 6. Average induced demand factor (IDF), and 7. Average geographic cost factor (GCF).   Please include market-level amounts for your carrier and statewide Plan Liability Components and Allowable Rating Components. Note that you are not required to display Plan Liability Components and Allowable Rating Components by metal level unless you estimate them as part of your rate development.  REMINDER: Do **NOT** revise the sign (receivables positive; payables negative) of the actual or projected risk adjustment transfer and HCRP amounts in any exhibit unless specifically instructed to do so. Clearly document the instances when the instructions specify a change in sign. |  |  |
| **b** | 2023 Risk Adjustment & HCRP by Plan:  (URRT Worksheet 2, Section II Risk Adjustment Transfer Amount, Field 2.7)  Using formulae, please separately show 2023 results by plan for risk adjustment transfer amounts, HCRP receipts, and HCRP assessments. |  |  |
| **18** | | 2025 Risk Adjustment & HCRP: |  | |
|  | **a** | 2025 Incurred Risk Adjustment & HCRP Development:  (URRT Worksheet 2, Section IV Projected Plan Level Information, Fields 4.7 and 4.16)   * Provide 2025 projected risk adjustment data, detailed like the data in #17, used to project your 2025 Risk Adjustment Transfer Amounts. Also provide 2025 projected HCRP assessments and receipts. * Submit the projected 2025 Statewide Average Premium (SWAP), including the 2024 and 2025 trends applied to the 2023 SWAP PMPM. * Provide the 2025 projections by metal level. * If your rate development projects differences by membership cohort, please also submit separate projections for the following membership cohorts. If projections do not vary by membership cohort, please explain.  1. 2023 members projected to persist into 2024, 2. New 2024 members, as of March 2024, projected to persist into 2025, 3. New members projected in 2025, and 4. Total 2025 projected membership. |  |  |
| **b** | 2025 Incurred Risk Adjustment & HCRP Development Explained:  (URRT Worksheet 2, Section IV Projected Plan Level Information, Fields 4.7 and 4.16)   * Explain in detail in the Part III actuarial memorandum how you estimated the 2025 risk adjustment factors (e.g., PLRS, IDF, GCF, AV, and ARF), including the four membership groupings in (a), as applicable. (See URR Instructions regarding the requirements to provide detailed information and justification for risk adjustment.) * Provide detailed support and a description of the rationale for each assumption, including persisting membership, stating the most current data used, its “as of” date, and its source (e.g., internal, CMS, etc.). * Describe how your projections considered the 2025 risk adjustment model changes. * Explain 2025 HCRP estimated assessments and receipts. * We expect the following.   + Risk adjustment transfer amounts by plan should be consistent with applicable metal level and catastrophic level projections.   + Applicable risk adjustment transfer amount parameters projected for your own risk pool will be consistent with assumptions in the rate development (e.g., population and other factors in URRT, age and geographic calibration factors, etc.). Please explain any deviations. |  |  |
| **c** | 2025 Risk Adjustment & HCRP on Allowed Basis:  (URRT Worksheet 1, Section II Projections)  Include the calculation of the projected Risk Adjustment Payment/Charge, on an allowed dollar basis, as entered in URRT Worksheet 1, Section II. See checklist #27. |  |  |
| **d** | Projected 2025 RADV impacts:  Explain in the Part III actuarial memorandum any impacts due to Risk Adjustment Data Validation (RADV) audits. For example, explain any impact to the company or statewide 2025 PLRS projections due to the 2021 RADV audit report. |  |  |
| **e** | HCRP, 2025 versus Prior:  Compare (i) actual HCRP receipts and assessments for 2021, 2022, and 2023 versus (ii) projected HCRP receipts and assessments for 2021, 2022, 2023, 2024, and 2025. Explain differences. |  |  |
| **f** | 2025 Risk Adjustment Transfers & HCRP by Plan:  Using formulae, please show results broken out by the following:   * 2025 projected risk adjustment transfers separate from HCRP assessments and receipts, and * On an incurred basis separate from an allowed basis. |  |  |
| **RETENTION LOADS**  **URRT WORKSHEET 2, SECTION III ADMINISTRATIVE COSTS** | | | | |
| **19** | | Administrative Expense:  (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.6) |  |  |
|  | **a** | Administrative Expense Development:   * Justify the 2025 PMPM and/or percent of premium load for each item. * If you do not apply a flat load across all plans, explain and then compare the different loads applied in URRT Worksheet 2, Field 3.6. * At a minimum, the detailed calculations of each projected amount for the following should be included:  1. Quality improvement (QI) expenses. 2. Commissions. 3. Commercial reinsurance premium (if applicable). 4. An offset for anticipated investment income (if applicable). 5. General administrative expenses.  * The commissions load should be consistent with the submitted commission certification (see also #34). The commissions load may include adjustments for bonuses which are not specific to the small group line of business and, therefore, not covered in the certification. Any such bonuses should be explained in the Part III actuarial memorandum and exhibits. * Include in the Part III actuarial memorandum, a description of the projected quality improvement initiatives. |  |  |
| **b** | Administrative Expense Loads, 2025 versus Prior:  Include a table comparing the 2021, 2022, 2023, 2024 and 2025 PMPM and percent of premium loads for each separate administrative expense and total administrative expenses. |  |  |
| **c** | Prior Actual Administrative Expenses:  Include a table comparing the experienced expense PMPMs incurred in 2021, 2022, and 2023 and the percent of premium amounts for the various administrative expense line items listed in part a above.  Combine these amounts with actual taxes and fees to reconcile to Expenses shown in the WAC 284-43-6660 summary (see also 20c). |  |  |
| **20** | | Taxes and Fees:  (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.7) |  |  |
|  | **a** | Taxes and Fees Development:   * Justify the 2025 PMPM and/or percent of premium load for each item. * If you do not apply a flat load across all plans, explain and then compare the different loads applied in URRT Worksheet 2, Field 3.7. * Some state assessments are charged based on the member’s residence rather than the group’s location. If the carrier chooses to include loads based on the member’s residence:   + Identify each state’s resident-based assessments (including WA’s). For completeness, include any state with membership, but no applicable assessment.   + Show the detail calculations of each amount.   + Include a comparison of the current membership distribution by state versus the projected distribution.   + Identify the regulatory and/or administrative code authorizing each out-of-state assessment. * At a minimum, the detailed calculations of each projected amount for the following should be included:  1. Patient-Centered Outcomes Research Institute (PCORI) Fee (Internal Revenue Code sections 4375 and 4376). Include a discussion of the latest information on the IRS website and the National Health Expenditure (NHE) trend projections. Note that the fee changes annually by policy end date. Calculate your fee based on the end date of your policies in the plan year (Q1-3 and Q4 fees); see the IRS Q&A on this topic for details). 2. Federal Income Tax. 3. Premium Tax [RCW 48.14.020 or 0201]. 4. WSHIP Assessment [RCW 48.41.090]. Include a discussion of the current and projected assessment information in the Annual Report available at <https://www.wship.org/> as well as the WSHIP information separately sent to you as a member plan. 5. Regulatory Surcharge [RCW 48.02.190]. Include a discussion of the current information available at <https://www.insurance.wa.gov/regulatory-surcharge-calculation>. 6. Insurance Fraud Surcharge [RCW 48.02.190]. Include a discussion of the current information available at <https://www.insurance.wa.gov/fraud-surcharge-calculation>. 7. Washington Partnership Access Line (WAPAL) Assessment [WAC 182-110-0500]. Include a discussion of the historical assessments paid and the current information available at <https://wapalfund.org>. 8. Risk Adjustment user fee. The 2025 per capita risk adjustment user fee is set at $0.18 PMPM. 9. Mitigating Inequity Fee [WAC 284-43-6590], if applicable (see also #38 below).   In the actuarial memorandum, justify any item with a $0.00 load. Note: simply stating that an amount is immaterial is insufficient justification. |  |  |
| **b** | Tax and Fee Loads, 2025 versus Prior:  Include a table comparing the 2021, 2022, 2023, 2024 and 2025 PMPM and percent of premium loads for each separate tax and fee and the total load for taxes and fees. |  |  |
|  | **c** | Prior Actual Taxes and Fees:  Include a table comparing the actual expense PMPMs incurred in 2021, 2022, and 2023 and the percents of premium broken down by the various tax and fee line items listed in part a above. Please also comment about any amounts from 2021, 2022, and 2023 that are not included in the part a list.  Combine these amounts with actual administrative expenses to reconcile to Expenses shown in the WAC 284-43-6660 summary. (see also 19c) |  |  |
| **21** | | Profit & Risk Load:  (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.8)   * Profit & Risk load is the portion of the projected earned premium that is not directly associated with claims or expenses. * The amount must be the same across all plans. |  |  |
|  | **a** | Profit & Risk Load Development:  Justify that your Profit & Risk load is reasonable [RCW 48.43.734] in relation to your company’s surplus, capital, and profit levels.   * Discuss in detail how you established your 2025 plan year load. * Clarify whether your experience unpaid claims liability estimate also includes any margin or if the estimate reflects your best estimate. * Explain whether other plan year 2025 rating assumptions include their own margin provisions. |  |  |
| **b** | Profit & Risk Loads, 2025 versus Prior:  Include a table comparing the 2021, 2022, 2023, 2024 and 2025 PMPM and percent of premium loads applied in URRT Worksheet 2, Field 3.8. Compare them to observed margins for 2021, 2022, and 2023. |  |  |
| **DOCUMENTATION AND EXHIBITS** | | | | |
| **22** | | Company Rate Information and Rate Review Detail:  For the “Company Rate Information” and “View Rate Review Detail” on the Rate/Rule Schedule tab of the SERFF rate filing, provide an exhibit with the following information.   * The information should represent your **initial requested rate change**. * Note: If post submission updates are necessary to correct any information, update the exhibit to indicate what was updated and the reason for the update(s). * The following items include instructions for some mandatory fields for issuers with renewal plans. For more information related to “Company Rate Information” and “View Rate Review Detail,” see SERFF and Rate Filing Instructions. |  | |
|  | **a** | Company Rate Information:  Provide the calculation, explanation, and/or source of the information.  Note the following:   1. Number of policy holders affected for this program: The number of subscribers as of March 2024. 2. Minimum and Maximum % changes: From the initial Uniform Product Modification Justification (UPMJ) Q5 rate changes by plan. 3. Overall % rate impact: The calculated overall average rate change in UPMJ Q5. 4. Written Premium for this Program and Written Premium Change for this Program: Annual amounts; see Written Premium in the NAIC glossary. |  |  |
| **b** | Rate Review Detail (RRD):  Provide the calculation, explanation, and/or source of the information.   * 1. Products, Number of Covered Lives: The number of covered lives (members) as of March 2024. If applicable, differentiate renewing products which list current lives versus new products which list projected lives (see instructions in the RRD in SERFF).   2. Trend Factors: Annual incurred claims trend factor, including leveraging, which matches the weighted average of the trends by category in the initial 2025 WAC 284-43-6660 summary. (see also #6b)   3. Forms: List all forms for the rate filing in the applicable categories. If a category does not apply to any form in the filing, leave it blank. (see SERFF instructions)   Note: since the ACA requires that all non-grandfathered individual and small group health plans be guaranteed issue, the “Affected Forms for Closed Blocks” in the Forms Section should be left blank.   * 1. Requested Rate Change Information:      1. Change period: Annual.      2. Member months: Membership for the 2023 experience period.      3. Min, Max, and weighted average rate change: Match the initial UPMJ Q5.   2. Prior Rate:      1. Total earned premium & total incurred claims: Projected earned premiums and incurred claims, respectively, for 2024.      2. Minimum and maximum per member per month (PMPM): Be consistent with the rates in the 2024 final Rate Schedule.      3. Weighted average PMPM: Be consistent with the current community rate in the initial WAC 284-43-6660 summary.   3. Requested Rate:      1. Projected earned premium & projected incurred claims: For 2025, be consistent with the initial URRT Worksheet 2.      2. Minimum and maximum PMPM: From the initial 2025 Rate Schedule.      3. Weighted average PMPM: Be consistent with the weighted average PMPM premium rate consistent in the initial URRT Worksheet 2. |  |  |
| **c** | Current Enrollment:  Compare current enrollment information across the various rate filing exhibits, including, but not limited to the following:   1. RRD Number of Covered Lives. 2. URRT Worksheet 2, Field 2.10 Current Enrollment. 3. UPMJ Q1 Enrollment as of 3/31/2024. 4. Part III supporting exhibits’ current enrollment.   Explain any inconsistencies. |  |  |
| **d** | Projected Enrollment:  Compare projected enrollment information across the various rate filing exhibits, including, but not limited to the following:   1. RRD (Projected Earned Premium) / (Requested Rate Weighted Avg. PMPM). 2. URRT Worksheet 2, Field 4.9 Projected Member Months. 3. Part II written explanation projected enrollment. 4. Part III supporting exhibits’ projected enrollment.   Explain any inconsistencies. |  |  |
| **23** | | Impacts of Changes 45 CFR §154.301(a)(4):   * Document the methodology, justification, and calculations used to determine the impacts of the changes outlined in the Effective Rate Review Program under 45 CFR §154.301(a)(4) (i) through (xv). * Note that if you change the contribution to surplus from the prior submission, you must provide additional support for why the change is warranted. * *To add context to the factors listed below, please also summarize in the actuarial memorandum the approximate percent impact of the most significant contributors* ***to the proposed aggregate rate change*** *(see URR Instructions section 4.3, for example)*. |  | |
| (i) The impact of medical cost trend ***changes by major service category***. Include a discussion of the cost trend change for each specific benefit category listed in URRT Worksheet 1, Section II. |  |  |
| (ii) The impact of utilization ***changes by major service category***. Include a discussion of the utilization trend change for each specific benefit category listed in URRT Worksheet 1, Section II. |  |  |
| (iii) The impact of cost-sharing ***changes by major service category***, including actuarial values. Include a discussion of the cost-share changes for each specific benefit category listed in URRT Worksheet 1, Section II. |  |  |
| (iv) The impact of benefit *changes*, including essential health benefits and non-essential health benefits. |  |  |
| (v) The impact of *changes in* enrollee risk profile and pricing, including rating limitations for age and tobacco use under section 2701 of the Public Health Service Act. |  |  |
| (vi) The impact of any *overestimate or underestimate* of medical trend for prior year periods related to the rate increase. Include a discussion and analysis of actual to expected medical trends. |  |  |
| (vii) The impact of *changes in* reserve needs. Include a discussion of any change in reserve needs. |  |  |
| (viii) The impact of *changes in* administrative costs related to programs that improve health care quality. Include a discussion of any such changes. |  |  |
| (ix) The impact of *changes in* other administrative costs. Include a discussion of any such changes. |  |  |
| (x) The impact of *changes in* applicable taxes, licensing, or regulatory fees. Include a discussion of any such changes. |  |  |
| (xi) Medical loss ratio (MLR). Include a projected federal MLR calculation [45 CFR §158.221; also see CMS MLR Filing Instructions for Contract Year 2022].  Numerator: Incurred claims [45 CFR §158.140(a)] – Net Risk Adjustment, including HCRP amounts (receivables positive; payables negative, which means that a payable subtracts a negative amount) + Quality Improvement Expenses.  Denominator: Earned Premiums – Taxes & Fees – Community Benefit Expenditures (CBE).  If applicable, include discussion of the total CBE experience along with the following:   1. How the total amount is allocated to lines of business (individual, small group, and large group); and 2. The impact, if any, of the CBE limitation of the highest of either:    1. Three percent of earned premium; or    2. The highest health insurance coverage premium tax rate in the State for which the report is being submitted, multiplied by the issuer's earned premium in the applicable State market.   Comment about how the following recent MLR reporting regulation changes were considered [see 45 CFR §158; 2022 & 2023 CMS Notices of Benefit and Payment Parameters (NBPP); final 2025 CMS NBPP]:   1. Deduct from incurred claims not only prescription drug rebates received by the issuer, but also any price concessions received and retained by the issuer, and any prescription drug rebates, and other price concessions received and retained by an entity providing pharmacy benefit management services to the issuer. (e.g., 2022 NBPP) 2. Report prescription drug rebates and other price concessions received and retained by an entity providing pharmacy benefit management services to the issuer as non-claims costs. (e.g., 2022 NBPP) 3. Report expenses for services outsourced to or provided by other entities in the same manner as expenses for non-outsourced (i.e., incurred directly by the issuer) services. (45 CFR §158.110(a)) 4. Allowance for the Individual market to report certain wellness incentives described in 45 CFR §158.150(b)(2)(iv)(A)(5)(ii) as quality improvement activities. 5. Only those provider incentives and bonuses that are tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers may be included in incurred claims for MLR reporting and rebate calculation purposes. (e.g., see 2023 NBPP) 6. Only expenditures directly related to activities that improve health care quality may be included in QIA (Quality Improvement Activities) for MLR reporting and rebate calculation purposes. (45 CFR §158.150(a) and 2023 NBPP) 7. Removing the option for issuers to report an amount equal to 0.8 percent of earned premium in the relevant State and market in lieu of reporting the issuer’s actual expenditures for activities that improve health care quality (e.g., see 2022 NBPP). 8. Allowance to prepay a portion or all of an estimated MLR rebate for a given MLR reporting year in advance of deadlines set forth in §§ 158.240(e) and 158.241(a)(2) and filing the MLR Annual Reporting Form, and establishing a safe harbor allowing such issuers, under certain conditions, to defer the payment of rebates remaining after prepayment until the following MLR reporting year (e.g., see 2022 NBPP). |  |  |
| (xii) The health insurance issuer's capital and surplus. Note: This is one of only two items not written in terms of the impact of changes (the other is (xi) for MLR). This checks whether the rate development considered your issuer’s current capital and surplus levels. For example, are changes required to your premium to surplus ratio? Include a discussion in the actuarial memorandum. |  |  |
| (xiii) The impacts of geographic factors and variations. |  |  |
| (xiv) The impact of *changes within* a single risk pool to all products or plans within the risk pool. |  |  |
| (xv) The impact of reinsurance (which is N/A for Washington) and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act. |  |  |
| **24** | | Drug Manufacturer Support of Member Out-of-Pocket Costs:  Per revised 45 CFR §156.130(h), for plan years beginning on or after January 1, 2020, amounts paid toward cost sharing using any form of direct support offered by drug manufacturers to insured patients to reduce or eliminate immediate out-of-pocket costs for specific prescription brand drugs are permitted, but not required, to be counted toward the annual limitation on cost sharing. RCW 48.43.435 further outlines requirements for plans issued or renewed on or after January 1, 2023.  Indicate what you implemented related to these requirements and justify any impact to your rate development. |  |  |
| **25** | | Financial Statement Analysis: |  | |
|  | **a** | Reconcile to Additional Data Statement (ADS) Form for the Year Ending December 31, 2023:  For carriers not required to file an ADS, please respond “N/A.” For ease of review for carriers who file an ADS, please include with the rate filing a copy of the ADS pages.  For HMOs and HCSCs, show ADS amounts total revenues (line 7), total hospital and medical claims (line 17), and administrative expenses (line 19 + line 20).  Please list any adjustments required to reconcile between ADS amounts and amounts in the Summary of Pooled Experience in the WAC 284-43-6660 summary and in URRT Worksheet 1, Section I. Calculate the amount and percentage unreconciled and explain any significant unreconciled amounts.  Explain any difference in the projected risk adjustment amount included in the ADS premium amount versus the experience period risk adjustment amount entered in URRT Worksheet 1, Section I.  Also compare the average monthly membership from the WAC 284-43-6660 summary’s 2023 experience period with the average monthly membership calculated from the quarter ending enrollment listed in the ADS. Explain any significant differences. |  |  |
|  | **b** | Months of Surplus:  For all issuers, please provide a calculation of your company’s Months of Surplus using information in the 2023 annual statement and one of the following formulas, with one decimal place of accuracy.  Health Statement: Months of Surplus = [(Annual Statement Page 3, Line 33: Total capital and surplus) / (Page 4, Line 18: Total hospital and medical (Lines 16 minus 17))] \* 12.  Life Statement: Months of Surplus = [(Annual Statement Page 3, Line 38: Total (Lines 29, 30, & 37)) / (Page 4, Line 20: Total (Lines 10 to 19))] \* 12. |  |  |
| **26** | | Abortion services for which public funding is prohibited:  (see also #10d & #12) For Exchange filings, document the pricing per member per month (PMPM) for voluntary abortion services and the “EHB Percent of Total Premium” to be listed in the Plans & Benefit Template (PBT) in the binder filing. See 45 CFR §156.280(e)(4). See QHP Application Instructions for EHB Percent of Total Premium calculation guidance.  Note: The Index Rates in URRT Worksheet 1, Section II must include allowed claims for abortion services even for Exchange plans. Voluntary abortion services are *only* considered a non-EHB for Exchange plans in the percentages listed in the PBT and in URRT Worksheet 2 field 3.5. Otherwise in Washington State, voluntary abortion services are considered EHBs for Exchange plans. Additionally, non-Exchange plans will consistently consider voluntary abortion services as an EHB. | **N/A** | **Note: Per Washington Health Benefit Exchange (WAHBE), there will be no Exchange SHOP plans for small groups for plan year 2025.** |
| **SEPARATE DOCUMENTS**  Address the following items in addition to any other relevant items covered elsewhere in this checklist. | | | | |
| **27** | | **Part I Unified Rate Review Template (URRT):**  Note: The various index rates (Index Rate, MAIR, etc.) in the URRT are the official amounts. For calculations in your supporting exhibits requiring one of these amounts, such as the Exchange User Fee input for URRT Worksheet 1 Section II, please use and reference the applicable amount(s) calculated in the URRT.  Please do not disable the macros in the Excel version of the URRT; please submit a macro-enabled URRT workbook.  The URRT worksheets allow up to 16 characters including decimal places. Only apply rounding to amounts directly loaded into the URRT and only to the extent necessary to meet the 16-character limitation. Do not round any intermediate amounts. |  | |
|  | **a** | URRT Exchange User Fees:  (URRT Worksheet 1, Section II Projections)  If the issuer is only outside the exchange, please respond “N/A.”  The Exchange user fee for 2025 is $5.11 PMPM.   1. For issuers marketing both inside and outside the Exchange, confirm that the Exchange user fees, or Exchange assessment fees, are spread across the entire pool. 2. For issuers only marketing inside the Exchange: The default expectation is that 100% of membership will be on the Exchange. If your project less than 100% Exchange membership, include an explanation in the Part III actuarial memorandum. 3. Justify the Exchange User Fees’ percentage load entered in URRT Worksheet 1, Section II. Compare the result against the required amount per member per month (PMPM). There should be a reasonable assumption for the distribution of enrollees inside and outside the Exchange. 4. If any Exchange membership is projected for plan year 2025, please check that a nonzero dollar amount flows through to URRT Worksheet 1, Section II Exchange User Fees. 5. Ensure the amount is adjusted to reflect an allowed dollar basis as discussed below in #27b. | **N/A** | **Note: Per Washington Health Benefit Exchange (WAHBE), there will be no Exchange SHOP plans for small groups for plan year 2025, so the amount should be $0 and 0%.** |
| **b** | URRT Paid-to-allowed factor:  Include justification for the paid-to-allowed factor used to calculate the allowed basis for Risk Adjustment Payment/Charge PMPM and Exchange User Fees for URRT Worksheet 1, Section II. The adjustment should be the aggregate impact of the four plan factors from URRT Worksheet 2 (i.e., Fields 3.3, 3.4, 3.5, and 3.9). All of these plan factors are applied in future steps, so it seems that they should be divided out in URRT Worksheet 1. |  |  |
| **c** | URRT Worksheet 1, Section II, 2025 versus 2024:  Compare the projections in URRT Worksheet 1, Section II in this year’s filing for 2025 versus those in last year’s filing for 2024. |  |  |
| **d** | URRT Worksheet 2 terminated plan mapping:  Document and justify URRT Worksheet 2 product and plan mapping for terminated plans, in accordance with the following:   1. For the inside Exchange plans and plans that are both inside and outside Exchange, follow the mapping information you (the issuer) provided to WAHBE and as required by 45 CFR §155.335(j). 2. For the outside Exchange plans, follow your procedure as indicated in the letter(s) provided to the policyholder(s) and consistent with Uniform Product Modification Justification (UPMJ).   Note: each 2024 plan should map all members in the plan to the same 2025 plan.  Respond “N/A” if no 2024 plans are terminating. |  |  |
| **e** | URRT Worksheet 2, Section I General Product and Plan Information  Cumulative Rate Change % for Composite Plans:  For any plan in URRT Worksheet 2 which is the composite of more than one plan in UPMJ Q5, include an exhibit detailing the calculation of the Cumulative Rate Change % (over 12 mos. Prior) based on the overall average rate change by plan in UPMJ Q5.  If there are no composite rate changes, respond as “N/A.” |  |  |
| **f** | URRT Worksheet 2, Section IV Projected Plan Level Information  Projected Allowed Claims, Incurred Claims & Premiums:   * Include an exhibit that calculates the projected dollar amounts by plan for URRT Worksheet 2, Section IV. * Amounts should be consistent with plan adjustment factors in URRT Worksheet 2, Section III.    + Include calculations for projected Retention Amounts PMPM that are implied but not entered in URRT Worksheet 2, Section IV. Amounts should equal (the percent loads in Fields 3.6, 3.7, and 3.8) x (Premium PMPM) + (Exchange User Fees PMPM).   + The overall incurred claims PMPM should equal (Premium PMPM) + (Risk Adjustment Transfer Amount PMPM) – (Retention Amount PMPM). Note that although this result is expected in aggregate, differences may be reasonable for specific plans. Show how plan-level results from this calculation compare to Incurred Claims PMPM amounts in URRT Worksheet 2, Section IV field 4.15; research and explain plan-level differences. * For clarity, please also show calculations of the plan-specific and aggregate projected PMPM amounts for the remaining fields 4.11 through 4.17.   Note that the following results are expected:   1. The Total Allowed Claims PMPM in field 4.11 should be consistent with the [Projected Index Rate] + [average PMPM of the CSR load (on an allowed basis)] + [average PMPM for non-EHB, excluding abortion services reported as non-EHB (on an allowed basis)]. 2. The Allowed Claims PMPM by plan in field 4.11 should only differ from the Total Allowed Claims PMPM due to URRT Worksheet 2 fields 3.3 AV and Cost Sharing Design of Plan (a.k.a. Pricing AV), 3.4 Provider Network Adjustment, 3.5 Benefits in Addition to EHB, and 3.9 Catastrophic Adjustment. |  |  |
| **g** | URRT projected members by plan:  Please document the following in the actuarial memorandum:   * Explain how member months were projected by plan. * Explain how URRT membership projections align with 2025 company expectations for the product line. * Justify any new or renewing plans with zero projected enrollment. * If the opining actuary relied on membership projections from another area of your company, please indicate as such in the reliance section of the actuarial certification. |  |  |
| **h** | URRT Projected PAIR versus Premium PMPM:  Compare the weighted-average Plan Adjusted Index Rate (PAIR; URRT Worksheet 2, Field 3.10) to the aggregate premium PMPM projected in Field 4.17. Weight the PAIR amounts by projected member months. Explain any differences. |  |  |
| **i** | URRT Controlled Group Renewal Clarification:  Based on input from CMS/CCIIO, if you are an issuer renewing only one 2024 plan that will be offered by a health insurance issuer within your controlled group, please include the following (see also #29b and #30c). If not applicable, indicate “N/A.”  In URRT Worksheet 2 for the current and new issuers:   1. The Plan Name (Field 1.3) and Plan ID (Field 1.4) will be unique to each issuer. 2. Indicate the plan as a renewing plan (Field 1.7). 3. Include the current rate from the current issuer (Field 2.11) in the new issuer’s URRT. 4. Use the current rate in the calculation of the rate increase (Field 1.11) in the new issuer’s URRT. 5. The experience must only be included in section II of the current issuer’s URRT to match the totals in Worksheet 1. |  |  |
| **28** | | **Part II Written Description Justifying the Rate Increase:**   1. Follow content guidance outlined in URR Instructions. 2. Include key drivers of the risk pool’s rate increase as well as relevant plan details such as those described below. 3. Changes in Benefits: Consumers tend to view cost-share changes as “benefit changes,” so a summary of the cost-share changes should be included in this section, along with other significant benefit changes. Note: the cost-share changes in this document should just be an overview of major changes, such as general discussion of the range of deductibles or changes in copays, rather than a repeat of the detailed list in UPMJ Q4a & 4b. 4. Administrative Costs and Anticipated Margins: Consumers tend to view all retention loads, other than profit, as “administrative costs,” so taxes and fees should be included in this section along with other administrative expenses. 5. Please also note the plan’s projected profit & risk load. |  |  |
| **29** | | **Part III Actuarial Memorandum and Certification:**   1. Submit the actuarial memorandum exhibits in a separate Excel spreadsheet and corresponding PDF. Note: the PDF version of the actuarial memorandum exhibits can be submitted on the URRT tab rather than the Supporting Documentation tab in SERFF so that it will be uploaded to CMS. The Excel spreadsheet, however, must be submitted on the Supporting Documentation tab. 2. Note: to reduce the review time required to sift through duplicate file versions, please do NOT submit additional complete copies of the URRT Worksheets, the WAC 284-43-6660 summary, or the Rate Schedules with the actuarial memorandum exhibits. 3. Note: Washington requires that the redacted actuarial memorandum must match the unredacted actuarial memorandum. |  | |
|  | **a** | Actuarial Certification:  Include an actuarial certification as prescribed in the Part III Actuarial Memorandum and Certification Instructions found in the URR Instructions. Include the signature date in the signatory block of the certification and update the date throughout the filing review season, as needed, if assumptions or rates change. |  |  |
| **b** | Controlled Group Renewal Clarification for Part III:  Based on input from CMS/CCIIO, if you are an issuer renewing only one 2024 plan that will be offered by a health insurance issuer within your controlled group, please include the following (see also #27i and #30c). If not applicable, indicate “N/A.”  In both the current and new issuers’ actuarial memorandums, add a crosswalk detailing the current and renewing plan information. Include:   1. The name of the current and new issuers offering the plan. 2. A comparison of the 2024 and 2025 HIOS Plan IDs and plan names. 3. A comparison of the 2024 counties in the service area for the renewing plan and the 2025 counties offered by the new issuer to demonstrate meeting the requirement to cover a majority of the same service area. 4. Discuss the cost-share changes to the plan and confirm that the product network type and covered benefits remain the same. |  |  |
| **c** | UPMJ versus URRT Rate changes:  Rate changes by plan in URRT Worksheet 2, Field 1.11 should match rate changes by plan in UPMJ Q5. For clarity, discuss in the actuarial memorandum the differences in the calculation of the official aggregate rate change in UPMJ Q5 and the rate change amounts in URRT Worksheet 2, Fields 1.12 and 1.13. |  |  |
| **30** | | **Uniform Product Modification Justification (UPMJ):**  Review and follow the general instructions as well as the UPMJ instructions for each question. |  | |
|  | **a** | UPMJ Q4a & 4b:   1. For UPMJ Q4a, keep in mind that the content will ultimately be included in our decision memorandum that is posted for public consumption, so explain the cost-share changes as you would to an existing or prospective member. 2. For each cost-share amount listed in UPMJ Q4a, include dollar, comma, and percent symbols as well as numeric amounts. 3. Spell out the first occurrence of each acronym in Q4a and Q4b. For example, “Maximum Out-of-Pocket (MOOP).” 4. Note: For plans that add or remove out-of-network (OON) coverage, the change should be listed as a member cost-share change rather than a benefit change. |  |  |
| **b** | UPMJ Q5:   1. Column 5(d):    * + 1. Only include enrollment from renewing counties.        2. If you are exiting any counties, please address the following:   Since you are exiting counties, total enrollment in Q5 may not match the UPMJ Q1 total, so include an exhibit in the filing with current enrollment by plan split between renewing and terminating counties. Note that UPMJ Q1 should include all enrollment before reductions for terminating counties.   1. Display rate changes for every renewing and terminated plan, even if the 03/31/2024 enrollment is 0. A plan should only reflect 0.00% across columns 5(g), 5(h), 5(i), and 5(j) if there are no experience, benefit, and cost-share rate changes for the plan. 2. Submit an exhibit supporting rate changes for each UPMJ Q5 column.    1. Ensure UPMJ Q5 rate changes are consistent with the benefit and cost-share changes in UPMJ Q4a and Q4b.    2. Justify each rate change by showing the calculation or explaining how the percentages were determined and ensure rate filing documents consistently support the rate changes.    3. Note that it is acceptable to back into column 5(g), Experience Rate Change for Plan, using justified amounts for 5(j), Overall Average Rate Change for Plan; 5(i), Cost-Share Rate Change for Plan; and 5(h), Benefit Rate Change for Plan.    4. Explain any large plan variations in 5(g), Experience Rate Change for Plan. We expect that there should be little variability due to the single risk pool requirement.    5. Specify the source of the 2024 and 2025 rates used to calculate the overall increase for each plan. The changes should be consistent with the changes to the Rate Schedule. |  |  |
| **c** | Controlled Group Renewal Clarification for UPMJ:  Based on input from CMS/CCIIO, if you are an issuer renewing only one 2024 plan that will be offered by a health insurance issuer within your controlled group, please include the following (see also #27i and #29b). If not applicable, indicate, “N/A.”   1. *Current issuer*: UPMJ Q4a and Q5b will be blank. 2. *New issuer*: UPMJ Q4a must include the benefit changes from the current issuer’s plan to the new issuer’s plan. Q5b should include a line with the new plan’s rate change percentage with zero members. |  |  |
| **d** | Quarterly Trend Factors:   1. Document and justify the quarterly premium trend factors. 2. Compare the 2025 quarterly premium trend factors with those used in 2022, 2023, and 2024. |  |  |
| **31** | | **WAC 284-43-6660 summary:** |  | |
|  | **a** | Proposed Rate Summary:   1. Proposed Community Rate must be consistent with the aggregate projected premium PMPM in URRT Worksheet 2, Section IV Field 4.17. 2. Percentage Change must be consistent with the overall average rate change in UPMJ Q5b. 3. Current Community Rate = (Proposed Community Rate) / (1 + Percentage Change). |  |  |
| **b** | Components of Proposed Community Rate:   1. Component (a) Claims should match (URRT Worksheet 2, Section IV Field 4.15 Incurred Claims PMPM) minus (URRT Worksheet 2, Section IV Field 4.16 Risk Adjustment Transfer Amount PMPM). 2. Component (b) Expenses combined with component (d) Investment Earnings must be consistent with the combined values of (Exchange User Fees in URRT Worksheet 1, Section II) + (URRT Worksheet 2, Section III Field 3.6 Administrative Expense) + (URRT Worksheet 2, Section III Field 3.7 Taxes and Fees). 3. Component (c) Contribution to Surplus Contingency Charges, or Risk Charges must be consistent with (URRT Worksheet 2, Section III Field 3.8 Profit & Risk Load). 4. Total row (e) must match the Proposed Community Rate from the above section (i.e., Proposed Rate Summary) in the WAC 284-43-6660 summary. |  |  |
| **c** | Trend Factor Summary:  (see also #6b)   1. If the WAC 284-43-6660 summary shows the same trend for each type of service, please explain whether you expect any variation by type of service. If variation is expected, please explain the choice of a single trend factor for this summary. 2. For plans with embedded dental, ensure the embedded dental trend is included in the Other trend category, and then add a note to the General Information section #5 that the embedded dental trend is included in the Other trend category. This is to be consistent with the URR Instructions, section 2.1.3.1. |  |  |
| **d** | General Information #4:  Respond with “See Rate Schedule.” |  |  |
| **32** | | **Benefit Components:**  Provide a completed Benefit Components Speed-to-Market Tool.   * The file “Format - Rates - 2025 Med Benefit Components” is provided on the Washington State OIC website. * The cost-shares for all embedded benefits, including pediatric dental, must have every different cost-share visible such as for different kinds of pediatric dental care (e.g., cleaning versus extensive surgeries, or as preventive, basic, major services), if applicable. * Note, the information you provide in this file should be consistent with the other documents in your binder, rate, and form filings (e.g., PBT, AVC Screenshots, MH/SUD Certification). * The plans should indicate integrated or separate medical and drug deductibles consistent with the AVC screenshots (see #9 above). |  |  |
| **33** | | **Mental Health and Substance Use Disorder (MH/SUD) Financial Requirement Parity:** |  | |
|  | **a** | MH/SUD Financial Requirement Parity Certification:  Complete the “Mental Health and Substance Use Disorder Financial Requirement Parity Certification” Speed-to-Market Tool. The file “Certification – Rates – 2025 Mental Hlth and Subst Use Dis Financial Reqs” can be found at <https://www.insurance.wa.gov/speed-market-tools-health-coverage-analysts>. |  |  |
| **b** | MH/SUD Parity Calculations:  Complete an MHSUD Parity Speed-to-Market Tool that documents MHSUD financial requirement parity testing.   * A file template “Certification - Rates - 2025 MHSUD Parity Calculations” is provided on the Washington State OIC website. * In the Mapping Information and each MHSUD Parity Testing Worksheet, please use the same benefit descriptions listed (both EHB and non-EHB) in the Benefit Components. The list should include all benefits, including inpatient, emergency care and prescription drugs. Carriers with the same cost-share for all MHSUD outpatient services but who want to test office visits and all other outpatient services separately must list the MHSUD cost-share for both office visits and all other outpatient services. * Categories can be split in some cases if, for example, you want to split services between office visits and all other outpatient services. If you combine categories, indicate in the notes which categories are included. For example, a therapies category in the testing can combine rehabilitative speech therapy and rehabilitative occupational and physical therapies from the Benefit Components. * For easy comparison, enter the plans in the same order and use the same tab names in the MHSUD Parity and Benefit Components workbooks. It would also be helpful if the Service Descriptions in the worksheets are in the same order as the Benefit Components. * The cost-shares for all embedded benefits, including dental and vision, must have every different cost-share visible, such as for different kinds of pediatric dental care, in the list of medical/surgical benefits. * The Plan Projected Allowed Amounts should be annual dollar amounts which reflect a reasonable projected dollar amount [WAC 284-43-7040(1)(c)(ii)] as attested to in the MH/SUD Financial Requirement Parity Certification (section II.B.2). The amounts should be consistent with the allowed claims projected in URRT Worksheet 2, Section IV. |  |  |
| **34** | | **Commission Certification:**  (see also #19a) Provide detailed proposed commission schedules, even if no commissions are expected to be paid for this block of business for plan year 2025. They should be signed and dated by an officer or a senior manager of your company who oversees commission schedule implementation. The officer or senior manager should certify that the information is accurate to the best of their knowledge at the time of the rate submission. The commission schedule must comply with CMS guidance below and 45 CFR 147.104(e) and 156.225(b).  <https://www.cms.gov/files/document/agent-broker-compensation-and-guaranteed-availability-coverage.pdf?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=>  Broker bonus programs determined across multiple lines of business are not part of this certification, but they should be noted and accounted for in the rate development.  **Note:** Commission schedules filed in individual and small group rate filings must be finalized prior to the final disposition. The commission schedule will not be allowed to change after the rate filing is approved. |  |  |
| **35** | | **Rate Schedule:**  Provide a complete rate schedule using the “Format - Rates - 2025 Individual Non-grandfathered Health Plan Rate Schedule template.” Be mindful of the following:   * Ensure you use the most current version of the template. * The 1.0000 premium rates (age factor 1.0000 such as for age 21; tobacco factor (wellness discount) 1.0000; area factor 1.0000) should be consistent with the Calibrated Plan Adjusted Index Rate (CPAIR) amounts in URRT Worksheet 2, Field 3.14. (see also #10f) * Submit on the Rate/Rule Schedule tab in SERFF. |  |  |
| **36** | | **Rate Example:**  Submit a rate calculation example on the Rate/Rule Schedule tab in SERFF. Address the following:   * Use the rates in the Rate Schedule, * Include a statement that rates are charged to no more than the three **oldest** covered children under 21 for family coverage [45 CFR §147.102(c)(1)]. * If your premium rates adjust for tobacco (wellness), please include in the example at least one family member whose rates would be impacted. |  |  |
| **37** | | **Composite Rate Example:**  Is composite rating allowed for any of your small group plans in this filing? If yes, address items (a) and (b) below. If no, please respond “N/A.”  For each plan, explain in detail whether composite premium setting under 45 CFR §147.102(c)(3) is an available choice for small employers.  Submit all composite examples in a single document on the Rate/Rule Schedule tab in SERFF. |  | |
|  | **a** | Illustrative Example for Composite Rating:   * Include an illustrative example as a separate document in the Rate/Rule Schedule tab and name the file “Illustrative Example for Composite Rating.” * Use the rates in the Rate Schedule. * Show how to calculate a two-tiered-only composite premium structure for a small employer that satisfies the following requirements: * The composite premium for covered adults age 21 and older is the average enrollee premium amount calculated at the beginning of the plan year for covered adults age 21 and older, regardless of whether they are an employee or adult dependent. * The composite premium for covered individuals under age 21 is simply the average enrollee premium amount for covered individuals under age 21. * The premium for a given family composition is determined by summing the average enrollee premium amount applicable to each family member covered under the plan, considering no more than three covered children under age 21. * The average enrollee premium amount calculated for any individual covered under the plan does not include any rating variation for tobacco use (Under Federal rule, for small group plans, tobacco use factor must be tied to wellness activities defined in Federal rule). The rating variation for tobacco use is determined based on the premium rate that would be applied on a per-member basis with respect to an individual who uses tobacco and then included in the premium charged for that individual. * If a composite premium is chosen by a small employer, an average enrollee premium amount calculated based on applicable enrollment of participants and beneficiaries at the beginning of the plan year does not vary during the plan year with respect to a particular plan, even if the composition of the group changes. The issuer would recalculate the average enrollee premium amount for the group only upon renewal. |  |  |
| **b** | Form filing that addresses composite rating:  Provide the form filing tracking number, document name, and the language that meet the requirements stated above. |  |  |
| **38** | | **Requirements for mitigating inequity in the health insurance market (WAC 284-43-6590):**  If applicable, submit a separate certification detailing the calculation of a fee for excluding any benefit mandated or required by Title 48 RCW or rules adopted by the commissioner. The certification must be signed by a member of the American Academy of Actuaries (MAAA). (see also #20a) |  |  |