2019 (Individual and Small Group) EHB Dental Rate Filing Checklist

## Instructions:

**For each item in Section I, you must provide the response in this document. For each item in Section II, you must provide the rate filing document name, and Section number, page number, or Exhibit number of the document that address the checklist item.** You must submit only one public rate filingfor all individual essential health benefit (EHB) dental plans and one public rate filing for all small group EHB dental plans. You may request a corresponding proprietary rate filing. For more information, see Washington State SERFF Health and Disability Rate Filing General Instructions.

## Response Information:

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| **General Information** | |
| Issuer Name: |  |
| Applicable Market: | *[Enter Individual EHB Dental or Small Group EHB Dental]* |
| Plan Year: | 2019 |

## Section I: Please provide a response for each item.

1. For each plan, list the plan name, HIOS Plan ID, and the Actuarial Value (AV). Explain whether the plan is a stand-alone pediatric dental plan or stand-alone family dental plan (that includes pediatric dental benefits), and marketed inside the Exchange only, outside the Exchange only or both inside and outside the Exchange.

**Response:**

1. For plans marked both inside and outside of the Exchange, the exchange user fee must be spread across the total expected membership. State your membership assumption inside and outside the exchange. If you are marketing only outside the Exchange, state “N/A.”

**Response:**

1. Issuers must set one statewide rate per member per month (PMPM) for a stand-alone pediatric dental EHB plan regardless of the child’s age. State your child rate PMPM and the age limit of a child for the stand-alone pediatric dental EHB plan. If you are not marketing any stand-alone pediatric dental plans, state “N/A.”

**Response:**

1. For family dental plans marketed inside exchange, due to Exchange functionality restriction, issuers must set one statewide rate PMPM for a child who qualifies to receive pediatric dental EHB benefits, and one statewide rate PMPM for an adult. State your rate PMPM for child and adult separately, and the age limit of a child to receive the pediatric dental EHB benefits. If you are not marketing any family plans inside the Exchange, state “N/A.”

**Response:**

1. Indicate your small group dental plans will only be marketed outside the Exchange. If you are not filing small group EHB dental plans, state “N/A.” (The WAHBE Board may certify stand-alone QDPs for plan year 2019 to be offered in the off-Exchange small group market. These plans must include the pediatric dental essential health benefit and must meet all certification criteria applicable to plans offered outside the Exchange.)

**Response:**

1. For each plan, describe whether the plan includes additional non-EHBs and the rate impact PMPM for each additional non-EHB. For family dental plans, the adult dental portion of the rate should be include as non-EHBs.

**Response:**

1. For each plan, describe the annual limit on cost-sharing for the pediatric dental benefits and for the adult dental benefits (if applicable). Note that per 45 CFR § 156.150 (a), for a stand-alone dental plan covering the pediatric dental EHB, cost sharing may not exceed $350 for one covered child and $700 for two or more covered children.

**Response:**

1. Confirm that the Washington premium tax is applied to the entire dental plan.

**Response:**

## Section II: For each item listed in this section, provide the rate filing document name, and Section number, page number, or Exhibit number of the document that addresses the item. For example: See Section III of the “Actuarial Memorandum” and Exhibit 5 of the “Supporting Documentation” file in the proprietary rate filing.

1. Summary for Individual and Small Group Contract Filings under WAC 284-43-6660 and data to support WAC 284-43-6660.
2. Contents of Individual and Small Group Filings under WAC 284-43-6100 and data to support WAC 284-43-6100.
3. A copy of plan summary from the form filing or a summary of the benefits that include a complete cost sharing requirement for all applicable enrollees.
4. A description of EHB benefit components and the model used for the development of each plan’s AV.
5. If applicable, the documentation and justification of geographic rating area factors, including any changes to factors or rating areas, for adult dental benefits.
6. Documentation of how the projected member months were determined and confirm that each plan in the 2019 filing has a projected enrollment.
7. Using the following table format, provide the calculations of the proposed average rate change for this line of business and break out the average rate change by benefit and by experience. For the 2018 plans that will discontinue in 2019, please apply appropriate mapping of membership for purposes of calculating the average rate increase.

Column Heading of the Table:

* 1. 2018 Plan Names. List all 2018 Plan Names and place each 2018 Plan Name in one row.
  2. 2018 HIOS Plan IDs. List all 2018 Plan IDs and place each 2018 Plan ID in one row.
  3. Renewed or Terminated Plan. List whether the 2018 plan is a renewal plan (based on whether the plan has the same HIOS ID) or terminated plan.
  4. 2018 Enrollment. The enrollment by plan as of March 31, 2018.
  5. 2019 Plan Name. The corresponding 2019 Plan Name mapped from the 2018 Plan.
  6. 2019 Plan ID. The corresponding 2019 Plan ID mapped from the 2018 Plan.
  7. Experience Rate Change by Plan. Experience rate change by plan mapped from the 2018 Plan to the 2019 Plan.
  8. Benefit Rate Change by Plan. Benefit rate change by plan mapped from the 2018 Plan to the 2019 Plan.
  9. Overall Average Rate Change by Plan. This is equal to (1+Experience Rate Change)\*(1+ Benefit Rate Change)-1.

Please include the total membership and overall average rate change (weighted by March 2018 enrollment) for this line of business as a separate line item.