2019 Plan Year Small Group Nongrandfathered Health Plan (Pool) 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.

## Response Information:

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| **General Information** |
| Issuer Name: |  |
| Applicable Market: | Small Group Nongrandfathered Health Plans |
| Plan Year: | 2019 |

## Section I:

Please provide a response for each item in Section I.

| **Section I: Table 1** |
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| **Line** | **Task** | **Issuer Response:** |
| **1** | Explain whether you are marketing inside the Exchange only, outside the Exchange only or both inside and outside the Exchange. |  |
| **2** | For Inside the Exchange plans, confirm that you will offer at least one qualified health plan (QHP) in the silver coverage level and at least one QHP in the gold coverage level throughout each service area in which you offer coverage through the Exchange. See 45 CFR §156.200(c)(1). |  |
| **3** | Do you have any bronze health plan under 45 CFR §156.140(c) in which the variation in AV is between +2% and +5%? In other words, do you have any (expanded) bronze plan in which the actuarial value is between 62% and 65%? If yes, describe how each plan meets **one** of the following requirements:1. At least one major services, other than preventive services, is provided before the deductible.
2. The 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).
 |  |
| **4** | For outside the Exchange plans, if you offer a bronze plan, you must also offer at least one silver plan and one gold plan throughout each service area in which you offer a bronze plan (RCW 48.43.700). Confirm that you meet this requirement. |  |
| **5** | For issuers marketing both inside and outside the Exchange, confirm that the Exchange user fees or Exchange assessment fees are spread across the entire market; and submit justification for the PMPM load. There should be a reasonable assumption for the enrollment distribution of the inside and outside enrollees. |  |
| **6** | Do you set your rates based on a quarterly trend? If yes, provide the amount for the approved 2018 quarterly trend and the proposed 2019 quarterly trend. |  |
| **7** | **a** | Do you offer a Tobacco Use factor (i.e. wellness programs/discounts in the small group)? (Yes or No) |  |
| **b** | If your answer is yes to line 7a, state the factor used and whether it is the same as the factor used in the 2018 filing. |  |
| **8** | Provide the geographic rating area factor by service area and by county. See final rule R 2017-11 (WSR 18-17-053) for new geographic rating areas effective on or after January 1, 2019. Note, if Area 1: King County is not your service area, the geographic rating area, of the county with the largest enrollment in the issuer’s service area, must be set at 1.00. If the insurer is new to the Washington state market, the geographic area with the greatest number of counties must be set at 1.00. | **Area Number** | **Area Factor (If applicable)** |
| **1** |  |
| **2** |  |
| **3** |  |
| **4** |  |
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| **6** |  |
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| **8** |  |
| **9** |  |
| **9** | If your service area varies by plan, for each plan, list the plan’s HIOS ID, the plan name, and the service area and county. | See Section I, Table 2 below. |
| **10** | **a** | Do you have any plan with a unique benefit design? |  |
| **b** | **1** | If yes, for each unique plan, provide a brief description why the plan is unique. | See Section I, Table 2 below. |
| **2** | Provide the specific actuarial certification language under 45 CFR §156.135(b)(2) or 45 CFR §156.135(b)(3). | See Checklist #21 |
| **3** | See checklist # 21 in Section II for special requirements for submitting AV screenshots. | See Checklist #21. |
| **11** | For each plan, explain in detail whether the pediatric dental benefits are included as an embedded set of benefits, or through a combination of a health benefit plan and a stand- alone dental plan that includes pediatric dental benefits certified as a qualified dental plan. See WAC 284-43-5702. | See Section I, Table 2 below. |
| **12** | **a** | Provide a description by plan for the non-essential health benefits (EHBs) used for pricing and rate development. | See Section I, Table 2 below. |
| **b** | Rate impact PMPM for each non-EHB. | See Section I, Table 2 below. |
| **13** | **a** | Per WAC 284-43-5640(4)(a)(vii), voluntary termination of pregnancy **may be** included in an issuer's essential health benefits package, but nothing in this section requires an issuer to offer the benefit, consistent with 42 U.S.C. 18023 (b)(1)(A)(i) and 45 CFR. 156.115. This means that issuers are not required to cover voluntary abortion services. However, if issuers decide to cover voluntary abortion services, the abortion services will be part of essential health benefits. In addition, 45 CFR §156.280(e)(4) sets certain requirements for pricing termination of pregnancy. Provide the following questions related to termination of pregnancy. | For each plan listed in the rate filing, indicate whether voluntary termination of pregnancy is a covered service. | See Section I, Table 2 below. |
| **b** | If voluntary termination of pregnancy is covered, indicate the pricing per member per month (PMPM). See 45 CFR §156.280(e)(4). | See Section I, Table 2 below. |
| **c** | Explain in detail that Part I Unified Rate Review Template (URRT) Worksheet 2 is entered appropriately in terms of termination of pregnancy for each plan. See URRT Instructions. |  |
| **14** | Are the renewing plan rate changes consistent among URRT (Worksheet 2), View Rate Review Detail under SERFF Rate/Rule Schedule tab, Part II (Written Description Justifying the Rate Increase), and Uniform Product Modification Justification (UPMJ) Documentation? If not, please explain. |  |
| **15** | Are the financial data in URRT Worksheet 1, Section I, Part II, and WAC 284-43-6660 consistent as of March 2018? If not, please explain. The percentage change in WAC 284-43-6660 should match the calculated overall average rate change in UPMJ Q5; and the Proposed Community Rate should be consistent with the Single Risk Pool Gross Premium Avg. Rate, PMPM in URRT Worksheet 2, Section IV. |  |

| **Section I: Table 2: 2019 Plan Information** |
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| **Table 1 Line Number** |  |  | **8** | **9** | **10** | **11** | **12** |
| **a** | **b** | **a** | **b** | **a** | **b** |
| **HIOS Plan ID** | **Plan Name** | **Metal Level** | **Service Area Number and Counties**  | **Unique Plan Design (Yes/No)** | **Description of unique benefit design** | **Pediatric Dental Embedded (Yes/No)** | **Description of Non-Essential Health Benefits (EHBs)** | **Rate Impact for each Non-EHB** | **Voluntary termination of pregnancy is a covered service. (Yes/No)** | **Indicate the pricing per member per month (PMPM). See 45 CFR §156.280(e)(4).** |
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## 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 address the item. For example: See Section III of the “Part III Actuarial Memorandum” and Exhibit 5 of the “Supporting Documentation” file in the rate filing.

| **Section II: Table 1** |
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| **Line** | **Task** | **Issuer Response:** |
| **Document Name** | **Section / Page / Exhibit Number** |
| **16** | **a** | Completed WAC 284-43-6660 Summary for Individual and Small Group Contract filings, and provide data to support WAC 284-43-6660 without the 3 Rs (Reinsurance, Risk Adjustment and Risk Corridor) information in the 2017, 2016 and 2015 calendar year experience reports listed in Summary of Pooled Experience of WAC 284-43-6660.  |  |  |
| **b** | Create a document or Exhibit called “Summary of Pooled Experience with 3 Rs” using the “Summary of Pooled Experience” table in WAC 284-43-6660 and add the following four separate rows at the end of the table: total credits or payments for Reinsurance, Risk Adjustment, Risk Corridor, and Gain/Loss for the 2017, 2016 and 2015 calendar year experience reports. Provide documentation and justification for all estimated 3 Rs for 2017, 2016, and 2015, and documentation of amounts from the federal Reinsurance and Risk Adjustment Payments Reports. |  |  |
| **17** | In addition to the required information in Part II (Written Description Justifying the Rate Increase), provide the information listed in item 16(b) above in Part II. |  |  |
| **18** | Rate filing file names for Parts I, II, and III of HHS Forms. (Note that these are requirements per RCW 48.02.120 (5) and 45 CFR §154.215. You must follow Part I (URRT) Instructions prescribed by HHS, which include the instructions for Parts I, II and III (Actuarial Memorandum and Certification). |  |  |
| **19** | A description of benefit, cost-sharing, and network used for the development of the rates for each plan. Name the file “Benefit Components.pdf.” Provide a brief description of the type of network, when and where the network information was filed, and whether the plan provides any out-of-network benefits. |  |  |
| **20** | Applicable AV Calculator screenshots in PDF format showing “Calculation Successful.” State the corresponding HIOS Plan ID on each AV Screenshot. For the 2019 AV Calculator and Methodology, see links: <https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html><https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2019-AV-Calculator-Methodology.pdf> |  |  |
| **21** |  | Do you have any plan that is a unique benefit design? If yes, for each unique 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 must provide the exact AV value for the plan:***Special note about AVs for plans that include “Services not Subject to Deductible and without a copay”:*** *Row 68 on the User Guide sheet of the AV Calculator states “Services not Subject to Deductible and without a copay are treated as covered at 100% by the plan until the deductible is met through enrollee payments for other services.” When this occurs AV Calculator 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. However, the exact difference is unknown without using an effective copay to approximate the coinsurance in the deductible range, which requires a unique benefit design. If your plans include this type of cost-sharing design, you will be required to show that their AVs are within the acceptable metal level range using unique benefit designs.* |  |  |
| **a** | If you use 45 CFR §156.135(b)(2), you must provide the required actuarial certification and language and provide justification and detailed calculations how you estimate a fit of the plan design into the parameters of the AV Calculator. In this case, you must submit one AV screenshot for each plan to show that the benefit design after the fit is a legal metal plan. You must also provide the required certification and language stated in 45 CFR §156.135(b)(2). |  |  |
| **b** | If you use 45 CFR §156.135(b)(3), you must provide the required actuarial certification and provide justification and detailed calculations how you use the AV Calculator to determine the AV **for the plan provisions** that fit within the calculator parameters. You may provide two or more AV screenshots, which must include one extreme high and one extreme low based on the plan provisions. You must explain how the methodologies and appropriate adjustments are used to develop the EXACT AV for this plan based on the multiple AV screenshots provided. You must also provide the required certification and language stated in 45 CFR §156.135(b)(3). |  |  |
| **22** | Documentation and justification of Tobacco Use factor (i.e. wellness programs/discounts in the small group). Unless you are a new issuer in 2019, you must also describe how the factor has changed from the 2018 filing to the 2019 filing. If the factor has changed, include justification for and documentation of the 2019 factors.  |  |  |
| **23** | Documentation and justification of Geographic Rating Area factor. Unless you are a new issuer in 2019, you must also include a table showing each region’s factor in the 2019 filing compared to that of the 2018 filing. You must provide justification for and documentation of the 2019 factors showing that the following health-status related factor are not used to establish a rating factor for a geographic rating area.(i) Health status of enrollees or the population in an area;(ii) Medical condition of enrollees or the population in an area,including both physical and mental illnesses;(iii) Claims experience;(iv) Health services utilization in the area;(v) Medical history of enrollees or the population in an area;(vi) Genetic information of enrollees or the population in anarea;(vii) Disability status of enrollees or the population in anarea;(viii) Other evidence of insurability applicable in the area.See final rule R 2017-11 (WSR18-07-053) for new geographic rating areas effective on or after January 1, 2019.  |  |  |
| **24** | An illustrative example and rule of how your rating factors are applied, including a statement stating that rates are charged to no more than the three **oldest** covered children under 21 for a family coverage (45 CFR §147.102 (c)(1)). |  |  |
| **25** | For each plan, explain in detail and provide justification whether the premium rate for the plan varies from the market wide index rate for the following factors:1. The actuarial value (AV) and cost-sharing design of the plan.
2. The plan’s provider network and delivery system characteristics, and utilization management practices.
3. Plan benefits in addition to the essential health benefits.
4. Administrative costs, excluding Exchange user fees.

You must also provide a table that summarizes the above factors for each plan, and show the projected membership by plan and the weighted average factors for the risk pool. |  |  |
| **26** | For each plan that is a renewal plan in 2019, provide a table that summarizes the items listed above (#25) in your 2019 filing and in the 2018 filing. For a change to any factor, explain the reason for the change and documentation of the proposed 2019 value.In particular, for a change to each network factor, explain in detail how the previous factor was established noting what network is represented by a factor of 1.000 and whether the network factors reflect efficiency, fee schedule, fee for service or bundled payments, whether the factors are derived using projected 2019 data or current/historical data. Please state the adjustment made to URRT Section II to show the impact of the networks compared to the experience period.State whether the company’s provider compensation includes bonuses in addition to other payments. If it does, explain how the anticipated payment was determined and where in URRT it has been included. |  |  |
| **27** | For the “Company Rate Information” and “View Rate Review Detail” under Rate/Rule Schedule tab of SERFF rate filing, provide an explanation or the source of the information listed in each section. The information should represent your **initial requested rate change**. 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 the Rate Filing Instructions.Company Rate Information1. The number of policy holders is the number of groups, as of March 2018.
2. The minimum and maximum % change should match the initial Uniform Product Modification Justification (UPMJ) Q5.

Rate Review Detail* 1. The number of covered lives (members) as of March 2018;
	2. Requested Rate Change Information:
		+ Member months for the 2017 experience period;
		+ Min, Max, and weighted average rate change matching the initial UPMJ Q5;
	3. Prior Rate:
		+ Projected earned premiums and incurred claims for 2018;
		+ Minimum and maximum per member per month (PMPM) should be consistent with the rates in the 2018 final Rate Schedule;
		+ Weighted average PMPM should be consistent with requested PMPM and average rate change;
	4. Requested Rate:
		+ Projected earned premiums and incurred claims for 2019;
		+ Minimum and maximum PMPM from initial 2019 Rate Schedule;
		+ Initial weighted average PMPM rate consistent with URRT Worksheet 1;
	5. Indicate that your trend factor is an annual trend factor.

Please note, since ACA requires that all non-grandfathered individual and small group health plans must be guaranteed issued, the Affected Forms for Closed Blocks” in the Forms Section should be N/A. (Note: Post-submission updates must include a list of changes and justification for the changes.) |  |  |
| **28** | The methodology, justification, and calculations used to determine the impacts of changes stated in the Effective Rate Review Program under 45 CFR § 154.301(a)(4) which includes contribution to surplus, contingency charges, or risk charges included in the proposed rates In addition, if you change the contribution to surplus from the prior submission, Part III Actuarial Memorandum and Certification Instructions states that, to the extent that the target as a percent of premium has changed from the prior submission, provide additional support for why the change is warranted. |  |  |
| **29** | Risk Adjustment: The 2019 per capita risk adjustment user fee is $1.80 per enrollee per year, or $0.15 PMPM. See Final 2019 HHS Notice of Benefit & Payment Parameters. (Note that Part I Unified Rate Review Template (URRT) Instructions state that risk adjustment user fees should be reflected in “Projected Risk Adjustments,” and not in the Taxes & Fees.). |  |  |
| **30** | **a** | For information related to risk adjustment data, provide a table showing the following summary transfer formula elements by state, by your own risk pool specific information, and by metal plan from the HHS interim public summary report in March 2018, or other comparable report. The information should include the Plan Liability and Allowable Rating Components used in the denominator of the Risk Transfer Formula:1. billable member months;
2. average plan liability risk score (PLRS);
3. average allowable rating factor (ARF);
4. average actuarial value (AV);
5. average induced demand factor (IDF); and
6. geographic cost factor (GCF).
 |  |  |
| **b** | Provide 2019 projected risk adjustment data, similar to the data in part (a), used to project your 2019 Risk Adjustment. Also include the projected 2019 State Average Premium. For each metal level of the projected risk adjustment data, provide the 2019 projection broken down by:1. 2017 members projected to persist into 2019;
2. new 2018 members, as of March 2018, projected to persist into 2019;
3. new members projected in 2019; and
4. total 2019 projected membership outcomes.
 |  |  |
| **c** | Explain in detail in Part III how you developed the estimated 2019 risk adjustment revenues, including the four groupings in (b). (Also see Instructions in URRT regarding the requirements to provide detailed information and justification for risk adjustment). Provide detailed support, and a description of the rationale for each assumption, stating the most current data used, its “as of” date, and its source (internal, CMS, etc.).We expect that the applicable transfer value parameters projected for own risk pool will be consistent with the assumptions in the rate development (e.g. Population and Other factors in URRT, age and area calibration, etc.). |  |  |
| **31** | Documentation and Justification for URRT Worksheet 1 (Market Experience), Section I: Experience period data should be updated and include IBNR estimate for claims based on runoff through March 2018 or later. |  |  |
| **32** | Documentation and Justification for URRT Worksheet 1, Section II: Allowed Claims, PMPM basis. Provide detailed explanation and support for actuarial assumptions underlying each factor used in the section. |  |  |
| **33** | Documentation and Justification for URRT Worksheet 1, Section III: Projected Experience. You must provide the support for all the assumptions made leading to the calculation of the Single Risk Pool Gross Premium Avg. Rate, PMPM. |  |  |
| **34** | For each factor applied in Sections II and III (#32 and #33 above), provide a table comparing the 2019 value with the 2018 Value. As an example, Rx Average Cost/Service factors assumed for 2019 compared to 2018. A second example would be Paid to Allowed Factor for 2019 compared to 2018. |  |  |
| **35** | Documentation and Justification for URRT Worksheet 2: Plan Mapping Instructions for a discontinued plan per the following guidance:1. For the inside Exchange plan, follow the mapping information you (the issuer) provided to WAHBE and as required by 45 CFR § 155.335(j).
2. For the outside Exchange plan, follow your procedure as indicated in the letter provided to the policyholder and consistent with Uniform Product Modification Justification.
 |  |  |
| **36** | Documentation and Justification for URRT Worksheet 2 (Plan Product Information), Section I: General Product and Plan Information. |  |  |
| **37** | Documentation and Justification for URRT Worksheet 2 (Plan Product Information), Section II: Components of Overall Premium Increase. The rate change for plans with a one-to-one mapping, must match the rate change in the UPMJ. Provide the calculation of the rate increase for plans involving the mapping of multiple plans under a single plan, from the individual plan rate changes in the UPMJ. |  |  |
| **38** | Documentation and Justification for URRT Worksheet 2 (Plan Product Information), Section III: Experience Period Information estimated as of March 2018. |  |  |
| **39** | Documentation and Justification for URRT Worksheet 2 (Plan Product Information), Section IV: Projected (12 months following effective date). |  |  |
| **40** | 1. Step-by-Step documentation of the build-up and Justification for the following items:
	1. Index Rate;
	2. Market Adjusted Index Rate (MAIR);
	3. Plan Adjusted Index Rate (PAIR);
	4. Age Curve Calibration;
	5. Geographic Calibration, including any changes to the insurer’s service area;
	6. Tobacco Calibration; and
	7. Base Premium Rate (BPR) by plan (rate with 1.00 factor for age, area and tobacco).
 |  |  |
| **41** | Provide a table showing the comparison of the filed 2018 and 2019 calibration factors for age, area and tobacco. |  |  |
| **42** | Documentation of how the projected member months were determined and confirm that each plan in the 2019 filing has a projected enrollment. |  |  |
| **43** | For Silver level plans inside the Exchange, describe the methodology used to estimate the portion of projected enrollment that will be eligible for cost sharing reduction subsidies at each subsidy level. State the resulting projected enrollment by plan and subsidy level. |  |  |
| **44** | Removal of all Health Insurance Provider fees. Your rate development should not include any allowance of Health Insurance Provider fees. The Fee is part of administrative costs for health insurance plans. Because the Fee is not being collected for the 2019 fee year, administrative costs for plans in all impacted markets are expected to be adjusted appropriately to account for the moratorium. With regard to single risk pool filings in the individual and small group markets, administrative costs are one of the permissible plan-level adjustments to the index rate. It is expected that the 2019 plan adjusted index rate will be adjusted downward to account for the moratorium of the Fee where appropriate. For more information, see FAQs published by HHS: <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL_9010_FAQ_2-29-16.pdf> |  |  |
| **45** | Actuarial certification and language as prescribed in the Part III Actuarial Memorandum Instructions. |  |  |
| **46** | **As a separate document**, provide detailed information listing all commission payment schedules for this block of business for plan year 2019 from an officer of your company who is in charge of implementing the commission schedule. The officer must also sign and certify that to the best of his or her knowledge, the information provided includes all proposed commission schedules for this block of business for the 2019 plan year. | **Commission Information and Officer Certification** | **Commission Information and Officer Certification** |

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| **47** |  | For each plan, explain in detail whether composite premium setting under 45 CFR §147.102(c)(3) is an available choice for small employers. If yes, provide the following information: |  |  |
| **a** | Include an illustrative example as a separate document in the Rate/Rule Schedule tab and name the file “Illustrative Example for Composite Rating.” You must show how you calculate a two-tiered only composite premium structure for a small employer and satisfy 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, taking into account 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** | Provide the form filing tracking number, document name, and the language that meet the requirements stated above. |  |  |