2022 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, and Section number, page number, or Exhibit number of the document that addresses each checklist item.

Excel spreadsheet submissions must be filed with a PDF that includes all the information from the spreadsheet, including all hidden cells and worksheets, and all font colors must be visible. The file names must match except that the Excel spreadsheet name should end with “duplicate”. Keep any internal links and formulas, and break all external links. Ensure your rate development exhibits include formulas that show how the inputs and assumptions flow through the workbook and rating methodology to the final projected premium base rates; note this is important to facilitate review and ensure consistency in the rate development. Please review PDFs for completeness and readability.

## Section I – General Information:

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

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

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

##### Exchange Only Outside Only Both Inside and Outside Exchange

1. **We will offer the following plan designs:** (Check all boxes that apply.)

At least one silver plan and one gold plan throughout each service area 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 #15 below.

New plans have been added and we confirm that no previously-retired Plan IDs have been reused in this rate filing. Note 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, what causes this plan to be a UBD? If no, N/A.** |
|  |  |  |  |  |  |
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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%?**

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 a

(1) High Deductible Health Plan or

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

The expanded bronze plans are summarized in the following table.

Note: Only one major service needs to be listed 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 2021?**

No

Yes, we are making the following changes:

|  |  |  |
| --- | --- | --- |
| **Geographic Rating Area** | **Additional Counties Covered** | **Reduction of Counties Covered** |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |
| 6 |  |  |
| 7 |  |  |
| 8 |  |  |
| 9 |  |  |

1. **Network Information:**

|  |  |  |
| --- | --- | --- |
| **Network Name** | **Type** | **Date Filed** |
|  |  |  |
|  |  |  |

1. **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.

Name the Part I PDF file “Part I Unified Rate Review Template” and the corresponding Excel file “Part I Unified Rate Review Template Duplicate.xlsx.”

Name the Part II PDF file “Part II Written Description Justifying the Rate Increase.”

Name the Part III PDF file “Part III Rate Filing Documentation and Actuarial Memorandum.”

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

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 “Part III Rate Filing Documentation and Actuarial Memorandum” and Exhibit 5 of the “Supporting Documentation” file in the rate filing.

| **Line** | | | **Task** | **Issuer Response:** | |
| --- | --- | --- | --- | --- | --- |
| **Document Name** | **Section / Page / Exhibit Number** |
| **EXPERIENCE PERIOD DATA** | | | | | |
| **1** | |  | Include the complete experience for all 2020 small group plans.  Note that prescription drug claim information should be net of rebates received from drug manufacturers; please document in the Part III Actuarial Memorandum where and how this is addressed. |  |  |
| **a** | Are the financial data in URRT Worksheet 1, Section I and the WAC 284-43-6660 summary consistent as of March 2021? If not, please explain. |  |  |
| **b** | In support of the information provided in URRT Worksheet 1, Section I, provide the 2020 Allowed and Incurred Claims   * By Month of Incurral and Month of Payment, * Separately for Medical and Rx, and * Paid through March 2021   Also state the estimated payable or recovery (reinsurance, overpayments, rebates, and other) amounts as of March 2021 for Medical and Rx.  Note: Risk adjustment does not need to be listed by month. |  |  |
| **c** | Consistent with 1.b above, provide the following additional information in support of URRT Worksheet 1, Section II and the WAC 284-43-6660 summary.   1. The 2020 allowed claims by month by EHB benefit category from URRT Worksheet 1, Section II plus an additional category/(ies) for the non-EHBs. 2. Adjustments for the beginning (i.e. previous year’s 3/31) claim reserves and current year’s 3/31 ending claims reserves in order to calculate the total incurred claims by category. 3. The calculation of the incurred claims PMPM by category. 4. A paid-to-allowed factor by category used to calculate the allowed claims PMPM for each category.   Additionally, please explain if the EHB allowed claims were obtained from the claims records or imputed from paid claims. |  |  |
|  | | **d** | Provide documentation explaining how the company analyzed the actual and projected experience (for 2020) per 45 CFR §154.301(a)(3)(ii). Ensure your response identifies significant findings, and material changes (rating methodology and assumptions) resulting from the analysis. |  |  |
| **2** | | | If you use a credibility-blended estimate, explain the process in detail, per guidance in URR Instructions 4.4.3.3, for establishment of the Manual EHB Allowed Claims PMPM for WA and 4.4.3.4 for establishment of the credibility percentage for URRT Worksheet 1, Section II.   1. Explain the relevance of the data that was used to determine the Manual EHB Allowed Claims PMPM and any adjustments made to the data. 2. Describe the credibility methodology and assumptions used per ASOP 25. Identify the actuarially sound and appropriate credibility procedure used to develop your credibility estimate and the corresponding threshold for full credibility. Show the credibility estimate calculation in your rate development using the credibility procedure. |  |  |
| **3** | **a** | | Complete the WAC 284-43-6660 summary for Individual and Small Group Contract filings and data to support WAC 284-43-6660 without adjustments for Risk Adjustment and High-Cost Risk Pool (HCRP) transfers and assessments. |  |  |
| **b** | | 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, for the 2020, 2019 and 2018 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. Total commercial reinsurance reimbursements received and expected; 5. Adjusted Gain/Loss; 6. Total anticipated MLR rebates; 7. If necessary, also list any subsequent adjustments for prior years according to when the payments were received. Document the amount and incurred year for each adjustment. For example, if a Risk Adjustment amount was received or paid in 2020 for a prior period at an amount other than the amount in item (i), it should be listed as a separate adjustment to the 2020 experience.   Provide documentation and justification for all amounts estimated for 2020, 2019, and 2018 as well as for the final federal Risk Adjustment Payments Reports for each year. Note: Since the Federal Reinsurance and Risk Corridor programs ended in 2016, they should no longer be included in the table of adjustments.  Include a copy of this table in the Part II Written Description. |  |  |
|  | **c** | | Provide an exhibit showing separately the 2020, 2019 and 2018 calendar years’ experience expenses PMPMs broken down by administrative costs, commissions and taxes & fees compared to the 2020, 2019 and 2018 expense loads applied in the development of the rates. |  |  |
| **4** | | | Provide documentation and justification for URRT Worksheet 2, Section II: Experience Period and Current Plan Level Information. Include justification for the allocated amounts by plan, and explain any differences between the URRT Worksheet 2, Section II totals and the amounts in URRT Worksheet 1, Section I. |  |  |
| **TREND FACTORS** | | | | | |
| **5** | **a** | | Allowed Claims Trend (EHB)  Provide observed rolling average six-month and twelve-month allowed claims PMPM for 2018 through 2020 and calculate rolling twelve month trends for both PMPMs using the experience of all WA members; show utilization and unit cost outcomes separately, if available. Include the information by EHB category, or combination of categories, in support of the factors in URRT Worksheet 1, Section II.  Also provide the following 2018, 2019 and 2020 experience alongside 2022 projections Utilization/1,000 and Unit Cost for each EHB category shown on URRT Worksheet 1. |  |  |
| **b** | | 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 the adjustments made to the data. Note, your response should address how your estimate reflects Washington State trends. 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 2022 as well as how much of the projected reimbursement trend is already locked in for plan year 2022. Explain any significant provider reimbursement terms expected to remain outstanding. |  |  |
| **c** | | Explain how you separated expected utilization changes due to changes in average health status of the population (aka morbidity) versus 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** | **a** | | Incurred Claims Trend (EHB)  Provide documentation and justification for the leveraging factor applied to the EHB allowed claims trend amounts by category in item 5 above, and the calculation of the incurred claims trend. Document the WAC 284-43-6660 summary category that the EHB trends are applied to. |  |  |
| **b** | | Incurred Claims Trend (non-EHB)  Provide documentation and justification for the incurred claims trend for the non-EHB benefit(s). Document the WAC 284-43-6660 summary category that the non-EHB trends are applied to. |  |  |
| **c** | | Show the calculation of the incurred claims trend by category for the WAC 284-43-6660 summary using the weighted-product of the EHB trend (6a) and the non-EHB trend (6b). |  |  |
| **OTHER ADJUSTMENT FACTORS AND LOADS** | | | | | |
| **7** | | | Provide detailed explanation and support for actuarial assumptions underlying each of the non-trend factors used in URRT Worksheet 1, Section II. 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. |  |  |
| **8** | | | 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 2022 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/Draft-2022-AV-Calculator-Methodology.pdf](https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2021-AV-Calculator-Methodology.pdf)  Metal Levels  Platinum – 90%, range -4/+2%.  Gold – 80%, range -4/+2%.  Silver – 70%, range -4/+2%.  Bronze – 60%, range -4/+5% including Expanded Bronze (-4/+2% if not expanded). |  |  |
| **9** |  | | 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 must 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 exhibits; you should include enough detail for the reviewer to determine whether the methods and assumptions are appropriate and the results are reasonable. Note that you must provide justification for AVs when actual plan designs deviate from the AVC’s functionality, even if the actuary assumes the impact of the differences is immaterial to the AVC.  **Notes About Plan Designs**  *Plans that include Coinsurance During the Deductible Phase or otherwise described as “Services not Subject to Deductible and without a copay”:*Excel row 72 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 187 and 188 for additional information.  *Plans that include “Services not Subject to Deductible and with a copay”:* When a plan design has a covered service that is not subject to deductible but requires a copay, the AVC requires the copay to count toward the deductible in order not to be a “unique benefit design.” If a copay does not count toward the deductible, then it must be considered a “unique benefit design.”  *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 document the cost-share variations in the Benefit Components document and account for the differences between the plan design and the AVC functionality in your AV calculations. For example, if a plan design includes different cost-shares for MHSUD office visits and MHSUD outpatient non-office visits, the AVC only accepts one cost-share structure, so the plan design does not align with standard use of the AVC. |  |  |
| **a** | | If using the 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 method in 45 CFR §156.135(b)(3), provide the required actuarial certification language as well as justification and detailed calculations of (1) how the AVC was used to determine the AV Metal Value for the plan provisions that fit within the calculator parameters while (2) appropriate adjustments were made to the AVC output(s) for plan design features that deviate substantially from the parameters of the AVC. Submit two or more AVC screenshots including at least one extreme high AV and one extreme low AV based on inputs similar to the plan provisions. Explain how adjustments are made to develop the EXACT final AV Metal Value for each plan using the provided AVC screenshots. |  |  |
| **c** | | Include a completed Unique Plan Design Supporting Documentation and Justification form which can be found on the CMS website. |  |  |
| **10** |  | | Geographic Rating Area and Geographic Calibration Factors. |  |  |
| **a** | | Provide documentation and justification for the 2022 factors including certification that the following items were not used to establish any geographic rating area factor. Note: if your service area is limited to a single area, no geographic rating area analysis needs to be submitted because that area factor is always 1.0000.   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.   Additionally, demonstrate that your geographic rating area factors comply with WAC 284-43-6681 ratio requirements.  Unless you are a new issuer in plan year 2022, include a table comparing each region’s factor in the 2022 filing versus that of the 2021 filing. If the factors have not changed, indicate when the area factors were last evaluated and the experience period of the data used in the evaluation.  Provide the geographic rating area factors as requested in URRT Worksheet 3. See WAC 284-43-6701 for geographic rating areas effective on or after January 1, 2019.  Note, 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. |  |  |
| **b** | | Provide the calculation of the geographic calibration factor. |  |  |
| **c** | | Compare the 2022 area factors and the calibration factor with the 2019, 2020 and 2021 factors. |  |  |
| **11** |  | | Tobacco (Wellness) Use and Tobacco (Wellness) Calibration Factors. |  |  |
| **a** | | Provide documentation and justification for the 2022 Tobacco Use (Wellness Discount) factor. If the factor has not changed, indicate when the factor was last evaluated and the experience period of the data used in the evaluation. |  |  |
| **b** | | Provide the calculation of the tobacco (wellness) calibration factor. Note: each calibration factor (area, age, or tobacco) must be calculated independently. |  |  |
| **c** | | Compare the 2022 tobacco (wellness) factor and the calibration factor with the 2019, 2020 and 2021 factors. |  |  |
| **12** |  | | Age and Age Calibration Factors. |  |  |
| **a** | | Provide the calculation of the age calibration factor. |  |  |
| **b** | | Compare the 2022 age calibration factor with the 2019, 2020 and 2021 factors. |  |  |
| **c** | | Provide actuarial justification for the methodology employed in the calculation of the average age. |  |  |
| **13** |  | | AV and Cost Sharing Design of Plan (Pricing AV) Factors.  Provide documentation and justification for the factors including the (a) through (c) component pieces below.  Note: In order to comply with the single risk pool requirement, the induced demand and paid-to-allowed components should not be based on the actual or projected utilization of the projected membership. |  |  |
| **a** | | EHB paid-to-allowed factor. This component in aggregate should match the paid-to-allowed factor used to determine the risk adjustment on an allowed basis in URRT Worksheet 1, Section II. If you have commercial or other (e.g. internal) reinsurance/pooling agreement, include the projected recoverable amount in the paid-to-allowed factor. |  |  |
| **b** | | Induced demand factor. Include a discussion clarifying how the IDF by metal type/plan were determined. Calculate the product of the EHB paid-to-allowed factor and the induced demand factor by plan. Then normalize the resulting product such that the weighted average matches the weighted average of the EHB paid-to-allowed factors. |  |  |
| **c** | | Calculate the difference between the 1.0000 premium rates (age factor 1.0000 such as for age 21; tobacco (wellness discount) factor 1.0000; and area factor 1.0000) for each plan and the Calibrated Plan Adjusted Index Rate (CPAIR) amounts in URRT Worksheet 2, field 3.14. The differences should be within a few cents. |  |  |
| **d** | | Compare the AV Metal Value, Metallic AV calculator IDF x Paid to Allowed factor versus the Pricing AV. Normalize the AV Metal Values, adjusted pricing AV, and the Pricing AVs to the plan with the highest AV Metal Value plan and calculate the difference as the Pricing AV minus the AV Metal Value. Justify and explain in detail Pricing AV plan relativities that vary from the AV Metal Value plan relativities. |  |  |
| **e** | | Include a table that shows the 2020 Paid (Incurred) to Allowed Claims ratio experience by metal level. |  |  |
| **14** | | | Provider Network Adjustment Factors.  Provide documentation and justification for these factors. Note that they should be normalized to 1.0000 when weighted by the projected membership by plan. |  |  |
| **15** | | | Benefits in Addition to EHB Factors.  Provide documentation and justification for these factors. Note that they should be developed as loads on EHB incurred claims. |  |  |
| **16** | **a** | | Quarterly Trend Factors.  Provide documentation and justification of the quarterly trend factors. |  |  |
| **b** | | Compare the 2022 quarterly trend factors with the 2019, 2020 and 2021 factors. |  |  |
| **RISK ADJUSTMENT AND HIGH COST RISK POOL (HCRP)** | | | | | |
| **17** | **a** | | For information related to 2020 risk adjustment data, provide an Excel file table showing the following summary transfer formula elements by state, your own risk pool specific information, and metal (and catastrophic) level from the HHS interim public summary report in March 2021, or other comparable report. The information should also include the Plan Liability and Allowable Rating Components used in the denominator of the Risk Transfer Formula and the Statewide Average Premium assumed:   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. Average geographic cost factor (GCF).   Using formulae, please show the 2020 PMPM risk adjustment transfer amount using the information above. Additionally, please show the 2020 HCRP assessments and receipts.  NOTE: 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** | | Provide 2022 projected risk adjustment data, similar to the data in part (a), used to project your 2022 Risk Adjustment. Submit the projected 2022 Statewide Average Premium, including the 2021 and 2022 trend amounts applied to the 2020 PMPM. **For each metal level** of the projected risk adjustment data, provide the 2022 projection broken down by:   1. 2020 members projected to persist into 2022; 2. New 2021 members, as of March 2021, projected to persist into 2022; 3. New members projected in 2022; and 4. Total 2022 projected membership outcomes. |  |  |
| **c** | | Explain in detail in Part III how you developed the estimated 2022 risk adjustment factors (PLRS, IDF, GCF, AV, and ARF), including the four membership groupings in (b). (Also 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 (internal, CMS, etc.). State whether your projection is based on the 2022 calibrated model; if not, what assumption has been made for the impact from the new 2022 model?  We expect that the applicable transfer value parameters projected for your 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.). Please explain any deviations. |  |  |
| **d** | | Explain in Part III any impacts due to Risk Adjustment Data Validation (RADV). For example, explain any impact to the company or statewide 2022 PLRS projections due to the 2018 RADV report. |  |  |
| **18** | | | Provide both the 2020 HCRP payment and assessment amounts as well as documentation and justification for the separate 2022 projected amounts. |  |  |
| **19** | | | Using formulae, please show the total 2022 projected risk adjustment plus HCRP payment and assessment on an incurred and allowed basis as well as on an incurred basis by plan in support of the amounts listed in URRT Worksheet 1, Section II and Worksheet 2, Section IV. The risk adjustment projections by plan should be consistent with the metal level risk PMPM projections, for the risk transfer portion of the amounts entered. |  |  |
| **RETENTION LOADS** | | | | | |
| **20** | **a** | | Administrative Costs.  Provide justification for the 2022 PMPM or percent of premium load for each category. Include the actual 2020 PMPM or percent of premium experience amounts. At a minimum, the detailed administrative expense categories should include quality improvement (QI) expense, commissions, commercial reinsurance premium and/or anticipated investment income, if applicable, and general administrative expenses.  Note that the commission load should be consistent with the commission certification (see #38 below). The load may include adjustments for bonuses which are not specific to the individual line of business and, therefore, not covered in the certification. |  |  |
| **b** | | Include a table comparing the 2021 and 2022 PMPM and percent of premium loads for each administrative cost and the total administrative cost load. 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. |  |  |
| **21** | **a** | | Taxes and Fees.  Provide justification for the PMPM or percent of premium load for each category. At a minimum, the detailed taxes and fees categories should include:   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; 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 available at wship.org as well as the WSHIP information separately sent to you as a member plan; 5. Regulatory Surcharge [RCW 48.02.190]; 6. Insurance Fraud Surcharge [RCW 48.02.190]; 7. Risk Adjustment user fee. The 2022 per capita risk adjustment user fee is $3.00 per enrollee per year, or $0.25 PMPM. See Final 2022 HHS Notice of Benefit & Payment Parameters.   For any category with a $0.00 load, include an explanation and justification in the actuarial memorandum. |  |  |
| **b** | | Include a table comparing the 2021 and 2022 PMPM and percent of premium loads for each individual tax and fee and the total load for taxes and fees. 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. |  |  |
| **22** | **a** | | Profit & Risk load is the portion of the projected earned premium that is not directly associated with claims or expenses. The percent of premium for the Profit & Risk load must be the same across all plans. |  |  |
| **b** | | Include a table comparing the 2021 and 2022 premium PMPM and percent of premium loads applied in URRT Worksheet 2, field 3.8. |  |  |
| **23** | | | 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. Submit justification for the PMPM load and the percentage load entered in URRT Worksheet 1, Section II. There should be a reasonable assumption for the enrollment distribution of the inside and outside enrollees. If any Exchange membership is projected for plan year 2022, please check that a nonzero amount flows through to URRT Worksheet 1 Exchange User Fees. | **N/A** | **Note: Per Washington Health Benefit Exchange (WAHBE), there will be no Exchange SHOP plans for small groups for plan year 2022.** |
| **DOCUMENTATION AND EXHIBITS** | | | | | |
| **24** | | | Include an exhibit showing the calculated rate changes by category entered in UPMJ Q5, which are consistent with the benefit and cost-share changes in UPMJ Q4a and Q4b. Note: it is acceptable to back into the experience adjustments from the total rate change, based on the final average premium rates.  Explain any large variations in the experience change by plan. Our expectation is that there should be low variability for the experience change due to the single risk pool requirement. |  |  |
| **25** |  | | 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. If post submission updates are necessary to correct the information, update the exhibit to indicate what was updated and the reason for the update.  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. |  |  |
| **a** | | Company Rate Information: Provide the calculation, explanation, and/or source of the information.   1. The number of policy holders affected is the number of subscribers as of March 2021. 2. The minimum and maximum % changes should come from the initial Uniform Product Modification Justification (UPMJ) Q5. 3. The overall % rate impact should match the calculated overall average rate change in UPMJ Q5. |  |  |
| **b** | | Rate Review Detail (RRD): Provide the calculation, explanation, and/or source of the information.   * 1. The number of covered lives (members) as of March 2021. If applicable, document the renewing products which list current lives, and new products which list projected lives (see instructions in the RRD in SERFF);   2. Requested Rate Change Information:      1. Member months for the 2020 experience period;      2. Min, Max, and weighted average rate change matching the initial UPMJ Q5;   3. Prior Rate:      1. Projected earned premiums and incurred claims for 2021;      2. Minimum and maximum per member per month (PMPM) should be consistent with the rates in the 2021 final Rate Schedule;      3. Weighted average PMPM should be consistent with requested 2021 PMPM and average rate change;   4. Requested Rate:      1. Projected earned premiums and incurred claims for 2022;      2. Minimum and maximum PMPM from initial 2022 Rate Schedule;      3. Initial weighted average PMPM premium rate consistent with URRT Worksheet 2;   5. Annual incurred claims trend factor, including leveraging, which matches the weighted average of the trends by category in the WAC 284-43-6660 summary.   Please 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 “N/A”. |  |  |
|  | **c** | | Compare the 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 3/31/2021; 4. Part III supporting exhibits.   Explain any inconsistencies. |  |  |
|  | **d** | | Compare the 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; 4. Part III supporting exhibits.   Explain any inconsistencies. |  |  |
| **26** | | | 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, Part III Actuarial Memorandum and Certification Instructions state that, to the extent that the target as a percent of premium has changed 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. |  |  |
| (i) The impact of medical trend *changes* by major service categories. |  |  |
| (ii) The impact of utilization *changes* by major service categories. |  |  |
| (iii) The impact of cost-sharing *changes* by major service categories, including actuarial values. |  |  |
| (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. |  |  |
| (viii) The impact of *changes in* administrative costs related to programs that improve health care quality. |  |  |
| (ix) The impact of *changes in* other administrative costs. |  |  |
| (x) The impact of *changes in* applicable taxes, licensing or regulatory fees. |  |  |
| (xi) Medical loss ratio (MLR). Include a projected federal MLR calculation [45 CFR §158.221; also see CMS MLR Filing Instructions for Contract Year 2019].  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   1. How the total amount is allocated to the lines of business (individual, small group, and large group); and 2. The impact, if any, of the CBE limitation of the highest of either: 3. Three percent of earned premium; or 4. 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.   Include commentary about how the following 2022 MLR reporting year regulation changes were considered [see also the 2021 CMS Notice of Benefit and Payment Parameters]:   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; 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; 3. Report expenses for services outsourced to or provided by other entities in the same manner as expenses for non-outsourced services; and 4. Allowance to report certain wellness incentives as quality improvement activities in the individual market. |  |  |
| (xii) The health insurance issuer's capital and surplus. Note: This is the only item not written in terms of the impact of changes. It appears to mean the impact, if any, on the rate increase due to your current capital and surplus levels. For example, if any adjustment is needed for your premium to surplus ratio. |  |  |
| (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 and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act. |  |  |
| **27** | | | Per new 45 CFR §156.130(h)(2), for plan years beginning on or after January 1, 2021, 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.  Indicate if you are implementing this option and, if so, include in your rate development the documentation and justification for the impact. |  |  |
| **28** |  | | **Financial Statement Analysis** |  |  |
| **a** | | For HMOs and HCSCs, provide an exhibit showing the 2020 Additional Data Statement (ADS) outcomes including total revenues (line 7), total hospital and medical claims (line 17), and administrative expenses (line 19 + line 20); also show each specific adjustment leading to the amounts listed in this rate filing. For ease of reference, please also include a copy of the ADS pages.  Please reconcile the differences between the amounts shown in the ADS and the earned premium, incurred claims, and expenses listed 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; 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 2020 experience period with the average monthly membership calculated from the quarter ending enrollment listed in the ADS. Explain any significant differences. |  |  |
| **b** | | For all issuers, please provide a calculation of your company’s Months of Surplus based on the information in the 2020 annual statement using 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. |  |  |
| **c** | | Provide an explanation and justification for the Profit & Risk load.  Note that Profit & Risk load is the portion of the projected earned premium that is not directly associated with claims or expenses. The percent of premium for the Profit & Risk load must be the same across all plans.   1. List the percentage of Profit & Risk load in the 2021 Plan Year (PY) filing. 2. List the percentage of your proposed Profit & Risk load in the 2022 PY filing. 3. Discuss in detail why you believe your proposed 2022 PY Profit & Risk load is reasonable. 4. Clarify whether your experience unpaid claims liability estimate also includes any margin or if the estimate reflects your best estimate. Also explain whether other plan year 2022 rating assumptions include their own margin provisions. |  |  |
| **29** | | | For Exchange filings, include documentation and calculation of the pricing per member per month (PMPM) for voluntary abortion services and the percent EHB listed in the binder filing. See 45 CFR §156.280(e)(4). See QHP Application Instructions for EHB Percent of Total Premium calculation guidance. | **N/A** | **Note: Per Washington Health Benefit Exchange (WAHBE), there will be no Exchange SHOP plans for small groups for plan year 2022.** |
| **30** |  | | Rating Examples.  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 in items (a) and (b) below.  Submit all of the examples in a single document on the Rate/Rule Schedule tab in SERFF. |  |  |
| **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. |  |  |
|  | **c** | | Include an illustrative rate calculation, based on the rates in the Rate Schedule, and rules of how your rating factors are applied, including 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 use (wellness), in the example, please include at least one enrollee who participates in the wellness program and would then be subject to the adjustment. |  |  |
| **SEPARATE DOCUMENTS** | | | | | |
| **31** |  | | **Part I Unified Rate Review Template (URRT):** In addition to the items covered above:  Note: The various index rates (Index Rate, MAIR, etc.) in the URRT are considered to be the official amounts. For calculations in your supporting exhibits requiring one of these amounts, such as the calculation of the Exchange User Fee as a percentage input in 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 workbook. |  |  |
| **a** | | Include a comparison of the input amounts in URRT Worksheet 1, Section II (for the 2022 projection) and the 2021 amounts. |  |  |
| **b** | | Provide documentation and justification for URRT Worksheet 2 product and plan mapping for terminated plans, in accordance with the following:   1. For the inside Exchange plans, 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 provided to the policyholder and consistent with Uniform Product Modification Justification (UPMJ). |  |  |
| **c** | | URRT Worksheet 2, Section I: For any plan in 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. |  |  |
| **d** | | Include an exhibit that calculates the projected dollar amounts by plan in URRT Worksheet 2, Section IV (address fields 4.2, 4.4, and 4.8 in particular; note that field 4.7 is already covered in checklist #19 above). These amounts should be consistent with the plan adjustment factors in Section III. |  |  |
|  | **e** | | Include how the projected member months were determined by plan, whether they are consistent with company expectations for the product line for 2022 and confirm that each plan in the 2022 filing has nonzero 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. |  |  |
| **f** | | Calculate the weighted-average Plan Adjusted Index Rate (PAIR; URRT Worksheet 2, field 3.10), and compare it to the aggregate premium PMPM projected in field 4.17. Weight the PAIR amounts by projected member months. Explain any differences. |  |  |
| **g** | | Based on input from CMS/CCIIO, if you are an issuer renewing only one 2021 plan that will be offered by a health insurance issuer within your controlled group, please include the following (also see #33b and #34d). If not, indicate “N/A.”  In URRT Worksheet 2 for the current and new issuers:   1. The Plan Name (line 1.3) and Plan ID (line 1.4) will be unique to each issuer; 2. Indicate the plan as a renewing plan (line 1.7); 3. Include the current rate from the current issuer (line 2.11) in the new issuer’s URRT; 4. Use the current rate in the calculation of the rate increase (line 1.11) in the new issuer’s URRT; and 5. The experience must only be included in section II of the current issuer’s URRT in order to match the totals in Worksheet 1. |  |  |
| **32** | | | **Part II Written Description Justifying the Rate Increase:** In addition to the items covered above:   1. Changes in Benefit: Consumers tend to view cost-share changes as “benefit changes,” so a summary of the cost-share changes should be included in this section. Note: the cost-share changes should be an overview of the major changes rather than a repeat of the detailed list in UPMJ Q4a. 2. 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. |  |  |
| **33** |  | | **Part III Rate Filing Documentation and Actuarial Memorandum:** In addition to the items covered above, please address items a, b, and c below:  Note: 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. |  |  |
| **a** | | Include an actuarial certification as prescribed in the Part III Actuarial Memorandum Instructions found in the URR Instructions. |  |  |
| **b** | | Based on input from CMS/CCIIO, if you are an issuer renewing only one 2021 plan that will be offered by a health insurance issuer within your controlled group, please include the following (also see #31g and #34d). If not, 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 issuer offering the plan; 2. A comparison of the 2021 and 2022 HIOS Plan IDs and plan names; 3. A comparison of the 2021 counties in the service area for the renewing plan and the 2022 counties offered by the new issuer to demonstrate meeting the requirement of covering a majority of the same service area; and 4. Discuss the cost-share changes to the plan and confirm that the product network type and covered benefits remain the same. |  |  |
|  | **c** | | Include a discussion of 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. |  |  |
| **34** |  | | **Uniform Product Modification Justification (UPMJ):** Review and follow the general instructions as well as the UPMJ instructions for each question. In addition to the items covered above: |  |  |
| **a** | | Spell out the first occurrence of each acronym in Q4a and Q4b. For example, Maximum Out-of-Pocket (MOOP). |  |  |
| **b** | | For UPMJ Q4a, keep in mind that the content will ultimately be included in our decision memorandum posted for public consumption, so explain the cost-share changes as you might to an existing or prospective member. For each cost share amount listed in UPMJ Q4a, include dollar, comma, and percent symbols as well as numeric amounts. |  |  |
| **c** | | UPMJ Q5: Display rate changes for every renewing and terminated plan, even if the 03/31/2021 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, or cost-share rate changes for the particular plan. |  |  |
| **d** | | Based on input from CMS/CCIIO, if you are an issuer renewing only one 2021 plan that will be offered by a health insurance issuer within your controlled group, please include the following (also see #31g and #33b). If not, indicate “N/A.”   1. *Current issuer*: UPMJ Q4a and Q5 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. Q5 should include a line with the new plan’s rate change percentage with zero members. |  |  |
| **35** |  | | **WAC 284-43-6660 summary:** In addition to the items covered above: |  |  |
| **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 calculated in UPMJ Q5. 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 value of URRT Worksheet 2, Section III fields 3.6 Administrative Expense, 3.7 Taxes and Fees, and the Exchange user 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 in the WAC 284-43-6660 summary. |  |  |
| **c** | | Summary of Pooled Experience:  If your company accelerated MLR payments as a partial refund of 2020 premium, include the adjustment in the premium amount listed in the table, and add a note to General Information #5 indicating the amount of the refunds. Please also thoroughly explain such refunds in the actuarial memorandum. |  |  |
|  | **d** | | Trend Factor Summary:  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.  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. |  |  |
| **e** | | General Information #4: Respond with “See Rate Schedule.” |  |  |
| **f** | | General Information #5: If any of the Summary of Pooled Experience amounts changed in the first or second prior periods versus last year’s filing, add a note identifying and explaining the changes. |  |  |
| **36** | | | **Benefit Components:** Provide a completed Benefit Components Speed-to-Market Tool. The file Format - Rates - 2022 Med Benefit Components is provided on the Washington State OIC website. Note, the information provided in the template should be consistent with the other documents in your filings (e.g., PBT, AV Screenshots, MH/SUD Certification). |  |  |
| **37** |  | | **Mental Health and Substance Use Disorder (MH/SUD) Financial Requirement Parity:** |  |  |
| **a** | | Complete the Mental Health and Substance Use Disorder Financial Requirement Parity Certification. The file Certification – Rates – 2022 Mental Hlth and Subst Use Dis Financial Reqs can be found at https://www.insurance.wa.gov/speed-market-tools-health-coverage-analysts. |  |  |
| **b** | | Confirm that all MH/SUD checklist documentation is submitted as requested. In particular, please indicate your Excel file that summarizes the financial requirements and demonstrates the parity testing results. |  |  |
| **38** | | | **Commission Certification:** Provide detailed information listing all proposed commission schedules, even if no commissions are paid, for this block of business for plan year 2022. It should be signed, dated, and certified, by an officer or a senior manager of your company who is in charge of implementing the commission schedule, that the information is accurate to the best of his or her knowledge at the time of the rate submission. Broker bonus programs which are 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 the individual and small group rate filing must be finalized prior to the final disposition. The commission schedule will not be allowed to change after the rate filing is approved. |  |  |
| **39** | | | **Rate Schedule:** Provide a complete rate schedule using the Format - Rates - 2022 Individual Nongrandfathered 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 (wellness discount) factor 1.0000; and area factor 1.0000) should be consistent with the Calibrated Plan Adjusted Index Rate (CPAIR) amounts in URRT Worksheet 2, field 3.14. (see Checklist #13.c above) |  |  |