February 1, 2019

Instructions for Completing the Virginia Rate Filing Template (Version 2020 - May 8, 2019)

The Virginia Rate Filing Template (the Template) has been designed exclusively for the submission of annual single risk pool non-grandfathered individual and small group ACA rate filings, effective January 1, 2019 and later. The intent of the Template is to: (1) facilitate the rate review process, (2) consolidate and standardize the inputs supporting a rate filing, and (3) allow for the generation of reports to provide an overview of the individual and small group markets in Virginia. The Template contains updated versions of previous Virginia required forms (namely Form 130A, Form 130B, the Virginia Rate Template, and the Plan Schedule Comparison), in addition to other information, data, and assumptions that support the rate filing.

It is intended that the information reported in the Template is consistent with current State or Federal laws and regulations. If any subsequent changes are made to State or Federal laws/regulations/guidance that are in conflict with these instructions, the revised laws/regulations/guidance will supersede these instructions.

The Template requires two types of inputs: Manual Input – Free Form (yellow cells) and Manual Input – Dropdown List (orange cells). Calculations (blue cells) do not require inputs and ***should not be changed***. Carriers are highly encouraged to submit additional exhibits to further support the actuarial assumptions contained in a rate filing and within this Template.

Once populated with the required information, the Template should be submitted in Excel format in SERFF on the Supporting Documentation tab of the rate filing.

For purposes of completing the Template, the following definitions apply:

Allowed Claims are claims after the removal of any duplicates, claims for noncovered services or COB, and after the application of provider discounts, but prior to reduction for any member cost sharing.

Incurred Claims are claims after removal of any duplicates, claims for noncovered services or COB, and after the application of provider discounts and reduction for any member or HHS (as applicable) cost sharing.

Please employ the following when completing the Template:

▪ Do not adjust allowed or incurred claims for non-medical items (e.g., quality improvement expenses) that can be added to the numerator in the Federal Medical Loss Ratio (MLR) calculation.

▪ The treatment of (inclusion or exclusion) any claims processed outside of the claims system should be consistent with how such claims were handled in pricing. The actuarial memorandum should include documentation of any adjustments made for non-system claims.

▪ The HIOS Plan ID field should be populated using the Standard Component Plan ID assigned in HIOS. The required information should include data for all non-grandfathered policies underlying the single risk pool included in the filing, including data for plans that were active during the experience period but are or will be terminated by the rate effective date.

All worksheets in the Template have been protected so that data entry is allowed only in the cells where applicable. This is primarily so that rows/columns are not accidentally inserted/deleted, and the format of the workbook is not altered***. Do not attempt to alter the format of the worksheets or workbook in any way***. Alteration may cause the analytical tools to not function properly, in which case the carrier may be required to resubmit the Template. When completing sections of the Template where the number of rows a carrier may enter is variable (e.g., Tab V Plan Rates), please enter the first row of data in the first row of colored cells. Enter all subsequent rows of data in a continuous manner; ***do not leave any blank rows between the records***.

All links to other workbooks should be removed prior to submitting the template. Failure to remove links may cause the analytical tools to not function properly, in which case the carrier may be required to resubmit the Template.

The following are descriptions of each tab in the Template, including instructions for manual and dropdown entries. The row and column references of the input section for each tab is in parentheses for convenience. **Please note: changes from the 2019 filing season version of the template will be in bold underlined.**

Tab I: Data (A1:N54)

Table 0. Identifying Information

- **Carrier Name:** Enter the name of the legal entity submitting the filing.
- **NAIC Number:** Enter the legal entity's NAIC number.
- **Product(s):** Enter the product(s) included in the filing (HMO, PPO, etc.)
- **Market Segment:** Drop down indicating either individual or small group.
- **Projected Rating Period:** Enter the first effective date of the rating period. For individual this must be January 1, 20XX; for small group, this should be the beginning of the first calendar quarter for which the filed rates apply.
- **Experience Period & Manual Experience Period:** Once the Projected Rating Period is entered, these cells will auto-populate with beginning dates two years prior. If needed, these dates can be changed.

- **Most Recent Membership Date:** Once the Projected Rating Period is entered, this cell will auto-populate with a date **of March 1, 20XX-1 (e.g., for a projected rating period of January 1, 2020 the cell will auto-populate with March 1, 2019).**

Table 1. Number of Members

Enter the average age (rounded to the nearest tenth), members, and member months corresponding to the experience, current, and projected rating periods. Enter a zero or leave blank for any age range with no membership. The dates of the periods will auto-populate based on those entered in Table 0. Please note that the current period information is a membership snapshot as of March 1, 20XX-1 (i.e., a count of members and not member months).

Table 2. Experience Period Claims and Premium

Enter the following for the Experience Period:

- **Earned Premium:** This value should be net of MLR rebates and should equal the value reported on the URRT.
- **Incurred & Paid Claims:** This value should not include capitation or prescription drug rebates.
- **Ultimate Incurred Claims:** This value should include **Incurred & Paid Claims** and the carrier's best estimate of IBNR.
- **Estimated Cost Sharing (Member & HHS):** This value includes payments made by the member against allowed claims, in addition to payments made by HHS (as applicable) on behalf of low-income members.
- **Allowed Claims (Non-Capitated):** This value should include non-EHBs.
- **Non-EHB Portion of Allowed Claims:** This value should be the non-EHB portion of the above **Allowed Claims**.
- **Total Prescription Drug Rebates:** This value should be entered as a negative number.
- **Total Allowed EHB Capitation and Total Allowed non-EHB Capitation:** Enter capitation amounts, if applicable, for EHBs and non-EHBs.
- **Estimated Risk Adjustment:** This value should be negative for payments and positive for receipts.

Total Incurred Claims & Total Allowed Claims will be calculated automatically and should equal the amounts found on the URRT.

Table 3. Manual Experience Period Claims and Premium

The definitions for entries in this table are identical to those described above for Table 2. An entry is also required for **Member Months**. ***No entries are required if the experience period data is 100% credible.***

Tab II: Form 130A (A1:W30)

Table 4. Form 130A - Experience Information

This tab is very similar to and replaces VA Form 130A the carrier filed in previous years. Several cells will auto-populate from entries made in Tab I Data. A few items are worth noting:

- **IBNR:** These entries will be added to **Incurred & Paid Claims** automatically to result in **Incurred Claims.** Zeros should be entered if the associated calendar year claims are complete.
- **Estimated Risk Adjustment:** Enter either actual (if known) or estimated risk adjustment, net of any risk adjustment user fees. This value should be negative for payments and positive for receipts.
- **Net Incurred Claims** (Projected years only)**:** Enter projected calendar year incurred claims net of prescription drug rebates.
- **Interest Assumption:** Enter the interest rate that will be used to calculate present values.

In addition to **Estimated Risk Adjustment** and **Net Incurred Claims,** projected calendar year values should be entered for **Member Months** and **Earned Premium.**

Capitation has been added to Form 130A. Please enter total capitation dollars, not PMPM amounts. Dollar amounts will be added to Net Incurred Claims.

Note: Form 130A is also used for other types of business (e.g., Medicare Supplement) where future and lifetime loss ratio minimums must be met. This does NOT apply to ACA plans, where the statutory minimum loss ratio is 75% for the projected rating period.

Tab III: Form 130B (A1:U38)

This tab is very similar to and replaces VA Form 130B the carrier filed in previous years. Several cells will auto-populate from entries made in Tab I Data.

Table 5a. Form 130B – Trend Information

Enter values for calendar years in the Actuals and Projected sections, corresponding to the basis used to project **Allowed Claims** cost and utilization trends by service category: **Inpatient Hospital, Outpatient Hospital, Physician, Prescription Drugs, Other and Capitation**. Entries are also required for Actual and Projected **Member Months**. Projected Rating Period

trends by service category should correspond to those in the URRT and reflect the amounts used in rate development.

Drop down boxes are provided to describe the unit of measurement for cost and utilization (e.g., Admits, Days or Other for Inpatient Hospital).

Table 5b. Form 130B – Trend Calculation

Annual trends are calculated from the values entered in Table 5a. No entries are required.

Tab IV: Rate Development (A1:N73)

This tab provides details for the development of the Projected Index Rate and the Market-Adjusted Index Rate, in addition to Retention and Commission information. Several cells will auto-populate from entries made in Tab I Data and Tab III Form 130B.

Table 6. Development of the Projected Index Rate, Market-Adjusted Index Rate, and Total Allowed Claims

The following are manual entries and should be entered under Actual Experience Data and Manual Data (if applicable):

- **Change in Morbidity:** Enter the value as defined in the URRT instructions.
- **Change in Demographics/Network/Benefits/Other:** Enter the value(s) as defined in the URRT Instructions. These are possible components of the Change in Other, in addition to trend and change in morbidity.
- **Credibility Factors:** Enter the amount of credibility assigned to Actual Experience Data (Manual Data credibility will auto-populate).
- **Projected Paid to Allowed Ratio:** Enter the Paid to Allowed Ratio in the Projection Period as defined in the URRT Instructions.

The following are manual entries for the Market-wide Adjustments:

- **Projected Risk Adjustment PMPM:** Payments should be negative and receipts should be positive. Value should be net of risk adjustment user fees.
- **Projected Paid Exchange User Fees PMPM:** Enter the expected Exchange User Fee based on the amount specified in the corresponding HHS Final Annual Notice of Benefit and Payment Parameters.

The Market-Adjusted Index Rate will be calculated automatically. If applicable, enter **Projected Allowed Non-EHB Claims PMPM.** The Market-Adjusted Projected Allowed Total Claims PMPM will be calculated automatically.

Table 6a. Small Group Projected Index Rate with Quarterly Trend

Please refer to the URRT Instructions under "Guidance for Quarterly Rate Increases" for the required entries in this table. The Months of Trend and Annualized Quarterly Trend will auto-populate but can be changed if necessary.

Table 7. Retention

This section requires retention details that support the retention categories as defined in the URRT Instructions. All values should be entered under Percentages, and the PMPM values will be calculated automatically.

The following are allowed entries under Administrative Expenses and the total should equal the Administrative Expense Load on the URRT:

- **General and Claims**
- **Agent/Broker Fees and Commissions**
- **Quality Improvement Initiatives**

The following are allowed entries under Taxes & Fees and the total should equal Taxes & Fees on the URRT:

- **PCORI Fees**
- **VA Premium Tax (if applicable)**
- **Federal Income Tax**
- **Health Insurance Providers Fee**
- **Risk Adjustment Fee**

Note: The totals for Administrative Expenses and Taxes and Fees, in addition to Profit/Contingency (after tax) are auto-populated from entries on Tab V Plan Rates. It is acceptable for the user to enter the above retention details prior to making entries in Tab V; when this is done, the following error message will appear: "The calculated percentage does not equal the sum of the pieces below." Once the correct values are entered in Tab V, this error message will disappear.

If all entries have been made correctly, the calculated cell Projected Required Revenue PMPM should equal the Single Risk Pool Gross Premium Avg. Rate, PMPM on the URRT.

The following should be entered under Commission Details (on either a percent or PMPM basis; entering both for any of the following categories will result in an error message):

- **New Business**
- **Renewing Business**
- **Special Enrollment Period**

Tab V: Plan Rates (A1:AL523)

Table 8. Plan Rates

This tab calculates current year calibrated plan adjusted index rates for all new and existing plans contained in the rate filing. Up to 500 plans can be entered Please do not skip any rows when making entries.

- **Age Calibration Factor**
- **Geographic Calibration Factor**
- **Tobacco Calibration Factor**

The Aggregate Calibration Factor will be calculated automatically.

The following are Free Form entries for each plan:

- **Current year HIOS Plan ID** (up to 14 alphanumeric values per plan ID): Each unique HIOS Plan ID should only appear on one row of this tab
- ~~**Plan Marketing Name**~~ **(Deleted)**
- ~~**Prior year HIOS Plan ID** (if applicable)~~ **(Deleted)**
- **Metallic Tier Actuarial Value:** Enter the value determined using the Actuarial Value Calculator.
- **Pricing AV:** Enter the actuarial value that was determined by the carrier.
- **Benefit Richness:** Enter the value that represents induced demand.
- **Non-Funding of CSR Adjustment:** Enter the value that represents the cost to the carrier for the lack of CSR (Cost Sharing Reduction) funding. Please enter 1.000 for any plan where such cost has no impact on rates.
- **Benefits in Addition to EHBs:** Enter the value of any non-EHBs, if applicable. Please enter 1.000 for any plan that covers only EHBs.
- **Provider Network:** Enter the value of the provider network and delivery system for each plan, as well as utilization management practices.
- **Catastrophic Eligibility:** Enter the value that represents the expected impact of specific eligibility categories for these plans. Please enter 1.000 for all other plans.
- **Admin Costs:** Enter the value that represents administrative expenses.
- **Taxes & Fees:** Do not include Exchange User fees in this value.
- **Profit or Contingency**

- **Prior Year Calibrated Plan Adjusted Index Rate:** Enter the value for each plan that was in existence in the prior year, with either no plan design changes or plans that have been modified (i.e., plans that underwent plan design changes).
- **Number of Members by Rating Area:** Enter the number of members for each plan by rating area as of March 1, 20XX-1. Please enter 0 or leave blank for plans with no membership in any rating area. The date shown in the title of the chart will auto-populate from Tab I. Data.

The following are Drop Down Lists:

- **Product Type**
- ~~**Existing, Modified, New, Discont. & Mapped, Discont. & Not Mapped:** Definitions of each are provided in the tab. **There should only be one line for each current plan. For current plans which have multiple prior plans mapped to it, please enter the prior information for only the most popular discontinued plan in order to avoid having multiple lines for the same current plan.~~ **(Deleted)**
- **Metallic Tier**
- ~~**Standard AV, Approach 1, Approach 2:** Standard AV are for plans for which the Actuarial Value Calculator was used; Approach 1/Approach 2 are acceptable alternatives if the plan design is not compatible with the Actuarial Value Calculator.~~ **(Deleted)**
- **Exchange Indicator**

Tab VI A: Plan Premiums Individual (A1:GM522)

This tab replaces the VA Rate Template for individual rate filings. Current and prior year's rates for a 21-year-old Non-Tobacco user, for each plan and rating area, are calculated from entries made in Tab V Plan Rates. ***Please note that these calculated amounts may not exactly match the rates in the Rates Table Template due to rounding differences*.** Average rate changes, weighted by enrollment, are also calculated.

Drop Down List entries indicate whether or not coverage is available in each county or independent city of a rating area. When the carrier submits a rating area factor for a rating area, the entry for all counties and independent cities in that area will default to "Y." The carrier should change this entry, if applicable, to an "N" for no coverage or a "P" for partial coverage to accurately present the availability of coverage in each county/independent city of the rating area. **"N/A" will appear for the premium amount if the county/independent city coverage is all "N" for that plan and rating area combination.** Please note that the entries will initially be populated with "N" until the appropriate rating area factors are populated on **Tab VIII Cons Factors & Rate Pres**.

Note: Please do not change the age entry of 21 in cell BB15. This has been provided for use by the Bureau to perform random rate checks.

Tab VI B: Plan Premiums Small Group (A1:IC522)

This tab replaces the VA Rate Template for small group rate filings. Entries are required for the prior year's Q1 rates for 21-year-old Non-Tobacco user, for each plan and rating area. Otherwise, please refer to the instructions above (Tab VI A Plan Premiums Individual).

Tab VII: Rate Change Calculation (A1:E43)

This tab calculates the estimated impact of various components of the rate change compared to the previous year's rate filing. Assumption values for the current year filing will be calculated automatically. Corresponding entries are required for the assumptions contained in the previous rate filing.

Tab VIII: Cons Factors & Rate Pres (A1:K104)

Entries are required for the current and prior year's tobacco and geographic factors. Please enter "N/A" if no plans are offered in the entire rating area. **Table 16 replaces a separate file that the Bureau distributes prior to the annual rate presentations, usually held near the end of July. This will allow carriers to complete these exhibits directly in conjunction with their submitted rate filings. The following entries have been added:**

- **Metallic Tier**
- **In-Network Plan Design Information**

~~Tab IX: Rate Presentation Exhibit (A1:H45)~~ (Deleted and combined with Tab VIII)

~~This tab replaces a separate file that the Bureau distributes prior to the annual rate presentations, usually held near the end of July. This will allow carriers to complete these exhibits directly in conjunction with their submitted rate filings. Please note that cells B37:B41 are free form entry to allow carriers to customize the components used in the breakdown of the rate changes.~~

Table 15. Overall Rate Change Information

Entries are required for carrier calculated amounts of total, adult, and child average rate changes.

Table 16. Plan Specific Rate Change Information

Entries are required for the Most Popular Plan (as of the date entered in Tab I Data), and plans with the Minimum and Maximum Rate Change. Drop Down Lists outline which rating area is used for the exhibits.

Tab IX: Plan Schedule Comparison (A1:N514)

This tab replaces the Virginia Plan Schedule Comparison previously filed separately by carriers to support plan management activities. The HIOS Plan ID and Metallic Tier will auto-populate from Tab V Plan Rates for the current year but can be overwritten if desired. Other required

information should be entered for each Schedule of Benefits form filed for use in the current benefit year for ACA plans.

For the prior year, enter the following if the plan is Existing or Modified in the current year:

- **HIOS Plan ID**
- **Plan Marketing Name**
- **Form Number**
- **Metallic Tier** (Drop Down List)
- **HDHP Indicator** (Drop Down List)
- **Form SERFF Tracking Number**

Note: Options for "Discontinued and Mapped" and "Discontinued and Not Mapped" have been removed from Column C.

For the prior year, enter "same" in each of the above Free Form cells if there are no changes to the Schedule of Benefits; enter "N/A" if the plan is New. In either case, both Drop Down List cells must be entered.

Tab X: Rate Template (A1:O513)

There are no entries required for this tab, as information is pulled directly from other tabs. For small group submissions, the quarterly trend factors are now included on this tab in order to have the ability to calculate rates for all quarters of the plan year. **Column H has been added to signify the rating areas in which a plan is offered (e.g., Areas 1, 2, 6, 8).**

A button has been added to print the tab and will automatically print as many sheets as needed based on the number of plans.