# PY2026

## ACA-Compliant

## Health Insurance Rate Filing Guidance

Pennsylvania Insurance Department

April 9, 2025

Are you new to Pennsylvania or considering moving into the individual or small group market for the first time?

Please let us know ASAP by reaching out to the following resource account: ra-rateform@pa.gov

## Contents

# Highlights for PY26 (Including Revisions)

1. Due to the uncertainty around the expiration of the enhanced subsidies, the Department requests insurers to file two sets of rates for Plan Year 2026. The initial rate filing should account for both scenarios, where one set of rates assumes the enhanced subsidies are not extended for Plan Year 2026, and another set of rates assumes they are extended. **When filling out the "General Information" and "Rate/Rule Schedule" tabs in SERFF, please use the rate information assuming the enhanced subsidies expire.** Please be sure to include the following within the rate filing:
    - Two complete versions of the PAAME, reflecting each scenario, and
    - A section in the actuarial memorandum that details what assumptions would change if enhanced subsidies were extended. Any assumption changes should be accompanied with a detailed quantitative exhibit that justifies the assumption revision's impact on rates.
2. Like last year, the ACA Rate Filing Guidance contains a section labeled "Standard Questions" which are expected to be completed and submitted with the initial rate filing submission. Please submit your responses within the Supporting Documentation tab in SERFF.
3. For all insurers in the Individual market, please file uniform adjustments as follows in the rate submission:
    - The Department is recommending carriers apply a morbidity adjustment within the range of 1.00 to 1.07 to account for the enhanced subsidies expiration. Include this adjustment in Table 5, Change in Morbidity – All Other.
    - CSR Defunding Adjustment factor within a range of 1.22 – 1.30 to all individual silver plans except those offered off-exchange only. The PID will continue to evaluate this flexibility and may adjust the range in response to its review of the rate filings.
    - Exchange User Fee of 3%.
    - As it pertains to Pennsylvania's Reinsurance program, the Department has received notice from CMS that our waiver extension application is complete as of January 29th, 2025. Per the requirements outlined in 45 C.F.R. § 155.1308(d) and 31 C.F.R. § 33.108(d), this date reflects the beginning of the 30-day federal public notice and comment process and the 90-day federal decision-making period for a waiver extension request. Given that the reinsurance program's extension application is not yet approved and the uncertainty surrounding the expiration of the enhanced subsidies, the Department advises insurers to submit initial rate filings assuming a 30% coinsurance rate, a $60K attachment point, and a $100K cap. The Department will inform insurers as soon as possible when a final determination has been made near the end of April regarding the extension application's status.
    - Risk Adjustment User Fee of $0.20 PMPM.
4. Public Rate Filing PDF files will be submitted twice in the rate review process. Submit the first Public PDF with the initial May submission and the final Public PDF after all revisions have been made, with the final submission. The final Public PDF should include the following documents:
    - Cover Letter
    - PA Actuarial Memorandum
    - PA Actuarial Memorandum Exhibits
    - Supplemental Exhibits (if applicable)
    - Standard Questions with Answers
    - PA Plan Design Summary and Rate Tables
    - Service Area Map
    - RFJ Part I
    - RFJ Part II (if applicable)
    - RFJ Part III
    - Federal Rates Template
    - Objections from the Department with responses and supporting exhibits

5. To help ensure the stability of the Individual and Small Group markets, the Department is imposing a deadline of July 31 for insurers to submit voluntary service area revisions related to individual and small group health insurance coverage. Plans may be withdrawn following this date if such withdrawal does not cause a change in service area.
6. The following updates have been made to the PAAM Exhibits:
    - New columns have been added to Tables 4 and 4b to collect additional cost and utilization trend details.
        i. For the GLP-1 and like drugs columns, carriers should include drugs within the "incretin mimetics" therapeutic class which includes GLP-1 receptor agonists like semaglutide (Ozempic, Wegovy), liraglutide (Victoza, Saxenda), dulaglutide (Trulicity), and exenatide (Byetta, Bydureon); and Dual GLP-1 and GIP receptor agonists like Tirzepatide (Mounjaro).
    - A cell for a description of the manual experience has been added to tab I.b. Manual Data. Insurers should enter a brief description of the manual data used, if applicable. The description should include the source of the data along with any markets/products represented.
    - An Exchange User Fee Calculation table, Table 5b, has been added to tab II Rate Development & Change.
    - New columns have been added to Table 13 to collect claims and premium information at the rating area level. These values should be entered such that the loss ratios produced in column S are risk-adjusted. Premium amounts should be adjusted for risk adjustment and claim amounts should reflect rebates and non-system claims.
    - Table 16A and 16B have been added to the "VII Risk Adjustment" tab based on insurer feedback during debrief calls and guidance feedback to collect insurer specific risk factors for each combination of Plan ID and Rating Area. Please enter Non-Catastrophic Plan data in Table 16A and Catastrophic Plan data in Table 16B. A table has also been added in columns G:I to collect the GCF for each rating area. This will be used to populate the GCF values in Table 16A/B. The data entered in Table 16A/B should be based on the experience period. The insurer specific risk factor calculations have been revised to use the Table 16A/B data. The Department will provide the statewide factors including and excluding risk score in early May to be entered in rows 13 and 14 of Table 16. The Insurer Specific Manual Adjustment PMPM entered in cell C28 of Table 16 should be used to make any applicable adjustments such that the value produced in cell C32 of Table 16 is the Incurred Risk Adjustment PMPM for the projection period. A separate Excel exhibit should be provided to support any manual adjustment.
    - "VIII MLR and Rebate Calc" is a new tab containing information from Part 3 of the medical loss ratio report submitted to the Department of Health and Human Services.
        - The requested information includes claims and premium data for the most recent 3 years, the current year, and the rating period.
    - "IX Retrospective Analysis" is a new tab designed to compare projected values from prior years to actual experience. In Table 17-1, columns C through F should be filled in with Table 4 data from last year's filing. For Table 17-2, the projected values should be filled in based on what was initially projected for the experience period two years ago. For example, in this year's submission the company should be using PY24's filing to fill in cells D44:D47.
    - "X Drug Data" is a new tab to collect more detailed drug claims data during the experience period to ensure PBM compliance with Act 77. The Department requests that all health insurers work closely with their associated PBM to obtain this information. Please see standard question #10 for all requested information pertaining to Act 77 compliance. When considering which non-affiliated pharmacy to use for this request, please consider the pharmacy with the largest script volume that is located within a reasonable distance from the affiliated pharmacy. The Department expects insurers to work closely with their PBM to conduct a good faith effort at collecting the requested data.

# A. General Instructions

This document outlines the rate filing requirements for all ACA-compliant plans offered in Pennsylvania and should be followed for all Pennsylvania rate submissions. The Unified Rate Review (URR) Instructions provide guidance for the completion and submission of federal documents. Please follow the PA guidance for the submission of PA rates and Actuarial Memorandum exhibits, and the federal guidance for all three parts of the URR. The term "ACA-compliant plans" refers to those plans that are regulated under the single risk pool requirements in the ACA, and those that must follow all ACA health reform rating rules. This term excludes grandfathered, transitional, and student health plans. Student health guidance is posted on the PID's website here.

The standardization of rate submissions provides consistent reporting processes among insurers and will enable the PID to expedite our review and approval process. Insurers may not modify Pennsylvania Actuarial Memorandum exhibits; only enter data as prompted.

## 1. Timeline

Filing submissions should follow the ACA QHP timelines in accordance with 45 C.F.R. 154.301(b)(3) and 154.220, regarding timelines for filing. Therefore, all health insurers who wish to issue or renew ACA-compliant individual and small group health insurance coverage on or after January 1st of the upcoming year must file their forms, rates and plan binders containing all the required templates via SERFF no later than the initial filing date listed below. Late or mid-year filings will not be accepted.

**Rate Filings for Individual and Small Group Plans**

- **May 15, 2025 – Filings Due**
  - All rate filings, for both individual and small group plans, on and off Exchange are due by this date.
- **July 17, 2025 – Revised Filings Due**
  - Revised filings to reflect updated risk adjustment and changes resulting from the second round of responses are due on this date.
- **July 31, 2025 – Revised Filings Due**
  - Revised filings to reflect changes resulting from the third round of responses are due on this date. This response should also include Final Public PDFs.
  - Deadline for insurers to submit voluntary service area revisions. Plans may be withdrawn following this date if such withdrawal does not cause a change in service area.
- **Late September – Final Approved Filings Made Public**
  - Final approved filings will likely be made public the final week in September 2025.

**Small Group Quarterly Update Filings**

- **December 17, 2025**
  - Submission date for a 2nd, 3rd, and 4th quarter filing.
- **March 18, 2026**
  - Submission date for a 3rd and 4th quarter or 4th quarter only filing.

In accordance with federal URR instructions, all quarterly updates to the annual small group rate filings on and off Exchange must be submitted no later than 105 days prior to the effective date. If the date is not a business day, the due date is the first business day before the due date. To accommodate the federally directed rate filing cycles, the PID will accept a 3rd and 4th quarter or 4th quarter only filing no later than March 18, 2026. Given federal timing guidelines, the submission date for a 2nd, 3rd, and 4th quarter filing would require a filing by December 17, 2025, which would severely truncate the time for publication and review. Moreover, the PID anticipates it will be unlikely that an insurer will have new data, that is, data not available to it during the annual filing review period, to actuarially justify changes for a 2nd,

3rd, and 4th quarter filing. Thus, the PID views it as extremely unlikely that a 2nd, 3rd, and 4th quarter filing would be submitted and approved for implementation on April 1.

Initial proposed small group quarterly updates will be made public uniformly at each quarterly interval. These rate filings will be published no later than 15 days after receipt, according to the PA Bulletin schedule. Filings will be open for a 30-day public comment period. Approved rates will be made public uniformly at each quarterly interval.

# 2. Pennsylvania Filing Requirements

## A. Required Documents and Redactions

Pennsylvania requires annual rate filings for all ACA-compliant individual and small group plans, whether on or off exchange, including those with rate decreases or unchanged rates. This aligns with the federal requirements in 45 C.F.R. § 154.215(a). All rate filings must be submitted in SERFF.

Filings will be considered incomplete and rejected if the items listed in Table A: Required Documents, are not included. Pennsylvania requires the inclusion of all three components of the Rate Filing Justification (RFJ), unless the requested rate change is below the "Rate Review" threshold.

| **Table A: Required Documents** | |
|---|---|
| ***Federal Documents Required to be Filed with PID*** | ***Format*** |
| RFJ Part I – Unified Rate Review Template (URRT)[1] | Excel |
| RFJ Part II – Consumer Friendly Justification (if any plan equals or exceeds 15%)[1] | PDF |
| RFJ Part III – Actuarial Memorandum[1, 2] | PDF |
| Federal Rates Template (QHP & non-QHP filed in both rate and binder filings)<br>Note: If any changes are made to the Federal Rates Template in the rate filing, those changes must also be made to the Federal Rates Template in the corresponding binder filing. | Excel |
| ***Pennsylvania Documents Required to be Filed with PID*** | ***Format*** |
| Cover (Submission) Letter | PDF |
| PA Actuarial Memorandum[2] | PDF |
| PA Actuarial Memorandum Rate Exhibits | Excel |
| PA Plan Design Summary and Rate Tables | Excel |
| Service Area Map | PDF |
| Public Rate Filing PDF | PDF |
| Completeness and Redaction Checklist, and, if applicable, Redaction Justification | PDF |
| PID Standard Questions | PDF |

The PID does not anticipate redactions other than the following items:

a) AV screenshots,
b) Statements specifying a company's anticipated risk level in relation to the state average risk level (e.g., the underlined portion may be redacted in the following statement: "we expect the risk level of the membership to be X% higher/lower than the state average risk level"),
c) Opining actuary's name,
d) Specific provider contracting,
e) Commission schedules,

[1] 45 C.F.R. § 154.215(h) specifies that CMS will make available on its website the information contained in Part II of the RFJ, and the information contained in Parts I and III of the RFJ that is not trade secret or confidential commercial or financial information as defined in HHS's Freedom of Information Act (FOIA) regulations at 45 C.F.R. § 5.31(d).

[2] Insurers can choose to submit the RFJ and PA actuarial memoranda separately, with the RFJ memorandum addressing the specific requirements of the URR instructions, and the PA memorandum addressing the specific instructions laid out in this guidance. If an insurer chooses to submit a single consolidated actuarial memorandum, the memorandum is expected to clearly and fully meet ALL the standards of BOTH the URR instructions and the instructions in this guidance. For both options, where URR and PA guidance instructions differ, the insurer is expected to clearly identify those differences and provide all data and documentation necessary to meet both sets of instructions.

f) Columns C through E in Tabs "II.a.Reins Table – Exp" and "II.b.Reins Table – Proj" in the PAAME,
g) Tables 16 and 16a in Tab "VII Risk Adjustment" in the PAAME, and
h) PBM and Act 77 of 2024 Compliance Information and Tab X Drug Data in the PAAME.

The "public rate filing PDF" should be submitted twice in the rating process for public review. The initial public PDF should be submitted with the initial filing and the second one with the final submission. The PDF document should contain all required documents, tables, and exhibits. The required documents that should be included are:

- Cover Letter
- PA Actuarial Memorandum
- PA Actuarial Memorandum Exhibits
- Supplemental Exhibits (if applicable)
- Standard Questions with Answers
- PA Plan Design Summary and Rate Tables
- Service Area Map
- RFJ Part I
- RFJ Part II (if applicable)
- RFJ Part III
- Federal Rates Template
- Objections from the Department with responses and supporting exhibits (only applicable for Final public PDF)

Please do not include redacted pages of the AV screenshots. If an insurer chooses to make the limited redactions anticipated by the PID, those redactions should be made only in these documents. In this manner, the PID will not have to select the component documents in making redacted items available for public inspection but will instead have one complete document for public review.

***The PID will only permit revisions to a rate filing to correct clearly inadvertent errors that impact the rates, for unforeseen circumstances that impact the industry, for risk adjustment after the CMS Risk Adjustment Report, or at the PID's request.***

***If the PID asks a data call question regarding a factor used in the rate development methodology, then the insurer may update the factor but must provide quantitative and qualitative support.***

If an insurer seeks to submit a quarterly rate filing to update rates filed and approved in its small group annual filing, the PID expects the company will submit quarterly filings for all ACA-compliant small group plans. Please make all filings in SERFF. The PID notes that all small group annual filings will have been created, peer reviewed and certified by actuaries representing the filing insurer and reviewed by PID. Therefore, it is the PID's expectation that an update should only reflect material modifications that were unforeseen at the time of, or during the review period of, the annual filing submission.

Insurers should not introduce new plans in quarterly filings. Rather, the quarterly filings are for updates as may be necessary to account for unforeseen material modifications, such as more recent experience, trends, single risk pool adjustment factors (i.e., change in morbidity / demographics / network / benefits / other), and taxes and fees (if appropriate). The PID anticipates that changes to the single risk pool adjustment factors in quarterly filings will usually be nominal. All other assumptions and factors should be the same as in the 2026 annual filing.

For quarterly filings, only the items listed below should be updated. All other factors should be the same as in the 2026 annual filing:

1. Membership (Departmental tables 1, 10)
2. Experience period should move forward by 6 months for a 3rd and 4th quarter or 4th quarter only filing. The experience period should move forward by 3 months if an insurer makes a 2nd, 3rd, and 4th quarter filing. However, as noted in item "1. Timeline" above, the 3 months of additional data would have been available

during the review period for the annual filing submission. Hence, it is anticipated that the experience period will not be an item used to support a 2nd, 3rd, and 4th quarter filing. (Departmental tables 0, 1, 2, 2b, 4, 4b)
3. Trend (Departmental tables 3, 3b)
4. Factors related to experience, which the PID anticipates would typically change only nominally. (Departmental table 5 and the calibration factors associated with table 10)
5. Taxes and fees, if the tax structure in place at the time of the annual filing has changed. (Departmental tables 6, 10)

For quarterly filings, the Part III actuarial memorandum should state four rate change amounts:

1. The additional rate change over the 2025 approved quarter rate,
2. The total rate change consumers will see year over year (i.e., updated quarter rate over the same quarter rate in the prior year),
3. The additional rate change over the total average approved annual rate, and
4. The total average rate change that consumers will see year over year.

## B. SERFF Submission

Please use the following Types of Insurance (TOI) and Filing Types for ACA rate filings. Rate and form filings should be submitted as separate filings.

- TOI-Individual
  - H16I Individual Health – Major Medical
  - HOrg02I: Individual Health Organizations – Health Maintenance (HMO)
- TOI-Group
  - H16G Group Health – Major Medical
  - HOrg02G: Group Health Organizations – Health Maintenance (HMO)
- Filing Type: Rate

## C. SERFF Rate/Rule Schedule Tab / URRT Tab / Supporting Documentation Tab

The SERFF Rate/Rule Schedule tab should contain the proposed premium rates for all proposed plans, and Excel versions of the Federal Rates Template and the PA Plan Design Summary and Rate Tables. No other data or information should be included in this tab. An insurer should complete only one Federal Rates Template per company and should use separate tabs for each market.

The Company Rate Information and Rate Review Detail must be complete and accurate. The rate change data presented should be consistent with Table 11 and the number of policyholders affected should be populated using the total covered lives shown in Table 10 cell V15. The total requested rate change entered should be consistent with Cell AN13 of Table 11.

The URRT, Consumer Friendly Justification (if necessary), and Federal Actuarial Memorandum must be included in the URRT tab.

All supporting data and documents should be included in the Supporting Documentation tab, under the appropriate category. The subcategories under each category within the SERFF Supporting Documentation tab are standardized so that all insurers will file the required information in a consistent location as required by the category heading.

The naming conventions for the following requirements have been standardized:

1. Under the “Supporting Documentation” tab – The Pennsylvania Actuarial Memorandum Rate Exhibits = 2026_Market (SmGrp or Indiv)_Company Name_PAAMExhibits_Date (mmddyy).xlsm
2. Under the “Rate/Rule Schedule” tab – The Plan Design Summary and Rate Tables = 2026_Market (SmGrp or Indiv)_Company Name_PDSRateTable_Date (mmddyy).xlsm

### D. Pennsylvania Insurance Department Contact

Please send any questions or comments to the following resource account: ra-rateform@pa.gov

## B. Cover Letter

Please submit the cover letter as a Microsoft Word file (uploaded as a PDF text on SERFF) and please include the following information in the numbered sequence as shown below.

1. Company Name & NAIC number
2. Market (Individual or Small Group)
3. On/Off or Off Exchange
4. Effective date of coverage
5. Average rate change requested (Table 11, cell AN13 for annual filings; Table 11, cell EN19 for small group quarterly filings)
6. Range of rate change requested (Table 11, column AN for annual filings; Table 11, columns BU, DB, and EI for small group quarterly filings)
7. Total additional annual revenue generated from the proposed rate change
8. Product(s) (Indemnity, HMO, POS (HMOs only), PPO, or EPO)
9. Rating Areas and any changes from 2025
10. Metal Levels and Catastrophic Plans
11. Current number of covered lives and of policyholders as of February 1, 2025, as shown in cell V15 of Table 10
12. Number of plans offered in 2026 and the change this represents from 2025
13. Corresponding contract form number, SERFF and Binder ID numbers
14. HIOS ID number

## C. Pennsylvania Actuarial Memorandum & Rate Exhibits

The PA Actuarial Memorandum should be provided for all rate submissions. To provide for meaningful review of the rate submissions, insurers should avoid submitting generic actuarial memorandums. Within the memorandum, a discussion of a particular item must contain the specific proposed PMPM, percent of premium, adjustment factors etc. as shown in the corresponding Pennsylvania Actuarial Memorandum Exhibit.

This memorandum must at least:

- Document and show the development of the proposed per member per month 21-year-old premium rates starting from the experience period allowed claims data for the single risk pool. All adjustments and assumptions must be discussed and supporting documentation and data provided. Data elements include:
    - Index Rate Development
        - Base period allowed claims excluding transitional policy claims (both experience and manual, if a manual rate is used)
        - Morbidity adjustments (both experience and manual, if a manual rate is used)
        - Other adjustments with detail for all the elements included (both experience and manual, if a manual rate is used)
        - Utilization trends by type of service (both experience and manual, if a manual rate is used)
        - Cost trends by type of service (both experience and manual, if a manual rate is used)
        - Paid to allowed factor
        - Adjustment for non-EHB benefits
    - Market Adjusted Index Rate Development
        - Net risk adjustment on an incurred PMPM basis

        - Exchange user fee on an incurred PMPM basis
        - Reinsurance recoveries on an incurred PMPM basis
    - Plan Adjusted Index Rate Development
        - Actuarial value (paid to allowed factor)
        - Benefit richness factor (induced utilization) (before and after normalization)
        - Catastrophic plan factor
        - Network and managed care factor
        - Non-benefit factor (such as admin, taxes and fees, and profit)
    - Age 21 Premium Rate Development
        - Age calibration (show in Excel and discuss development)
        - Geographic calibration (show in Excel and discuss development)
        - Tobacco calibration (show in Excel and discuss development)
- Provide each plan's corresponding policy form numbers and AV screenshots. The HIOS Plan ID and contract form numbers must be included on the screenshot.
- Demonstrate that the proposed rates are based on the single risk pool and are developed in a manner consistent with applicable state and federal guidance.
- Demonstrate that the rates are commensurate to the benefits offered and further that the rates are not excessive, inadequate, or unfairly discriminatory.
- Disclose all factor and benefit changes from the prior approved rate filing, as appropriate, and provide supporting documentation and data.

The guidance that follows describes minimum requirements. Insurers are encouraged to provide as much detail as possible, including supporting documentation and data, to support the proposed rates.

Templates for the tables described throughout the guidance that follows are provided in the Excel workbook titled PA Actuarial Memorandum Rate Exhibits. The Excel workbook should be completed in conjunction with the PA Actuarial Memorandum. Cells in the workbook shaded yellow indicate that the filer is expected to enter information. Cells shaded blue contain formulas that calculate the required information. Cells shaded orange may be overwritten with justification.

## Individual vs. Small Group Tabs in the PA Actuarial Memorandum Rate Exhibits

Consistent with the 2025 Guidance, the PID has one Excel workbook that contains the Actuarial Memorandum Exhibits for both the Individual and Small Group Market. Tab IV/Table 11, which develops premiums by rating area, has been broken into two Tabs, Tab IV A for individual market filings and Tab IV B for small group market annual filings.

For annual filings, please delete the Tab IV versions that are not relevant to the filing. That is, for individual market filings, please delete the Tab labeled IV B Plan Premium SG Annual; for small group market annual filings, please delete the Tab labeled IV A Plan Premium Individual.

For small group quarterly filings, the "Adjust PA Act Memo Exhibits…" button in cell G2 of the "I Data" tab should be pressed for the file to display the appropriate information. Please note that macros must be enabled for the necessary adjustment to occur.

# 1. Basic Information and Data

## A. Company Information (Table 0)

Complete Table 0 in Tab I Data. Cells D6 and D7 require entry of insurer name and product type. Select the input from Cells D8 and D9 from the drop-down menu. Note that individual market rate filings and small group market annual rate filings will require a rate effective date of January 1, 2026. Consistent with the federal URR Instructions, the first date of

the experience period in Cell D10 is automatically calculated to be two years before the rate effective date, and the end date of the experience period calculated in Cell F10 is 364 days later (365 days later in leap years).

## B. Rate History and Proposed Variations in Rate Changes

Document the most recent three years of historical rate changes in Pennsylvania, including any quarterly trend update submissions for small group filings. The history should include the amount of the rate change and the SERFF ID number for the filing. Note and discuss if the three prior years' rate revisions were not applied uniformly across all rating areas and plans.

Clearly state whether the proposed rate revision applies uniformly or varies by plan or area. If there are variations, provide an exhibit showing the variation and explain the reason for the variation.

## C. Average Rate Change

List the average rate change for a 21-year-old-non-tobacco premium PMPM calculated in Table 11, Cell AN13 (Cells: AN13, BU13, DB13, EI13, for small group quarterly filings). For comparison purposes, list the average rate change from Table 10, AC15 (Cell BZ15 for small group quarterly filings).

## D. Membership Count (Table 1)

Provide the average age, age breakdown, and total number of members or member months, as indicated, for the periods shown in Table 1.

For small group market filings, include all members as of the specified date, regardless of the plan year.

## E. Benefit Changes

Provide an exhibit that identifies any benefit or cost sharing changes and the corresponding HIOS Plan IDs for the impacted plans.

Provide a discussion of the pricing assumptions used in the development of the cost for the benefit changes. Discuss the impact of changes to the AV calculator and the expanded de minimis ranges, if applicable.

## F. Experience Period Claims and Premium (Table 2)

For annual filings, in Table 2, provide experience period data for the most recent calendar year. Although CMS does not require calendar year data for small groups in Section I of Worksheet I of the URRT, insurers should complete this section using calendar year data in the annual rate filings.

For small group quarterly filings, in Table 2, provide experience period data. This should be updated from the annual filing and include documentation to support the rate request. The beginning of the 12-month experience period should be no more than 24 months before the requested quarterly effective date with at least two months of run-out for the entire single risk pool. Hence, for a 7/1/2026 update, the 12-month experience period would be no earlier than 7/1/2024 through 6/30/2025. Consistent with the federal URR Instructions, the first date of the experience period must be the first date of a calendar quarter, i.e., January 1, April 1, July 1, or October 1.

The experience period paid claims data should represent all non-grandfathered policies in the single risk pool, with at least two months of run-out, for the named entity and market. (Point-of-Service data may be based on multiple companies.)

If this data is not consistent with the data reported in Section I of Worksheet I of the URRT, discuss why. Note the change regarding the inclusion of claims and premium for Transitional Policies. CMS has clarified, in its discussion of the single risk pool in the 2020 URR Instructions, that an insurer is not required to include transitional plan experience from

the Experience Period. Therefore, this Guidance no longer requests the inclusion of Transitional Policy information in Tables 2 and 4.

The narrative should discuss any adjustments to the data, the basis for the adjustments and provide supporting data.

Additionally, the narrative should:

- Discuss the development of the premium data.
- Discuss the development of the allowed claims.
    - The quality incentive payments, or similar provider payments, should not be included in allowed claims as they are part of the administrative expenses.
- Separately identify non-EHB benefits and the experience period cost.
- Discuss capitated services, the capitation amount, and if the capitation is uniform or varies by age, for the experience period.
- Identify and discuss the impact of pharmacy rebates on the incurred claims.
- Discuss the development of the estimate risk adjustment. Estimated payments into the risk adjustment program should be entered as a negative number and estimated recoveries from the risk adjustment program should be entered as a positive number.
- State the loss ratio. This ratio is auto-calculated.

## G. Credibility of Data (Tables 2b, 3b, 4b)

Provide a narrative regarding the credibility of the data and provide the credibility formula and methodology.

If the experience data is not 100% credible, discuss and provide the manual data (as Tables 2b, 3b, and 4b) and source used for the manual rate. Provide a justification as to why the experience period data is not fully credible, or, if credible, discuss the reasons why the experience data was not used as the rate basis. Include all adjustments and assumptions and provide the data to support all adjustments and assumptions. A cell for a description of the manual experience has been added to tab I.b. Manual Data of the PAAM Exhibits. Insurers should enter a brief description of the manual data used, if applicable. The description should include the source of the data along with any markets/products represented. Table 5 accommodates the development of the credibility weighted Projected PMPM in Cell D25. See section 4.A. below for instructions.

## H. Trend Identification (Table 3)

In Table 3, identify the proposed annual medical and prescription drug allowed claims cost and utilization trends.

The Composite Trend is used in Table 5, Cell C12, to project the experience period data to the rating period. Please provide a discussion if the trend in Table 3 differs from the aggregate two-year trend in the URRT.

State the proposed trend and discuss the basis for the trend. Provide justification for each service category and show the weights used in the development of the total composite trend. Disclose the data source and all assumptions and adjustments.

- Show quantitatively the derivation of the trend assumptions for each benefit category in Table 3.
- Provide a detailed narrative that explains how this data was used in developing the trend, including all assumptions and adjustments.

Discuss the impact of provider contracting on trend. The specific provider contracting agreement and amount may be redacted, but not aggregate amounts.

Additionally, for a small group filing, the actuarial memorandum should specify whether quarterly rates are proposed.

### I. Historical Experience (Table 4)

Provide the data in Table 4, using the most recent 48 months (four calendar years for annual filings) of data with at least two months of run-out. Disclose the method used to develop the allowed claims. Discuss how the monthly data was used and adjusted to develop the total proposed annual Composite Trend identified in Table 3. If this data was not used to develop the trend, explain why, and provide the data (as Table 4b) and analysis used in the development of the proposed trend.

## 2. Rate Development & Change

### A. Projected Index Rate, Market-Adjusted Index Rate & Total Allowed Claims (Table 5)

Starting with the 2024 index rate, complete Table 5 and provide a detailed narrative of the development of the Projected Index Rate, Projected Market-Adjusted Index Rate, and Projected Total Allowed Claims. Cells C15 and D15 reflect the morbidity impact of the reinsurance program in the individual market, which is 0.0% as indicated above by the PID. Cells C16 and D16 reflect the insurer change in morbidity assumption. Table 5 shows the development of the credibility weighted Projected Index Rate using parallel actual experience and/or manual data inputs. Please input in Row 24 the credibility weights associated with the actual experience data and the manual data. Provide the credibility factors used and support these factors by providing a narrative including the credibility formula and methodology. All rating period adjustments must be shown and supporting data and narrative provided.

For small group quarterly filings, Cells C12 and D12 may be overwritten to the extent the two-year trend projection factor being used to develop the Index Rate is different than is currently included in these cells. If these cells are overwritten, a detailed narrative should be submitted to support the new data.

Discuss the calculation, and show quantitatively, in an Excel spreadsheet with formulas, the derivation and justification of each of the Single Risk Pool Adjustment Factors (Change in Morbidity – All Other, Change in Demographics, Change in Network, Change in Benefits, Change in Other) for actual and manual data and explain the variation (if any) between the two. Detail the contributing factors to the “Change in Benefits” factor. The “Change in Morbidity” and the “Total Non-Morbidity Changes” adjustments should equal those entered in Worksheet I, Section 2 of the URRT. If not, discuss in the actuarial memorandum. Adjustments captured in Cells C21 and D21, the “Change in Other” category, must be identified. Adjustments such as private reinsurance should be included in these cells. See the URR Instructions for additional items that may be reported in this section.

Cell C28 no longer requires an input but now is automatically calculated from cell K16 of Table 10. The PID has populated the paid-to-allowed factor field in Table 5 Cell C28 with a formula that auto-calculates projected required revenue based upon entries made in the Plan Pricing AVs, Non-Funding of CSR Adjustment and the Total Covered Mapped Lives as of the specified date (columns, K, P and V, respectively) in Table 10. Although cell C28 of Table 5 auto-calculates, the formula may be overwritten.

Tabs II.a. and II.b. have been added to the PAAM Exhibits for the calculation of the impact of the reinsurance program in the individual market. These tabs do not need to be completed for the small group market. On tab II.a., the carrier should input their experience period information by the annual incurred claim ranges specified. Each claim range should include the number of unique members, total member months, and total incurred claims for members which had annual incurred claims within the specified range. This information should tie to the membership and incurred claim information previously provided in the PAAM Exhibits. Tab II.b. will include the same inputs but should contain the information which was utilized in calculating the impact of the reinsurance program in the projection period. Provide a detailed narrative that describes the development of the data which is input into this table. The projected impact of the reinsurance program is calculated in cell E7 of tab II.b. and a PMPM amount based on this impact is calculated in cell C33 of Table 5. If the formula in cell C33 is modified or overwritten, justification should be provided and discussed in the Pennsylvania Actuarial Memorandum.

The reinsurance parameters have yet to be finalized for 2026. As a result, the parameter inputs in cells E3:E5 of the "II.a. Reins Table – Exp" tab are shaded orange and are editable such that the carrier can populate these cells for Individual market filings once the reinsurance parameters have been finalized. The projected impact of the reinsurance program is calculated in cell E7 of the "II.b. Reins Table – Proj" tab.

Reinsurance adjustments will be reviewed to determine and assess the overall impact to PA-Re and SLCS within the market. The PID is reviewing applicable information and may state expected limits upon this value. If any such limits are recommended, that information will be communicated to the insurers. Deviations from the average expectations may require additional justification.

Discuss the non-EHBs, included in Cell C38, and the development of the associated costs.

To the extent that the calculation of the items in Table 5 is modified to adjust for the treatment of capitation, demonstrate and explain those modifications in the narrative.
Show quantitatively, including an Excel spreadsheet with formulas, the derivation of the Projected Risk Adjustment PMPM amount. Provide a detailed narrative that describes the development of the estimated risk adjustment transfer payment. In demonstrating the development of the transfer payment, please show all risk transfer formula components, the estimated market-wide average risk assumptions, and support for those assumptions. Fill out the Exchange User Fee Calculation table on tab II Rate Development & Change. Input the number calculated in cell J41 into cell C32.

*Small Group Market Filings Only*
Only small group market filings using quarterly trended rates should complete Table 5A. For these filings, enter the number of member months renewing by quarter in Cells J29 through M29. The template includes default months of trend (0, 3, 6 and 9) in Cells J31 through M31. Cells J32 through M32 are highlighted in orange to indicate that the formulas in these cells may be overwritten to reflect trend changes, relative to Table 3. If overwritten, please provide and discuss the justification for the overwrite in the Actuarial Memorandum.

Small group rates are developed in Table 11 based on inputs from Table 5A. The 2026 Trend Factors by Quarter in row 34 of Table 5A are used in Table 11 to develop the Consumer Adjusted Index Rates for all four quarters for a 21-year-old consumer in all rating areas as the Market Adjusted Index Rate reflects a January 1 rate to match the URR template.

For small group quarterly filings, enter the data in Table 5A as follows:

- Cells J29 to M29 – Enter the number of member months for each quarter from the annual filing.
- Cells J32 to M32 may be overwritten to the extent the pricing trend being utilized is different than is currently included in these cells.

For 3rd and 4th Quarter Filings:

- Any values in cells J30, J34, K30, and K34 should be overwritten and left blank.
- Cells L31 and M31 – Enter 0 and 3 respectively for the months of trend.

For 4th Quarter Filings:

- Any values in cells J30, J34, K30, K34, L30, and L34 should be overwritten and left blank.
- Cell M31 – Enter 0 for the months of trend.

## B. Retention Items (Table 6)

Complete Table 6 and, in the narrative, separately identify all retention items and show the proposed percent of premium for the rating period. The values in Table 6 for total Administrative Expenses, total Taxes and Fees, and Profit/Contingency are imported from Table 10. If the sum of the administrative expenses or the sum of taxes and fees is inconsistent with the average amount in Column Q of Table 10, an error will present in Cell C49 or Cell C53 in Table 6. Table 6 provides a breakdown of the administrative expenses and taxes and fees, and the broken-out elements sum to the total administrative expenses and taxes and fees. Provide documentation and supporting data for all inputs --

administrative expenses including agent/broker fees and commissions and quality improvement initiatives, and taxes and fees, separately identified. Please note the following:

- If the administrative expenses vary by plan, explain why in the narrative.
- The narrative should discuss the development of the average commission and circumstances in which broker commissions will be paid and if they will vary based on geographic location, metal level, plan, open enrollment vs SEP enrollment, etc. Additionally, the current and 2026 broker agreements should be included.
- If profit, contribution to surplus or risk margins is included in the rate development, the PID expects a consistent percent of premium load for all plans. If the profit, contribution to surplus, or risk margin does vary by plan, explain why the variation is not discriminatory.
- A column is included for PMPM dollar amounts. No data entry is required as these cells are auto-calculated.
- The URRT requires input for the Risk Adjustment User Fee and this input has been added in Table 6.

## C. Normalized Market-Adjusted Projected Allowed Total Claims (Table 7)

The projected data is on an average basis. To more appropriately compare the average year-over-year rate change, as is done in Table 8, a normalization process is performed in Table 7. To normalize, the Market-Adjusted Projected Allowed Total Claims PMPM from Table 5, Cell K57 is normalized using the projected average factors for age, geography, tobacco, benefit richness (induced demand), and network.

Provide the 2025 Market-Adjusted Projected Allowed Total Claims PMPM, which should reflect a quarter 1 amount for the small group market, and the 2025 normalization factors. These numbers should match the numbers provided in the plan year 2025 rate filing. The 2025 Normalized Market-Adjusted Projected Allowed Total Claims PMPM is auto-calculated based on the 2025 input data.

The 2026 normalization factors should be based on the projection period member population. An Excel exhibit should be provided to show the development of the normalization factors, experience period and the projected period distributions. Additionally, the narrative should discuss any differences between the experience period and projected period distributions. The average age factor may include a factor of 0 for non-billable members, i.e., dependents in excess-of the three-child maximum under the age of 21.

## D. Components of Rate Change (Tables 8 and 9)

Document the components of change in the proposed 2026 Calibrated Plan Adjusted Index Rate (PMPM). Table 8 should include, at most, three data entries. First, enter the 2025 base period allowed claims in Cell C73. If necessary, complete "Change in Miscellaneous Items" for 2025 and 2026 in Cells C97 and D97. The narrative should detail any miscellaneous items and describe how the values for Cells C97 and D97 were calculated. The rest of the table will calculate based on entries elsewhere in the Excel workbook.

Row H of Table 8 should approximate Row A of Table 8. If Row H is substantially different from Row A, explain why in the narrative.

Table 9 collects data elements for 2025 and 2026 to support the calculations in Table 8. The amounts shown in the 2025 Column should match those entered in the 2025 Column in the plan year 2025 rate filing. If the amounts shown differ from those in the 2025 rate filing, explain why.

## 3. Plan Rate Development (Table 10)

The projected market-adjusted index rate is used to develop the calibrated plan adjusted index rates in Columns Z and AA of Table 10. Each plan's rate is developed as the product of the market-adjusted index rate, the allowable factors, and calibration for age, geography, and tobacco.

For small group quarterly filings, the PID notes that the only expected changes to Table 10, relative to the annual rate filing, are cells C8-C11, Columns R, S and T (if appropriate), cells T4-T6, Column W, and Columns AG-AO, AS, and AX.

### A. Instructions for Completing Table 10 of the PA Rate Exhibits

Column A, Rows 18-317 have been unlocked to allow insurers to edit the Plan numbers, if needed, in accordance with the mapping instructions of the guidance.

Beginning in Column B, Row 18, the template requests the HIOS Plan ID number for all plans that will be offered in 2026, and for all plans offered in 2025 that will not be offered in 2026. Column C should include plan type for each plan, consistent with the URRT. Column D should include the plan marketing name for each plan. This naming convention will be specific to each insurer but there should be consistency from filing to filing each year. Since plan offerings will need to conform to metallic tier offerings, and HHS has issued a new actuarial value calculator, some plans may be discontinued, others may be new, and others may be modified. Column E should indicate whether a plan will be existing (E) - i.e., no changes to the plan; modified (M); new (N); discontinued and mapped to a 2026 plan (DM); or discontinued and not mapped to a 2026 plan (DNM).

Plans must be discontinued if they exceed the federal uniform modification standards in 45 C.F.R. § 147.106.

### B. Mapping Scenarios – Individual Market

The insurer is expected to account for all enrollment as of 2/1/2025 on Table 10. This means that the number in Table 10, Cell AP15 should equal the number in Table 1, Cell D18. Plans may fall into several categories, which will necessitate different treatment in Table 10:

- The 2025 plan will continue to be available to all current enrollees in 2026 – in this case, all 2025 enrollees should be mapped into the continued 2026 plan. Input 2025 plan information in Columns B-D, W, Z, and AG-AO. Input “E” or “M” in Column E, as appropriate. Input 2026 plan information in all other input columns.
- The 2025 plan will be discontinued in 2026 – in this case, information for the 2025 plan should be entered in Columns B-D, W, Z, and AG-AO.
    - If enrollees will be mapped into a 2026 plan, input “DM” in Column E and input the information for the 2026 plan in all other input cells starting at Column F.
    - If enrollees will not be mapped into a 2026 plan, input “DNM” in Column E and leave all other input cells blank.
- The 2025 plan will be available to some, but not all, enrollees in 2026 due to reductions in service area or change in exchange participation from on-exchange to off-exchange – in this case, multiple rows should be used to account for all 2025 enrollees. Edit the plan numbers in Column A as follows – if the 2025 plan with enrollment being split into multiple paths in 2026 is, for example, plan 4 according to Table 10, input Plan 4a, Plan 4b, Plan 4c, etc., into Column A, and then renumber subsequent rows so that they continue with Plan 5, Plan 6, etc.
    - The first row (“Plan 4a” in this example) should include information on the 2025 enrollees who will be mapped into the continued 2026 plan. Input “M” in Column E. Columns W and AG-AO should show numbers for the 2025 enrollees who will be mapped into the continued 2026 plan.
    - The next row(s) (“Plan 4b” in this example) should be used to show information for any 2025 enrollees who will be mapped into a different 2026 plan. Input “DM” in Column E. If 2025 enrollees will be mapped into multiple 2026 plans, use a separate row for each 2026 plan. Columns A-D, and Z should show information pertaining to the 2025 plan. Columns F-T should show information pertaining to the 2026 plan. Columns W and AG-AO should show numbers for the 2025 enrollees who will be mapped to that plan.

- The last row ("Plan 4c" in this example) should be used to show information for any 2025 enrollees who will not be mapped into a 2026 plan. Input "DNM" in Column E. Columns A-D and Z should show information on the 2025 plan. Columns G-T should be blank. Columns W and AG- AO should show the number of 2025 enrollees who will not be mapped to a 2026 plan.

- The plan is new in 2026 – in this case, Columns W, Z, and AG-AO should be left blank.

## C. Mapping Scenarios – Small Group Market

The instructions presented above for how to present enrollment in Table 10 for an individual market filing should also be followed for a small group market filing. The PID recognizes that many small group market enrollees as of the specified date will still be in plan year 2024 or 2025 plans. The filer should map enrollees in plan year 2024 or 2025 plans to the plan year 2026 plan that the filer anticipates the enrollees will move into when they renew in 2026. If the plan will be continued in 2026, then the enrollees should be mapped to the 2026 plan. If the plan will not be continued in 2026, then the enrollees should be mapped to the 2026 plan that will be offered to them for renewal.

## D. General Instructions – Individual and Small Group Market

The 2025 Calibrated Plan Adjusted Index Rate in Column Z should reflect the 2025 plan and the 2026 Calibrated Plan Adjusted Index Rate in Column AA should reflect the 2026 plan. For new plans, we do not expect to see a 2025 rate.

Column G requests the metallic tier (Platinum, Gold, Silver, Bronze, Expanded Bronze, and Catastrophic) and Column H should include the metallic tier actuarial value. This is the actuarial value that the insurer calculates using the HHS Actuarial Value Calculator. If the HHS Actuarial Value Calculator does not accommodate an insurer's benefit designs, the insurer has one of two options:

- Approach 1 (45 C.F.R. § 156.135(b)(2)): The insurer may adjust the plan benefit design (for calculation purposes only) to fit the parameters of the calculator and have a member of the American Academy of Actuaries certify the methodology.
- Approach 2 (45 C.F.R. § 156.135(b)(3)): The insurer may use the calculator for the plan design provisions that correspond to the parameters of the calculator and then have a member of the American Academy of Actuaries make appropriate adjustments to the actuarial value.

In Column I, please indicate whether the metallic tier actuarial value was calculated using the HHS Actuarial Value Calculator ("Standard AV"), or whether it was calculated using "Approach 1" or "Approach 2." For those metallic tier actuarial values calculated with the AV calculator, provide screenshots of the calculations. The policy form number should be included on the screenshot.
Within the PA Actuarial Memorandum, please include the actuarial certifications for those metallic tier actuarial values calculated under Approach 1. The actuarial certification can be found in the federal form, Unique Plan Design Supporting Documentation and Justification. For those metallic tier actuarial values calculated under Approach 2, please provide supporting calculations within the PA Actuarial Memorandum.

In Column J, please indicate whether the plan offering will be through Pennsylvania's state-based exchange, Pennie®.

Columns K through P and Columns R through T should report the allowable factors to adjust the 2026 market adjusted index rate to calculate the plan adjusted index rate. The numbers entered in Columns K through P should be reported as a multiplier. Please note that Columns L and N should be normalized using the membership as of the specified date or the projected member distribution such that the resulting member-weighted average for each is equal to 1.000. Whichever distribution is used, the methodology should be internally consistent and described in the PA Actuarial Memorandum. The induced demand factors which are used in calculating the normalized factors in Column L should be based on the HHS induced demand factors utilized in the risk transfer formula and should use the following formula: (Plan AV)^2 – (Plan AV) + 1.24. This produces the HHS factors by metal level (i.e., a 0.60 pricing AV is a 1.00 factor, and a 0.90 pricing AV is a 1.15 factor) but accounts for the fact that not all plans within a metal level will have the same pricing

AV. The "Plan AV" should be the product of the "Pricing AV" (column K of Tab III) and "Non-Funding CSR Adjustment" (column P of Tab III).

Column P captures the CSR defunding adjustment for On Exchange Silver Plans. For On- Exchange Silver Plans, insurers should populate Column P with their selected value within the range of 1.22 – 1.30 such that CSR Defunding Adjustment can be applied in the development of the Calibrated Plan Adjusted Index Rate in Column AA. For all other plans, insurers should populate Column P with 1.00 for both Individual and Small Group markets.

Column Q calculates the pure premium by multiplying the market-adjusted index rate by the factors in Columns K through P. The numbers in Columns R through T should be reported as a percent of gross premium. Please note, the profit reported in Column T should be on an after-tax basis.

The insurer should provide supporting information for these allowable plan level adjustments within the PA Actuarial Memorandum. For further information on these allowable plan level adjustments, please refer to the URR instructions and the instructions for the Federal Part III Actuarial Memorandum.

In Cells T4, T5, and T6, the insurer should enter the age, geographic, and tobacco calibration factors. The age calibration may include an adjustment to account for the three-child-cap. The development of all factors must be quantitatively shown in an Excel spreadsheet.

Column V – it will autofill using the numbers entered in Columns AG – AO and totaled in Cell AP15 of this Table.

Column W requires Total Projected Lives by plan.

For annual filings, in Column Z, Row 18 and following, the insurer is expected to fill in the annual individual or January 1 small group 2025 approved calibrated plan adjusted index rates by plan offering. Starting in Row 18, Column AA, each 2026 calibrated plan adjusted index rate is calculated by applying the proposed 2026 plan adjustments in Columns K through P and R through T, and the calibration factor in Cell T7, to the market-adjusted index rate in Cell C11. Weighted average rates for 2025 and 2026 are calculated using the specified date membership distribution by plan offering.

For small group quarterly filings, cells AS11, AT11, AU11 and AV11 are auto-calculated. In Column AX, Row 18 and following, the insurer is expected to fill in the annual average small group 2025 approved calibrated plan adjusted index rates by plan offering, consistent with the amount shown for the 2025 column in the approved 2026 annual filing.[3]

For 3rd and 4th Quarter Filings:

- Any existing formulas in the cells in column AT referenced below should be overwritten with the information described.
- In column AS and AT (row 18 and below) the Q1 2026 and Q2 2026 amounts should be calculated, respectively, based on the most recent approved amounts for each corresponding quarter and entered.

For 4th Quarter Filings:

- Any existing formulas in the cells in columns AT and AU referenced below should be overwritten with the information described.
- In columns AS, AT, and AU (row 18 and below) the Q1 2026, Q2 2026, and Q3 2026 amounts should be calculated, respectively, based on the most recent approved amounts for each corresponding quarter.

[3] If a 2nd, 3rd, and 4th quarter filing is made (see note in "1 – Timeline"), in column AT (row 18 and below) the 1Q2026 amounts should be calculated from the previously approved rate filing (e.g., for each plan, the 1Q2026 Calibrated Plan Adjusted Index Rate).

## 4. Plan Premium Development for 21-Year-Old Non-Tobacco User (Table 11)

The projected calibrated plan-adjusted index rate is used to develop the 21-year-old non-tobacco premium in the individual market on Tab IV A, and the 1st, 2nd, 3rd and 4th quarter 21-year-old non- tobacco premium in the small

group market on Tab IV B. For individual market filings, 2025 and 2026 premiums are compared to calculate the average 21-year-old premium increase. For small group market filings, 1st quarter 2025 and 2026 rates are compared to calculate the average 21- year-old premium increase in the 1st quarter. Rates for 2nd, 3rd and 4th quarters may be changed through quarterly filings.

### Instructions for Completing Table 11 of the PA Rate Template

For annual filings, instead of using a single Table for both individual and small group filings, the PID has split Table 11 into two Tables, each on its own Tab: "PA Plan Premiums Individual" and "Plan Premiums SG Annual".

Based on the market segment selected, the other Tab for Table 11 should be deleted or hidden.

- If Market segment is Individual, the Annual Rates by Rating Area are auto-calculated, and no data entry is required.
- If Market segment is Small Group Annual, the rates for all four quarters of 2026 are auto-calculated. However, the first quarter 2025 approved rates should be entered in the yellow section.

In Table 11 Tab IV B, Columns I through Q, insurers are expected to enter the 1st quarter non-tobacco premium rate for each rating area. In Table 11, insurers are expected to enter the Number of Covered Lives as of the date indicated in cell AP10 for IND and BW10 for SG by County by Plan. Data will need to be entered in Columns AP:DL for the individual market tab and Columns BW:ES for the small group market tab (cells are highlighted yellow).

For small group quarterly filings, the projected calibrated plan-adjusted index rate is used to develop the subsequent quarterly rates for a 21-year-old non-tobacco user in the small group market on Tab IV C. On this tab, subsequent quarterly 2025 and 2026 rates are compared to calculate the average 21-year-old rate increase in the future subsequent quarters depending on the proposed quarter effective date. In Table 11 Tab IV, insurers are expected to enter the non-tobacco rates for each rating area.

- For 3rd and 4th quarter updates, BW through CE and DD through DL
- For 4th quarter updates, DD through DL

All other cells will automatically update.

## 5. Plan Factors

### A. Age and Tobacco Factors (Table 12)

Complete Table 12 by entering in the tobacco factor used for each age band. Pennsylvania uses the default federal standard age curve.

Note: The member-level rate build-up is capped such that no more than the three oldest covered children under age 21 may be taken into account when determining the total family premium.

### B. Geographic Factors and Adjusted Loss Ratios (Table 13)

Complete Table 13. If the proposed geographic factors are not consistent with the current approved factors, data and narrative should be provided indicating the development of each factor. The member-months entered should be based on the experience period. The PMPM values should be entered such that the loss ratios produced in column S are adjusted for risk and reinsurance (if applicable). Premium amounts should be adjusted for risk adjustment and claim amounts should reflect rebates and non-system claims. If any other applicable adjustments are applied, a narrative and demonstration should be provided showing those adjustments.

### C. Network Factors (Table 14)

Complete Table 14. For each network, please use only one network rating factor per state per market. That factor is applied to all plans the insurer has in all applicable rating areas uniformly. If multiple networks exist within a given rating area, please use a separate plan ID number for each network within the rating area.

### D. Rate Change Summary (Table 15)

Complete Table 15. For the Initial Requested Rate Change (Cell B4), please enter the initial filing's Table 11 average age 21, non-tobacco rate change. For the Key Information Section (Cells B14:B17), enter the financial information which should be consistent with Table 2. Since administrative expenses and after-tax profit are not captured in Table 2, the insurer is expected to report these amounts for the subject market for the 2024 rating period. For the Medical Costs to Increase (Cell D21), the percentage may be overwritten with an explanation. For the How It Plans to Spend Your Premium section (Cells I15:I18), percentages should be consistent with Tables 5 and 6, except that Taxes & fees should include exchange user fees. In the Explanation of requested rate change section (Cell B23), provide a non-technical description of why the insurer is requesting this rate increase. Identify and explain the key drivers of the increase.

### E. Service Area Composition

If multiple service areas exist, show the counties that comprise each service area. If this filing proposes Service Area changes relative to the last approved filing, detail the changes and their cause.

### F. Composite Rating

Pennsylvania will allow composite rating as described in 45 C.F.R. § 147.102(c)(3)(ii). If the insurer plans to use composite rating, indicate this in the narrative.

### G. Connectivity Factors

If the product filing has available connectivity features (broadband, data plans assistance, etc.), please describe in the narrative how the rate filing accounts for those connectivity features. If the rate filing does not account for such connectivity features but such features are available as part of the product, please state this in the response.

## 6. Additional Tabs in the PAAM Exhibits

### A. VII Risk Adjustment

Table 16A and 16B have been added to the "VII Risk Adjustment" tab based on insurer feedback during debrief calls and guidance feedback to collect insurer specific risk factors for each combination of Plan ID and Rating Area. Please enter Non-Catastrophic Plan data in Table 16A and Catastrophic Plan data in Table 16B. A table has also been added in columns G:I to collect the GCF for each rating area. This will be used to populate the GCF values in Table 16A/B. The data entered in Table 16A/B should be based on the experience period. The insurer specific risk factor calculations have been revised to use the Table 16A/B data. The Department will provide the statewide factors including and excluding risk score in early May to be entered in rows 13 and 14 of Table 16. The Insurer Specific Manual Adjustment PMPM entered in cell C28 of Table 16 should be used to make any applicable adjustments such that the value produced in cell C32 of Table 16 is the Incurred Risk Adjustment PMPM for the projection period. A separate Excel exhibit should be provided to support any manual adjustment.

### B. VIII MLR and Rebate Calc

"VIII MLR and Rebate Calc" is a new tab containing information from Part 3 of the medical loss ratio report submitted to the Department of Health and Human Services. The requested information includes claims and premium data for the most recent 3 years, the current year, and the rating period.

### C. IX Retrospective Analysis

"IX Retrospective Analysis" is a new tab designed to compare projected values from prior years to actual experience. In Table 17-1, columns C through F should be filled in with Table 4 data from last year's filing. For Table 17-2, the projected values should be filled in based on what was initially projected for the experience period two years ago. For example, in this year's submission the company should be using PY24's filing to fill in cells D44:D47.

### D. X Drug Data

"X Drug Data" is a new tab to collect more detailed drug claims data during the experience period to ensure PBM compliance with Act 77. The Department requests that all health insurers work closely with their associated PBM to obtain this information. Please see standard question #10 for all requested information pertaining to Act 77 compliance. Use the same pharmacy for all affiliated data. Use the same pharmacy for all non-affiliated data. When considering which non-affiliated pharmacy to use for this request, please consider the pharmacy with the largest script volume that is located within a reasonable distance from the affiliated pharmacy. Using last year's PA claims data:

- Complete cells P7-R16 to show the minimum, maximum, and average allowed amounts paid by the PBM to a retail pharmacy that is affiliated to the PBM.
- Complete cells S7-U16 to show the minimum, maximum, and average allowed amounts paid by the PBM to a retail pharmacy that is not affiliated to the PBM.
- Complete cells V7-X16 to show the minimum, maximum, and average allowed amounts paid by the PBM to an entity participating in the program under section 340(B) of 58 Stat. 682. 42 U.S.C. Section 256(B).
- Complete cells Y7-AA16 to show the minimum, maximum, and average allowed amounts paid by the PBM to an entity not participating in the program under section 340(B) of 58 Stat. 682. 42 U.S.C. Section 256(B).
- Complete cells AG7-AI12 to show the minimum, maximum, and average allowed amounts paid by the PBM to a retail pharmacy that is affiliated to the PBM.
- Complete cells AJ7-AL12 to show the minimum, maximum, and average allowed amounts paid by the PBM to a retail pharmacy that is not affiliated to the PBM.

## 7. Actuarial Certifications

At a minimum, the actuarial certification must include certifications that:

- All factor, benefit and other changes from the prior approved filing have been disclosed in the actuarial memorandum.
- A new plan is not a modification of an existing plan. See the uniform modification standards in 45 C.F.R. § 147.106.
- The information presented in the PA Actuarial Memorandum and PA Actuarial Memorandum Rate Exhibits is consistent with the information presented in the 2024 Rate Filing Justification.

# D. Additional Exhibits

## 1. PID Plan Design Summary and Rate Tables

Submit the PID Plan Design Summary and Rate Tables in Excel in the Rate/Rule Schedule Tab in SERFF. The information provided in all the three tabs of this workbook must be complete and consistent. The "Plan Design Summary" Tab has a macro/button to validate the template by checking if all information was entered for each plan and that the information entered corresponds to what is possible from the drop downs. The "Rate Pages" Tab has a macro/button to add additional plan columns If they are needed by the insurer in order to achieve consistency in added Columns across all insurers.

## 2. Service Area Map

Submit a map of the current 2025 service area and the proposed 2026 service area. Distinguish, if appropriate, between on-exchange and off-exchange service area by using the formatting indicated on the template to indicate the off-exchange service area and the on-exchange service area. If necessary, the 2025 and the 2026 service areas may be depicted on different maps. The PID has provided a template in a PowerPoint slide that insurers may use to submit this information, but an insurer is also welcome to use its own software to generate the map(s). To use the formatting indicated in the template, you may either right click on a county and select "fill" to change the color and/or select "format shape/pattern fill" to add the pattern overlay, or you may click the desired format in the key, select "Format Painter" on the Home Tab, and then click on the county you want to format.

# E. Standard Questions

1. Membership:
    a. If the projected membership for plan year 2026 significantly differs from the current 2/1/2025 membership, please explain why.

2. Experience Period Claims:
    a. Please confirm that all claims which are capitated have been removed from the experience period claims.
    b. Please confirm that all non-EHB claims have been removed from the experience period claims.
    c. How are drug rebates projected to change from the base period to the rating period? How has this change been reflected in the rate development?

3. Trend:
    a. [SG. Only] If the Total Annual Trend in Table 3 (weighted by credibility) and the Annual Trend used to calculate quarterly rates in Table 5A differ, please provide an explanation and exhibit in support of the variation.
    b. [SG. Only] In Table 5A, if cells K32:M32 are left to equal J32, please explain why that is a reasonable assumption.

4. Table 6 – Retention:
    a. Please confirm that the federal income tax is calculated using a Federal Income Tax Rate of 21%. If other adjustments were made in Table 6, cell C57, please provide a demonstration of how this number was calculated and an explanation of the other adjustments included in the calculation.
    b. Please confirm that the Risk Adjustment User Fee PMPM is consistent with HHS Final Notice of Benefit and Payment Parameters for plan year 2026.
    c. Please provide an exhibit showing the commission PMPM amount to be paid to brokers in the following situations: Open-Enrollment Enrollee – Renewing, Open Enrollment Enrollee – New, Special Enrollment Period Enrollee – New, Special Enrollment Enrollee – Renewing. If the commission PMPM is not consistent between the four options above, please provide a detailed explanation as to the reason for the difference.

5. Pricing AVs:
    a. Please confirm that the Pricing AVs were calculated using a single risk pool (i.e., claims/utilization experience is not separated by metal level).
    b. Please identify and support any differences between the company's metallic AV calculator results and the corresponding Pricing AVs.

6. Expanded Bronze Plans:
    a. Please provide an exhibit which demonstrates that the criteria for expanded bronze plans have been met.

7. PAAM Exhibits – Consumer Factors:
    a. Please provide quantitative and qualitative support for the proposed geographic rating area factors, if different from the previous year.
    b. Please provide quantitative and qualitative support for the proposed network factors, if different from the previous year.

8. Plan of Withdrawal:
    a. Please confirm that a Plan of Withdrawal has been submitted if any plans are being discontinued.
    b. For further information regarding the Plan of Withdrawal process, click here. Please send all Plan of Withdrawals to Jeff Rohaly, wrohaly@pa.gov.

9. Copay Adjustment Programs:
    a. Does the company use a copay adjustment program (also known as a copay accumulator program)?
        i. If the company uses a copay adjustment program, please provide a detailed narrative that describes how the program works and the motivation behind implementing the program.
    b. How does the company handle copay assistance coupons? For example, does the coupon apply to the MOOP?
    c. If any change to such a program has resulted in a pricing impact, please include a narrative describing how the impact has been included within the rate development and a detailed quantitative exhibit supporting the impact.

10. PBM and Act 77 of 2024 Compliance: The Department expects insurers to work closely with their PBM to conduct a good faith effort at collecting the requested data below.

    a. Is the PBM handling any part of the negotiations that impacts the cost of drugs?

    b. What is the email address, name, and phone number for the PBM contact?

    c. What is the amount of funds the PBM recouped from pharmacies due to Scrivener's errors?

    d. Use the same pharmacy for all affiliated data. Use the same pharmacy for all non-affiliated data. In Table 18 of the PAAME, using last year's PA claims data:
        i. Complete cells P7-R16 to show the minimum, maximum, and average allowed amounts paid by the PBM to a retail pharmacy that is affiliated to the PBM.
        ii. Complete cells S7-U16 to show the minimum, maximum, and average allowed amounts paid by the PBM to a retail pharmacy that is not affiliated to the PBM.
        iii. Complete cells V7-X16 to show the minimum, maximum, and average allowed amounts paid by the PBM to an entity participating in the program under section 340(B) of 58 Stat. 682. 42 U.S.C. Section 256(B).
        iv. Complete cells Y7-AA16 to show the minimum, maximum, and average allowed amounts paid by the PBM to an entity not participating in the program under section 340(B) of 58 Stat. 682. 42 U.S.C. Section 256(B).
        v. Complete cells AG7-AI12 to show the minimum, maximum, and average allowed amounts paid by the PBM to a retail pharmacy that is affiliated to the PBM.
        vi. Complete cells AJ7-AL12 to show the minimum, maximum, and average allowed amounts paid by the PBM to a retail pharmacy that is not affiliated to the PBM.

    e. The following questions pertain to rebates:
        i. Please provide the total amount of rebates remitted to the PBM in cell AO5 of Table 18.

ii. Please provide the total amount of funds (rebates, etc.) remitted to the insurer by the PBM for the previous claim year in cell AO6 of Table 18. If there are funds in addition to the rebates, please specify what those funds represent.
iii. Please provide the total amount of rebates remitted to the insurer by the PBM for the previous claim year in cell AO7 of Table 18.

f. What is the percent of rebates remitted to the insurer by the PBM for the previous claim year based on your response to parts i and iii above? Please confirm that this answer matches cell AO8 of Table 18.

g. Does the health plan have an arrangement with the PBM where the insurer has to meet specific contract requirements, such as reaching a threshold of filled scripts?
    i. If yes, what is the total amount of funds remitted for the previous claim year to the PBM by the insurer for unexpected fees, penalties, etc.? Please state this value in cell AO10 of Table 18.

h. In aggregate for the previous claim year, how much funds in total were received from non-affiliate pharmacies for post-sale or retroactive Direct and Indirect Renumeration?

i. In aggregate for the previous claim year, how much funds in total were received from affiliate pharmacies for post-sale or retroactive Direct and Indirect Renumeration?

RETURN TO TOP