

**MARYLAND HEALTH BENEFIT PLAN RATE FILING REQUIREMENTS**  
**INDIVIDUAL/ASSOCIATION AND SMALL EMPLOYER GROUPS**  
**REVISED ON MARCH 16, 2015**

INSTRUCTIONS: Include all required elements in the table below with the filed rates. The data elements listed in the Actuarial Memorandum should be consistent with the cover letter, if applicable.

Number	Data Element	Requirement Description	Individual/Association, and Small Employer Group	
			Has the Data Element Been Included?	Location of the Data Element
1	Purpose of Filing	State the purpose of the filing. Identify the applicable law. List the proposed changes to the base rates and rating factors, and provide a general summary.		
2	Form Numbers	Form numbers should be listed in the actuarial memorandum.		
3	HIOS Product ID	The HIOS product ID should be listed in the actuarial memorandum.		
4	Effective Date	The requested effective date of the rate change, at least 90 days (60 days for a nonprofit health service plan or an HMO) from the date of submission.  For filings effective 1/1/2016, follow filing due date requirements stated in Bulletin 15-01.		
5	Market	Indicate whether the products are sold in the individual or small employer group market.		
5.1	Inside or Outside the Exchange	Indicate whether the products are to be sold inside the Exchange, outside the Exchange or both.		
6	Status of Forms	Indicate whether the forms are open to new sales, closed, or a mixture of both, and whether the forms are grandfathered, non-grandfathered, or a mixture of both.		
7	Benefits/Metal level(s)	Include a basic description of the benefits of the forms referenced in the filing and the metal level of each plan design.		

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7.1	AV Value	Provide the actuarial value of each plan design using the AV calculator developed and made available by HHS.		
8	Average Rate Increase Requested	The weighted average rate increase being requested, incremental and year-over-year renewal. The weights should be based on premium volume. <b>In the small group market, please also provide weighted average rate increase requested for 2016Q1 over 2015Q1</b>		
9	Maximum Rate Increase Requested	The maximum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors, incremental and year-over-year renewal. (Does not include changes in the demographics of the covered members.)		
10	Minimum Rate Increase Requested	The minimum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors, incremental and year-over-year renewal. (Does not include changes in the demographics of the covered members.)		
11	Absolute Maximum Premium Increase	The absolute maximum year-over-year renewal rate increase that could be applied to a policyholder, including demographic changes such as aging.		
12	Average Renewal Rate Increase for a Year	Calculate the average renewal rate increase, weighted by written premium, for renewals in the year ending with the effective period of the rate filing. The calculation must be performed for each HIOS product ID.		
13	Rate Change History	Rate change history of the forms referenced in the filing. If nationwide experience is used in developing the rates, provide separately the rate history for Maryland and the nationwide average rate history.		
14	Exposure	Current number of policies, certificates and covered lives.		

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15	Member Months	Number of members in force during each month of the base experience period used in the rate development and in each of the two preceding twelve-month periods.		
16	Past Experience	Provide monthly earned premium and incurred claims for the base experience period used in the rate development and each of the two preceding twelve-month periods.		
17	Index Rate	Provide the index rate.		
17.1	Rate Development	Show base experience used to develop rates and all adjustments and assumptions applied to arrive at the requested rates. For less than fully credible blocks, disclose the source of the base experience data used in the rate development and discuss the appropriateness of the data for pricing the policies in the filing.		
18	Credibility Assumption	If the experience of the policies included in the filing is not fully credible, state and provide support for the credibility formula used in the rate development.		
19	Trend Assumption	Show trend assumptions by major types of service as defined by HHS in the Part I Preliminary Justification template, separately by unit cost, utilization, and in total. Provide the development of the trend assumptions.		
20	Cost-Sharing Changes	Disclose any changes in cost sharing for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for cost-sharing changes in the rate development. Provide support for the estimated cost impact of the cost-sharing changes.		
21	Benefit Changes	Disclose any changes in covered benefits for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for changes in covered benefits in the rate development. Provide support for the estimated cost impact of the benefit changes.		

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22	Plan Relativities	For rate change filings, if the rate change is not uniform for all plan designs, provide support for all requested rate changes by plan design. Disclose the minimum, maximum, and average impact of the changes on policyholders.  For initial filings, provide the derivation of any new plan factors.		
23	Rating Factors	Provide the age, area and smoking rating factors used. Disclose any changes to rating factors, and the minimum, maximum, and average impact on policyholders. Provide support for any changes.		
23.1	Wellness Programs	Describe any wellness programs (as defined in section 2705(j) of the PHS Act) included in this filing.		
24	Distribution of Rate Increases	Anticipated distribution of rate increases due to changes in base rates, plan relativities, and rating factors. This need not include changes in demographics of the individual or group.		
25	Claim Reserve Needs	Provide the claims for the base experience period separately for paid claims, and estimated incurred claims (including claim reserve). Indicate the incurred period used for the base period. Indicate the paid-through date of the paid claims, and provide a basic description of the reserving methodology for claims reserves and contract reserves, if any. Provide margins used, if any.		
26	Administrative Costs of Programs that Improve Health Care Quality	Show the amount of administrative costs included with claims in the numerator of the MLR calculation, demonstrating compliance with Ins. Article § 15-605(c). Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.		

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27	Taxes and Licensing or Regulatory Fees	Show the amount of taxes, licenses, and fees subtracted from premium in the denominator of your medical loss ratio calculation, demonstrating compliance with Ins. Art. § 15-605(c). Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.		
28	Medical Loss Ratio (MLR)	Demonstrate that the projected loss ratio, including the requested rate change, meets the minimum MLR requirements of Ins. Art. § 15-605(c). Show the premium, claims, and adjustments separately with the development of the projected premium and projected claims (if not provided in the rate development section). If the loss ratio falls below the minimum for the subset of policy forms in the filing, show that when combined with all other policy forms in the market segment in Maryland, the loss ratio meets the minimum.		
29	Risk Adjustment	Provide rate information relating to the Risk Adjustment program. Information should include assumed Risk Adjustment user fees, Risk Adjustment PMPM excluding user fees and assumed distribution of enrollment by risk score, plan, and geographical area. Provide support for the assumptions, including any demographic changes. Provide information/study on the development of risk scores and Risk Adjustment PMPM. Provide year end 2014 estimated risk adjustment payable or receivable amount and quantitative support for the amount.		

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29.1	Reinsurance	Provide information on the Reinsurance contribution assumption, consistent with the national contribution rate for the projection period. In individual filings, provide information on the Reinsurance recovery assumption, consistent with the company's continuation table used in pricing. Provide year end 2014 estimated reinsurance payable amount and quantitative support for the amount.		
29.2	Risk Corridor	Does the company assume Risk Corridor charges or payments? If so, provide support. Provide year end 2014 estimated risk corridor payable or receivable amount and quantitative support for the amount.		
30	Past and Prospective Loss Experience Within and Outside the State	Indicate whether loss experience within or outside the state was used in the development of proposed rates. Provide an explanation for using loss experience within or outside the state.		
31	A Reasonable Margin for Reserve Needs	Show the assumed Margin for Reserve Needs used in the development of proposed rates. Margin for Reserve Needs includes factors that reflect assumed contributions to the company's surplus or the assumed profit margin. Demonstrate how this assumption was derived, how the assumption has changed from prior filings, and provide support for changes. If the assumption for Qualified Health Plans exceeds 3% as assumed in the risk corridor formula, justify the excess in light of the company's surplus position.		

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32	Past and Prospective Expenses	<p>Indicate the expense assumptions used in the development of proposed rates. Demonstrate how this assumption was derived. Show how this assumption has changed from prior filings, and provide support for any change.</p> <p>Provide the assumed administrative costs in the following categories:</p> <ul style="list-style-type: none"> <li>• Salaries, wages, employment taxes, and other employee benefits</li> <li>• Commissions</li> <li>• Taxes, licenses, and other regulatory fees</li> <li>• Cost containment programs / quality improvement activities</li> <li>• All other administrative expenses</li> <li>• Total</li> </ul>		
33	Any Other Relevant Factors Within and Outside the State	Show any other relevant factors that have been considered in the development of the proposed rates. Demonstrate how any related assumptions were derived. Show how these assumptions have changed from prior filings, and provide support for any change.		
34	Other	Any other information needed to support the requested rates or to comply with Actuarial Standard of Practice No. 8.		
35	Actuarial Certification	Signed and dated certification by a qualified actuary that the anticipated loss ratio meets the minimum requirement, the rates are reasonable in relation to benefits, the filing complies with the laws and regulations of Maryland and all applicable Actuarial Standards of Practice, including ASOP No. 8, and that the rates are not unfairly discriminatory.		

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36	Part I Preliminary Justification (Grandfathered Plan Filings)	Rate Summary Worksheet provided on the Maryland Insurance Administration website. Provide this document with all Grandfathered plan filings. <b>Provide in Excel and PDF format.</b>		
36.1	Unified Rate Review Template (Non-Grandfathered Filings)	Unified Rate Review Template as specified in the proposed Federal Rate Review regulation. Provide this document with all Non-Grandfathered plan filings. <b>Provide in Excel and PDF format.</b>		
37	Part II Preliminary Justification	Written description justifying the rate increase as specified by 45 CFR § 154.210(f). Provide for <i>all</i> individual and small employer group filings (whether or not they are “subject to review” as defined by HHS).		
38	Additional Requirements for Stand-Alone Dental Plan Filings	Provide the following for stand-alone dental plan filings: <ul style="list-style-type: none"> <li>• Identification of the level of coverage (i.e. low or high), including the actuarial value of the plan determined in accordance with the proposed rule;</li> <li>• Certification of the level of coverage by a member of the American Academy of Actuaries using generally accepted actuarial principles; and</li> <li>• Demonstration that the plan has a reasonable annual limitation on cost-sharing.</li> </ul>		



## REQUEST FOR DETERMINATION

Maryland law stipulates that a carrier may request a finding by the Commissioner that certain information contained in a rate filing be considered confidential commercial information under MD. ANN. CODE, STATE GOVT. ART., § 10-617(D) and not subject to public inspection. An insurer making this request shall specifically identify the location of the information, including, but not limited to, the document, page number, and section number. Additionally, the carrier must state the reasons for considering the information confidential commercial information. Please provide any requests for determination in the format provided below. Additional pages may be attached if necessary.

Specific Information:

Location of Information:

Reasoning and justification of why the information should be considered confidential commercial information:

### CERTIFYING SIGNATURE

**The undersigned representative of the organization submitting this rate filing attests that all items contained in the above checklist have been included in the filing to the best of the company's ability.**

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Signature)