

Instructions to Child Health Plus Renewal Operating Plan and Premium Proposal Application

Introduction

The Renewal Operating Plan and Premium Proposal application is to be used only when revised premium rates are being proposed to an already approved service region, to an already approved rating region, and to the same plan of benefits as reflected in the current premium rates.

Applications are to be filed through SERFF using Filing Type CHP Renewal Rates and MLR Reporting. SERFF Filings for Calendar year 2022 rates are due Sept.1, 2021.

The Department of Financial Services may not be able to act upon the rate application by the requested effective date if the application is not received in a timely manner. The Department of Financial Services, at its sole discretion, may reject a rate application that is not received in a timely manner or does not follow the prescribed format.

Questions or inquiries regarding the Child Health Plus program or the revenue and expense categories should be directed to the NYS Department of Health, Office of Health Insurance Programs, at (518) 473-0566.

All other inquiries about the renewal rate application should be directed to Neil Gerritt at the NYS Department of Financial Services, Health Bureau, at (212) 480-5218 or neil.gerritt@dfs.ny.gov.

Form and Rate requests for a new service region (including expanding an existing service region to a new county), or for the addition of a new benefit or deletion of an optional benefit, or when two CHP plans merge, should be filed through SERFF.

Questions regarding rate approval issues for a new service region or for a benefit change should be directed David Boyd at to the NYS Department of Financial Services, Health Bureau, at (518) 408-2640 or David.Boyd@dfs.ny.gov.

Any company with existing service regions must submit a CHP Renewal Rates and MLR Reporting filing annually. Each filing must contain a statewide MLR report, but rates do not need to be filed if they are to continue unchanged. If there are multiple rating regions, rates can be filed for just the regions where a rate change is being requested. The standard procedure is for the health plan to submit a separate premium proposal application for each rating region (i.e., a region with a distinct premium rate). If a premium proposal application includes more than one rating region, a separate schedule for each region is to be prepared for Schedules A1, A2, A3, C1, C2, C2A, C3, E1, E2, E3, and E4. A Schedule E1-E4 is also to be prepared for all rating regions included in the premium proposal application combined.

Cover Sheet

Fill in the name of the health plan submitting the application in the space provided.

Contact Person/Certification Sheet

Enter the following information in the corresponding indicated space:

- Name of Insurer – this is the name of the health plan submitting the application.
- Mailing Address – this is the address to be used for correspondence related to this application.
- Contact Person – this indicates to whom questions or correspondence related to this application should be addressed. The cover letter submitted with the application may indicate a different contact for questions relating to the actuarial information included in the application.
- Enter the indicated information for the chief executive officer or executive director that is signing the certification statement.
- The certification statement must be signed and dated. An original copy of the certification statement must be included with each application submitted to the Department of Financial Services. If an actuary also signs the certification (optional), the contact person information, or the cover letter, should provide contact information for this actuary.

Schedules A1 and A2 – Actual and Projected Member Months and Members

If a plan is submitting a rate application involving more than one rating region, a separate Schedule A1 and A2 is to be completed for each rating region included in the rate application.

In the spaces indicated at the top of the page indicate the following information pertaining to this application:

- Plan Name – this is the name of the health plan requesting the proposed change in rates.
- Base Period –For 2022 filings (submitted 2021) the Base Period will be 1/1/2019-12/31/2019.
- Interim Actual Period – enter the 6-month period beginning 12 months prior to the start of the rate period (e.g., 1/1/2021 – 6/30/2021). Interim Projected Period – enter the 6-month period beginning 6 months prior to the start of the rate period (e.g., 7/1/2021 – 12/31/2021).
- Interim Total Period – enter the 12-month period beginning 12 months prior to the start of the rate period (e.g., 1/1/2021 – 12/31/2021).
- Rate Period – enter the calendar year period beginning with the start of the rate period (e.g., 1/1/2022-12/31/2022). This refers to the 12-month applicability period for the proposed rate(s).

Enter in the space provided the Rating Region identifier for the data that follows if the rate application includes more than one rating region.

Enter in the A1 table the actual or projected member months for each experience period indicated, including full year 2020, by each of the applicable premium categories and for all premium categories combined.

Enter in the A2 table the actual or projected number of members as of the end of each of the experience periods indicated by each of the applicable premium categories and for all premium categories combined.

If enrollment is expected to grow from the end of the interim actual period to the end of the rate period by more than 5%, the plan is to describe in Schedule L the reasons contributing to this growth in enrollment.

If enrollment is expected to decline from the end of the interim actual period to the end of the rate period by more than 5%, the plan is to describe in Schedule L the reasons contributing to this decline in enrollment.

Schedule A3 – Projected Monthly Enrollment over the Rate Period

If a plan is submitting a rate application involving more than one rating region, a separate Schedule A3 is to be completed for each rating region included in the rate application.

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Enter in the space provided the Rate Period beginning-ending dates if this has not been linked from the entry on Schedule A1.

Enter in the space provided the Rating Region identifier for the data that follows if the rate application includes more than one rating region.

In the A3 table indicate for each month in the rate period the appropriate month/calendar year. Then enter the number of members (or member months) for each month/year of the rate period. The total number of members should match the entry from Schedule A1, Total Member Months, for the rate period.

Schedule B – Rate Change Request Summary

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Enter in the space provided the Rate Period beginning-ending dates if this has not been linked from the entry on Schedule A1.

Enter in the table the member months for the rate period, the current premium rate pmpm, the proposed premium rate pmpm, and the percentage change, for each rating region included in this application. The current and proposed premium rates are to reflect the full payment rate (i.e., the non-subsidized rate if greater than the DOH payment rate), and any medical home adjustment that is applicable.

Schedule C1 – Base Period Actuarial Experience

If a plan is submitting a premium proposal application involving more than one rating region, a separate Schedule C1 is to be completed for each rating region included in the current application.

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Enter in the space provided the Base Period beginning-ending dates if this has not been linked from the entry on Schedule A1.

Enter in the space provided the Rating Region identifier for the data that follows if the rate application includes more than one rating region.

Data for this schedule is to be on an incurred basis. Data is before reduction for any reinsurance recoveries. The results are to be developed in a manner that is consistent with the development of the total

incurred expenses in Schedule H1.

The plan should utilize the guidance provided in the Child Health Plus Operations Report regarding the benefit service categories. If a plan needs additional guidance, it should contact the NYS Department of Health, Office of Child Health Plus.

The plan should use reasonable methods to allocate data on a consistent basis among the various benefit service categories and should avoid having the “other medical” category pmpm become too large. Any change to the allocation by service category methodology used in the previous rate application is to be discussed in Schedule D. Any difference in the allocation by benefit service category methodology used in completing this rate application from the allocation methodology used in completing the last Child Health Plus Operations Report is to be explained in Schedule D.

The plan must use plan specific experience data in completing Columns A-D of this schedule. In the event that such required experience is unavailable, the plan should call the Department of Financial Services early in advance to discuss alternatives before preparing the application.

Enter in Column A the actual utilization rate per member per year for the base period for each of the benefit service categories indicated on lines 1-24. Enter in Column B the actual unit cost per service for the base period for each of the benefit service categories indicated on lines 1-24. The utilization and unit cost data must be prepared on a mutually consistent basis.

Enter in Column C the cost per enrollee per year result for each of the benefit service categories on lines 1-24.

Enter in Column D the cost per enrollee per month result for each of the benefit service categories on lines 1-24.

Enter in Column D on line 25 the cost per enrollee per month for any incentive pool or risk pool that the plan may have with providers that is not reflected in the costs on the prior lines.

Enter in Column D on line 26 the cost per enrollee per month for reinsurance premiums.

Enter in Column D on line 27 the cost per enrollee per month for the Covered Lives Assessment (graduate medical expense surcharge).

Enter in Column D on line 28 the sum of the entries on lines 1-27.

Schedule C2 – Interim Actual Period and Interim Projected Period Actuarial Experience

If a plan is submitting a premium proposal application involving more than one rating region, a separate Schedule C2 is to be completed for each rating region included in the current application.

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Enter in the space provided the Interim Actual Period and the Interim Projected Period beginning-ending dates if these have not been linked from the entries on Schedule A1.

Enter in the space provided the Rating Region identifier for the data that follows if the rate application includes more than one rating region.

The entries are similar to the entries in Schedule C1. Actual values are entered for the interim actual

period (Columns A, C, E, and G), and projected values are entered for the interim projected period (Columns B, D, F, and H).

The plan must use plan specific experience data in completing Columns A, C, E and G of this schedule. In the event that such required experience is unavailable, the plan should call the Department of Financial Services early in advance to discuss alternatives before preparing the application.

The results for the interim actual period are to be developed in a manner that is consistent with the development of the total incurred expenses in Schedule H2.

Schedule C2A – Interim Total Period Actuarial Experience

If a plan is submitting a premium proposal application involving more than one rating region, a separate Schedule C2A is to be completed for each rating region included in the current application.

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Enter in the space provided the Interim Total Period beginning-ending dates if this has not been linked from the entry on Schedule A1.

Enter in the space provided the Rating Region identifier for the data that follows if the rate application includes more than one rating region.

The entries are similar to the entries in Schedule C1. The entries should reflect the weighted average of the entries for the interim actual period and the interim projected period so as to reflect estimates over the entire 12-month interim period.

Schedule C3 – Rate Period Projected Actuarial Experience

If a plan is submitting a premium proposal application involving more than one rating region, a separate Schedule C3 is to be completed for each rating region included in the current application.

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Enter in the space provided the Rate Period beginning-ending dates if this has not been linked from the entry on Schedule A1.

Enter in the space provided the Rating Region identifier for the data that follows if the rate application includes more than one rating region.

The entries are similar to the entries in Schedule C1. The entries should reflect the projected utilization and unit costs for the rate period.

Schedule D – Projected Cost Justification

Schedule D may be a separate attachment to the premium proposal application which covers each of the required issues in narrative form, with tables and exhibits attached as necessary to support the projection assumptions and projected values.

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Enter in the space provided the Rate Period experience period if this has not been linked from the entry on Schedule A1.

Provide a description of the methodology used to develop the utilization and unit cost factors for the various service categories for the base period and interim actual period for each rating region included in the application.

Provide a description of the methodology used to determine the projected utilization and unit costs. This should include, at a minimum, identifying the experience period used to project the interim projected and rate period values, any annual trend assumptions that were applied to each of the benefit service categories, how the annual trend assumptions were applied to the experience data to develop the projected values, and any other adjustment applied to the experience period data to develop the projected values. If the experience period is not the base period or the interim actual period, then exhibits in Schedule C and Schedule H format must be included showing the experience period data. Note that the claims paid through date used to analyze the incurred but unpaid claims for the experience period must reflect run-out experience through at least the end of the interim actual period and must extend at least one month beyond the end of the experience period.

Provide a descriptive paragraph for each of the medical and hospital benefit service categories shown on lines 1-24 of Schedules C2 and C3 detailing the plan's utilization and unit cost justification for the projected values used on Schedules C2 and C3. The response should include the data sources, annual utilization trends assumed and their justification, annual unit cost trends assumed and their justification, case intensity/case mix assumptions used and their justification, etc. The plan is to clearly indicate for each of the benefit service categories the adjustment factor applied to the experience period utilization to develop the interim projected period utilization and to develop the rate period utilization, and the justification for the adjustment factors applied. The plan is to clearly indicate for each of the benefit service categories the adjustment factor applied to the experience period unit cost to develop the interim projected period unit cost and to develop the rate period unit cost, and the justification for the adjustment factors applied. If the same adjustment factor applies to several benefit service categories, each such grouping of adjustment factors should be clearly identified.

Any distortion in the total medical and hospital claim expense \$mpm for the base period or the interim actual period caused by a high claim amount on individual members is to be discussed.

Services that are capitated should be clearly identified along with the name of the entity accepting the capitation, the capitation rate pmpm, and the effective date of the capitation rate. A copy of the signed capitation agreement, along with detailed mathematics showing how the capitation rate for the interim actual period was derived from the capitation contract, are to be submitted. Appropriate supporting documentation must be included for any increase in the capitation rate from the interim actual period to the rate period, and this must be supported by detailed mathematics showing how the capitation rate for the rate period can be derived from the information contained in the supporting documentation. If the renewal capitation agreement for the rate period has not yet been finalized, submit documentation showing the current stage of negotiation, for example a proposal made by the plan to the provider or a counterproposal by the provider to the plan.

If the claim cost pmpm for any benefit service category is paid partially on a fee-for-service basis and partially on a capitated pmpm rate, provide a breakdown between the two bases, and describe how the base period, interim actual period, interim projected period, and the rate period cost per enrollee per month values were developed.

Provide a descriptive paragraph for any incentive pool adjustment or risk pool adjustment entered on line

34 of Schedule E1 and show how the values were developed. Submit a copy of the contract establishing the incentive pool arrangement or risk pool arrangement.

Provide a descriptive paragraph for the Covered Lives Assessment (Graduate Medical Expense Surcharge) values entered on line 37 of Schedule E1 and how the rate period value was developed.

Provide a descriptive paragraph for any reinsurance recovery and any reinsurance premium entered on lines 7 and 36 of Schedule E1, respectively. Documentation should be included to support the reinsurance premium entered for the interim actual period and for the interim projected and rate periods.

Provide a descriptive paragraph for the adjustment for reinsurance recovery entered on line 39 of Schedule E1 for the rate period.

For each of the administration expense categories shown on lines 41-45 of Schedule E1 provide a descriptive paragraph detailing the plan's justification for the projected values assumed in Schedule E1 for the interim projected period and the rate period. The response should fully explain for any administration expense entry exceeding \$1 pmpm, any change in the pmpm value of more than 10% between the base period and the interim actual period, between the interim actual period and the interim projected period, between the interim projected period and the rate period, between the base period and the interim total period, and between the interim total period and the rate period. Any change to the method used in allocating administration expenses to Child Health Plus that affected the base period, interim period, or rate period is to be discussed in detail. Any difference in the methodology to allocate administration expenses to Child Health Plus used in completing this rate application from the methodology to allocate administration expenses used in completing the last Child Health Plus Operations Report or the last Managed Medicaid Care Operations Report is to be explained.

It is expected that the NYS Exchange will reduce administrative expenses from pre-Exchange levels. The impact of the Exchange on administrative expenses must be discussed and the administrative expense savings quantified. How these savings were reflected in the rate period administrative expenses must be discussed.

A copy of any administrative service agreement is to be submitted, and the health plan is to indicate whether the party providing the administrative services under the agreement is an affiliate or not. The plan should indicate for the base period, the interim actual period, the interim projected period, and the rate period, the dollar amount and pmpm included in the total administration expenses for any administrative service agreement.

Any administrative service agreement with an affiliated company should be at cost, and the plan will have to justify use of any amount that exceeds the actual cost of providing the administrative services. The plan must submit information on what the actual cost to the affiliated company is of providing the Child Health Plus administrative services under the administrative service agreement and supporting material to show how the actual cost was developed.

Provide a descriptive paragraph for any Medical Home expense entered on line 47 of Schedule E1 for each of the periods shown. It is expected that the Medical Home revenue will offset the Medical Home expense and that this program will have no impact on the income value shown on line 50 of Schedule E1.

Provide a descriptive paragraph for any New York State premium tax cost entered on line 48 of Schedule E1 for each of the periods shown.

Provide a descriptive paragraph for any extraordinary item shown on line 51 of Schedule E1. Explain the

cause(s) of the extraordinary item.

Provide a descriptive paragraph for any provision for federal and New York State taxes (other than premium taxes) shown on line 52 of Schedule E1. If applicable, the response should describe the formula for estimating the federal income tax amount and the New York State income tax amount for the base period, the interim actual period, the interim projected period, and the rate period. Any other taxes or assessments included in this item must be identified, quantified, and justified. The response should fully explain any change in the pmpm value of more than 10% between the base period and the interim actual period, between the interim actual period and the interim projected period, and between the interim projected period and the rate period.

Describe any time limit that may apply to providers for submitting claims for payment. Describe the procedure that applies for claims submitted after any applicable time limit and whether such claims would be paid or denied.

Provide a paragraph describing what steps the plan takes to control the increase in utilization of services.

Describe the methodology used to estimate the values entered in Columns C and D of Schedules H1 and H2. See the instructions to Schedules H1 and H2 for more details on the information to be discussed in Schedule D and the documentation to be provided.

Appendix A describes illustrative examples of supporting material that may be used in justifying utilization and unit cost trend assumptions.

Schedule E1 – Summary of Revenues and Expenses

If a plan is submitting a premium proposal application involving more than one rating region, a separate Schedule E1 is to be completed for each rating region included in the current application. Another Schedule E1 is to be completed for all the rating regions included in the current application combined.

Note that for the 2022 rate period there is an additional set of columns to enter 2020 actual data although this is neither the Base Period nor the Interim Period.

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Enter in the space provided the Rating Region identifier for the data that follows if the application includes more than one rating region.

Enter on line 1 the member months for each experience period if this has not been linked from the entries on Schedule A1.

Enter on line 2 the actual or projected revenue, in dollars and as \$pmpm, from the Department of Health on behalf of Child Health Plus enrollees for each experience period, excluding revenue due to the Medical Home program (which is entered on line 4). The rate period amount should reflect the premium rate being requested less the portion of the premium estimated to be paid by the subscriber (which is entered on line 3) and less the portion of the premium estimated to be paid by the Department of Health for the Medical Home program (which is entered on line 4). Discuss in Schedule D any significant difference between the actual revenue amount on line 2 plus line 3 plus line 4 for the base period or the interim actual period and what would have been received for the period had the various approved rates been applicable as of the effective date of each such rate.

Enter on line 3 the actual or projected revenue, in dollars and as \$mpm, from subscribers on behalf of Child Health Plus enrollees for each experience period. The line 2 plus line 3 plus line 4 \$mpm for the rate period should be the same as the proposed premium rate requested in Schedule B.

Enter on line 4 the actual or projected revenue, in dollars and as \$mpm, from any participation in the Medical Home program.

Enter on line 5 any investment income allocated to the Child Health Plus line of business for each experience period. At a minimum this would usually be investment earnings on the incurred but unpaid reserves.

Enter on line 6 any coordination of benefit savings that are not reflected as a reduction to the claim amounts shown on lines 10-33.

Enter on line 7 any reinsurance recovery amount for the period. Recovered amounts should be allocated to the period(s) giving rise to the recovery. No entry is made for the rate period since the adjustment for reinsurance recoveries is handled on line 39 instead.

Enter on line 8 any other revenue amounts. Schedule D should describe the source of any such revenues.

Enter on line 9 the sum of the amounts on lines 2-8.

Enter on lines 10-34 and 36-37 the actual or projected dollars and \$mpm for each benefit service category for each experience period. The \$mpm entries must be consistent with the corresponding cost per enrollee per month entries from Schedules C1-C3. Schedule D should discuss and explain any amounts entered on line 34 and show how the value for each experience period was developed.

Enter on line 35 the sum of the amounts on lines 10-34. Enter on line 38 the sum of the amounts on lines 35-37.

Enter on line 39, in the rate period column only, the reinsurance recovery amount from Schedule F line 4 that is being applied to reduce the projected medical & hospital expenses for the rate period. Enter the value in dollars and as \$mpm.

Enter on line 40 the amount on line 38 less the amount on line 39. For the base period, interim actual period and interim projected period the line 40 amount would equal the line 38 amount.

Enter on lines 41-45 the actual or projected dollars and \$mpm for each administration expense category for each experience period. Enter on line 41 all compensation amounts even if some compensation may be included on lines 42-45 in the Child Health Plus Operations Report. Enter on line 46 the sum of the amounts on lines 41-45. Only allowable administrative expenses are to be included. The plan should utilize the guidance provided in the Child Health Plus Operations Report regarding allowable and non-allowable administration expenses. If a plan needs additional guidance, it should be directed to the NYS Department of Health, Office of Child Health Plus.

Enter on line 47 the actual or projected dollars and \$mpm for the Medical Home expenses. The Medical Home program is to be neutral with the extra revenue offsetting the extra expenses. A profit charge cannot be added to the Medical Home expenses.

Enter on line 48 the actual or projected dollars and \$mpm for any New York State premium taxes. Schedule D is to discuss and explain any amounts entered on line 48.

Enter on line 49 the sum of the amounts on line 40, line 46, line 47, and line 48.

Enter on line 50 the net gain (loss) as the line 9 amount less the line 49 amount.

Enter on line 51 the actual or projected dollars and \$mpm for any extraordinary item for each experience period. Extraordinary revenues are entered as positive amounts, and extraordinary costs are entered as negative amounts, since the amount on line 51 is added to the value on line 50. Schedule D is to discuss and explain any amounts entered on line 51.

Enter on line 52 the actual or projected dollars and \$mpm for federal and New York State taxes (other than premium taxes) for each experience period. Enter such costs as positive amounts since the amount on line 52 is subtracted from the amount on line 50. Schedule D is to discuss and explain any amounts entered on line 52.

Enter on line 53 the amount on line 50 plus the amount on line 51 less the amount on line 52.

Schedule E2 – Summary of Base Period Revenues and Expenses

If a plan is submitting a premium proposal application involving more than one rating region, a separate Schedule E2 is to be completed for each rating region included in the current application. Another Schedule E2 is to be completed for all the rating regions included in the current application combined.

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Enter in the space provided the Rating Region identifier for the data that follows if the application includes more than one rating region.

Enter on line 1 the member months that were budgeted for the base period and the actual member months for the base period.

The entries for lines 2-53 are similar to the entries for Schedule E1 except that no entry is made on line 39. Enter in the Budget columns the dollar and \$mpm amounts that were budgeted for the base period for each line item. Enter in the Actual columns the actual dollar and \$mpm amounts for the base period for each line item. The actual results are to agree with the corresponding entries on Schedule E1 for the base period.

The Variance columns are calculated as the actual value less the budget value.

Schedule E3 – Summary of Interim Period Revenues and Expenses

If a plan is submitting a premium proposal application involving more than one rating region, a separate Schedule E3 is to be completed for each rating region included in the current application. Another Schedule E3 is to be completed for all the rating regions included in the current application combined.

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Enter in the space provided the Rating Region identifier for the data that follows if the application includes more than one rating region.

Enter on line 1 the member months for each experience period if this has not been linked from the entries on Schedule A1.

The entries are similar to the entries for Schedule E1 except that no entry is made on line 39. The entries for the interim actual and interim projected periods are to agree with the corresponding entries on Schedule E1 for the interim actual period and interim projected period, respectively. The values for the total interim period are to reflect the results over the full 12-month interim period.

Schedule E4 – Summary of Rate Period Revenues and Expenses

If a plan is submitting a premium proposal application involving more than one rating region, a separate Schedule E4 is to be completed for each rating region included in the current application. Another Schedule E4 is to be completed for all the rating regions included in the current application combined.

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Enter in the space provided the Rating Region identifier for the data that follows if the application includes more than one rating region.

Enter on line 1 the member months for the rate period if this has not been linked from the entries on Schedule A1.

The entries are similar to the entries for Schedule E1. The entries for the “Rate Period With Increase” column are to agree with the corresponding entries on Schedule E1 for the rate period.

The entries for the “Rate Period Without Increase” column are to reflect the financial impact of not receiving a change to the current rate.

The “Diff” columns are calculated as the “Rate Period With Increase” value less the “Rate Period Without Increase” value.

Schedule F – Reinsurance Recovery Account Balances

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Enter on line 1 the ending balance (line 5) from the Schedule F used in the prior premium proposal application. The line 1 amount is intended to be the cumulative amounts actually recovered from reinsurance since July 1, 2005 less the cumulative amounts used to reduce projected rate period claim costs in subsequent premium proposal applications (with any adjustment indicated by the Department of Financial Services).

Any assertion by the health plan that a recovery has been used to reduce renewal premiums that was not reflected on line 4 of the previous premium proposal application must be discussed in detail on Schedule D and the appropriate supporting detail provided.

Enter on the rows in line 2, all the actual reinsurance recoveries received for Child Health Plus that have occurred since this schedule was last prepared. For each such recovery enter the date the recovery was received and the dollar amount of the recovery. Enter the total of all the amounts entered on line 2 in the space provided.

Enter on line 3 the sum of lines 1 and 2. This represents the amount of reinsurance recoveries that can be used to reduce the projected claim costs during the rate period in the current application.

Enter on line 4 the amount of the reinsurance recoveries that is to be reflected in the rate period renewal calculation of the current application. The amount entered on line 4 is carried forward to line 39 on

Schedules E1 and E4.

Since reinsurance premiums are an allowed expense in developing the renewal premium, all monies actually received from reinsurance recoveries (regardless of the time period generating such recovery) must ultimately be used to lower the needed renewal premium. Recovery amounts need not be used up immediately, and a portion of the amount from line 3 can be used in the current application with the balance carried forward to reduce the premium increase in future premium proposal applications.

If the premium rate increase proposed in the current application is large, the Department of Financial Services may decide that the full amount on line 3 is to be used to reduce the proposed premium increase.

Enter on line 5 the amount on line 3 less the amount on line 4. This would be the beginning balance in the next premium proposal application, unless adjusted by the Department of Financial Services.

If the premium proposal application includes more than one rating region, Schedule D is to discuss how the amount on line 4 was allocated to each of the rating regions included in the current application.

Schedule G – Rate Period Administrative Budget Summary

Only allowable administrative expenses are to be included. The plan should utilize the guidance provided in the Child Health Plus Operations Report regarding allowable and non-allowable administrative expenses. If a plan needs additional guidance, it should contact the NYS Department of Health, Office of Child Health Plus.

When the administrative expense pmpm are the same for each rating region included in the premium proposal application, then one Schedule G may be prepared using the data for all the rating regions included in the current application combined.

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

In the FTE's column indicate for the rate period the number of full-time equivalent employees that are estimated to spend time on Child Health Plus for each expense category indicated. For example, when an employee works on many different product lines, an estimate should be made as to what percentage of that employee's time is spent on Child Health Plus related functions. Describe in Schedule D the method used to allocate FTE's to Child Health Plus.

In the Salary column indicate for the rate period the estimated salary spent on Child Health Plus for each expense category indicated. For example, when an employee works on many different product lines, an estimate should be made as to what percentage of that employee's time (and hence salary) is spent on Child Health Plus related functions. Describe in Schedule D the method used to allocate salary to Child Health Plus.

In the Non-Salary column indicate for the rate period the estimated non-salary expenses related to Child Health Plus for each expense category indicated. For example, when such an expense is incurred over many different product lines, an estimate should be made as to the percentage that should be allocated to Child Health Plus. Describe in Schedule D the method used to allocate non-salary to Child Health Plus.

In the Total Expense column enter the sum of the values from the Salary and Non-Salary columns.

In the Total Administrative Expense line enter the sum of the values from the previous lines.

The Total Administrative Expense-Salary amount is to match the value entered on line 41 of Schedule E1

for the rate period. Entries for the base period, interim actual period and interim projected period should be consistent with this methodology used for the rate period.

The Total Administrative Expense-Total Expense amount is to match the value entered on line 46 of Schedule E1 for the rate period.

On the lines provided, break out the “Other” expense category into its various components. For each component, indicate the component name, FTEs, salary amount, non-salary amount, and total expense amount.

The administrative expenses are not to include amounts for the Covered Lives Assessment (GME). These costs are shown separately on Schedules C1-C3 and E1-E4.

The administrative expenses are not to include amounts for the HCRA Surcharge. The HCRA costs are to be included in the unit costs of the affected service categories.

The administrative expenses are not to include any New York State premium tax that may be applicable. These costs are shown separately on Schedules E1-E4.

The administrative expenses are not to include any federal or New York State taxes (other than premium taxes) that may be applicable. These costs are shown separately on Schedules E1-E4.

The administrative expenses are not to include a cost for reinsurance that the plan may have for the Child Health Plus program. These costs are shown separately on Schedules C1-C3 and E1-E4.

The administrative expenses are not to include a contribution to surplus or profit component. The resulting contribution to surplus or profit is reflected on lines 50 and 53 of Schedules E1-E4.

The administrative expenses are not to include any adjustment to reflect the premium payments that may be payable by the Department of Health to a Child Health Plus plan participating in the Medical Home program. These payments are shown separately as revenue, and as expenses, on Schedules E1-E4.

A health plan should be prepared to explain how expenses were allocated to the Child Health Plus line of business and to justify the administrative expenses projected for the rate period. Any administrative service agreement with an affiliated company should be at cost, and the plan will have to justify use of any amount that exceeds the actual cost of providing the administrative services.

Recognizing that issues regarding administrative expenses vary from company to company, the Department of Financial Services will request specific information on a plan-by-plan basis to justify any administrative expense which exceeds \$1 pmpm in the rate period, represents more than a 10% increase from the interim actual period or base period, or appears to be out-of-line with the other Child Health Plans in the same geographic area.

Schedule H1 – Development of Base Period Incurred Claims

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Enter in the space provided the Base Period beginning-ending dates if this has not been linked from the entry on Schedule A1.

Enter in the Claim Paid Through Date field the last paid claim date reflected in the Column B data. The

claim paid through date used for the base period analysis must be at least through the end of the interim actual period.

Enter in Column B the amount of claims that were incurred during the base period and paid by the “claim paid through date”. Data should be entered separately for fee-for-service claims and for capitated/off-system/other claims, and then for all such claims combined. Data should be entered by each of the categories of service indicated. Include in the “capitated/off system/other claims” section HCRA and Covered Lives Assessment charges that are paid separately and not included in the underlying bills submitted by the providers.

Enter in Column C the estimate of claims incurred during the base period that have already been reported but that have not yet been paid by the “claim paid through date”. Enter in Column D the estimate of the claims incurred during the base period that have not yet been reported. When a plan estimates the Column C and D amounts combined, the plan should still make an estimate for how much of the combined amount should be allocated to Column C and how much should be allocated to Column D. This estimate can be based on an inventory of pending claims incurred for the experience period, historical ratios, or any other reasonable method.

Column A is the sum of the corresponding entries in Columns B-D.

The Column A-D data must reflect claim run-out experience at least through the end of the interim actual period. Estimates based on an older claim paid through date will not be accepted.

The Column A values in the Total Claims section should match the sum of the corresponding values entered on the indicated lines of Schedule E1 for the base period. The Column A Grand Total amount should match the entry on line 35 of Schedule E1 for the base period.

The plan must submit a description of the methodology used to estimate the values entered in Columns C and D, and must submit supporting documentation, including experience figures and illustrative numerical examples, showing how the values in Columns C and D were developed. For the fee-for-service claims, the plan must submit the underlying claims triangle table, the development of the completion factors, and how the total incurred claims were developed from the emerging paid claims.

Schedule H2 – Development of Interim Actual Period Incurred Claims

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Enter in the space provided the Interim Actual Period beginning-ending dates if this has not been linked from the entry on Schedule A1.

Enter in the Claim Paid Through Date field the last paid claim date reflected in the Column B data. The claim paid through date used in the analysis of the interim actual period must extend at least one month beyond the end of the interim actual period. For example, if the interim actual period is 1/1/2021-6/30/2021, then the claim paid through date must be 7/31/2021 or later.

Enter in Column B the amount of claims that were incurred during the interim actual period and paid by the “claim paid through date”. Data should be entered separately for fee-for-service claims and for capitated/off-system/other claims, and then for all such claims combined. Data should be entered by each of the categories of service indicated. Include in the “capitated/off system/other claims” section HCRA and Covered Lives Assessment charges that are paid separately and not included in the underlying bills submitted by the providers.

Enter in Column C the estimate of claims incurred during the interim actual period that have already been reported but that have not yet been paid by the “claim paid through date”. Enter in Column D the estimate of the claims incurred during the interim actual period that have not yet been reported. When a plan estimates the Column C and D amounts combined, the plan should still make an estimate for how much of the combined amount should be allocated to Column C and how much should be allocated to Column D. This estimate can be based on an inventory of pending claims incurred for the experience period, historical ratios, or any other reasonable method.

Column A is the sum of the corresponding entries in Columns B-D.

The Column A-D data must reflect claim run-out experience at least through one month beyond the end of the interim actual period. Estimates based on an older claim paid through date will not be accepted.

The Column A values in the Total Claims section should match the sum of the corresponding values entered on the indicated lines of Schedule E1 for the interim actual period. The Column A Grand Total amount should match the entry on line 35 of Schedule E1 for the interim actual period.

The plan must submit a description of the methodology used to estimate the values entered in Columns C and D, and must submit supporting documentation, including experience figures and illustrative numerical examples, showing how the values in Columns C and D were developed. For the fee-for-service claims, the plan must submit the underlying claims triangle table, the development of the completion factors, and how the total incurred claims were developed from the emerging paid claims.

Schedule I – Balance Sheet

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Enter at the top of the schedule in the spaces provided the dates being reported upon in the current period and previous year columns.

The previous year column should represent the most recently completed calendar year. The current period column should represent the most recently completed calendar quarter.

The data for this schedule should be consistent with the information on the corresponding financial statements.

Values for asset items 7, 13, 15, and 21 should be broken out in the spaces provided at the bottom of the exhibit.

Values for liability/net worth items 10, 14, and 21 should be broken out in the spaces provided at the bottom of the exhibit.

Schedules J-1 and J-2 – Plan Rate History

Schedule J-1 is the history of the full pay rates (i.e., the rate that applies to non-subsidized members), and Schedule J-2 is the history of the DOH payment rates (i.e., the rate that applies to fully subsidized members).

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Complete this schedule showing all rate changes approved for the program over the past three years. For each rate change show (a) the effective date of the approved revised rate, (b) the prior rate pmpm, (c) the

approved revised rate pmpm, (d) the percentage change, and (e) the reason(s) for the change. If there have been less than two approved rate changes over the past three years, enter data for the last two approved rate changes.

The current premium rate and the approved revised rate are to include any Medical Home program adjustment that may be applicable.

The current premium rate and the approved revised rate are to include any Facilitated Enrollment program adjustment that may be applicable. Include changes due to the plan either becoming a participant in the Facilitated Enrollment program or discontinuing such participation.

If the premium proposal application is for more than one rating region, a separate Schedule J-1 and J-2 is to be completed for each rating region included in the current application.

Schedule K – Territory of Operation

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Enter at the top of the schedule in the Period Ending field the ending date of the rate period.

Describe the extent of the service area that the plan actively promotes and operates this program. Please include a service map of the areas of operation.

Please list the counties for the service area included in the premium proposal application. This should include all approved counties in the service area whether or not there is actual membership in a specific county. If a plan is submitting an application that includes more than one rating region, the service area (counties) for each rating region must be separately indicated.

Schedule L – Marketing Plan

Enter at the top of the schedule the Plan Name if this has not been linked from the entry on Schedule A1.

Enter at the top of the schedule in the Period Ending field the ending date of the marketing plan period.

Describe in detail, or attach to the schedule, the marketing strategy the plan intends to employ in order to meet the future enrollment projected in this rate application. The strategy should be consistent with what was previously reported in the annual marketing plan.

If enrollment is expected to grow from the end of the interim actual period to the end of the rate period by more than 5%, explain the reasons contributing to this growth in enrollment.

If enrollment is expected to decline from the end of the interim actual period to the end of the rate period by more than 5%, explain the reasons contributing to this decline in enrollment.

Appendix A

This appendix describes illustrative examples of supporting material that may be used in justifying utilization and unit cost trend assumptions for non-capitated claims.

A non-capitated hospital or medical expense, which exceeds \$2 pmpm in the rate period, must be justified by separate analysis of the utilization trend and of the unit cost trend from which the pmpm cost is calculated.

A detailed description of the methodology used for developing the projected trends must be submitted and included in Schedule D. Such description should include illustrative numerical examples, supporting documents, and experience data wherever applicable.

The plan's own Child Health Plus experience data is to be used for all analysis based on actual experience. If the analysis is based on any other experience data, the plan must justify why such experience is representative of what is to be expected under the plan's Child Health Plus program.

If any rate period projected utilization rate, unit cost, or pmpm number is rejected due to lack of satisfactory supporting documentation and justification, the Department may replace it with a number that the Department considers to be appropriate for the specific program under consideration.

Utilization

1. Utilization rates may be developed from experience data provided there is a sufficient amount of data to fit a regression line with statistical reliability. A statistically reliable regression line is defined as a regression line that meets both (a) and (b) of the criteria below:
 - a. Rejects the null hypothesis that there is no linear relationship between the x and y values at the 95% confidence level (x units are the experience periods, y units the utilization rate for the experience period); and
 - b. The 95% confidence interval for the mean response for the rate period is within +/-5% of the regression line predicted utilization value for the rate period.
 - c. If condition (a) is met but condition (b) is not met, and the plan so proposes, the Department may consider along with other information pertaining to the rate application a predicted utilization value for the rate period calculated as 1.0526 times the lower bound of such 95% confidence interval.

Regression analysis should be done separately for each medical and hospital service category shown on lines 1-24 in Schedule C1. In the event there is not sufficient experience data for a service category to perform a statistically reliable regression analysis, it may be acceptable to divide the service categories into homogeneous groups and conduct a regression analysis separately for each group. Inpatient facility services should be grouped only with other inpatient facility services. Outpatient facility services should be grouped only with other outpatient facility services. The following services may not be included in a grouping and must be analyzed by a separate regression analysis: primary care, physician specialty, emergency room, dental, pharmacy (prescription drugs), and diagnostic testing lab/x-ray. A plan should discuss with the Department of Financial Services any grouping method it plans to use prior to submission of the premium proposal application package.

The time intervals used in a regression analysis must be non-overlapping, contiguous, and of equal length. The most current time interval should end with the most recent period in which experience

data can be accurately measured. Only monthly unit time interval is acceptable for input. The total experience period used in the regression analysis cannot be longer than 5 years(60 months). The input data points must be independent observations and moving average values are not acceptable input data points. All input data must be unmodified. Transformation of observed data to a different mathematical form before input to the regression model will not be acceptable.

Examples illustrating this technique, as well as a worksheet that can be used for testing the above conditions, is available from the Department of Financial Services upon request.

The regression line analysis, if used, must be included as a supplement to the premium proposal application.

A projected trend value calculated as the arithmetic or geometric mean of a few observed data points will not be considered acceptable.

2. Any other method which projects utilization rates, or utilization trends, based on experience data must adhere to the principles indicated in 1 above.
3. The projected value may be calculated as the arithmetic or geometric mean, or any other mathematical function, of a few observed data points only if the health plan can identify, for each specific benefit service category, the factors causing the observed increase or decrease in the result for each experience period, and provide satisfactory justification that these factors are likely to persist into the rate period. In addition, an explanation must be provided as to whether or not management has considered using any utilization control procedures to control or eliminate these factors before resorting to a premium rate increase.
4. Utilization increases may be justified based upon a projected increase in case intensity.
5. In support of the projected increase in case intensity the health plan may provide a list of claims (by claim number) identified during the experience period, with procedure codes and procedure names, and must explain why additional utilization would be expected from this data during the rate period. A list of the benefit service categories (e.g., ER, physician specialty, diagnostic testing, re-hospitalization, etc.) to be impacted by the increased intensity must also be specified and the impact on each such benefit service category quantified.
6. Utilization increases may be justified based upon a projected change in the mix of the Child Health Plus membership.

A health plan may have identified a particular subgroup of Child Health Plus enrollees that have higher than usual utilization rates. Such correlation must be demonstrated over several years by actual experience, and a satisfactory reason must be provided as to why this subgroup exhibits such higher utilization. The health plan must be able to satisfactorily demonstrate that the block of Child Health Plus enrollees will shift more towards this identified subgroup from the end of the interim actual period to the rate period. The impact of this shift on utilization rates must be quantified and justified for each benefit service category so affected. One example might be that new enrollees utilize a certain benefit service at a much higher rate than members enrolled more than a year ago.

Unit Cost

1. Unit cost increases may be justified by an anticipated increase in the service fees due to provider contract renewal. The projected unit cost increase may be computed as the weighted average increase in all service fees provided in the new contract. A copy of the current and renewal fee schedules must

be submitted as supporting documentation along with documentation showing how the weighted average increase was determined.

In the case of inpatient and outpatient hospital services, the projected unit cost increase may be computed as the weighted average increase of all hospitals that participate in the Child Health Plus program. The current and renewal contracts for at least three hospitals chosen from the list must be submitted as supporting documentation. Detailed mathematics must be provided to show how the unit cost increase for each of the three hospitals can be computed based on the information contained in that hospital's current and renewal contracts.

If the renewal fee schedule for the rate period has not yet been finalized, submit documentation showing the current stage of negotiation, for example a proposal made by the plan to the provider or a counterproposal by the provider to the plan.

2. Unit cost increases may be justified based upon a projected increase in case intensity or case mix.

In support of such projected increase, the health plan may provide a list of claims (by claim number) identified during the experience period, with procedure codes, procedure names and the average unit cost (or DRG rate, whichever is applicable) of the procedures indicated, and must explain why the existence of these cases will cause the unit cost for a specific benefit service category to increase during the rate period. Detailed mathematics must be provided to show the quantitative impact on each such benefit service category.

3. Unit cost increases may be justified based upon a projected change in the mix of the Child Health Plus membership.

A health plan may have identified a particular subgroup of Child Health Plus enrollees that have higher than usual unit costs. Such correlation must be demonstrated over several years by actual experience, and a satisfactory reason must be provided as to why this subgroup exhibits such higher unit costs. The health plan must be able to satisfactorily demonstrate that the block of Child Health Plus enrollees will shift more towards this identified subgroup from the end of the interim actual period to the rate period. The impact of this shift on unit costs must be quantified and justified for each benefit service category so affected.

4. For prescription drugs, both unit cost and utilization annual trends may also be justified using a broad-based survey, provided that a relevancy between the Child Health Plus program and the survey data can be established.