SERFF Tracking #:	*CFAP-132809076*	***State Tracking #:***		***Company Tracking #:***	*2569*

State:	*District of Columbia*	***Filing Company:***	*Group Hospitalization and Medical Services, Inc.*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.003A Small Group Only - PPO*		
Product Name:	*2569 - DC ACA Small Group GHMSI*		
Project Name/Number:	*2569 - DC GHMSI SG ACA ON-EXCHANGE/2569*		

Supporting Document Schedules

Satisfied - Item:	District of Columbia Plain Language Summary
Comments:	
Attachment(s):	2569 - DC SG - GHMSI - PartII Rate Justification.pdf
Item Status:	
Status Date:	

DC GHMSI

Rate Filing Justification Part II (Plain Language Summary)

Pursuant to 45 CFR 154.215, health insurance issuers are required to file Rate Filing Justifications. Part II of the Rate Filing Justification for rate increases and new submissions must contain a written description that includes a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. The Part II template below must be filled out and uploaded as an Adobe PDF file under the Consumer Disclosure Form section of the Supporting Documentation tab.

Name of Company	Group Hospitalization & Medical Services Inc.
SERFF tracking number	CFAP-132809076
Submission Date	5/17/2021
Product Name	BluePreferred

Market Type: ○ Individual ◉ Small Group

Rate Filing Type: ◉ Rate Increase ○ New Filing

Scope and Range of the Increase:

The 8.8 % increase is requested because:

The main drivers supporting the rate change are an increase in the trend and plan level benefit factors, an improvement in the base period experience of the combined pool, and a decrease in the administrative assumption. The increase in trend is due to an adjustment made for Covid. As a result of the pandemic, the 2020 experience period had decreased claims driven by the deferred or avoided care. An adjustment was made to bring the 2020 experience up to the level it would be at in the absence of Covid.

This filing will impact:

# of policyholder's 12,418 # of covered lives 20,540

The average, minimum and maximum rate changes increases are:

- Average Rate Change: The average premium change, by percentage, across all policy holders if the filing is approved 8.8 %
- Minimum Rate Change: The smallest premium increase (or largest decrease), by percentage, that any one policy holder would experience if the filing is approved 8.2 %
- Maximum Rate Change: The largest premium increase, by percentage, that any one policy holder would experience if the filing is approved 22.2 %

Individuals within the group may vary from the aggregate of the above increase components as a result of:

Product selection, changes in age factors, and changes in family composition.

Financial Experience of Product

The overall financial experience of the product includes:

In 2020, a total of $172.1 million in premium was collected and $127.5 million in claims were paid out. We received $15.2 million in risk adjustment, for a loss ratio of 65.2%. However, the rate increase of the product is driven partially by the combined Individual and Small group experience, which collected $230.6 million in premium and paid out $203.0 million in claims and received $25.3 million in risk adjustment for a loss ratio of 77.1%.

The rate increase will affect the projected financial experience of the product by:

The proposed rate increases are aimed to bring the loss ratio for the combined Individual/small group pool to a projected 86.0%.

Components of Increase

The request is made up of the following components:

Trend Increases – 9.6 % of the 8.8 % total filed increase

1. Medical Utilization Changes –Defined as the increase in total plan claim costs not attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts. Examples include changes in the mix of services utilized, or an increase/decrease in the frequency of service utilization.

   This component is 4.2 % of the 8.8 % total filed increase.

2. Medical Price Changes – Defined as the increase in total plan claim costs attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts.

   This component is 5.2 % of the 8.8 % total filed increase.

Other Increases – (0.8) % of the 8.8 % total filed increase

1. Medical Benefit Changes Required by Law – Defined as any new mandated plan benefit changes, as mandated by either State or Federal Regulation.

   This component is 0.0 % of the 8.8 % total filed increase.

2. Medical Benefit Changes Not Required by Law – Defined as changes in plan benefit design made by the company, which are not required by either State or Federal Regulation.

   This component is 2.0 % of the 8.8 % total filed increase.

3. Changes to Administration Costs – Defined as increases in the costs of providing insurance coverage. Examples include claims payment expenses, distribution costs, taxes, and general business expenses such as rent, salaries, and overhead.

   This component is -1.6 % of the 8.8 % total filed increase.

4. Changes to Profit Margin – Defined as increases to company surplus or changes as an additional margin to cover the risk of the company.

   This component is 0.0 % of the 8.8 % total filed increase.

5. Other – Defined as:

Improvement in the base period experience of the combined pool.

This component is (1.1) % of the 8.8 % total filed increase.