

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

**Instructions for the Submission of 2014 Premium Rates
For INDIVIDUAL On-Exchange Plans and Off-Exchange Plans**

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1. General Introduction:

These instructions are to be used for the submission of 2014 individual premium rates for both “standard” and “non-standard” (as those terms are used in the “Invitation to Participate in the New York Health Benefit Exchange”) On-Exchange and Off-Exchange products.

On-Exchange and Off-Exchange plans will be considered new or amended products, therefore the rate applications must be submitted under Section 3231(d) or Section 4308(b) of the New York Insurance Law. Because of new ACA requirements for Essential Health Benefits, risk pooling, actuarial value and metal level requirements, standardized rating regions, standardized census tier factors and other requirements, the rate application process is being supplemented as specified in these instructions.

2. Essential Health Benefits:

Companies must provide the Essential Health Benefits specified by DOH for calendar years 2014 and 2015.

3. Actuarial Value (AV) Metal Values:

Except for the impact of cost-sharing reduction subsidies, each product must fall within one of the following specified actuarial value (AV) levels based on cost sharing features of the product and determined using the HHS AV Calculator found at <http://www.cciio.cms.gov/resources/regulations/index.html#hie>

| | |
|-----------|--------|
| Bronze: | 60% AV |
| Silver: | 70% AV |
| Gold: | 80% AV |
| Platinum: | 90% AV |

A de minimus variation of +/- 2% AV is permissible

The AV Metal Values determine what metal level a particular plan-design belongs in, and the HHS Actuarial Value Calculator must be used in the calculation of these AV Metal Values.

4. Actuarial Value (AV) Pricing Values:

[To eliminate confusion, the actuarial values developed using the HHS Actuarial Value Calculator are referred to as the AV Metal Values, while the actuarial values developed for pricing are referred to as the AV Pricing Values.]

For premium rates based on claims experience under inforce plan-designs, the Department's review will rely on the relationships in the AV Pricing Values between (a) inforce design plans and (b) On-Exchange standard and non-standard plans and Off-Exchange plans, AND on adjustments to reflect Induced Demand as expressed by HHS in their regulations.

For inforce plan-designs, the metal identification level is defined as described below:

Bronze: Less than 65% AV Metal Value
Silver: AV Metal Value of 65% to 75%
Gold: AV Metal Value of 75% to 85%
Platinum: AV Metal Value more than 85%

[Note: this is for pricing purposes only. All non-grandfathered products will have to fall within one of the AV Metal Values specified in Section 3 above]

The final AV Pricing Values developed by the Company's actuary should include not just the pure change in cost sharing, but should also reflect a component for induced demand. The induced demand component must be the same for all plans in a given metal tier, and the induced demand component utilized for each metal tier must be disclosed in the Actuarial Memorandum.

A Company may, but does not have to, use the AV Calculator to determine AV Pricing Values. A Company may use external sources or guidelines, such as the Milliman Guidelines, or internal guidelines developed by the Company. If such alternate guidelines are used, details as to the pricing differentials, their development and the source of the data must be provided in the Actuarial Memorandum. Note that some of these alternate guidelines would reflect the impact of Induced Demand (see Section 5 below) directly in the Actuarial Values calculated, which is not the case for the Actuarial Value Calculator developed by HHS. Therefore, care should be exercised so as not to double count the impact of the adjustments for Induced Demand.

5. Induced Demand:

Induced Demand reflects differences in a standard population's spending pattern attributable to differences in the richness of the plan of benefits, but should not reflect differences in health status.

Regardless of the source of information for calculating the AV Pricing Values, the induced demand adjustment factors adopted may not exceed the induced demand adjustment factors used by HHS in its final regulation on Notice of Benefits and Payment Parameters for 2014, which are detailed below. Furthermore, the variations in the adopted induced demand adjustment factors between any two metal plans may not exceed similar variations in the HHS induced demand adjustment factors.

- 1.00 for Catastrophic and Bronze metal levels;
- 1.03 for Silver metal level;
- 1.08 for Gold metal level and
- 1.15 for Platinum metal level.

While Induced Demand may be reflected in the development of the AV Pricing Values, any Induced Demand factor may not reflect differences in the health status of enrollees. Therefore, any Induced Demand factor would have to be determined on a basis consistent with the concept that the Individual market is one rating pool and that the same standard population enrolls in each of the individual plan-designs offered. The rating differential between plan-designs in a given rating region cannot, in whole or in part, be based upon differences due to age, sex, occupation or health status among the actual or assumed enrollees in a particular plan-design (with the limited exception for catastrophic plans included in the Individual Exchange as mentioned in the HHS Regulations).

Note: The Continuance Tables incorporated in HHS's AV Calculator reflect the impact of Induced Demand, but the impact on the AV Metal Values is minimal -- less than 1.0%. On the other hand, the impact of induced demand is far more significant on the "Premium Rates".

Example: Assuming a given plan of benefits which qualifies as a Gold level plan, the AV Metal Value based on the Gold level continuance table would be say 80.0%. Running the same "Gold" plan through the Platinum level continuance table would produce an AV Metal Value very similar to the 80.0% AV Metal Value obtained through the Gold level continuance table.

Assuming two given plans of benefits which qualify as a Gold level plan and as a Platinum level plan respectively, the AV Metal Values obtained by running such plans through their own respective metal continuance tables would produce Actuarial Values at about 80.0% and 90.0% respectively. The premium rates for the Platinum plan should be (a) 112.5% (90% over 80%) of the premium rates for the Gold plan, plus (b) an adjustment to reflect the differences in the Induced Demand Adjustment. Using the

scale published by HHS would yield another adjustment of up to 106.5% (1.15 over 1.08) for a total adjustment of 119.8% (112.5% times 106.5%).

Simply said, the relationships in the claim provisions included in the premium rates for the various metal plans will not be consistent with the AV Metal Values, but rather with a combination of external or internal guidelines plus adjustments for the induced demand adjustment factors. These last two elements determine the AV Pricing Values. Note that if the external or internal guidelines have built-in induced demand adjustment factors, care needs to be exercised so that the aggregate induced demand adjustment factors, including both the built-in factors and the additional factors do not exceed, the HHS induced demand adjustment factors.

6. Single Risk Pool / Index Rate:

Under the ACA and applicable regulations, a Company (i.e., licensed entity) must consider all of its enrollees in all health plans (other than grandfathered health plans) offered by the Company to be members of a single risk pool in the Individual market or Small Group market, respectively. This requirement applies to health plans both inside and outside the Exchange for both markets. HHS regulations requires each Company to determine the “index rate” for the risk pool and make permissible adjustments, both Market-Wide (uniform for all plans) and Plan-Level (varying at the plan design level) to the index rate.

Accordingly, the pricing basis used must be consistent with the concept that the individual market is now one rating pool, and that the same standard population enrolls in each of the individual plan-designs offered, and that the rating differentials between plan-designs in a given rating region cannot, in whole or in part, be based upon differences due to age, sex, occupation or health status among the actual or assumed enrollees in a particular plan-design. (The rating differential for the catastrophic plans pool can reflect the impact of specific eligibility categories for those plans.)

Premium rates under Small Group On/Off Exchange plans are determined based on the claim experience in prior years under such Small Groups, in accordance with the ACA regulations regarding Single Risk Pool/Index Rate. With respect to Individual On/Off Exchange plans, the same requirements of a Single Risk Pool/Index Rate apply and the same approach as on Small Groups will be followed.

Through adjustments as described below pertaining to (a) Market-Wide Index Rate Adjustments and (b) Plan-Level adjustments, premium rates are developed based on claims experience.

The process is the same for both Small Group plans, where there is meaningful claim experience, and for Individual plans, where the claims experience in past years may not be as meaningful.

It is therefore up to the company's actuaries to use his/her expertise in the derivation of the adjustments required as part of the development of the premium rates.

Specifically with respect to the market-wide adjustment in (e) below regarding the impact of anticipated changes in the expected covered membership risk characteristics of the market-wide risk pool for Individual plans, various studies are available to assist the actuaries in the assessment of this adjustment.

It is required that for companies in the Small Group line of business that the Small Group claims experience be used as a starting point with a market-wide adjustment in (e) corresponding to the assessed ratio of (a) Post ACA morbidity under Individual plans to (b) Post ACA morbidity under Small Group plans.

Market-Wide Index Rate Adjustments:

All Market-Wide adjustments must be discussed and supported in the Actuarial Memorandum (each of the following items must be discussed in the actuarial memorandum even if no adjustment is deemed warranted). Market-Wide adjustments include, but are not limited to, the following:

- (a) Total expected market-wide payments and charges under the federal risk adjustment program and federal transitional reinsurance program.
- (b) Total expected Exchange user fees (Note: because New York has not determined the amount of the Exchange user fees, Companies cannot include an adjustment for these fees in 2014 premium rates).
- (c) Impact of compliance with Essential Health Benefits (e.g., not all inforce plans include all the required Essential Health Benefits, and additional benefits need to be eliminated);
- (d) Impact of changes in the provider network, fee schedule levels, or utilization management that apply to the entire market-wide risk pool not included in the claim trend;
- (e) Impact of anticipated changes in the expected covered membership risk characteristics of the market-wide risk pool;
- (f) Impact of anticipated changes in the distribution of membership in the risk pool by the standard rating regions;
- (g) Impact of adjustments for the experience period claim data not being sufficiently credible;
- (h) Impact of other changes that affect the entire market-wide risk pool as detailed by the Company's actuary.

Plan-Level Adjustments:

Plan-Level adjustments include, but are not limited, to the following:

- (a) The actuarial value and cost-sharing design of the plan (e.g., based on the various Pricing AV Values);
- (b) The Company's provider network, delivery system characteristics, and utilization management practices specific to that product or plan-design beyond what is reflected in the index rate;
- (c) The benefits provided under the plan that are in addition to the Essential Health Benefits. These additional benefits must be pooled with similar benefits within the single pool and the claims experience from those benefits must be utilized to determine the rate variations for plans that offer those benefits in addition to essential health benefits.
- (d) Administrative costs, excluding Exchange user fees, and provisions for Profit or Contribution to Surplus margins.

7. Standardized Rating Regions:

The ACA requires standardized rating regions. New York has standardized the geographic rating regions as specified in the "Invitation to Participate in the New York Health Benefit Exchange". Companies may make adjustments to premiums in the different standardized rating regions, based on HHS regulations on rate review.

Companies need to develop a table of area factors for each applicable standard rating region, which must be included with each rate submission.

8. Claims Experience Data:

- (a) For companies currently participating in the Small group market, the premium rates for the Exchange Individual plans must be based on the claim experience under small group plans, through the application of a ratio of Post-ACA Individual morbidity to Post-ACA Small Group morbidity. Factors pertaining to administrative costs, profit margins, claim trends, etc. would be specific to the Individual market pool.

The actuarial memorandum must provide information as to the approach used in the development of Post-ACA morbidity ratio of Individual risks to Small Group risks.

- (b) For other companies, the premium rate development must be specifically described in the Actuarial Memorandum, including the source of the data (e.g. publications, preparing organizations, or consultants).

9. Standardized Census Tiers:

Companies must use the following census tiers and relativities:

- Single = 1.00
- Single + Spouse = 2.00
- Single + Child(ren) = 1.70
- Single + Spouse + Child(ren) = 2.85

10. Child Only Plans:

Companies must offer a child only product in each metal tier that conforms with the Standard Product designs. Only one child-only product is required per metal tier level. A separate policy form must be created and provided to enrollees of child-only products. The child-only rate must be set at 41.2% of the corresponding single rate product.

For a Child Only plan that covers two children in a family, the premium rate would be twice the one child premium rate. For a Child Only plan that covers three or more children in a family, the premium rate would be three times the one child premium rate, consistent with HHS Regulations.

11. HHS Rate Filing Requirements:

The information specified in these instructions is in addition to any rate review information and data required by HHS. Companies should submit to DFS all information that is submitted to HHS.

The completion of HHS's Unified Rate Review Template must be done on a basis consistent with the various assumptions incorporated in the development of the premium rates and with Exhibit 8 Worksheet on Index Rate/Plan Design Adjustments

12. General Overview of Pricing Development:

In the development of the Exchange premium rates the following process is required by the Department. More details are provided in the Section 13.

- (a) For each Inforce Plan-Design of benefits, determine the applicable Metal Level, using HHS Actuarial Value Calculator, with ranges described above, for example Silver Level with a range of AV Metal Value of 65% to 75%.
- (b) For each Inforce Plan-Design of benefits, determine the AV Pricing Values using the guidelines/calculator(s) selected by the Company, and the scale of Induced Demand factors. As indicated above, this scale may not have variations between any two metal levels greater than similar variations in the HHS induced demand scale reflected in the determination of the Risk Adjustments.

- (c) For all inforce plans, determine the weighted-average “AV Pricing Value” and the weighted-average “Induced Demand” adjustment factor, using as weights the member months in the most recent experience period as submitted in Exhibit 7. The total AV Pricing Values would include the induced demand component.
- (d) For all inforce plans combined, determine the Average PMPM Incurred Claims for the latest experience period (without any adjustment for Regulation 146 and Stop-Loss Reimbursements Pools). In accordance with the concept of a Single Risk Pool and market-wide Index Rate as mandated by HHS; PMPM incurred claims are not to be determined by Metal Tier Level.
- (e) Project the average PMPM Incurred Claims in (d) above for the impact of claim trends, from the mid-point of the experience period to the midpoint of the applicability period.
- (f) For all inforce plans combined, determine the “Index” PMPM Claim Rate applicable for all Non-Grandfathered plans combined (to be sold on the Exchange or off the Exchange). This step reflects all Market-Wide adjustments. Note that such adjustments may not vary by the plan-design level.
- (g) Determine the provisions for incurred claims for each Non-Grandfathered plan (to be sold both On-Exchange and Off-Exchange) based on the Index PMPM Claim Rate determined in (f) above, times (A) over (B) :
- (A) The AV Pricing Value determined for each Non-Grandfathered plan; and
- (B) The Average AV Pricing Value (per (c) above) for all inforce plans.
- The AV Pricing Values used in (A) and (B) would be the total AV Pricing Values that include the induced demand component.
- (h) Determine composite premium rates for each Non-Grandfathered plan based on (g) above, plus Plan-Level adjustments for administrative costs and profit margins and all other Plan-Level changes, not already reflected, as discussed above. Note that such adjustments may vary at the product and plan-design level.

The process described above is simplified and does not discuss details by (a) Census Cells, (b) Regions and (d) More. Description below incorporates such details.

13. Material to be Included in Rate Application:

Each rate application must incorporate basic documents as described below. The exhibits referenced below are similar to those submitted for rate adjustment applications submitted pursuant to sections 3231(e)(1) and 4308(c) of the Insurance Law.

- (a) Exhibit 1: This exhibit provides general information about the submission.
- (b) Exhibit 7: This exhibit provides details as to the premium and claims information for the prior three completed 12 month periods for all Individual policy forms. While the proposed HHS regulations on rate review prescribe that all rating pools be combined for the purpose of the determination of premium rates, information on rating pools as last used in the most recent or current Sections 3231(e)(1)/4308(c) Rate Adjustment applications is requested by the Department in this transitional phase. More details are provided below as to the specific information to be provided in this Exhibit 7, and in a separate attachment.
- (c) Exhibit 8 – This exhibit summarizes for a particular market segment, all the market wide adjustment factors and all plan-level adjustment factors used to develop the premium PMPM for each of the non-grandfathered plan designs to be sold on or off the Exchange. More details are provided below as to the specific information to be provided in this Exhibit 8, and in a separate attachment.
- (d) Exhibit 9: This exhibit provides details as to the assumptions for annual claim trend rates, the various administrative costs, and the profit margins, both on a percent of premium basis and on a per member per month basis. More details are provided below as to the specific information to be provided in this Exhibit 9, and in a separate attachment.
- (e) As an attachment to the actuarial memorandum, provide a listing of all plans included in the risk pool, both on and off Exchange, including:
 - (a) Whether On-Exchange or Off-Exchange (or both);
 - (b) Product Name;
 - (c) Associated Metal Tier Level;
 - (d) Metal AV Value; and
 - (e) Description of the cost sharing features and benefits.
- (f) As an attachment to the actuarial memorandum provide printouts of all AV calculation pages using the HHS AV Calculator for the non-grandfathered plans to be sold on the Exchange and off the Exchange. Each page should clearly indicate the plan identifier so that the Department can cross check the calculator input to the cost sharing parameters for that particular plan-design.

(g) As an attachment to the actuarial memorandum, provide a description of all quality improvement/cost containment programs that impact the health plans included in the risk pool, specified by health plan if the programs only affect certain plans. This should tie in with the activities that improve health care quality, as specified in Exhibit 9, the HHS MLR report and the Supplemental Health Care Exhibit.

(h) Actuarial Memorandum providing details on the following information:

The process used for the determination of the Index Rate and premium rates for both On-Exchange and Off-Exchange plans are described below. A simplified description of this process was provided above in the sections dealing with the Induced Demand and the General Overview of Pricing Development. This process includes:

- (1) Average PMPM Incurred Claims for the latest experience period (typically 10/1/11 – 09/30/12, but needs to be 12 months with 3 months of claims runout unless the Department has agreed to 2 months of runout) for all inforce plans combined. The Company's actuary should exclude from this PMPM amount any adjustments for the impact of the current Regulation 146 risk adjustment pool and Stop-Loss Reimbursements pools. Discuss if Grandfathered plans were included or excluded and any particular product excluded.
- (2) Average AV Pricing Value determined for all inforce plans in effect during the latest experience period, based on member-months in the experience period for each inforce plan.
- (3) Average Induced Demand Adjustment factor determined based on member-months in the experience period for each inforce plan.
- (4) Assumptions as to average annual claim trend rates for all components, including inflation, utilization, leverage, and other factors.
- (5) Projection trend factor from midpoint of experience period to midpoint of applicability for Calendar Year 2014 premium rates.
- (6) Projected Average PMPM Incurred Claims determined from (1) and (5) above.
- (7) Market-wide index rate adjustments as discussed in Section 6, not already reflected. The adjustment for Federal Risk Adjustment is to be based on the simulations being developed by the Department. Please note that the DFS simulations are based on business that was in force prior to January 1, 2014. Insofar as the Federal Risk Adjustment requirements and regulations apply to all new and renewal non-

grandfathered business beginning after January 1, 2014, the transfer amount shown in DFS simulation may need to be modified to reflect projected new and renewal business in force after January 1, 2014. If the simulation adjustments are modified, the Company must explain the modifications in the Actuarial Memorandum. It is anticipated that major modifications will be introduced due to the significant differences in covered membership.

The Company's actuary should not include any estimate of Exchange User Fees anticipated for calendar year 2015.

- (8) Market-wide adjustments to reflect the impact of the Federal Transitional Reinsurance Program Recovery, if not already reflected.
- (9) For all inforce plans combined, determine the "Index" PMPM Claim Rate. This step reflects the Projected PMPM Incurred Claims per (6) above with Market-Wide adjustments prescribed in HHS regulation per (7) and (8) above. Note that such adjustments do not vary by the plan-design level.
- (10) Determine the starting point PMPM Claim Rate for each Non-Grandfathered Plan (both On-Exchange and Off-Exchange) by multiplying the Index PMPM Claim Rate for all inforce plans combined per (8) above by the ratio of (A) to (B), as follows:
 - (A) The AV Pricing Value for each Non-Grandfathered Plan, both On-Exchange and Off-Exchange, at each of the Metal Tier levels;
 - (B) The Average AV Pricing Value per (2) above for all inforce plans.The AV Pricing Values used in (A) and (B) are the total values including the induced demand component.
- (11) Plan-Design Level Adjustments for the various differences in characteristics as described above. Full details need to be provided in the Actuarial Memorandum for each such item, including an indication that there is no adjustment for an item, if so determined by the Company's actuary. The adjustments, and the result after these adjustments, needs to be indicated.
- (12) Plan-Design Level Adjustments for Administrative Costs and Profit Margins per Exhibit 9. Note that such adjustments may vary at the plan level and by Metal Tier Levels.

- (13) Preliminary PMPM Premium Rate for each Non-Grandfathered Plan, as determined from items (11) and (12) above, e.g., (11) divided by 100% less (12).
- (14) Final (all regions combined) Premium Rates for all Non-Grandfathered Plans for Employees only, for Employees and Spouse, for Employees and Child (ren) and for Employees and Spouse and Child(ren), based on census factors prescribed by the Department. The development of the conversion factor (PMPM rate to single premium rate) must be included in the actuarial memorandum and must be based on the distribution of members and subscribers (employees) by census cells during the experience period used in (1) above as modified by the Market-Wide Index Rate Adjustment for such anticipated changes with support for such anticipated changes included in the actuarial memorandum.
- (15) Final Premium Rates for each Non-Grandfathered Plan for each applicable rating region based on the area factors by region as determined by the Company's' actuary, and as explained in the Actuarial Memorandum. This step yields the Final Premium Rates for each Non-Grandfathered plan for calendar year 2014, by Census Tier and by Rating Region. If any product or plan-design is not to be offered in a particular rating region, that should be mentioned in the actuarial memorandum.

(i). Supporting details on the key assumptions and additional information to be included in actuarial memorandum:

- (1) Assumptions on annual claim trend rates, including if available, information on experienced annualized claim trend rates on allowed charges;
- (2) Justification for the assumed utilization, unit cost and composite annual trend factors. Discuss the impact and provide justification for any case mix change, intensity of service change, population/demographic (aging) change, adverse selection, or deductible leveraging component incorporated into the utilization and/or unit cost trend factor components that is not part of the Market-Wide Index Rate Adjustments;
- (3) Assumptions on administrative costs components, including (a) explanations for differences in expense components between the current Exhibit 9 for Non-Grandfathered plans and the Exhibit 2 submitted for inforce plans in the most recent/current Sections

3231(e)(1)/4308(c) Rate Adjustment submission, and (b) reconciliation with administrative costs information reported in latest financial statements; and

- (4) Assumptions on profit margins or contribution to surplus, including a discussion on Return on Equity.
- (5) Details as to adjustments to Actuarial Values determined based on HHS AV Calculator for inforce plans.
- (6) SERFF Number of the associated QHP Template filing.
- (7) Details as to the restructuring of the various “composite” premium rates into separate premium rates for the various census cells, i.e. Employees only, Employees and Spouse, Employees and Child(ren) and Employees and Spouse and Child(ren), using the census factor tier factors prescribed by the Department. Such details should include information as to the distribution of both subscribers and members by the various census cells. The premium rates for employees only are determined by dividing the composite premiums rates by the average prescribed census factors, weighted by subscribers; the premium rates for other census cells are determined by multiplying the premium rates for employee only by the prescribed census factors.
- (8) Details as to the determination of the premium rates by the standardized rating regions. Companies need to determine area factors for all applicable rating regions and use these factors to arrive at Non-Grandfathered premium rates by rating region. Details also need to be provided in support of the area factors selected by the Company’s actuary, including some confirmation that such area factors are in compliance with HHS proposed regulations on rate review. Specifically, such area factors may not reflect, in whole or in part, differences due to age, sex, occupation or health status among the actual or assumed enrollees in that rating region. Differences may however reflect differences in Provider Network Characteristics, differences in Delivery System Characteristics, and differences in Utilization Management Practices.
- (9) Details as to adjustments to the premium rates for the impact of risk adjustments and the impact of the transitional reinsurance program, including the results for the simulations performed by the Department and the support for the adjustments introduced.
- (10) Details and support on any other adjustments deemed necessary by the Company’s actuary.

- (11) If the source data for the determination of the premium rates for the Exchange plans is other than the actual claims experience under Non-Grandfathered/Grandfathered plans, indicate the source of this data (e.g., the publication, organization, or consultants), and the applicability of this source data.

14. Actuarial Memorandum - Actuarial Qualifications:

- (a) Member of the Society of Actuaries or member of the American Academy of Actuaries; and
- (b) Meets the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.

15. Actuarial Certification: The application should include an actuarial certification that states the following:

- (a) The submission is in compliance with all applicable laws and regulations of the State of New York;
- (b) The submission is in compliance with the appropriate Actuarial Standards of Practice (ASOP’s) including:
- ASOP No. 5, Incurred Health and Disability Claims
 - ASOP No. 8, Regulatory Filings for Health Plan Entities
 - ASOP No. 12, Risk Classification
 - ASOP No. 23, Data Quality
 - ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
 - ASOP No. 41, Actuarial Communications
- (c) The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York;
- (d) The benefits are reasonable in relation to the premiums charged; and
- (e) The rates are not unfairly discriminatory.

16. Objection Letters:

The application is subject to objection letters being raised by the Department.

Due to the tight timeframes required for Exchange certification of QHPs, the Department requests that due diligence be exercised by the Companies in responding promptly to the Department's objection letters. The Department will assign an actuary within the Department's Actuarial Unit to monitor the objection letters and the responses by the Companies. It is imperative that Exhibit 1 provides identification data, including e-mail addresses and telephone numbers of the Company's actuaries involved in the preparation of the rate submissions.

17. Additional Requirements:

a. Filing Type Code

New filing type codes have been added to SERFF which are to be used for the April-May 2013 for On-Exchange and Off-Exchange form and rate product filings:

Exchange Form & Rate Filing.
Off Exchange NG Form & Rate Filing

Separate SERFF filings are needed for non-grandfathered small group and for non-grandfathered individual products. A SERFF filing may no longer include both non-grandfathered small group and individual products.

b. Format of Attachments:

Each attachment to the rate adjustment application must be compatible with the following software: Microsoft Word 2010, Microsoft Excel 2010, or Adobe Acrobat 9.

When an attachment is submitted via SERFF as other than an Adobe Acrobat PDF file, another copy of that attachment is to also be included in Adobe Acrobat PDF file format. This can occur when one of the standard exhibits is required to be submitted as an Excel workbook, or when an appendix/attachment to the actuarial memorandum is submitted in other than PDF format. Failure to include a PDF version of each attachment will result in a notification letter being sent for the missing material.

c. Rate Manuals:

The submissions must include rate manuals for both the standard and non-standard On-Exchange and the Off-Exchange plans, for all 4-tier census cells and for child only and for all applicable regions.

The rate manuals are to be attached to the Supporting Documentation tab of the initial SERFF submission.

d. SERFF/HHS Requirements:

This rate application for the Exchange plans is also subject to other SERFF and HHS requirements.

e. Amendment to Submission:

An “amendment” to a SERFF submission, as described beginning on page 183 of the SERFF Industry Manual (available online via SERFF), is used when the amendment is not in response to an objection letter from the Department. For example: the filer has decided to add a schedule item; the filer has noticed an error in one of the originally submitted schedule items and is submitting a correction before the error is raised in an objection letter from the Department. If a schedule item (e.g., actuarial memorandum, standard exhibit, rate manual, etc.) needs to be amended, the entire schedule item attachment is to be resubmitted using this process and not just the pages that need to be corrected.

A revision to a previously submitted schedule item made in response to an objection letter from the Department is to use the “Revising Schedule Items” process described beginning page 170 of the SERFF Industry Manual. This is the method that is to be used when any schedule item needs to be revised in response to a letter, including a revised rate manual to be submitted in response to the Department’s decision. If a schedule item (e.g., actuarial memorandum, standard exhibit, rate manual, etc.) needs to be revised in response to a letter from the Department, the entire schedule item attachment is to be resubmitted using this process and not just the pages that need to be revised.

f. Commission Schedules:

New or revised commission schedules or broker fee schedules must first be placed on file using a rate submission with a “Normal Pre-Approval” SERFF submission type code and the associated premium impact. Once the new or revised schedule has been placed on file, then the commission schedule would be included in all future filings. Given that some companies will be filing new or revised commissions/broker fees for use with the new form and rate filings, and the revised commissions/broker fees may not have been approved at the time the rate and form filing for non-grandfathered On-Exchange or Off-Exchange products are submitted, the form and rate filing should reflect the requested commissions schedule in the premium development, and the actuarial memorandum must indicate the commission filing is pending (SERFF number of the commission filing is to be provided), and indicate the impact on the premium rates of the pending change in commissions/broker fees.

Checklist – Definitions:

- a. **Company** refers to the licensed entity providing the insurance coverage reflected in the rate application.

- b. A Company's **commercial book of business** includes all of the following: large group, small group, direct pay, Healthy New York, and Medicare Supplemental. It excludes all government programs, such as, Medicare, Medicaid, Family Health Plus, and Child Health Plus.

- c. **Loss ratio** refers to incurred claims divided by earned premiums for a given period of time. Incurred claims includes the impact of the Regulation 146 (11 NYCRR 361), New York State stop loss reimbursements, covered lives assessments, and the HCRA surcharge. Incurred claims do not include any administrative expenses, including "quality improvement expenses" or "community benefit expenses". Earned premiums do not include any adjustment for assessments or taxes. For the new plans to be sold through the Exchange, incurred claims includes the impact of new individual reinsurance program and the new risk adjustment mechanism instead of the prior state sponsored Regulation 146 pool.

- d. **Market segment** refers to Individual or Direct Pay as defined in New York Insurance Law and Regulation.

- e. **Product street name** refers to the product name as advertised to consumers, and the product name which consumers are most likely to use when communicating with the Department.

- f. **Rate applicability period** refers to the length of time in which the rates in a rate table are assumed to remain in effect.
 - (i) Example 1: A non-rolling rate table is developed to be effective January 1, 2014 and is expected to be revised January 1, 2015. The rate applicability period for this table is January 1, 2014 through December 31, 2014.
 - (ii) Example 2: A quarterly rolling rate table is developed for issues and renewals in January – March 2014 and incorporates a 12 month rate guarantee period. The average rate applicability period for this table is February 1, 2014 (mid renewal date) through January 31, 2015.

- g. **Standardized earned premiums** is the earned premiums for the period adjusted to assume that all premiums for the period are payable at the most current approved (or deemed approved) rate level, reflecting rate increases exclusive of rate changes due to contract language changes (i.e., excluding rate changes due to benefit revisions or members migrating to different plan designs since the impact of such changes would be automatically reflected in the earned premiums and incurred claims once such a change becomes effective). Refunds payable pursuant to Regulation 146 or pursuant to a loss ratio report have no impact on the earned premiums or standardized earned premiums shown in Exhibit 7 or in the rate development analysis.

For this rate application submission, the Standardized earned premiums are applicable only for the Non-Grandfathered/Grandfathered plans, and the standard rate scale to be used is the rate scale for the Fourth Quarter of 2013 for a quarterly rolling rate structure, and the premium rates for calendar year 2013 for non-rolling rate structure. The historical experience shown in Exhibit 7 would include the experience for each of the three 12 month periods requested, even though the policyholder/contract holder may have had “grandfathered” status during some part of that experience periods.

Exhibit 7 – Historical Claim Experience Data by each Policy Form:

This Exhibit is applicable only to companies currently in the Individual market.

This standard form illustrates the experience for the prior three [3] years for selected policy forms.

The policy forms selected are those policy forms for Non -Grandfathered plans, and if included, for Grandfathered plans providing comprehensive benefits for hospital, medical and prescription drugs changes. As indicated previously, some policy forms, previously included in Sections 3231(e)(1)/4308(c) rate adjustment applications may be excluded, for example hospital only plans, medical only plans, limited benefit plans, plans supplementing Medicare benefits, and other discontinued or closed group policy forms.

Note that discontinued plans within a policy form being continued are not to be excluded.

Also note that Healthy New York plans on Individuals and Sole Proprietors must also be included in this Exhibit 7.

This exhibit is to be used in the analysis of the claims experience for prior years and will be used for the development of the 2014 premium rates for the On/Off Exchange plans for Individual plans.

This exhibit similar to the Exhibit 7 as used for Sections 3231(e)(1)/4308(c) Rate Adjustment applications.

- a. This Standard Exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of this Standard Exhibit is fixed; inset additional rows as needed. Use only the first tab for data entry.
- b. Top of Exhibit 7: Indicate the Company name, the NAIC code, the SERFF number and the Market Segment [Individual].
- c. Policy Form: Use a separate row for each base medical policy form. Data is to be shown for each policy form for Non-Grandfathered/Grandfathered plans. The distinctions as to “rating pools” must be the same as the most recent/pending Sections 3231(e)(1)/4308(c) Rate Adjustment rate application.
- d. Columns 1a, 1b and 1c: Indicate the form number for each base medical policy form, the product name as in the rate manual, and the street product name.
- e. Column 2 - Rating Pool Identifier: Enter same response as in the most recent/pending Sections 3231(e)(1)/4308(c) Rate Adjustment application.

- f. Column 3 - Effective Date of Rate Change: Indicate January 1, 2014.
- g. Columns 4 through 7: Use drop down menu to identify Market Segment, Product Type, Rolling/Non Rolling rate structure and Open/Closed Policy Form.
- h. Columns 8 and 9: Enter the number of policyholders and the number of covered lives affected by this rate application, for a full 12 month cycle.
- i. Experience Data: The experience entered for the three [3] indicated experience periods is the New York statewide experience for the indicated base medical policy form plus all associated riders.
 - a. Each experience period is to be for 12 months (or shorter if a new form).
 - b. The ending date of the recent experience period cannot be earlier than September 2012. For most Companies, this experience period will be from October 2011 through September 2012. If available, the Department will accept an experience period corresponding to calendar year 2012. The starting date of the recent experience period may not be prior to October 2011.
 - c. The first prior experience period is the immediately prior 12 month experience period (or shorter period if a new form). The second prior experience period is the immediately prior 12 month experience period (or shorter if a new form) prior to the first prior period.
 - d. The incurred claims for each of the three experience periods must be based on at least 3 months of claims run-out beyond the end of the experience period. The actuarial memorandum is to provide a clear description of how these incurred claims were developed for each experience period and how many months of claim run-out were reflected in the development of the incurred claims.
 - e. Loss ratio report refunds or refunds pursuant to Regulation 146 are to have no impact on the earned premiums or standardized premiums shown. Such refunds do not reduce the earned premiums or resultant standardized earned premiums.
- j. Standard Premiums: The actuarial memorandum is to include a clear description of how the standardized earned premiums for each experience period were developed from the earned premiums for the applicable experience period, and include documentation and supporting exhibits showing how the standardized premiums were developed for each experience period. A numerical example illustrating the development methodology for one non-rolling rate product and one rolling rate product included in the rate submission is to be included as part of the actuarial memorandum, as applicable. The same standard rate level is used for all of the experience periods. This standard rate scale corresponds to Calendar Year 2013 rates for non-rolling structure and to Fourth Quarter 2013 for rolling rate structure.

Exhibit 8: Index Rate /Plan Design Adjustment Worksheet:

This Exhibit is applicable to all companies.

For companies participating in Individual and Small Group market, two Exhibits 8 need to be submitted, one showing on lines 10A through 12 the information on Small Group plans and the other one showing the information on Individual plans. Subsequent lines 13 through 42 would then be filled only for the “Small Group” version.

For other companies, Exhibit 8 must be completed in full.

- a. This Exhibit 8 must be submitted as an Excel file and as an Adobe PDF file. The format of this exhibit is fixed; insert more columns as needed.
- b. Top of Exhibit 8: Indicate the Company name, the NAIC code, the SERFF Number and the Market Segment [Individual].
- c. Use separate columns for each of the On/Off Exchange plan designs, separately for Standard and Non-Standard plans.
- d. Information on Lines 1 through 9 is to be entered for each plan design.
- e. Information on lines 10A through 10B is to be entered in the left most column, for all inforce plans combined. This information is as illustrated in Exhibit 7. Other columns on lines 10A through 10C are to be left blank.
- f. Information on lines 11 and 12 is to be entered in the left most column, for all inforce plans combined. Other columns on line 11 are to be left blank. Information on line 12 is to be carried to all other columns used for the various plan designs.
- g. Information on lines 13 through 26 are to be entered in the left most column, for all inforce plans combined. This information corresponds to adjustments to be introduced as Market-Wide adjustments as prescribed by HHS regulations. Other columns on lines 13 through 26 are to be left blank.
- h. Information on line 27 is to be determined based on the prescribed formula in the left most column and this information is to be carried to all other columns used for the various plan designs.
- i. Information on lines 28 through 40 is to be entered in all columns for each plan.
- j. Information on line 41 is to be determined based on the prescribed formula for all columns for the various plan designs.
- k. Information on line 42 is determined as line 12 times line 27 times line 41.

Exhibit 9: Summary of Claim Trend, Administrative Expenses and Profit Margins:

This Exhibit is applicable to all companies, including companies currently not in the Individual or Small Group market.

- a. This exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of this exhibit is fixed; insert more rows as needed. Only use the first tab for data entry.
- b. Top of Exhibit 9: Indicate the Company name, the NAIC code number for that entity, and the SERFF number and the Market Segment [Individual].
- c. This exhibit applies only to the non-grandfathered plans to be sold on the Exchange or off the Exchange.
- d. For all the On/Off-Exchange plans, use a separate row to enter information for each plan at each metal level (including catastrophic). This includes both the standard plans and the non-standard design plans to be sold through the Exchange design, and the Off-Exchange plans.
- e. Information is for medical base plans and all associated riders combined.
- f. Column 1: Enter Metal Tier Level using drop-down menu.
- g. Column 2: Enter On/Off-Exchange Designation using drop-down menu.
- h. Column 3: Enter the On/Off-Exchange Product Name as applicable.
- i. Columns 4.1 - 4.2: Enter the applicability period.
- j. Column 5: The average claim trend is the average annualized claim trend rate to adjust source data forward to the applicable applicability period.
- k. Columns 6.1 through 6.7: The administrative expense components must reflect the anticipated expenses for applicability in calendar year 2014.
- l. Columns 7 through 10: The profit margins components must reflect the provision for profit margin required for applicability in calendar year 2014.
- m. Both the administrative expenses and the profit margins are to be entered both as percentages of premiums in columns 6.1 through 11, and as per member per month amounts in columns 12.1 through 17.