

**NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES**

**Instructions for the Filing of 2016 Premium Rates  
Individual and Small Group – “On” and “Off” Exchange Plans**

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## NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

### **A. General Introduction:**

These instructions apply to all rate filings submitted in calendar year 2015 for premium rates effective in calendar year 2016 for Individual and Small Group plans, both “On” and “Off” Exchange.

**For companies with 2015 rates on file in a particular market (i.e., Individual or Small Group), rate filings for calendar year 2016 are to be submitted pursuant to § 3231(e)(1) or § 4308(c) (Prior Approval Adjustment filings) for that market. Additional requirements, as specified by those Sections apply (e.g., notices of proposed rate changes to impacted policyholders at the time the rate filing is submitted, a notice of the approved rates to impacted policyholders 60 days prior to the effective date of renewal, specified time limits, etc.) Notices of proposed changes may be sent to policyholders after DFS has posted the rate applications. Note that for filings of this type, if the existing forms are being modified or if new plans are being introduced, then a separate Form Filing must be submitted. Both filings (i.e. the separate Rate and Form filings) must clearly reference each other by SERFF Filing Number.**

**For companies that do not have 2015 rates on file in a particular market, rate filings for calendar 2016 are to be submitted pursuant to § 3231(d) or § 4308(b) (Rate and Form filings) for that market.**

These rules apply at the legal entity (i.e., each separate and distinct NAIC number) level.

These instructions do not apply to (a) the rate filings for Grandfathered plans, (b) community-rated large group HMO products and (c) stand-alone dental plans.

Note that the 2016 version of the rate filing exhibits must be used as they include updates from the previous year.

### **B. Essential Health Benefits:**

Companies must provide the Essential Health Benefits specified by the New York State Department of Health (DOH) for calendar year 2016.

### **C. Separate Rate Filings for On and Off Exchange Plans:**

Separate rate filings need to be submitted for Individual and Small Group plans.

Separate rate filings need to be submitted for “On” and “Off” Exchange plans.

Rate manuals can include rates for both “On” and “Off” Exchange plans as long as there is a separate section for each (i.e., Only “On” Exchange rates are shown in the Exchange Section and only “Off” Exchange rates are shown in the “Off” Exchange Section.

Actuarial Memorandums may address both “On” and “Off” Exchange plans as long as any differences are clearly addressed.

### **D. HHS Proposed Notice of Benefit and Payment Parameters for 2016:**

Proposed regulations were released in December 2014. Generally speaking, HHS proposed requirements for 2016 are similar to 2015 as they apply to rates. There is no change with regard to the requirements for the Index Rate or Single Risk Pools. However, as noted below, some changes have

been introduced or proposed (Note that Final version of the 2016 Notice of Benefit and Payment Parameters has not yet been released).

**Some changes introduced include:**

- (a) Changes in the Parameters for the Federal reinsurance program (HHS is proposing to change the attachment point to \$90,000 from \$45,000 for 2016);
- (b) Maximum OOP Limit has increased to \$6,850 (from \$6,600);
- (c) Changes in some of the provisions for the Risk Corridors (i.e., the program is expected to be administered on a “budget neutral” basis); and
- (d) Changes to the AV Calculator (The Final 2016 version must be used).

**D (a) Reinsurance Program for Individual Plans:**

- (1) Amounts of fees scheduled to be collected are \$12B in calendar year 2014, \$8B in calendar year 2015 and \$5B in calendar year 2016;
- (2) HHS has proposed to increase the Attachment Point for calendar year 2016 to \$90,000 from \$45,000. No changes were proposed for the Coinsurance Rate (50%) and Cap (\$250,000);
- (3) HHS has proposed to reduce the Reinsurance Fee to \$27.00 per year (or \$2.25 per month) from \$44.00 per year (or \$3.67 per month) in calendar year 2016. These rates are per individual.

The reinsurance fee must be incorporated into expenses.

DFS estimates that the impact of the change in attachment point on Individual premiums is approximately 5.5% for calendar year 2016.

**D (b) Patient-Centered Outcomes Research Institute (PCORI) Fees**

Premium rates should reflect the PCORI fee as appropriate. This fee was established per the ACA as \$1.00 per covered life for each plan year ending before October 1, 2013, and \$2.00 for plan years ending before Oct 1, 2014. For subsequent plan years, (through October 1, 2019), the fee will be increased annually to reflect National Health Expenditures, as determined by the Secretary of HHS. Additional information regarding this fee can be found on the IRS website at:

<http://www.irs.gov/uac/Newsroom/Patient-Centered-Outcomes-Research-Institute-Fee>

**D (c) Changes in Deductibles and Maximum Out of Pocket (MOOP) Limits:**

The annual deductible limit for Small Group has been repealed.

For 2016, the HHS prescribed self-only coverage MOOP limit is \$6,850, and the family limit is \$13,700.

**D (d) Other ACA Fees:**

ACA fees include:

- (1) Risk Adjustment User fee of \$1.75 per member per year in 2016; and
- (2) There should be no explicit fees for Exchange funding as the NYSOH will be funded using the existing HCRA mechanism.

**E. New York State Standard Benefit Design:**

Due to the changes in the Deductible and Maximum out of Pocket Limit provisions noted in Section D(c) above, the Silver 200-250 CSR plan variation and the catastrophic plan require revision. We are in the process of revising the Standard Benefit Designs for these two plans and will notify carriers when they have been finalized. Additionally, because New York has elected to establish the Basic Health Plan (BHP)

option, the 200-250 FPL is the only CSR plan variation that will remain in 2016 as individuals below 200% FPL will be eligible for the BHP. Note that all other Standard Benefit Designs remain unchanged.

**F. 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 (2016 version) .

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

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

For Silver Cost Sharing Reduction (CSR) plans, each product must also fall within one of the following specified actuarial value (AV) levels based on Federal Poverty Level (FPL):

200% to 250% FPL 73% AV  
150% to 200% FPL 87% AV  
100% to 150% FPL 94% AV

For CSR plans, a *de minimus* variation of +/- 1% AV is permissible.

The AV Metal Values determine what metal level a particular plan-design belongs in, and the 2016 HHS Actuarial Value Calculator must be used in the calculation of these AV Metal Values.

The final version of the 2016 AV Calculator and accompanying documentation can be found in the following locations:

<http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2016-AV-Calculator-011514.xlsm>

<http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2016-AV-Calculator-Methodology.pdf>

**G. Actuarial Value (AV) Pricing Values:**

(Within these Instructions, 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 in-force plan-designs, the AV Metal Values are as described above in Section F. AV Pricing Values are defined as:

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 ACA Compliant must fall within the AV Metal Values specified above in Section F.**

The AV Pricing Values should reflect items not addressed by the HHS AV Calculator (e.g., provider networks, etc.) Companies may use the HHS 2016 AV Calculator to determine AV Pricing Values. Other source may also be used (e.g., internal guidelines developed by the Company, etc.) If such alternate sources are used, details regarding pricing differentials, their development and the source of the data

must be provided in the Actuarial Memorandum. Note that some available sources may already reflect the impact of Induced Demand (see Section H below), so care should be exercised to avoid double counting.

#### **H. 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.

The induced demand component must be the same for all plans in a given metal tier, and each such value must be disclosed in the Actuarial Memorandum.

Regardless of the source of information used for determining the AV Pricing Values, the induced demand component may not exceed the induced demand factors noted by HHS in its final Notice of Benefits and Payment Parameters for 2014, which are as follows:

- 1.00 for Catastrophic metal level (Individual Exchange Only);
- 1.00 for Bronze metal level;
- 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, it may not reflect differences in the health status of enrollees. Therefore, the Induced Demand component for a particular plan must be determined assuming that the Individual, Small Group, or Catastrophic Market is one standard population, and that the entire population of that Market enrolls in that particular plan (i.e., The rating differential between plan-designs in a given metal tier or 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).

#### **I. Single Risk Pool / Index Rate:**

Under the ACA and applicable regulations, a Company (i.e., at the legal entity level) 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 Small Group or Catastrophic market as applicable. This requirement applies to health plans both inside and outside the Exchange for each of these markets. HHS regulations require 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.

For purposes of the Small Group Index Rate, the single risk pool must incorporate all Non-Grandfathered Small Group experience, including the Small Group Healthy New York plans, but excluding Sole Proprietor experience.

For purposes of the Individual Index Rate, the single risk pool must incorporate all Non-Grandfathered Individual experience, including Sole Proprietor experience.

Accordingly, the pricing basis used must be consistent with the assumption that the Individual, Small Group, or Catastrophic Market is one standard population, and that the entire population of that Market enrolls in a particular plan (i.e., The rating differential between plan-designs in a given metal tier or 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).

While rate filings must be submitted separately for “On” and “Off” Exchange plans, the concept of a single risk pool must be maintained in aggregate for combined “On” and “Off” Exchange plans.

**J. 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 necessarily limited to, the following:

- (a) Impact of compliance with Essential Health Benefits (e.g., some in-force plans may not include all of the required Essential Health Benefits, and some additional benefits may need to be eliminated);
- (b) 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;
- (c) Market wide adjustment for impact on claim costs from quality improvement and cost containment initiatives;
- (d) Impact of anticipated changes in the risk characteristics of the expected covered membership of the market-wide risk pool;
- (e) Impact of anticipated changes in the distribution of membership in the risk pool across the standard rating regions;
- (f) Total expected market-wide payments and charges under the Federal risk adjustment program and anticipated reimbursements from the Federal transitional reinsurance program;
- (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.

**K. 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 plan beyond what is reflected in the index rate;
- (c) Impact on claim costs from quality improvements and cost containment initiatives;
- (d) Benefits provided under the plan that are in addition to the Essential Health Benefits. Such additional benefits must be pooled with similar benefits and the associated claims experience utilized to determine the rate variations for plans that offer those additional benefits;
- (e) Administrative costs and provisions for Profit or Contribution to Surplus margins;
- (f) Addition of Out-of-Network Benefit Option (e.g. POS or PPO);
- (g) The anticipated Stop Loss reimbursements from New York State for Small Group Healthy New York plans;
- (h) Impact of other Plan-Level adjustments, as detailed by the Company’s actuary.

#### **L. Standardized Rating Regions:**

The ACA requires standardized rating regions. The Standardized Rating Regions for New York have not changed for 2016. Companies may vary premiums between standardized rating regions in accordance with HHS regulations.

#### **M. Claims Experience Data:**

##### **M (a) Small Group Plans:**

For Companies currently participating in the Small Group market, premium rates for “On” and “Off” Exchange plans should be based on recent claims experience for Non-Grandfathered plans only.

The Index Rate for Small Group must incorporate the claims experience of all of the Company’s Small Group business (excluding Sole Proprietor experience which must be included with Individual experience) and including Small Group Healthy New York experience. Additional details are provided in the Instructions for Exhibit 17.

When sources other than in-force claims experience are used for determining premium rates, the source as well as appropriate justification must be included in the Actuarial Memorandum.

For Companies that do not currently participate in the Small Group market, the Actuarial Memorandum must describe the methodology used for determining anticipated claims experience.

##### **M (b) Individual Plans:**

For companies currently participating in the Individual market, the premium rates for Individual plans should be based on the claims experience of the company’s 2014 Individual (including Sole Proprietor) plans.

When sources other than in-force claims experience are used for determining premium rates, the source as well as appropriate justification must be included in the Actuarial Memorandum.

For Companies that do not currently participate in the Individual market, the Actuarial Memorandum must describe the methodology used for determining anticipated claims experience.

#### **N. Small Group Healthy New York Plans:**

While the Healthy New York program was eliminated for Individuals and Sole Proprietors with the introduction of the new ACA reforms on January 1, 2014, the Small Group Healthy New York program remains in effect and is still be eligible for stop loss reimbursements.

Small Group Healthy New York plans are available “Off” Exchange only and have been designated as Gold level plans.

Premium rates for Healthy New York plans are to be determined by applying a plan level adjustment to the Index rate. Such adjustment should reflect the impact of the Stop Loss reimbursements from New York State.

#### **O. Standardized Census Tiers:**

Premium rates for all plans must conform to the following census tier structure:

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

- Child only = 0.412

Census tier factors for calendar year 2016 are unchanged from 2015.

**P. Child-Only Plans (Individual Exchange Plans Only):**

All plans within the Individual Market (with the exception of Catastrophic) must include rates for Child-Only plans. This does not apply to Small Group.

Companies must offer a child-only product in each metal tier that conforms to the Standard Product designs. At least one child-only product is required per metal tier. A separate policy must be created and provided to enrollees of child-only products.

For a child-only plan that covers two children in a family, the premium rate will be twice the child-only premium rate. For a child-only plan that covers three or more children in a family, the premium rate will be three times the child-only premium rate, per HHS Regulations.

**Q. 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 information provided in the HHS Unified Rate Review Template must be consistent with Exhibit 18.

**R. General Overview of Pricing Development:**

In the development of the Exchange premium rates, DFS requires the following simplified process. More details are provided in the Section T(a) below.

- (a) For each In-force plan-design, determine the applicable Metal Level, using the HHS AV Calculator.
- (b) For each In-force plan-design, determine the AV Pricing Value with the restrictions mentioned in Section H above.
- (c) For all in-force plans, determine the weighted-average “AV Pricing Value” and the weighted-average “Induced Demand” factor, using member months as weights (for the most recent experience period as submitted in Exhibit 17). The weighted-average AV Pricing Value should include the Induced Demand component.
- (d) For all in-force plans combined, determine the Average PMPM Incurred Claims for the latest experience period (without any adjustment for Regulation 146 and Stop-Loss Reimbursements Pools).
- (e) Project the average PMPM Incurred Claims in (d) above for the impact of claim cost trend, from the mid-point of the experience period to the midpoint of the period for which the rates will be in effect (i.e., it should be assumed that individual rates will be in effect for a full calendar year and that small group rates will be in effect through the first quarter of 2016).
- (f) For all in-force plans combined, determine the “Index” PMPM applicable to all plans (“On” and “Off” Exchange) combined. This step reflects all Market-Wide adjustments.

- (g) Determine the provision for incurred claims for each plan (to be sold both “On” and “Off” Exchange) based on the Index PMPM Rate determined in (f) above, times (A) over (B), where (A) and (B) are:
  - A. The AV Pricing Value determined for each plan; and
  - B. The Average AV Pricing Value (per (c) above) for all in-force plans
- (h) Determine the PMPM rates for each 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 plan level.

The process described above is simplified and does not discuss details by (a) Census Cells, (b) Rating Regions, and (c) Applicable Effective Quarters. These items are addressed in Section T(a).

**S. Material to be Included in Rate Filing:**

Each rate filing must include the Exhibits described below. In many instances, these Exhibits are the same as those required for filings subject to Sections § 3231(e)(1) and § 4308(c).

Supplementary instructions are provided in subsequent pages for all Exhibits.

**(a) Exhibit 11 - General Information:** Requires general information about the filing. Information must be provided as to the identification of the actuary responsible for the preparation of the rate filing, (which identification may be redacted).

**(b) Exhibit 13A-13B - Numerical Summary and Rate Indication Calculation and Narrative Summary:** Requires a summary of key numerical values and an explicit calculation of the rate indication as well as a plain English summary of the rate change (including the reasons for such).

**(c) Exhibits 14A-14B - Summary of Requested Percentage Changes:** Provides details as to the changes in premium rates between the approved 2015 premium rates and the requested 2016 premium rates.

**(d) Exhibits 15A-15B - Distribution of Contracts by Requested Percent Adjustments:** Provides details as to the distribution of the rate changes by percentage brackets.

**(e) Exhibit 16 - Summary of Policy Form and Product Changes:** Requires details as to form filings that may impact the current rate filing.

**(f) Exhibit 17 - Historical Claim Data by Policy Forms:** Requires premium and claim data for the prior three completed 12 month periods for all Individual and Small Group policy forms.

**(g) Exhibit 18 (and Exhibit 18 Supplements)- Index Rate/Plan Design Level Adjustment Worksheet:** Summarizes all market wide and plan-level adjustments used in the development of the premium PMPMs for each plan to be sold.

**(h) Exhibit 19 - Summary of Average Claim Trend and Administrative Expenses and Profit Margin:** Requires details supporting assumptions used for claim trend, administrative costs, and profit margin on a percent of premium basis. Two sets of assumptions are required, including the current set of assumptions for use in the determination of the 2016 premium rates, and those used to determine 2015 premium rates.

**(i) Exhibit 20 -HIOS Mapping to Product Names:** Requires details for material benefit provisions for each plan at the HIOS ID level.

**(j) Exhibits 21A-21B - Hospital Unit Cost Development:** Requires details on average changes in the level of hospital charges, separately for the last three calendar years (2012-14), by provider, and separately for Inpatient services (Exhibit 21A) and for Outpatient Services (Exhibit 21B). These exhibits also require information on allowed claims.

**(k) Exhibit 22 - Small Groups Medical and Hospital Utilization Data:** Requires details for number of services, allowed charges and membership for the last three calendar years (2012-2014), by type of service.

**(l) Exhibit 23 - Requested 2016 Premium Rates:** Requires information on 2014-2016 premium rates for all plans. Information is requested separately for Small Group and Individual plans by metal level and rating region, separately for “On” and “Off” Exchange plans.

**(m) Exhibit 24 – Risk Corridors Estimate:** The purpose of this Exhibit is to provide an estimate of the Company’s expected Risk Corridors transaction for 2014 assuming the program is fully funded.

**(n) Exhibit 25 – Adjustment Factors for Major Variations from the Base Plan:** The purpose of this Exhibit is to provide the factors used to add/subtract major plan variations.

**(o) AV Calculations (Snapshots):** As an attachment to the Actuarial Memorandum, provide printouts of all AV calculation pages (snapshots) using the final HHS 2016 AV Calculator for all plans covered by the rate filing. Each page should clearly indicate the HIOS ID so that DFS can cross check the calculator input to the cost sharing parameters for that particular plan-design.

If adjustments are required for special benefit features, they must be clearly highlighted in the snapshots.

Calculations must be based on the benefit provisions incorporated in the rate manuals. Care must be exercised so that all boxes are properly checked (or not checked) as applicable.

**(p) Quality Improvements:**

A copy of the Company’s Quality Improvement Strategy under section 1131(g) of the ACA should be included as an attachment to the Actuarial Memorandum. A description of any other quality improvement/cost containment programs that impact the various plans included in the risk pool (specified by plan if the programs only pertain to certain plans) should be included as well. This information should tie in with the activities that improve health care quality, as specified in Exhibit 19, the HHS MLR report and the Supplemental Health Care Exhibit.

**T. Actuarial Memorandum:**

This section is divided into two subsections:

- (a) Process used in the development of the Index Rate; and
- (b) Supporting Details for Material Assumptions.

**T (a) Process in Development of Index Rates and Premium Rates:**

The process used for the determination of the Index Rate and premium rates for both “On” and “Off” Exchange plans is described below. A simplified description of this process was provided above (note the restriction on Induced Demand). This process includes:

1. Average PMPM Incurred Claims for the latest experience period (1/1/2014 – 12/31/2014, with 2 months of claim run-out) for all non-grandfathered in-force plans combined. Discuss whether any particular products were excluded and the rationale for doing so.

2. Average AV Pricing Value determined for all in-force plans in effect during the latest experience period, based on member-months in the experience period for each in-force plan. Note that this average AV Pricing Value reflects the impact of Induced Demand.
3. Average Induced Demand Adjustment factor determined based on member-months in the experience period for each in-force plan. Note that this should be the value that has already been reflected in step (2) above.
4. Assumptions for all components of claim trend, including inflation, utilization, leverage, and other factors.
5. The factor used to project the assumed underlying claim trend from the midpoint of experience period to midpoint of the period for which the proposed rates will be in effect.
6. Projected Average PMPM Incurred Claims determined from steps (1) and (5) above.
7. Market-wide index rate adjustments as discussed in Section J above. The Actuarial Memorandum must explain how the Company developed its adjustment for the Federal Risk Adjustment (i.e., explicitly addressing any modifications introduced to the simulation results provided by DFS).
8. For all in-force plans combined, determine the “Index” PMPM Rate. This step reflects the Projected PMPM Incurred Claims per (6) above with Market-Wide adjustments prescribed by HHS regulation per step (7) above. Note that such adjustments may not vary by the plan.
9. Determine the starting point PMPM Rate for each Non-Grandfathered Plan (both “On” and “Off” Exchange) by multiplying the Index PMPM Rate for all in-force plans combined per step (8) above by the ratio of (A) to (B), where (A) and (B) are:
  - A. The AV Pricing Value for each Non-Grandfathered Plan, both “On” and “Off” Exchange, at each of the Metal Tier levels; and
  - B. The Average AV Pricing Value per step (2) above for all in-force plans.

The AV Pricing Values used in (A) and (B) are the total AV Pricing Values that reflect induced demand.
10. Plan-Level Adjustments for the various items described above. Full details must be provided in the Actuarial Memorandum for each such item (even if no adjustment is being made for a particular item). The adjustments, and accompanying results, must be indicated.
11. Plan-Level Adjustments for Administrative Expense and Profit Margin per Exhibit 19. Note that such adjustments may vary at the plan level and by Metal Tier, but not by rating region.
12. Determine preliminary PMPM Premium Rate for each plan  $((12) = \{(10) / [1.00 - (11)]\})$ .
13. Calculate final premium rates (for all Regions combined) for the various rating tiers that are required in New York: A conversion factor (i.e., to convert PMPM rates to Individuals/Employees premium rates, etc.) must be developed and fully explained in the Actuarial Memorandum. Such conversion factor must be based on the distribution of members and subscribers (individuals/employees) by census cells during the experience period used in step (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.
14. Calculate final premium rates (all regions combined) for all plans based on the Standardized Census Tier factors in Section O above. The Actuarial Memorandum must clearly outline the

development of the conversion factor used to convert preliminary rates to final rates. Such conversion factor must be based on the distribution of enrollees by census cells during the experience period 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 Small Group plans for subsequent quarters in calendar year 2016 are determined by applying the appropriate trend rate (such trend rate should be consistent with the trend rate in Exhibit 19).

**T (b) Supporting Details for Material Assumptions:**

The Actuarial Memorandum must provide details regarding material assumptions and additional information as follows:

1. Assumptions used for **trend**, all components, including inflation, utilization, leverage impact and other factors as applicable, including (if available) information on claim trend rates for 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 used for **administrative expense**, including (a) an explanation of changes in Exhibit 19 expense components from the prior year, and (b) a reconciliation with information on administrative costs reported in latest financial statements;
4. Assumptions for **profit** and contribution to surplus, including a discussion pertaining to Return on Equity;
5. Details regarding **adjustments to Actuarial Values** produced by the HHS AV Calculator;
6. Details regarding **conversion factors** used to convert Preliminary PMPM Rates to actual premium rates for each of the Standardized Census Tiers prescribed by DFS. This should include information on the distribution of both individuals/subscribers and members by the various census cells.
7. Details regarding how premium rates are determined for **standardized rating regions**. Companies must determine factors for all applicable standardized rating regions to arrive at premium rates by rating region and address the following:
  - a. Details must be provided in support of the regional factors.
  - b. Confirm that such regional factors are in compliance with HHS regulations must be provided (i.e., that they do not reflect regional differences in age, sex, occupation or health status. Regional factors may reflect differences in Provider Network Characteristics, Delivery System Characteristics, and Utilization Management Practices).
  - c. Provide details regarding differences between the regional factors developed by the Company and the risk adjusted region factors calculated by DFS as part of the Simulation Project.
8. Details regarding how the Company determined its AV Pricing Values, including but limited to whether or not external data sources were utilized.

9. Support for the **Federal reinsurance adjustment** factor used to develop the Index Rate for Individual plans.
10. Support for adjustments to the premium rates for the impact of **Federal risk adjustment**, including the results for the simulation performed by DFS and support for any adjustments introduced.
11. Details supporting any **material pricing ratios used for morbidity**.
12. There should be no inconsistencies between the information in the Actuarial Memorandum and the information contained in Exhibit 18 (Index Rates).
13. Support for adjustment factors used for **Out-of-Network benefits**.
14. Support for any **significant premium rate differences** between plans in the same metal level.
15. Details must be provided on any **Propriety Studies** used to develop or modify premiums rates covered by this filing.
16. Details need to be provided on any adjustments introduced under the category of **“Management Adjustments”**, including justification that such adjustments are in compliance with HHS regulations.
17. Details and support for any **other adjustments** deemed necessary by the Company’s actuary.
18. Data sources that are not based on the actual claim experience of the Company’s Non-Grandfathered plans must be clearly highlighted (e.g., the publication, organization, or specific consultant), and the applicability of the source must be justified.

#### **U. Rate Manuals:**

##### **U (a) Premium Rate Manuals – General Instructions:**

Rate manuals must be submitted with the rate filings.

Premium rates for Small Group, “On” and “Off” Exchange must vary by quarter. Quarterly step up factors for changes from the first quarter to subsequent quarters must be included in the Actuarial Memorandum, with appropriate support.

Premium rates for Individual plans, “On” and “Off” Exchange may not vary by quarter.

Joint “On” and “Off” Exchange Rate Manuals may be submitted as long as there are separate and distinct “On” and “Off” Exchange Sections (i.e., Separate “On” and “Off” Exchange Rate Manuals can be combined into one PDF file).

The rate manuals must include premium rates for standard and non-standard plans, all applicable Standardized Census Tiers, and all applicable Rating Regions. Small Group rate manuals must include premium rates for all quarters during calendar year 2016.

##### **U (b) Premium Rate Manuals – Required Items:**

Rate manuals must include the following items:

1. Table of Contents;
2. Insurer/corporation name on each consecutively numbered rate page;
3. Identification by form number of each policy, rider or endorsement to which the

4. rates apply;
5. Commission Schedule and/or Fees;
6. An expected loss ratio page. The expected loss ratio is to be calculated using the
7. traditional New York State methodology (not the Federal rebate methodology) as outlined in Circular Letter 15 from 2011:  
[http://www.dfs.ny.gov/insurance/circltr/2011/cl2011\\_15.pdf](http://www.dfs.ny.gov/insurance/circltr/2011/cl2011_15.pdf);
8. Underwriting Guidelines;
9. An explanation of how the premium rate for a specific plan design is determined, including an example of the actual rate calculation (i.e. showing how the rate tables and formulas included in the rate manual are used to determine the final rate for a given plan design);
10. A detailed description of the cost sharing provisions applicable to each plan-design, including details on prescription drugs;
11. The base premium rate for a plan with the following characteristics:
  - a. without “through Age 29 Coverage”; and
  - b. with “Family Planning Coverage”; and
  - c. with “Domestic Partner Coverage”; and
  - d. without “Pediatric Dental Coverage”.
12. Factors must be provided for the following major variations:
  - a. with “through Age 29 Coverage”; and
  - b. without “Family Planning Coverage”; and
  - c. without “Domestic Partner Coverage”; and
  - d. with “Pediatric Dental Coverage”.
13. The Standardized Census Tiers and accompanying factors as prescribed by DFS must be included.
14. Factors for Geographic Rating Regions must be included.
15. A listing of the counties included in each region in which the Company plans to market each of its products;
16. Other information as applicable.

**U (c) Premium Rate Manuals – Prescription Drug Premium Rates:**

Premium rates for prescription drugs must be proportional to premium rates for medical coverage, including:

1. Variations by geographical regions: If medical premium rates for region X are set at 15% above medical premium rates for region Y, then prescription drug premium rates for region X must be set at 15% above prescription drug premium rates for region Y;
2. Prescribed census tier factors for variations in premium rate relationships apply to both medical and to prescription drug premium rates; and
3. Premium rates in the rate manuals and in the binder filings must be for combined medical and prescription drug rates.

**U (d) Premium Rate Manuals - Adjustments for the Age 29 Rider:**

The premium rate adjustments for the Age 29 rider may not be applied solely to the census cells with children. The premium rate adjustments must be spread over all census cells.

Such premium rate adjustments must also vary by region based on the same variation patterns as for the premium rates for the basic medical benefits.

Such premium rate adjustments must also vary by census cells, based on the factors prescribed for the basic medical benefits.

DFS will review the differentials in premium rates for “with” and “without” “Through Age 29” coverage.

**U (e) Premium Rate Manuals - Adjustments for Pediatric Dental Coverage:**

The premium rate adjustment for inclusion of the Pediatric Dental coverage may not be applied solely to the census cells with children. The premium rate adjustments must be spread over all census cells.

Such premium rate adjustments must also vary by regions based on the same variation patterns as for the premium rates for the basic medical benefits.

Such premium rate adjustments must also vary by census cells, based on the factors prescribed for the basic medical benefits.

**U (f) Premium Rate Manuals –Presentation:**

In past years, many companies have submitted items such as pages of premium rates and summary of benefit charts that were ‘reduced’ to such an extent that DFS was not able to review them. In such cases, DFS actuaries had to increase the magnification to 200% or even 300%, which resulted in headings and line designations being lost. Companies must submit manual of premium rates in an unreduced version, even if this means that multiple pages must be used. Companies submitting pages that are unreadable will be asked to resubmit their rate filings.

**V. 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

**W. Actuarial Certification:** The filing should include an actuarial certification that states the following:

- (a) The filing is in compliance with all applicable laws and regulations of the State of New York;
- (b) The filing is in compliance with the appropriate Actuarial Standards of Practice (ASOP’s) including but not limited to:
  - 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) These rates have been established to produce an expected loss ratio that meets the minimum requirement of the State of New York;

- (d) The benefits are reasonable in relation to the premiums charged; and
- (e) The premiums are not unreasonable, excessive, inadequate, or unfairly discriminatory.

**X. Objection Letters:**

The rate filings are subject to Objections being raised by DFS through SERFF.

For Prior Approval Rate Adjustments, such Objections are governed by the provisions of Insurance Law § 3231(e)(1) or § 4308(c), including the special provisions applicable for objections raised between the 50<sup>th</sup> and 60<sup>th</sup> day after the filing date (20 additional days added to the initial 60 days).

For Rate and Form Rate Filings, such rate objections are governed by the provisions of Insurance Law § 3231(d) or § 4308(b), which provisions do not include the above mentioned time limits. Due to the tight timeframes required for Exchange certification of QHPs, DFS requests that due diligence be exercised by the Companies in responding promptly to DFS's Objections.

**Y. Additional Requirements:**

**Y (a) Filing Type Codes**

New filing type codes have been added to SERFF which are to be used for this year's filings:

**Prior Approval Rate Adjustment Filings (Companies with 2015 rates on file):**

"Prior Approval Exchange Rates" for "On" Exchange plans; and

"Prior Approval Off-Exchange Rates" for "Off" Exchange plans.

**Rate and Form Filings (Companies that do not have 2015 rates on file):**

"Exchange Forms & Rates" for "On" Exchange plans; and

"Off Exchange Forms & Rates" for "Off" Exchange plans.

**Y (b) Format of Attachments:**

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

When an attachment is submitted via SERFF in a format other than an Adobe Acrobat PDF, 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.

**Y (c) SERFF/HHS Requirements:**

Filings for Exchange plans are also subject to other SERFF and HHS requirements.

**Y (d) Filing Amendments:**

An "amendment" to a SERFF filing, as described in the SERFF Industry Manual (available online via SERFF), is used when the amendment is not in response to an objection letter from DFS (e.g.,

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 DFS, etc.) If a schedule item (e.g., Actuarial Memorandum, standard exhibit, rate manual, etc.) needs to be amended, the entire schedule item attachment must be resubmitted using this process (i.e., not just the pages that need to be corrected).

When making revisions to a previously submitted schedule item in response to an objection letter from DFS, the “Revising Schedule Items” process described in the SERFF Industry Manual must be used. This method must be used when any schedule item is revised in response to a DFS objection letter, including a revised rate manual submitted in response to a DFS decision. If a schedule item (e.g., Actuarial Memorandum, standard exhibit, rate manual, etc.) needs to be revised in response to a letter from DFS, the entire schedule item attachment is to be resubmitted using this process (i.e., not just the pages that need to be revised).

New or revised commission schedules or broker fee schedules must first be placed on file using a rate filing with a ‘Normal Pre-Approval’ SERFF filing type code. Once the new or revised schedule has been placed on file, any rate impact can be included in the filing for On-Exchange plans and Off-Exchange plans. Any impact on premium rates is to be discussed in the Actuarial Memorandum.

## **Z. Other Miscellaneous Items:**

### **Z (a) Risk Adjustment Simulation:**

DFS has worked in conjunction with Deloitte in performing various assignments:

- (1) Simulation of the estimated impact that the risk adjustment program based on plans in force during calendar 2014;
- (2) Analysis of impact of the Federal reinsurance program based on paid claims in calendar year 2014; and
- (3) Calculation of health-risk neutral geographic rating region factors based on paid claims in calendar year 2014;

### **Z (b) Membership Survey as of March 1, 2015:**

DFS has worked with all companies that are participating in the Individual and/or Small Group markets in developing a survey of all membership by age and gender, metal level, and rating region. Results of this survey may be used to assist companies in estimating the impact of the Federal Risk Adjustment program.

### **Z (c) Minimum Loss Ratio:**

Loss ratios should be calculated using the New York State definition (i.e. Incurred Claims to Earned Premiums, without the adjustments introduced in the HHS definition), not the Federal rebate methodology, as outlined in Circular Letter 15 from 2011:

[http://www.dfs.ny.gov/insurance/circltr/2011/cl2011\\_15.pdf](http://www.dfs.ny.gov/insurance/circltr/2011/cl2011_15.pdf);

The minimum loss ratio is 82% for both Individual and Small Group plans. This means that the provisions for administrative expenses, premiums taxes, commissions and fees, including ACA fees and for pre-tax profit provision may not exceed 18.0%.

The provision for all expenses and profit may not vary by rating region; however, provisions for expenses and profit may vary by metal level.

If there are differences in expenses by rating region as discussed above, then the regional or area factors may be determined so as to absorb any such differences.

Of course, variations by regions may not reflect differences in items such as age, sex, health status, etc.

**Z (d) Minor/Major Changes in Benefits:**

Rate adjustment filings for existing products (i.e. products approved last year by DFS) will be submitted as Prior Approval Adjustment filings under § 3231(e)(1) or § 4308(c). Minor benefit changes (i.e., “Uniform Modifications”) will be handled within the same Prior Approval process.

Major benefit changes (e.g., introduction of new plans not offered in 2015, etc.) require a separate Form filing. However, the premium rates for such major changes in benefits will be handled as part of the same Prior Approval process, while the policy forms approval will be handled separately (i.e., § 3231(e)(1) or § 4308(c)).

With respect to companies that are not participating in a particular market during calendar year 2015, rate filings for premium rates to be effective in calendar year 2016 will be handled as Rate and Form filings under Insurance Law § 3231(d) or § 4308(b), as described in Section A (General Introduction) above.

**Z (e) Uniform Rate Review Template (URRT):**

URRT worksheets and accompanying Actuarial Memorandum must be completed in accordance with HHS requirements.

DFS raised objections with regard to 2015 filings for several companies related to reconciliations between the values in the URRT worksheets and the comparable values in DFS’s Exhibits 17, 18 and 19, related to Incurred Claims, Risk Sharing Adjustments, Impact of Reinsurance, Expenses and Profit Provision, and other items.

Care should be exercised in the preparation of 2016 filings to ensure consistency between values for the items noted above.

**Z (f) Rate Review Detail Data (R2D2)**

The “Rate Review Detail” screen must be completed per HHS requirements. HHS reviews these screens and has requested that DFS instruct companies to address inconsistencies in the values for the various components.

DFS raised several objections with regard to 2015 filings related to the following items:

- (1) Rate Review Detail screen is incomplete;
- (2) Instances where average values are less than Minimum values;
- (3) Maximum values appear to be too high;
- (4) Minimum, Maximum, and Average values were expressed as PMPM rates (they should be expressed as annualized premium rates);

- (5) Screen shows “N/A” under “Forms, Affected Forms and Other Affected Forms”; items must be left blank if they do not apply (i.e., making an entry implies the form is impacted);
- (6) Requested Rate Period data is all zeros in some cases, the projected premiums and claims required revisions to reflect projected membership, and/or Minimum, Maximum, and Average PMPM values were not provided.

Note that for 2016 premium rate filings, the Rate Review Detail must be completed in a manner consistent with the preparation of the Rate Review Details completed for 2014 premium rates.

**Z (g) Dental Coverage**

Instructions for Dental filings will be available on our website.

**NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES**

**Instructions for the Filing of 2016 Premium Rates**

**Individual and Small Group,  
“On” and “Off” Exchange Plans**

**Instructions – Definitions:**

- a. **ACA Compliant** data means the data associated with plans which are subject to the market reforms that went into effect on 1/1/2014 such as the EHB, Metal Tiers, AV, etc. By Non-ACA Compliant, we mean those plans that are Non-Grandfathered which are not subject to the market reforms that went into effect on 1/1/2014.
- b. **Company** refers to the licensed entity (distinct NAIC Number) providing the insurance coverage reflected in the rate filing.
- c. A Company’s **commercial book of business** includes all of the following: large group, Small Group, Individual, Healthy New York, and Medicare Supplemental. It excludes all government programs, such as, Medicare, Medicaid, Family Health Plus, and Child Health Plus.
- d. **Loss ratio** refers to incurred claims divided by earned premiums for a given period of time. Incurred claims include the 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 ACA compliant plans, incurred claims include the impact of the federal reinsurance and risk adjustment programs.
- e. **Market segment** refers to Small Group or Individual business as defined in New York Insurance Law and Regulations.
- f. **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 DFS.
- g. **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 (Individual Plans): A non-rolling rate table is developed to be effective January 1, 2016 and is expected to be revised for January 1, 2017. The rate applicability period for this table is January 1, 2016 through December 31, 2016.
  - (ii) Example 2 (Small Group Plans): A quarterly rolling rate table is developed for issues and renewals in January – March 2016 and incorporates a 12 month rate guarantee period. The rate applicability period for this table is January 1, 2016 through March 31, 2017.
- g. **Standardized earned premiums** are the earned premiums for the period adjusted to assume that all premiums for the period are payable at the most current 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 17 or in the rate development analysis.

The standard rate scale to be used is that which was last approved by DFS (See the table in the instructions for Exhibit 17).

**NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES**

**Instructions for the Filing of 2016 Premium Rates**  
**Individual and Small Group,**  
**“On” and “Off” Exchange Plans**

**Additional Instructions regarding Exhibits to be Included in Rate Filings**

**General**

Summary information was provided in the Instructions above. Additional instructions for each Exhibit are provided in this section regarding their applicability to Individual and Small Group plans both “On” and “Off” Exchange.

Instructions are also provided at the end of this section regarding required exhibits for Rate and Form filings for Prior Approval Adjustment filings for (a) Grandfathered plans and (b) community-rated large group HMO products.

Special Rules are also provided at the end of this section for the preparation of the required Exhibits, to potentially reduce the total number of exhibits to be submitted.

All Exhibits must be submitted as an Excel file and as an Adobe PDF file.

**Exhibit 11 - General Information about the Rate Filing**

This exhibit provides general information about the rate filing.

Information must be provided for a general Contact Person as well as an Actuarial Contact (i.e., the identification of the actuary responsible for the preparation of the rate filing, including telephone number and e-mail address). Actuarial contact information may be redacted.

This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings. The same exhibit may be used for both “On” and “Off” Exchange filings.

**Exhibit 13A - Numerical Summary and Rate Indication Calculation & Exhibit 13B - Narrative Summary**

Exhibit 13 has been split into two separate Exhibits (13a and 13b). The Numerical Summary portion (Exhibit 13a) has been updated to include a high-level rate indication calculation. Exhibit 13b has been added as a placeholder for the “Narrative Summary”. The Narrative Summary is intended to be a plain English description of the rate change and the reasons for such.

With regard to Exhibit 13a, if there were no relevant products offered in prior years for a particular market, an indication of “N/A” should be inserted in the relevant sections.

Additional Details:

A. Average 2015 and 2016 Premium Rates:

This information needs to be completed for all rate filings, separately for both Individual and Small Group plans. The average premium rates are to be determined as the member month weighted average of all premium rates for the applicable metal level plan described in Exhibit 13, for all plans, both On and Off, and for all regions combined.

B. Weighted Annual Percentage Adjustments (2015 to 2016):

This information needs to be completed for all rate filings, for both Individual and Small Group plans. This information is as illustrated in Exhibits 14A or 14B. This calculation should be based on membership as of 12/31/2014.

C. Weighted Annual Percentage Adjustments (Prior Years):

This information needs to be completed for Small Group plans. With respect to the adjustments for '2013-2014', enter "N/A" unless the actuary has estimated an overall change in premium rates for those years. Note that calculation of rate adjustments between years 20XX and 20XX+1 should be based on membership as of 12/31/20XX.

For Individual plans, the actuary should enter "N/A" for the period between 2012 and 2014.

D. Average Medical Loss Ratios for 2012-14:

For Small Group plans, enter the MLRs as illustrated in the current year Exhibit 17. For Individual plans, refer to comments in Section C above.

E. Claim Trend Rates and Ratios to Earned Premiums (2014-2016):

E 1 Claim Trend Rates (2014-2016):

For Individual and Small Group plans, enter the claim trend rates used for 2016 and 2015 as illustrated in the current year Exhibit 19. For 2014, enter the claim trend rate for 2014 as illustrated in Exhibit 19 of the Prior Approval rate filing submitted in calendar year 2013 for premium rates effective in 2014. If not applicable, enter "N/A".

E 2 Ratios to Earned Premiums (2014-16):

For Individual and Small Group plans, enter the various ratios as illustrated in the current year Exhibit 19, for 2015 and 2016; for 2014, enter the ratios in Exhibit 19 of the Prior Approval rate filing submitted in calendar year 2013 for premium rates effective in calendar year 2014. If not applicable, enter "N/A".

Note that Exhibit 19 does not specifically illustrate the ratios for Pre-Tax Profit provision, and this item needs to be determined as the sum of the Post Tax Profit provision plus the components for State and Federal taxes.

This Exhibit is only applicable to Prior Approval Adjustment filings.

The same exhibit may be used for both "On" and "Off" Exchange filings.

F. For purposes of the Rate Indication Calculation, the Grey boxes in Column G should be filled per the instructions in Column H.

**Exhibits 14a and 14b: Summary of Requested Percentage Changes:**

This exhibit provides details as to the changes in premium rates between the approved 2015 and requested 2016 premium rates.

Information is requested by (a) Metal Level; by (b) Rating Region; and by (c) Effective Date of the premium rates.

Effective dates are 01/01/2016 for all Individual plans, and 01/01/2016, 04/01/2016, 07/01/2016 or 10/01/2016 for Small Group plans.

Required information includes Lowest, Highest and Weighted Average requested percentage rate changes.

Note that this information should be provided for each distinct combination of market segment, rating period (small group only), metal level, rating region, and product name, as specified in Notes 4 and 5 on the Instructions tab.

Exhibit 14A applies to Individual Plans (**Calculations must be based on membership as of 3/1/2015**).

Exhibit 14B applies to Small Group Plans (**Calculations must be based on membership as of 12/31/2014**).

This Exhibit is only applicable to Prior Approval Adjustment filings. The same exhibit may be used for both "On" and "Off" Exchange plans (i.e., DFS is not requiring that the changes in premium rates be identified separately for "On" vs. "Off" Exchange plans). **Note that the format of this Exhibit has been modified in order to allow for more efficient internal processing. Additional columns should not be added to this Exhibit.**

#### **Exhibit 15a and 15b - Distribution of Contracts by Requested Percent Adjustments**

This exhibit requires details regarding the distribution of the proposed rate change.

Information is required by (a) Metal Level; (b) Region; and (c) Effective Date.

Effective dates are 01/01/2016 for all Individual plans, and 01/01/2016, 04/01/2016, 07/01/2016 or 10/01/2016 for Small Group plans.

Exhibit 15A applies to Individual Plans (**Calculations must be based on membership as of 3/1/2015**).

Exhibit 15B applies to Small Group Plans (**Calculations must be based on membership as of 12/31/2014**).

This Exhibit is only applicable to Prior Approval Adjustment filings. The same exhibit may be used for both "On" and "Off" Exchange plans (i.e., DFS is not requiring that the changes in premium rates be identified separately for "On" vs. "Off" Exchange plans). **Note that the format of this Exhibit has been modified in order to allow for more efficient internal processing. Additional columns should not be added to this Exhibit.**

#### **Exhibit 16 - Summary of Policy Form and Product Changes**

This exhibit requires details regarding other rate filings which may impact the current rate filing.

This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings. The same exhibit may be used for both "On" and "Off" Exchange filings.

#### **Exhibit 17 – Historical Claim Experience Data by Policy Forms**

This exhibit illustrates the premiums and claims experience for the prior three (3) calendar years (2012-2014) by policy form.

The policy forms covered are those for all plans (as described in the table below) providing comprehensive benefits for hospital, medical and prescription drugs charges. As noted above, some policy forms previously included in Insurance Law § 3231(e)(1) or § 4308(c) Prior Approval Adjustment filings must be excluded (i.e., hospital only plans, medical only plans, limited benefit plans, plans supplementing Medicare benefits, and other discontinued or closed group policy forms should be excluded). Note that discontinued plans are not to be excluded.

Also note that all Sole Proprietor experience should be included with individual experience (for purposes of this Exhibit as well as Exhibit 18). Additionally, Small Group Healthy New York experience must be included in this Exhibit (as well as in Exhibit 18) with the Company's Small Group experience. Individual Healthy New York experience should be included with the Company's Individual experience.

This Exhibit will be used in our analysis of the claims experience for prior years and to assist in our evaluation of the Company's development of 2016 premium rates for "On" and "Off" Exchange plans for both Individual and Small Group business.

- a. The format of this Standard Exhibit is fixed; insert additional rows as needed. Use only the first tab for data entry.
- b. Policy Form: Use a separate row for each base medical policy form. Data is to be shown for each policy form as described in the table below.
- c. Columns 1a, 1b, and 1c: Indicate the Company Name, NAIC Code and SERFF Filing number.
- d. Columns 1d, 1e and 1f: 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 "Filing Type": This field should indicate the Section of the Insurance Law under which the rates are being submitted (or which they were last submitted) (e.g., § 3231(e)(1), § 4308(c), etc.)
- f. Column 3 Effective Date of Rate Change: Indicate the date on which the latest approved rate scale became effective (e.g., 1/1/2015 for individual ACA-Compliant plans).
- g. Columns 4 through 7: Identify the Market Segment, Product Type, Rolling/Non Rolling rate structure and whether or not the policy form is open or closed (i.e., Open/Closed).
- h. Columns 8 and 9: Enter the number of policyholders (number of Small Group accounts) and the number of covered lives (members) affected by this rate filing, as of December 31, 2014.
- 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.
- j. Each experience period is 12 months (or shorter if a new form).
- k. The ending date of the most recent experience period is December 31, 2014. For most Companies, this experience period will be from January 1, 2014 through December 31, 2014.
- l. 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 prior to the first prior period.
- m. The incurred claims for each of the three experience periods must be based on at least 2 months of claims run out beyond the end of the experience period, plus a remaining reserve. The Actuarial Memorandum must provide a clear description of how incurred claims were developed for each experience period and how many months of claim run-out were reflected in the development of incurred claims. Incurred claims in Column 14.7 should not be adjusted for commercial reinsurance, Federal Reinsurance, Risk Adjustment or Risk Corridors payments/receipts. **Also, Column 14.9 should not reflect Risk Corridor payments/receipts or commercial reinsurance.**
- n. Loss ratio report refunds or refunds/payments pursuant to Regulation 146 are to have no impact on the earned premiums or standardized premiums shown. Such refunds do not impact earned or standardized earned premiums.
- o. Standard Premiums: The Actuarial Memorandum must clearly describe how standardized earned premiums for each experience period were developed from the earned premiums for the applicable experience period. A numerical example illustrating the development methodology for one non-rolling rate product and one rolling rate product included in the rate filing must be included as part of the Actuarial Memorandum, as applicable. The same standard rate level must be used for all of

the experience periods. The appropriate Standardized Premium Scale represents the latest scale that was approved by DFS as described in the last column of the table below

**Note that for a specific legal entity, one version of Exhibit 17 may be provided for all filings submitted by Company that covers all relevant business for that legal entity (i.e., one Exhibit 17 that includes all Individual, Small Group, Catastrophic, etc. “On” and “Off” Exchange). Experience should be broken out as follows:**

Market	Description	Entry for Exhibit 17, Column 4	Group Definition	Counting Method	Notes	Standardized Premium Scale
Individual	ACA Compliant Individual Plans (Excluding CSR variations that will move to BHP in 2016)	Individual-ACA	N/A	N/A	Issued on or after 1/1/2014	2015 Rates
Individual	BHP - CSR variations of ACA Compliant Individual Plans that will move to BHP in 2016	Individual-ACA-BHP	N/A	N/A	Issued on or after 1/1/2014	2015 Rates
Individual	Healthy New York - Individual Plans	Individual-HNY	N/A	N/A	Issued or renewed prior to 1/1/2014	2013 Rates
Individual	Sole Proprietor - Non Healthy New York Plans (Formerly Small Group)	SoleProp-Non-HNY	N/A	N/A	Issued or renewed prior to 1/1/2014	4th Quarter 2013 for rolling; 2013 for non-rolling
Individual	Sole Proprietor - Healthy New York Plans (Formerly Small Group)	SoleProp-HNY	N/A	N/A	Issued or renewed prior to 1/1/2014	4th Quarter 2013 for rolling; 2013 for non-rolling
Small Group	ACA Compliant Small Group Plans (Excluding Healthy New York plans)	SG-ACA	1-50	Current New York	Issued on or after 1/1/2014	4th Quarter 2015 for rolling; 2015 for non-rolling
Small Group	ACA Compliant Small Group Healthy New York Plans	SG-ACA-HNY	1-50	Current New York	Issued on or after 1/1/2014	4th Quarter 2015 for rolling; 2015 for non-rolling
Small Group	Non-ACA Compliant Small Group Plans (Excluding Healthy New York)	SG-NON-ACA	1-50	Current New York	Non Grandfathered Plans Issued or renewed prior to 1/1/2014	4th Quarter 2013 for rolling; 2013 for non-rolling
Small Group	Non-ACA Compliant Healthy New York Small Group Plans	SG-NON-ACA-HNY	1-50	Current New York	Non Grandfathered Plans Issued or renewed prior to 1/1/2014	4th Quarter 2013 for rolling; 2013 for non-rolling
Small Group	Any Small Group Plans that do not fall into the above two categories (e.g., Grandfathered Plans)	SG-Other	1-50	Current New York	Primarily Grandfathered Plans	The 4th quarter of last scale approved by DFS

Large Group	Current Large Group business that would be classified as Small Group assuming a small group definition of 1-100 with the New York Counting Methodology not already counted above	LG-100	51-100	Current New York	All experience for calendar years	4th Quarter 2015 for rolling; 2015 for non-rolling
Catastrophic	ACA Compliant Catastrophic Plans	Catastrophic	N/A	N/A	Issued on or after 1/1/2014	Issued on or after 1/1/2015

**\*Please be aware that although DFS may adopt the Federal FTE method of counting employees, all data in this Exhibit should be based on the current method used in New York.**

This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings, except in situations where a company did not participate in the Individual or Small Group Markets as applicable in calendar year 2014. **Note that the format of this Exhibit has been modified in order to allow for more efficient internal processing. Additional columns should not be added to this Exhibit.**

**Exhibit 18 - Index Rate /Plan Design Adjustment Worksheet**

Exhibit 18 applies to all filings and must be prepared on a PMPM basis, not on a PEPM basis.

Use separate columns for each separate and distinct “HIOS Standard Component ID”. **Note that additional rows should not be added and cells should not be merged.**

Information on Lines 1 through 9 must be entered for each plan (i.e., there should be a separate column for each distinct 14 digit HIOS Standard Component ID).

**For Companies that participated in the relevant Market during calendar year 2014:**

a1. For lines 10A and 10B, information for all Plans (Including any relevant Non-ACA compliant plans) should be entered in column D, and information for Non-ACA compliant plans only should be entered in column E. This information should be consistent with Exhibit 17 (e.g., Sole Proprietor experience should be included with Individual as opposed to Small Group, etc.) Line 10C (Average Incurred Claims) will be calculated as line 10A divided by Line 10B. All other columns in Line 10C are to be left blank.

a2. Information on line 11 (Average Pricing Actuarial Value) is to be entered in Column D, for all in-force plans combined. All other columns in Line 11 are to be left blank. The value in Line 12, Column D must be carried to all other columns for use as the starting point for all plans.

a3. Go to step b.

**For Companies that did not participate in the relevant Market during calendar year 2014:**

a1. For lines 10A and 10B, information must be entered in Column D, based on premium rate development which must be specifically identified in the Actuarial Memorandum, including any relevant sources (e.g. publications, preparing organizations, consultants, etc).

a2. Information on lines 10A and 10B must correspond to the experience period for which the proposed rates are based, excluding any projection for trend, and excluding any provision for expenses and profit margin. The annual claim trend used must be shown in the appropriate column in Exhibit 19, and the impact of any claim trend must be shown on line 23 of Exhibit 18. The expense and profit provisions must be shown in Exhibit 19, and the expense and margin factors must be shown on lines 36 and 37 of Exhibit 18.

a6. Go to step b.

**For all Companies regardless of whether they participated in the relevant market in calendar year 2014:**

- b. Lines 13 through 27 are intended to represent the Market-Wide Adjustments described in 45 CFR 156.80(d)(1). Relevant factors that are appropriate for all plans combined are to be entered in Column D. All other columns in Lines 13 through 27 are to be left blank. Note that Column D of Exhibit 18 should match Column G from "Exhibit 18-Supplement" for these specific Lines.
- c. The value in Line 28, Column D is to be calculated as the product of Lines 13 through 27 of Column D. The value in Line 28, Column D must be carried to all other columns in Line 28 and must be used for all plans.
- d. Factors for any relevant Plan Level Adjustments as described in 45 CFR 156.80(d)(2) are to be entered in Lines 29 through 44 for Columns F and subsequent as appropriate for each plan.
- e. The values in Line 45 are to be calculated as the product of Lines 29 through 44 for all columns (i.e., for each specific plan).
- f. The value in Line 46, Column D is intended to be used in Line 5 of Exhibit 13a for purposes of the Rate Indication Calculation.
- g. Line 47 should be populated with actual 2015 rates (i.e., first quarter of 2015 for Small Group) for each of the respective plans and Line 48 should be populated with actual membership as of 3/1/2015 of those who have purchased or renewed to a 2015 plan (i.e., individuals still in a 2014 plan should not be included).
- h. The values in Line 49 are determined as the product of Lines 12, 28 and 45. Note that the value in Line 49 Column E, should be equal to the value in Column D (as indicated by the formula in that cell. The Value in Column E is intended to be used for purposes of calculating the impact of the proposed rate change).

**Additional Notes**

1. **No additional lines should be added to this Exhibit.** If additional lines are deemed necessary, then the Actuary should contact the Department.
2. Information in Lines 36 and 37 (Expense and Profit) must be provided for each specific plan (i.e. average values may not be used).
3. Values in Lines 36 (Administrative Expense) and 37 (Profit and Contribution to Surplus) must be consistent with the relevant values in Exhibit 19.

- a. For example, if the Administrative Expense and Profit values in Exhibit 19 are 13.0% and 2.0% respectively, then the Factors on Lines 36 and 37 should be 1.1529 ( i.e. the ratio of 98% to 85%, where 98% is 100% less 2.00%, and 85% is 100% less 13.00% less 2.00%), and 1.0204 ( i.e. the ratio of 100% to 98%, where 98% is 100% less 2.00%, and 100% is given) respectively.
4. Lines 36 and 37 may **not** be reported as 1.000, with the provisions for expenses and profit reflected elsewhere in this Exhibit. Additionally, all expense and profit must be reflected in Lines 36 and 37.

This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings. A Separate Exhibit is required for each relevant Market (i.e., Individual, Small Group, and Catastrophic); however, the same Exhibit may be provided for “On” and “Off” Exchange filings within a particular Market.

### **Exhibit 18 – Supplemental Exhibits**

The purpose of these supplemental Exhibits is to provide details regarding how each of the various ACA and Pre-ACA Market segments must be adjusted (including the impact of removing the BHP population from the Individual market) in order to arrive at the final Market Wide Adjustments used in Column D of Exhibit 18.

Note that there is a separate supplemental Exhibit for Individual (which also applies to Catastrophic) and Small Group filings. (There is only one base Exhibit 18 template for both Individual and Small Group filings). For Individual business, the values in Column D, for Lines 10-28 of Exhibit 18 should be consistent with the values in Column I, Lines 10-28 of “Exhibit 18 Supplement-IND”. For Small Group business, the values in Column D, for Lines 10-28 of Exhibit 18 should be consistent with the values in Column G, Lines 10-28 of “Exhibit 18 Supplement-SG”.

### **Exhibit 19 - Summary of Claim Trends, Administrative Costs and Profit Margins**

This exhibit applies to non-grandfathered plans to be sold both “On” and “Off” the Exchange.

The format of this Exhibit is fixed (in terms of the specific Columns); however, additional rows may be inserted as needed. Only use the first tab for data entry. Information in this exhibit may not vary by region.

Regulatory fees, including New York State 206 (formerly Section 332) assessment as well as fees associated with the Federal Reinsurance and Risk Adjustment programs should be entered in columns 6.1 and 16.1. All other State and Federal taxes and fees should be entered in columns 6.5 and 16.5. For 2016, the proposed fee for the federal Reinsurance program is \$27.00 (changed from \$44.00 for 2015). Note that the reinsurance fee may not be deducted from the impact of the Federal reinsurance adjustment on incurred claims.

Administrative expenses may not include adjustments for HCRA surcharges or Covered Lives assessments [GME]; such items are to be reflected in Incurred Claims.

Within each market, data should be provided separately for Standard vs. Non-Standard plans as well as for “On” vs. “Off” Exchange plans. Additionally, data should be provided separately for each Metal tier.

Information is for comprehensive medical base plans and all associated riders combined.

- a. Column A: Company Name.

- b. Column B: NAIC Code.
- c. Column C: SERFF Filing Number.
- d. Column D: Market (Individual, Small Group or Catastrophic).
- e. Column 1: Enter Metal Tier.
- f. Column 2: Indicate whether the specific category is “On” or “Off” Exchange, as well as whether it is “Standard” or “Non-Standard” (e.g., Enter “Exchange STD”, “Exchange-NonSTD”, “OffExchange-STD” or OffExchange-NonSTD”).
- g. Column 3: Enter Membership at mm/dd/yyyy, excluding Pre ACA members. Note that this number should be estimated for 2016.
- h. Columns 4.1 - 4.2: Enter the applicability period.
- i. Column 5: The average claim trend is the average annualized claim trend rate to adjust source data forward to the applicable applicability period.
- j. Columns 6.1 through 6.7: The administrative expense components must reflect the anticipated expenses for applicability in calendar year 2016.
- k. Columns 7 through 10: The profit margins components must reflect the provision for profit margin required for applicability in calendar year 2016.
- l. Both the administrative expenses and the profit margins are to be entered as percentages of premiums in columns 6.1 through 11.
- m. Columns 14.1 through 21 must be proposed on a basis consistent with the basis used for columns 4.1 through 11.

This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings.

The same Exhibit may be submitted for “On” and “Off” Exchange filings as well as for Individual and Small Group filings (i.e., one file containing all of the relevant data can be developed and submitted with each filing). **Note that the format of this Exhibit has been modified in order to allow for more efficient internal processing. Additional columns should not be added to this Exhibit.**

**Exhibit 20 - HIOS ID Mapping to Product Names:**

This Exhibit requires the following details for all distinct 14 digit HIOS ID numbers:

- a. HIOS ID;
- b. Previous HIOS ID;
- c. Rate Manual Plan Name;
- d. Metal Level;
- e. “On” or “Off” Exchange;
- f. Standard or Non Standard Design;
- g. Limiting Child Age 26 or 29;
- h. Domestic Partner coverage Included or Excluded;
- i. Family Planning coverage Included or Excluded;

- j. Pediatric Dental coverage Included or Excluded;
- k. Out of Network Benefits Included or not included; and
- l. Additional Benefits to EHB, Yes or No.

The purpose of this exhibit is to facilitate the mapping of premium rates in the Rate Manuals to the premium rates in the Binder filings. This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings. The same Exhibit may be submitted for “On” and “Off” Exchange filings. **Note that the format of this Exhibit has been modified in order to allow for more efficient internal processing. Additional columns should not be added to this Exhibit.**

**Exhibit 21 - Hospital Unit Cost Development:**

This Exhibit is intended to provide details regarding changes in average fees charged by Hospitals for Inpatient Services (21A) and Outpatient Services (21B) by examining the level of Allowed charges by Provider:

- a. From calendar year 2015 to calendar year 2016; and
- b. From calendar year 2014 to calendar year 2014; and
- c. From calendar year 2013 to calendar year 2014.

As noted on the Instructions tab of this Exhibit, actual allowed amounts are requested for 2014. These 2014 amounts will be used to weight the percentage change in fees so that the weighted average change between the various time periods (i.e., the change from 2013 to 2014, 2014 to 2015, and 2015 to 2016) can be determined.

Exhibit 21A applies to Inpatient Services.

Exhibit 21B applies to Outpatient Services.

For hospital contracts with risk sharing features or incentive payments for performance (e.g., meeting quality improvement criteria for purposes of the federal rebate calculation), the financial impact of such features should not be taken into consideration in the determination of the average changes.

Some information in Exhibit 21 may be redacted (i.e., columns (4) through (7)).

Consistent with Exhibits 17 and 18, Healthy New York experience should be included and any Sole Proprietor experience should be classified as Individual.

This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings for with the exception of companies that did not participate in the relevant markets in 2014. **This Exhibit applies to Individual and Small Group business.**

The same exhibit may be used for “On” and “Off” Exchange filings. **Note that the format of this Exhibit has been modified in order to allow for more efficient internal processing. Additional columns should not be added to this Exhibit.**

**Exhibit 22 - Medical and Hospital Utilization:**

This exhibit requires details regarding the medical/hospital services provided in the Individual and Small Group Markets, separately for calendar years 2014, 2013 and 2012.

Information requested includes:

- a. Number of Services;
- b. Amounts of Allowed Charges;

- c. Average Membership;
- d. Average Allowed Charges per Service  $(=b)/(a)$ ;
- e. Average Utilization per Member  $(=a)/(c)$ ; and
- f. Average Allowed Charge per Member  $(= (b)/(c))$ .

The information in this Exhibit 22 may be redacted.

Consistent with Exhibits 17 and 18, Healthy New York experience should be included and any Sole Proprietor experience should be classified as Individual.

This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings for with the exception of companies that did not participate in the relevant markets in 2014. **This Exhibit applies to Individual and Small Group business.**

The same exhibit may be used for “On” and “Off” Exchange filings. **Note that the format of this Exhibit has been modified in order to allow for more efficient internal processing. Additional columns should not be added to this Exhibit.**

**Exhibit 23 - Summary of Requested 2015 Premium Rates:**

The purpose of this exhibit is to provide the actual distribution of all base Premium Rates for all Metal Tiers and Rating Regions.

Information requested includes:

- a. Company Name; and
- b. NAIC Code; and
- c. SERFF Filing Number; and
- d. Market (i.e., Individual, Small Group or Catastrophic); and
- e. HIOS ID Number (14 Digit); and
- f. Metal Level (Excluding Silver CSR plans); and
- g. “On” or “Off” Exchange; and
- h. Standard or Non Standard plan design; and
- i. Premium Rates by Standardized Rating Region (2015 and 2016); and
- j. Member Months by Standardized Rating Region (2015 and estimated 2016) as of 3/1/2015.

For Individual plans, the premium rates are the requested 2016 calendar year rates for the Individual Only Census Tier only.

For Small Group plans, the premium rates are the first quarter requested 2016 rates for the Employee Only Census Tier.

To simplify the preparation of this exhibit, the only plans to be reported are those with all of the following benefit features (note that Exhibit 25 requires factors for major plan variations):

- a. Without “Through Age 29” coverage; and
- b. With Family Planning coverage; and
- c. With Domestic Partner coverage; and
- d. Without Pediatric Dental coverage.

This Exhibit is applicable to all filings, both (a) Rate and Form filings and (b) Prior Approval Adjustment filings. **Note that the format of this Exhibit has been modified in order to allow for more efficient internal processing. Additional columns should not be added to this Exhibit.**

### **Exhibit 24 – Risk Corridors Estimate:**

The purpose of this exhibit is to provide an estimate of the Company's position with regard to the federal Risk Corridors program assuming the program is fully funded.

A separate Exhibit should be completed for each market (i.e., Individual, Small Group, and Catastrophic) in which the Company participated in during calendar year 2014.

Information requested includes:

- a. **Line 1:** Earned Premium, as defined by § 158.130, for the entire specific market (i.e., not just QHPs) for calendar year 2014 should be entered in the first grey box (Column 3). Earned Premium for QHPs only (including plans that are "Substantially Similar" as defined in 45 CFR 153.500), within the specific market for calendar year 2014 should be entered in the second grey box (Column 4).
- b. **Line 2:** Federal and State licensing and regulatory fees paid (per § 158.161(a)).
- c. **Line 3:** Federal and State taxes and assessments paid (per § 158.162(a)(1) and § 158.162(b)(1)).
- d. **Line 6:** Administrative Costs: Total non-claim costs including taxes and regulatory fees incurred by all of the Company's ACA Compliant business (i.e., New plans written on or after 1/1/2014).
- e. **Line 7:** Federal Risk Adjustment Payments/Receipts (i.e., per the ACA Compliant data only portion of the DFS simulation).
- f. **Line 8:** Federal Reinsurance Payments received (i.e., per the DFS simulation).
- g. **Line 9:** Incurred Claims (per § 158.140) (Excluding adjustments for direct and direct remuneration) Prior to adjusting for Risk Adjustment and Reinsurance. Two months of claim run-out should be used.
- h. **Line 11:** Adjustments for any direct and indirect remuneration (per § 158.140(b)(1)(i)).
- i. **Line 12:** Expenditures for activities that improve health care quality (per § 158.150).
- j. **Line 13:** Expenditures associated with health information technology and meaningful use requirements (per § 158.151).
- k. **Line 14:** Enter any adjustments specified by § 153.530(b) that are not reflected in Lines 7 and 8 (Items (e) and (f) above).

**Please note the following with regard to this Exhibit:**

1. The Calculations in this Exhibit reflect our interpretation of the following statement from the final version of the "Exchange and Insurance Market Standards for 2015 and Beyond" set of rules: **"Data from individual and small group market plans that comply with the Affordable Care Act market reforms will be included in a QHP issuer's risk corridors calculation as described in 45 CFR 153 subpart F. However, consistent with our existing regulations set forth in subpart F of part 153, any risk corridors payment or charge amount, including any adjusted payment or charge amount resulting from the adjustment implemented in this final rule or the 2015 Payment Notice, will be calculated for a QHP issuer in proportion to the premium revenue that the issuer receives from its QHPs, as defined in §153.500."**
2. Information entered in Column 3 must be with regard to all ACA-compliant plans (i.e., those subject to the market reforms that became effective on 1/1/2014 such as EHB, Metal Tiers, AV, etc.) Information related to plans in-force prior to 1/1/2014 should not be included in this Exhibit.

3. Information should only be entered in the grey boxes.
4. Additional lines should not be added and formulas should not be modified.
5. Any adjustments made to Items (e) and (f) above should be fully explained and justified in the Actuarial Memorandum.
6. A separate Exhibit must be provided for each Market in which the Company participates and in which the Company had Qualified Health Plans (QHPs) in-force during calendar year 2014.
7. For the purpose of this Exhibit, QHP is as defined in 45 CFR 153.500 (Note that this definition includes plans sold “Off” Exchange that are the same as a QHP sold “On” the Exchange as clarified by that Section).
8. With respect to a specific Market, the same Exhibit may be submitted with the Company’s “On” and “Off” Exchange filing.
9. Claims data as of 12/31/2014 with two months of run-out should be used for this Exhibit.

**Exhibit 25 – Adjustment Factors for Major Variations from the Base Plan:**

The purpose of this Exhibit is to provide the Adjustment Factors needed to modify the “Base Plan” for major variations. For a given Metal Tier, DFS considers the following combination of benefits to comprise the “Base Plan”:

- a. Without “Through Age 29” coverage; and
- b. With Family Planning coverage; and
- c. With Domestic Partner coverage; and
- d. Without Pediatric Dental coverage.

This Exhibit requires the factors needed to adjust the “Base Plan” as follows:

- a. To Add “Through Age 29” coverage; and
- b. To Remove Family Planning coverage; and
- c. To Remove Domestic Partner coverage; and
- d. To Add Pediatric Dental coverage.

**Note:** Companies that do not use explicit factors should provide the implied factors.

This Exhibit is intended to be a supplement to Exhibit 23. The same Exhibit may be provided for “On” and “Off” Exchange filings as well as for filings submitted for the various Markets.

**Filing Types:**

As discussed in Section A (General Introduction), most filings for premium rates effective in calendar year 2016 will be of the Prior Approval Adjustment type (Insurance Law § 3231(e)(1) and § 4308(c)), as most companies submitted rate filings in 2014 for premium rates effective in calendar year 2015. **Note that for filings of this type, if the existing forms are being modified or if new plans are being introduced, then a separate Form Filing must be submitted. Both filings (i.e. the separate Rate and Form filings) must clearly reference each other by SERFF Filing Number.**

For companies that did not submit a rate filing in 2014 for premium rates effective in calendar year 2015, a Rate and Form filing (Insurance Law § 3231(d) and § 4308(b)) is required for premium rates effective in calendar year 2016.

The required Exhibits for “Prior Approval” and “Rate and Form” filings, applicable to “On” and “Off” Exchange filings for all applicable Markets, are described below.

**Companies that participated in a particular Market during calendar year 2014 (or did not participate in 2014 but filed rates for 2015 in a particular Market) and wish to modify rates for that Market are subject to § 3231(e)(1) and § 4308(c), Prior Approval, and must provide the following Exhibits:**

- Exhibit 11: General Information;
- Exhibit 13: Narrative Summary and Numerical Summary;
- Exhibit 14A-B: Requested Percentage Changes;
- Exhibit 15A-B: Distribution by Percentage Changes;
- Exhibit 16: Summary of Policy Form Changes;
- Exhibit 17: Claims Experience Data;
- Exhibit 18: Index Rate/Plan Design Level Adjustment;
- Exhibit 19: Claim Trend and Administrative Expenses;
- Exhibit 20: HIOS Mapping to Product;
- Exhibit 21A-B: Hospital Unit Costs;
- Exhibit 22: Medical and Hospital Utilization Data;
- Exhibit 23: Summary of Requested 2015 Premium Rates;
- Exhibit 24: Risk Corridors Estimate;
- Exhibit 25: Adjustment Factors for Major Variations from the Base Plan.

**Companies that did not participate in a particular Market during calendar year 2014 and do not have 2015 rates filed for that Market are subject to § 3231(d) and § 4308(b), Rate and Form Filings, and must provide the following Exhibits:**

- Exhibit 11: General Information;
- Exhibit 16: Summary of Policy Form Changes;
- Exhibit 18: Index Rate/Plan Design Level Adjustment;
- Exhibit 19: Claim Trend and Administrative Expenses;
- Exhibit 20: HIOS Mapping to Product;
- Exhibit 23: Summary of Requested 2015 Premium Rates (Required to be submitted);
- Exhibit 25: Adjustment Factors for Major Variations from the Base Plan.

**Special Rules for the Preparation of the Required Exhibits:**

As discussed in Section B, separate filings must be submitted for “On” and “Off” Exchange plans, including separate Exhibits (i.e., for a particular Market, the same completed Exhibit should be filed with both the “On” and “Off” Exchange filing). Additionally, separate filings need to be submitted for Individual and Small Group business.

For example, a Company submitting rate filings for both the Individual and Small Group Markets, for plans to be sold both “On” and “Off” Exchange in both of those Markets, a total of four separate filings and accompanying sets of Exhibits would need to be submitted.

To simplify the process, DFS has adopted some special rules as described in the table below, where the same Exhibit may be used for more than one filing, when a given Exhibit is required to be submitted. Instructions were provided above as to when the various Exhibits have to be submitted.

Exhibits	Subject	SG / Ind.	On / Off	Min Number of Distinct Exhibits*
11	General Information	Different	Same	2
13	Narrative Summary	Different	Same	2
14A-B	Requested % Changes	Different	Same	2
15A-B	Distribution by Percent	Different	Same	2
16	Forms and Products	Different	Same	2
17	Claims Experience	Same	Same	1
18	Index Rate	Different	Same	2
19	Expenses and Profit	Different	Same	1
20	HIOS ID Mapping	Different	Same	2
21A-B	Hospital Charges	Same	Same	2
22	Utilization Date	Same	Same	1
23	Rate Summary	Same	Same	1
24	Risk Corridors Estimate	Different	Same	2
25	Base Plan Factors	Same	Same	1

\*Assuming a company participates in all markets (individual, small group and Catastrophic).

**SG / Ind:** Small Group / Individual.

**Same:** The same exhibit may be used for both SG/Ind or for both On/Off as long as all relevant information is included and appropriate identifiers are present.

**Different:** The same exhibit may not be used for both SG/Ind or for both On/Off as applicable.

**Number:** Total number of different exhibits to be prepared. This assumes that a company includes all relevant data in a particular Exhibit. For example, for Exhibit 17 (as well as Exhibits 21-23) a company may include all Individual and Small Group experience for both “On” and “Off” Exchange in one Exhibit (as long as the “Market Segment” column is properly filled out), and then submit that same Exhibit with all four filings.