NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions for the Filing of 2027 Premium Rates
Individual and Small Group – "On" and "Off" Exchange Plans

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WHAT'S NEW FOR 2027?

This Section is intended to alert your attention to the more significant changes that are relevant to the 2027 rate filing process. Please note that this Section is not intended to be a comprehensive list of all changes and anyone who is involved in the preparation of a rate filing to which these instructions apply should review this entire document as there are additional changes.

1. **Filing Date:**

   a. All 2027 Individual and Small Group ACA filings should be submitted on May 21st, 2026 through SERFF.

2. **Rate Notice Template Updates:**

   a. The 30-day consumer comment period will begin 5 business days from the date on which the notice is postmarked. This change was first implemented for 2025 rate filings.

3. **2027 Rate Development:**

   Individual Market:

   Individual products should be priced assuming that the 1332 Waiver does not exist.

   a. **The return of the 200-250% FPL population from the Essential Plan (EP) to the Individual Market.**
      I. Insurers will need to adjust their 2025 Individual experience to be consistent with the assumption that the members who migrated to the EP on 4/1/2024 will return to the Individual Market for all of 2027. This adjustment should be made in Line 23b of Exhibit 18 (see Section 5(a)(iii) below).
   b. **There will be no IRIP in 2027.**
      I. The Waiver will be terminated effective 7/1/2026, resulting in the 200-250% FPL population that was insured in the Individual Market prior to the existence of the Waiver to return to the Individual Market. Therefore, all other things being equal, the assumption that the Waiver does not exist will not result in a premium shortfall for 2027. As such, the IRIP will no longer be necessary.
   c. **The state funded cost sharing subsidies for diabetes and maternity benefits will no longer be available in 2027.**
   d. **Eligibility for Silver CSR variations will revert to what it was prior to the Waiver (see Section (F) for 2027 CSR variation eligibility).**
   e. **Insurers may adjust their 2025 Individual and Small Group experience to reflect $0 cost sharing for insulin which became effective 1/1/2026.**
      I. For 2026 Individual plans, the cost associated with this item was reimbursed using State Pass-through funds (i.e., Insurers were not allowed to reflect this item in their Individual premiums). Insurers were allowed to include a provision for this Item in their Small Group premiums. However, since this item was new in 2026, these costs will not be reflected in the 2025 experience of either Market.

4. Membership as of 3/31/2026 should be used for purposes of all projections.

   Individual and Small Group Markets:

   a. **Rate Development Starting Point:**

i. For purposes of populating Exhibit 18:

1. Lines 10, 10A, 10B, and 12A should be populated using 2025 experience with two months of claims run-out where applicable; and

2. The factor in Line 18 should reflect two years of trend; and

3. 2025 risk adjustment results should be used as the starting point to develop the 2027 risk adjustment assumption. See additional instructions regarding risk adjustment below.

ii. For purposes of populating the URRT:

1. 2025 data should be used as the starting point; and

2. The data should be trended for two years; and

3. Cell F-35 of the "Wksh 1 – Market Experience" tab should include an adjustment that results in a value in cell F-46 that is equal to Line 29 Column D (cell D-71) of Exhibit 18; and

4. The adjustment referenced in Item 3(a) above should be explicitly detailed in the Actuarial Memorandum that supports the URRT.

b. **Risk Adjustment:**

i. The factor in Line 19 of Exhibit 18, "Federal Risk Adjustment Impact", should:

1. Be developed using 2025 risk adjustment results as the starting point; and

2. Include a provision for expected 2027 Risk Adjustment Data Validation (RADV) transfers up to a maximum of +/- 1.0%. Any provision for RADV must be based on a prospective estimate of the expected 2027 RADV impact that is clearly explained and actuarially justified in the Actuarial Memorandum; and

3. Should not project morbidity deterioration/improvement beyond what is known at the time of the filing.

ii. For purposes of documenting the market wide Risk Adjustment (RA) factor used in Line 19 of Exhibit 18, the following information should be included in the Actuarial Memorandum:

1. Any sources (e.g., CMS Final 2025 Reports, Wakely study results, etc.) that were used to develop the market wide RA factor.

2. A clear explanation and of how those sources were used to develop the market-wide RA factor included in the filing.

3. **Risk Adjustment Mappings:** Mappings should be sufficiently clear such that we can interpret how your proposed rates would have been different, should actual 2025 risk adjustment results differ from what was anticipated in the filing. At the very least, mappings should consider changes in Metal mix (2025 experience vs membership survey as of 3/31/2026), changes in Regional mix (2025 experience vs

membership survey as of 3/31/2026), and expected change in the statewide average premium (i.e., 2025 vs expected 2027):

a. The above-mentioned demonstration should be provided in spreadsheet format and at a minimum include the following items (whether they are used in the company's risk adjustment mapping/demonstration formulas or not):

- The Company's expected 2025 RA transfer; and
- The Company's expected 2027 RA transfer; and
- 2025 RADV component; and
- 2027 RADV component; and
- Expected 2025 PMPM metal level RA transfers; and
- Expected 2027 PMPM metal level RA transfers; and
- Actual 2025 member months for each metal level; and
- Expected 2027 member months for each metal level; and
- The trend assumption used (and an explanation of how it was developed); and
- Impact of the termination of the 1332 Waiver (Individual only); and
- Formulas clearly illustrating how the company's expected 2025 RA transfer estimate was adjusted/used to determine the company's 2027 RA transfer estimate; and
- Formulas clearly illustrating how the company's expected 2025 RA results translate to the company's 2027 market wide RA factor; and
- Illustrations of how differences between the actual and expected 2025 results would impact the Company's expected results for 2027, as well as how those differences would impact the accompanying market-wide RA factor included in the 2027 rate application; and
- All applicable formulas (i.e., no hard-coded values) used in items x, xi, and xii above.

4. If material differences exist between a company's actual and expected 2025 risk adjustment results, DFS may use this information to make an objective determination as to how the Company's rates should be modified. Such adjustments may increase or decrease the Company's initially filed rates.

c. **Trend:**

i. As in past years, 2025 data should be trended forward **two** years. Any assumptions associated with general inflation should be included in Line 18 of

Exhibit 18 as a component of trend. Provider contract details included in the rate filing materials in support of trend assumptions may be redacted. Additional instructions regarding trend can be found in Section Q.

ii. **Note: The trend factor in Line 18 should exclude any trend associated with GLP-1 drugs as that component will be captured in Line 23c.**

5. 2027 Exhibit Updates:

a. **Exhibit 18:**

i. 2025 data should be used as the starting point for purposes of developing 2027 premium rates.

ii. For purposes of populating Lines 1 – 12A, any plans that were discontinued after 2025 should still be included along with each such plan's respective experience data provided by 14-digit HIOS Id.

iii. **New Market-Wide Adjustments – the following Lines have been recently added or modified:**

Line 22: "Change in morbidity not reflected in the experience data that is known and quantifiable at the time of the rate filing": This adjustment is intended to reflect information that is not reflected in the experience period data, related to events that have already occurred, which are known and quantifiable at the time the filing is submitted (e.g., significant membership changes between 12/31/2025 and 3/31/2026, etc.). This Line should not reflect any further projection of such change beyond what is known at the time of the filing.

Line 23a: "Covered Lives Assessment Impact": Impact associated with the Health Care Reform Act (HCRA) Covered Lives Assessment. Note that this item should not reflect any HCRA surcharges that are included as part of hospital charges as those amounts should already be reflected in paid claims.

Line 23b: "Adjustment to add the 200-250% FPL population (applies to Individual Only)". This line should be populated with a factor that adjusts the 2025 experience to be consistent with the assumption that Individual products must be priced under the assumption that the 200-250% FPL population returned to the Individual Market for all of 2025 and will remain in the Individual Market for all of 2027.

Line 23c: "Impact of GLP-1 Drugs": Impact associated with coverage of GLP-1 drugs that is not reflected in the experience period (any such impact reported in Line 23c must NOT also be included in the trend assumption reported on Line 18).

Line 23d: "Impact of NYS Legislative changes that are not reflected in the experience data": This Line is intended to capture the impact of legislative changes that became effective in 2026 or may become effective in 2027 for which the experience data does not already reflect the impact due to the lag in pricing. Insurers should develop separate estimates as appropriate for any

relevant items and develop a single factor that represents the combined impact of all such Items. The Actuarial Memorandum should provide justification for each individual component of any such factor that is included in Line 23d.

Line 23e: "Impact Due to Expiration of ARP" (American Rescue Plan subsidies also known as enhanced Premium Tax Credits (ePTC)) – Components of this factor should be itemized and quantified, as well as fully explained and justified in the Actuarial Memorandum (even if some, or all, components are considered offsetting).

Line 23f: "CMS NBPP Impact (due to Final NBPP being different from what was proposed)"- Components of this factor should be itemized and quantified, as well as fully explained and justified in the Actuarial Memorandum (even if some, or all, components are considered offsetting).

Line 27a: This line is for DFS use only and should not be modified.

iv. **Plan Level Adjustments:**

1. **Line 44: "Adjustment to add CSR Payments on the Plan Level" –** As long as CSR payments are removed from the starting experience in Line 13A in the Market Wide adjustments section, this line does not need to be revenue neutral. (This instruction was first updated for 2022).
2. **Line 45: "Rating Region Factor" -** This line is intended to account for distribution by rating region at the plan level. It is intended to ensure that the weighted average PMPM value in Line 56 Column D (Cell D-115) matches the value in Cell Z-74 of Exhibit 13c. (This was new in 2020).

v. **Expenses:**

1. **Line 50a: "Fixed Expense: MCO Tax" –** This should be expressed as a PMPM amount. This item is not included in the calculated Total Expense Load (Line 53). This line should reflect MCO Tax amounts that are expected to be assessed during calendar year 2026.

vi. **Exhibit 18 to Exhibit 23 Mappings:** The Actuarial Memorandum should include a mapping that illustrates how the 2027 premiums in Exhibit 23 are calculated based on the rates in Exhibit 18. The mapping should cite the specific lines or cells in Exhibit 18 that are used in each step, and clearly demonstrate how regional factors are applied. The regional factors used in the mapping should be consistent with the regional factors in the URRT.

vii. **Exhibit 18 – The "18 Supp-1332" tab has been deleted**.

b. **Exhibits 21A/21B (Changes first implemented for 2026 rate filings):**

i. Two columns were added to both exhibits.

1. Column 7a: "Affiliated/Non-Affiliated Hospital indicator" - Enter "Yes" or "No" to indicate whether the Insurer has any affiliation or association with the named provider.

Note: For purposes of this exercise, "Affiliate" means a corporation a majority of whose shares is owned or controlled by shareholders, directors or officers of another corporation, who own or control a majority of the shares of the other corporation."

2. Column 12: "2025 Paid Amounts" - Enter the paid amounts for calendar year 2025.

a. Exhibit 21A: amounts should only be for hospital inpatient services.

b. Exhibit 21B: amounts should only be for hospital outpatient services.

c. **Exhibit 22 (Changes first implemented for 2026 rate filings):**

i. New tabs, "Non-Capitated-Setting" and "Capitated-Setting", were added to the exhibit.

ii. The "Non-Capitated" and "Capitated" tabs from previous versions of the exhibit are now named "Non-Capitated-Service" and "Capitated-Service", respectively.

1. New input columns have been added to these tabs:

a. Column 8: "Amounts of Paid Charges (1/1/2025-12/31/2025)"

b. Column 17: "Amounts of Paid Charges (1/1/2024-12/31/2024)"

2. Additional calculated columns have been added.

3. The "Membership" columns from prior versions of the exhibit are now labeled "Member Months".

iii. DFS will provide query logic to populate the "Non-Capitated" tabs.

iv. Refer to the README file for additional instructions.

d. **Exhibit 23:**

i. The exhibit instructions page has new items (Columns 6 and 7) that were introduced starting in 2024 (for 2025 rates):

1. Data should be provided on the **16-digit HIOS ID Level**, although Zero Cost Sharing and Limited Cost Sharing plans with no membership may be excluded.

ii. If a cell becomes highlighted red, then an input error has been detected - review to ensure that the data input exactly matches an option from the drop-down menu available in that column. The dropdown options in columns 7 and 8 have changed:

1. Column 7 (Metal Level or Catastrophic) options are now Platinum, Gold, Silver, Bronze, and Catastrophic.

2. Column 8 (Exchange/CSR Type) options are now Off, On, Zero-Cost Sharing, Limited Cost Sharing, Silver CSR [200-250], Silver CSR [150-200], Silver CSR [100-150].

6. Healthy New York:

2027 Healthy New York Funding levels will be established to be consistent with a 17.7% reduction in claims for the program. For purposes of completing Line 39 of Exhibit 18, this is consistent with a factor of approximately 0.823. DFS will use this factor as the basis of determining the appropriate 2027 funding level.

7. **Commissions:**

   a. **See recent DFS Guidance regarding Producer Compensation:**

      Insurance Circular Letter No. 20 (2017):

      https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2017_20

      Supplement No. 1 to Circular Letter No. 20 (2017):

      https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2018_cl2017_20_s01

      Frequently Asked Questions regarding CL-20 (2017) – Posted in February of 2018:

      https://www.dfs.ny.gov/apps_and_licensing/health_insurers/faqs_cl2017_20_201802

      Frequently asked Questions regarding CL-20 (2017) and Supplement No. 1 to CL-20 (2017) – Posted in October of 2018:

      https://www.dfs.ny.gov/apps_and_licensing/health_insurers/faqs_cl2017_20_and_cl2017_20_s1_201810

8. **2027 Filing Types:**

   a. **"2027 Prior Approval ACA Rates"** - If 2026 rates were filed in the relevant Market.

   b. **"Exchange Forms & Rates"** - If 2026 rates were not filed in the relevant Market.

   c. **"Off Exchange NG Forms & Rates"** - If 2026 rates were not filed in the relevant Market.

   d. One of the following TOIs must be selected within SERFF in order for the URRT tab to appear in the filing:

      i. H16G Group Health – Major Medical

      ii. H16I Individual Health - Major Medical

      iii. HOrg02G Group Health Organizations - Health Maintenance (HMO)

      iv. HOrg02I Individual Health Organizations - Health Maintenance (HMO)

9. **2027 Rate Notice Templates:**

   a. **Available on our website in the following location:**

      https://www.dfs.ny.gov/apps_and_licensing/health_insurers/prior_approval_checklist_and_exhibits

      Notices of proposed changes should be sent to policyholders after DFS has posted the rate applications (DFS will send a blast email to let insurers know when the posting has occurred).

10. 2027 Standard Plan Documents:

a. **Available on our website in the following location:**

https://www.dfs.ny.gov/apps_and_licensing/health_insurers/prior_approval_checklist_and_exhibits

11. Rate Manuals and Rate Data Template:

a. Rate Data Templates should be submitted in both the rate filing and the binder filing. The Rate Data Template should be placed in the "Rate Data Template" section of the Supporting Documentation tab in the rate filing. (This was new for 2025)

b. Rate manuals should reference the premium rates in the Rate Data Template. It is not necessary to include premium rates in the rate manual pages.

12. Individual and Small Group Discontinuances:

a. Insurers that wish to discontinue any existing plans for 2027 must provide the specific details in Exhibit 15a as part of the rate filing that is due on May 21, 2026. For any discontinuance identified in Exhibit 15a, a discontinuance submission should be provided outside of the rate filing in accordance with the instructions found in the links below.

- **Individual Products:**
  - Instructions-for-Individual-Insurers-for-2027.pdf
- **Group Products:**
  - Instructions-for-Group-Insurers-for-2027.pdf

A. General Introduction:

These instructions apply to all comprehensive medical rate filings submitted in calendar year 2026 for premium rates effective in calendar year 2027, for Individual and Small Group plans, both "On" and "Off' Exchange.

For companies with 2026 rates on file in a particular market (i.e., Individual or Small Group), rate filings for calendar year 2027 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 should be sent to policyholders after DFS has posted the rate applications (DFS will send a blast email to let insurers know when the posting has occurred). 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 2026 rates on file in a particular market, rate filings for calendar year 2027 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 or (c) stand-alone dental plans.

B. Essential Health Benefits:

Companies must provide the Essential Health Benefits as specified in the 2027 model language.

C. Combined Rate Filings for On and Off Exchange Plans:

Separate rate filings need to be submitted for each market (i.e., Individual and Small Group).

Within a market, "On" and "Off" Exchange plans must be combined into one filing.

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). Separate rate manuals within the combined "On" and "Off" Exchange Rate filing may also be provided.

Actuarial Memorandums must address both "On" and "Off" Exchange plans with any differences clearly addressed.

A PDF version of all rate filing materials, including the Actuarial Memorandum and its accompanying exhibits, must be provided.

- **If there is any specific information within these documents that a Company has the option to withhold from public view and the Company wishes to exercise that option, it is the responsibility of the Company to also provide a redacted version of the relevant documents in PDF format, as well as an explanation of why the information is being redacted.**

- **Redacted documents must be clearly marked as such by including the word "Redacted" in the filename.**
- **In instances where we receive redacted versions of a rate filing document, the redacted version will be posted on our website (otherwise, the non-redacted version will be posted).**
- **Insurers should exercise caution when redacting files. Instances where files are over-redacted may result in the un-redacted version being posted. If there are any questions regarding whether a particular item may be redacted, please contact us.**
- **Note that Exhibits 21A, 21B, and 22 will not be posted on our website; therefore, redacted versions of these Exhibits do not need to be provided.**
- **The Rate Manual (i.e., all pages) should also be provided in both PDF and Excel format.**

D. Notice of Benefit and Payment Parameters for 2027:

Generally speaking, HHS final requirements for 2027 are similar to 2026 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.

(a) Patient-Centered Outcomes Research Institute (PCORI) Fees:

The PCORI fee has been extended into 2029. As of the time these instructions were published, the level of assessment had not yet been released. Additional information regarding this fee can be found on the IRS website at:

https://www.irs.gov/newsroom/patient-centered-outcomes-research-institute-fee

(b) Changes in Deductibles and Maximum Out of Pocket (MOOP) Limits:

There continues to be no annual deductible limit for Small Group.

For 2027, the HHS prescribed self-only coverage MOOP limit is $12,000, and the family limit is $24,000.

(c) ACA Fees:

Affordable Care Act Provision 9010 - Health Insurance Providers Fee:

This fee has been repealed and therefore should not be reflected in 2027 premium rates.

Risk Adjustment User Fee:

Per the 2027 Proposed NBPP, the Risk Adjustment User fee will be $0.20 **per member per month**.

NOTE: There should be no explicit fees for Exchange funding as the NYSOH is being funded using the existing HCRA mechanism.

E. New York State Standard Benefit Design:

Standard benefit designs must conform to those found on our website in the following location: https://www.dfs.ny.gov/apps_and_licensing/health_insurers/prior_approval_checklist_and_exhibits

F. Actuarial Value (AV) Metal Values:

Except for Silver Cost Sharing Reduction (CSR) plans, 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 (2027 version must be used).

Bronze: 60% AV (de minimis range of -2%/+2%; or -2%/+5% if one major service covered prior to the deductible)

Silver: 70% AV: de minimis range:
Individual:
On-Exchange (per NYSOH):
0%/+2%
Off Exchange:
-2%/+2%
Small Group: -2%/+2%

Gold: 80% AV (de minimis range of -2%/+2%)

Platinum: 90% AV (de minimis range of -2%/+2%)

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):

Eligibility Range	**AV**
200% to 250% FPL	73%
150% to 200% FPL	87%
100% to 150% FPL	94%

For CSR plans, *de minimis* variation of 0%/+ 1% AV is permissible (per NYSOH).

Note: The minimum permissible AV differential between the Silver (70% AV) and Silver CSR (73% AV) is two (2) percentage points.

The AV Metal Values determine what metal level a particular plan-design belongs in, and the 2027 HHS Actuarial Value Calculator must be used in the calculation of these AV Metal Values.

The final version of the 2027 AV Calculator and accompanying documentation is expected to be posted on the CMS website:

https://www.cms.gov/cciio/resources/regulations-and-guidance

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 plans must fall within the AV Metal Values using the 2027 HHS AV Calculator as 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 2027 AV Calculator to determine AV Pricing Values. Other sources 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 along with sufficient justification. 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 (including Catastrophic) or Small Group 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 (including Catastrophic) or Small Group (including Healthy New York) 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 level).

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.

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

Accordingly, the pricing basis used must be consistent with the assumption that the Individual or Small Group Market is one standard population (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).

The concept of a single risk pool must be maintained in aggregate for combined "On" and "Off" Exchange plans within each market.

See Appendix C for additional details.

J. Standardized Rating Regions:

The ACA requires standardized rating regions. The Standardized Rating Regions for New York have not changed for 2027. Companies may vary premiums between standardized rating regions in accordance with HHS regulations and DFS Guidance.

K. Claims Experience Data:

(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 claims experience of the Company's ACA compliant Small Group (including Healthy New York) plans only.

Any sources used to adjust in-force claims experience must be included in the Actuarial Memorandum along with appropriate justification.

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.

(b) Individual Plans:

For companies currently participating in the Individual market, the premium rates for "On" and "Off" Exchange plans should be based on the claims experience of the company's ACA compliant Individual (including catastrophic) plans only.

Any sources used to adjust in-force claims experience must be included in the Actuarial Memorandum along with appropriate justification.

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

L. Small Group Healthy New York Plans:

Small Group Healthy New York plans must be designed as the Standard Gold level plan.

2027 Healthy New York Funding levels will be established to be consistent with a 17.7% reduction in claims for the program. For purposes of completing Line 39 of Exhibit 18, this is consistent with a factor of approximately 0.823. DFS will use this factor as the basis of determining the appropriate 2027 funding level.

M. Standardized Rating Tiers:

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

- Single = 1.00
- Single + Spouse = 2.00
- Single + Child(ren) = 1.70
- Single + Spouse + Child(ren) = 2.85
- Child only = 0.412

Rating tier factors for calendar year 2027 are **unchanged** from 2026.

N. Child-Only Plans (Individual Plans Only):

All standard plans offered On-Exchange (with the exception of Catastrophic) must include rates for Child-Only plans. For companies that are not participating in the Exchange, at least one child-only plan must be available at each metal level.

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.

A separate policy must be created and delivered for enrollees of child-only products.

O. 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 (except as specified in Item 3 of the "What's New for 2027" Section above).

P. Rate Filings - Materials that must be Included:

The specific Exhibits that must be included are determined by the SERFF "Filing Type" as follows:

(a) SERFF Filing Types:

- "2027 Prior Approval ACA Rates" – To be used if the legal entity for which the filing is being made currently has 2026 rates on file with DFS in the applicable market.
- "Exchange Forms & Rates" – To be used if the legal entity for which the filing is being made does not currently have 2026 rates on file with DFS in the applicable market, and plans will be sold both "On" and "Off" the Exchange.
- "Off Exchange NG Forms & Rates" - To be used if the legal entity for which the filing is being made does not currently have 2026 rates on file with DFS in the applicable market, and plans will be sold "Off" Exchange only.
- The TOI must be one of the following in order for the URRT tab to appear:
  - H16G Group Health – Major Medical
  - H16I Individual Health - Major Medical
  - HOrg02G Group Health Organizations – Health Maintenance (HMO)
  - HOrg02I Individual Health Organizations – Health Maintenance (HMO)

(b) Required Exhibits by Filing Type:

Filings submitted under the SERFF Filing Type "2027 Prior Approval ACA Rates" must include the following Exhibits:

- 2027 Rate Filing Checklist;
- Exhibit 11: General Information;
- Exhibit 13 (A): Numerical Summary and Rate Indication Calculation;
- Exhibit 13 (B): Narrative Summary;
- Exhibit 13 (C): Two tabs: Average Premium Details and Distribution by Rating Tiers;
- Exhibit 14: Summary of Requested Percentage Changes;
- Exhibit 15a: Product Discontinuance Certification (this exhibit only needs to be completed if the company is discontinuing plans for 2027);
- Exhibit 15b: Mental Health Parity and Addiction Equity Act (MHPAEA) Certification;
- Exhibit 16: Summary of Policy Form and Product Changes;
- Exhibit 17: Historical Claims Data by Policy Forms included in Rate Adjustment Filing;
- Exhibit 18: Index Rate/Plan Design Level Adjustment Worksheet;
- Exhibit 21 (A): Hospital Unit Cost Development – Inpatient Services;
- Exhibit 21 (B): Hospital Unit Cost Development – Outpatient Services;
- Exhibit 22: Medical and Hospital Utilization Data;
- Exhibit 23: Summary of Requested 2027 Premium Rates;

Note that only Individual experience should be provided in Exhibits submitted with Individual rate filings and only Small Group experience should be provided in Exhibits submitted with Small Group rate filings.

(c) Filings submitted under the SERFF Filing Types "Exchange Forms & Rates" or "Off Exchange Forms & Rates" must include the following Exhibits:

- 2027 Rate Filing Checklist;
- Exhibit 11: General Information;
- Exhibit 15b: Mental Health Parity and Addiction Equity Act (MHPAEA) Certification;
- Exhibit 16: Summary of Policy Form and Product Changes;
- Exhibit 18: Index Rate/Plan Design Level Adjustment Worksheet;
- Exhibit 23: Summary of Requested 2027 Premium Rates;

(d) Regardless of Filing Type, in addition to the appropriate Exhibits, all filings must also include the following items:

- **Rate Filing Checklist**
- **Actuarial Memorandum**
- **AV Snapshots**
- **URRT**
- **Rate Manual**

(e) AV Calculations (AV Snapshots):

As an attachment to the Actuarial Memorandum, provide printouts of all AV calculation pages (snapshots) using the final HHS 2027 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. The text on each page must be readable/searchable. Instructions for making the text on each page readable/searchable can be found in Appendix D.

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.

(f) Quality Improvement Strategy:

A copy of the Company's Quality Improvement Strategy under section 1131(g) of the ACA must 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) must be included as well. This information should tie in with the activities that improve health care quality, as specified in the HHS MLR report and the Supplemental Health Care Exhibit.

Q. Actuarial Memorandum:

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

1. For purposes of documenting the market wide Risk Adjustment (RA) factor used in Line 19 of Exhibit 18, the following information should be included in the Actuarial Memorandum **(Note:** Consistent with the requirement for morbidity, the Risk Adjustment assumption should not project improvement/deterioration beyond what is known at the time of the filing).
    a. Any sources (e.g., CMS Final 2025 Reports, Wakely study results, etc.) that were used to develop the market wide RA factor.
    b. A clear explanation of how those sources were used to develop the market wide RA factor included in the filing.
    c. A clear explanation and accompanying demonstration of how the market wide RA factor would change if actual 2025 results differ from expected. At the very least, mappings should consider changes in Metal mix (2025 experience vs membership survey as of 3/31/2026, Regional mix (2025 experience vs membership survey as of 3/31/2026), and expected change in the statewide average premium (i.e., 2025 vs expected 2027).
        i. The above-mentioned demonstration should be provided in spreadsheet format and at a minimum include the following items (whether they are used in the company's risk adjustment mapping/demonstration formulas or not):
            1. The Company's expected 2025 RA transfer; and
            2. The Company's expected 2027 RA transfer; and
            3. 2025 RADV component; and
            4. 2027 RADV component; and
            5. Expected 2025 PMPM metal level RA transfers; and
            6. Expected 2027 PMPM metal level RA transfers; and
            7. Actual 2025 member months for each metal level; and
            8. Expected 2027 member months for each metal level; and
            9. The trend assumption used (and an explanation of how it was developed); and

10. Impact of the termination of the 1332 Waiver (Individual only); and
11. Formulas clearly illustrating how the company's expected 2025 RA transfer estimate was adjusted/used to determine the company's 2027 RA transfer estimate; and
12. Formulas clearly illustrating how the company's expected 2025 RA results translate to the company's 2027 market wide RA factor; and
13. Illustrations of how differences between the actual and expected 2025 results would impact the Company's expected results for 2027, as well as how those differences would impact the accompanying market-wide RA factor included in the 2027 rate application; and
14. All applicable formulas (i.e., no hard-coded values) used in items 10, 11, and, 12 above.

d. If there are material differences between a company's actual and expected 2025 risk adjustment results, DFS may use this information to make an objective determination as to how the Company's rates should be modified. Such adjustments may increase or decrease the Company's initially filed rates.

2. 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.

   a. The Actuarial memorandum should include an explicit breakdown of the various components of the trend factor used to develop the 2027 premium rates. Such breakdown should include support for the unit cost, utilization, deductible leveraging, and projection components of the trend factor used in Exhibit 18. The breakdown should also address changes in provider contracts that impact trend.

   b. The Actuarial Memorandum should explicitly address any offsets to deductible leveraging which result from plan design modifications that are necessary to maintain specific metal levels.

   Note: The trend factor in Line 18 should exclude any trend associated with GLP-1 drugs as that component will be captured in Line 23d.

3. 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.

4. Assumptions used for **administrative expense**, including (a) an explanation of changes in Exhibit 18 Supplement expense components from the prior year, and (b) a reconciliation with information on administrative costs reported in latest financial statements.

5. Assumptions for **profit** and contribution to surplus, including a discussion pertaining to Return on Equity.

6. Details regarding **adjustments to Actuarial Values** produced by the HHS AV Calculator.

7. Details regarding the **conversion factors** (Cells C-47, L-47 and U-47 of Exhibit 13c) used to convert Preliminary PMPM Rates to actual premium rates for each of the Standardized Rating

Tiers prescribed by DFS. This should include information on the distribution of both individuals/subscribers and members by the various rating tiers. Additionally, any inconsistencies between the actual conversion factors used and the information contained in Exhibit 13c and 13c Supplement should be explained.

8. **Regional Premium Relativities**:
    a. For purposes of establishing regional relativities, the following guidelines are to be used and documented in the Actuarial Memorandum:
        i. Regional incurred claims net of regional risk adjustment transfers are to be used as the starting point to effectively remove health status.
        ii. To the extent that regional data is less than fully credible, an appropriate credibility procedure is to be used and must be fully explained in the Actuarial Memorandum
            1. Such procedure must be clearly defined and consistently applied (i.e., to all regions, all years, etc.)
            2. The procedure should clearly specify the insurer's standard for full credibility (e.g., in terms of the number of member months, or number of claims, etc.)
            3. The procedure should also explain how the compliment of credibility is chosen. Such explanation should include the ranking of credibility compliments in situations where the insurer uses more than one option.
        iii. Additional adjustments may be made to the extent they can be actuarially justified (e.g., to reflect regional differences in provider contracts, cost of living differences, pooling of the excess portion of high-cost claims across all regions, etc.) Any details included in the Actuarial Memorandum related to provider contracts may be redacted.
        iv. Any instances where judgement is used to override an insurer's adopted credibility procedure must be fully explained in the Actuarial Memorandum.
        v. All calculations associated with premium relativity determination should be provided in an Excel spreadsheet with all formulas included (i.e., there should be no "pasted values").
9. **Exhibit 23 Premium Development:** The Actuarial Memorandum should include a mapping that explains how the 2027 premiums in Exhibit 23 are calculated based on the rates in Exhibit 18. The mapping should cite the specific lines or cells in Exhibit 18 that are used in each step, and clearly demonstrate how regional factors are applied. The regional factors used in the mapping should be consistent with the regional factors in the URRT.
10. Details regarding how the Company determined its AV Pricing Values, including but not limited to justification for differences between AV Pricing Values versus values produced by the AV Calculator and sources for any external data sources that were utilized.
11. Support for adjustments to the premium rates for the impact of **Federal risk adjustment**.
12. Details supporting any **material pricing ratios used for morbidity**. Morbidity changes should not be projected beyond what is known and quantifiable at the time of the filing.

13. There should be no inconsistencies between the information in the Actuarial Memorandum and the information contained in Exhibit 18 (Index Rates).
14. Support for adjustment factors used for **Out-of-Network benefits**.
15. Support for any **significant premium rate differences** between plans at the same metal level.
16. Details must be provided on any **Proprietary Studies** used to develop or modify premiums rates covered by this filing.
17. Details and support for any **other adjustments** that were made.
18. Data sources that are not based on the actual claim experience of the Company's ACA Compliant Non-Grandfathered plans must be clearly highlighted (e.g., the publication, organization, or specific consultant), and the applicability of the source must be justified.

R. Rate Manuals:

(a) Premium Rate Manuals – General Instructions:

Rate manuals must be submitted with the rate filings.

Premium rates for Small Group, "On" and "Off" Exchange may 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 or uploaded separately).

The rate manuals must include reference to the Rate Data Template in the "Rate Data Template" section of the filing that has premium rates for standard and non-standard plans, all applicable Standardized Rating Tiers, and all applicable Rating Regions. Small Group Rate Data Templates must include premium rates for all quarters during calendar year 2027. The Rate Data Template must be submitted in both the rate filing and the corresponding binder filing.

(b) Premium Rate Manuals – Required Items:

Rate manuals must be provided in both "Excel" and "PDF" format and include the following items:

1. Table of Contents.
2. Insurer/corporation name on each consecutively numbered rate page.
3. Identification by HIOS ID and form number of each policy, rider or endorsement to which the rates apply.
4. Commission Schedule and/or Fees.
5. An expected loss ratio page. The expected loss ratio is to be calculated using the traditional New York State methodology (i.e., Expected incurred claims divided by expected earned premiums without the adjustments permitted in the Federal rebate methodology) as outlined in Circular Letter 15 from 2011:

   https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2011_15

6. 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).
7. A detailed description of the cost sharing provisions applicable to each plan-design, including details on prescription drugs.
8. The Standardized Rating Tiers and accompanying factors as prescribed by DFS must be included.
9. Factors for Geographic Rating Regions must be included.
10. A listing of the counties included in each region in which the Company plans to market each of its products.
11. Reference to the applicable Rate Data Template.
12. Other information as applicable.

(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; and
2. Prescribed rating tier factors for variations in premium rate relationships apply to both medical and 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.

(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 rating tiers with children. The premium rate adjustments must be spread over all rating tiers.

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 rating tier, 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.

(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 rating tiers with children. The premium rate adjustments must be spread over all rating tiers.

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 rating tier, based on the factors prescribed for the basic medical benefits.

(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 premium rate manual pages that are readable without magnification (i.e., pages should not be reduced in size to the point where they are not readable, even if this means that multiple pages must be used). Companies submitting pages that are unreadable will be asked to resubmit their rate filings.

S. Actuarial Memorandum - Actuarial Qualifications:

(a) A Fellow of the Society of Actuaries; or

(b) Both an Associate of the Society of Actuaries and a member of the American Academy of Actuaries.

T. 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
- ASOP No. 42, Determining Health and Disability Liabilities other than Liabilities for Incurred Claims
- ASOP No. 45, The Use of Health Status Based Risk Adjustment Methodologies
- ASOP No. 50, Determining Actuarial Value and Minimum Value under the ACA

(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.

U. 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 50th and 60th 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.

V. Additional Requirements:

(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 2026 rates on file):
"2027 Prior Approval ACA Rates" - Note that there is only one filing type under this category as "On" and "Off" Exchange rate filings must be combined.

Rate and Form Filings (Companies that do not have 2026 rates on file):

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

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

(b) Format of Attachments:

Each attachment to the rate adjustment filing must be compatible with the following software: Microsoft Word 2013 (or higher), Microsoft Excel 2013 (or higher), 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.

(c) SERFF/HHS Requirements:

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

(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).

W. Other Miscellaneous Items:

(a) Membership Survey as of March 31, 2026:

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 specific survey must be used to complete the various Exhibits. This information may also be used to assist companies in estimating the impact of the Federal Risk Adjustment program.

(b) 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:

https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2011_15

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 expenses and profit may not vary by plan, metal level or rating region beyond what is produced by the application of a constant percentage across all such levels (i.e., a constant percentage and/or fixed dollar amount applied consistently across all metal levels, rating regions and plans must be used).

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

(c) 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 2026, 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 2026, rate filings for premium rates to be effective in calendar year 2027 will be handled as Rate and Form filings under Insurance Law § 3231(d) or § 4308(b), as described in Section A (General Introduction) above.

(d) Uniform Rate Review Template (URRT):

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

In the past, DFS has raised objections regarding the filings of several companies related to reconciliations between the values in the URRT worksheets and the comparable values in DFS's Exhibits 17 and 18 related to Incurred Claims, Risk Sharing Adjustments, Expenses and Profit Provision, and other items.

Care should be exercised in the preparation of 2027 filings to ensure consistency between values for the items noted above (except as specified in Item 3 of the "What's New for 2027" Section above).

(e) Rate Review Detail Data (R2D2)

The "Rate Review Detail" screen must be completed per HHS requirements. The values should reflect the proposed rate action. HHS reviews these screens and has requested that DFS instruct companies to address inconsistencies in the values for the various components.

In the past, DFS has raised several objections regarding the filings of several insurers 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 annual premium rates (they should be expressed as Annualized PMPM 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 zeroes 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 2027 premium rate filings, the Rate Review Detail must be completed in a manner that is consistent with prior years.

(f) Dental Coverage

Instructions for Dental filings will be available on our website.

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

2027 Rate Filing Exhibit Instructions

General

For a given Market, 2027 proposed rates for "On" and "Off" Exchange business must be submitted as a combined filing as opposed to submitting two separate filings. Only Individual experience data should be included within Exhibits submitted with Individual rate filings and only Small Group experience data should be included within Exhibits submitted with Small Group filings.

All Exhibits must be submitted in both "Excel" and "PDF" format.

For Exhibits with a separate Instructions tab (labeled "Exhibit Number - I"), the "Company Name", "NAIC Code", "SERFF Number", and "Market Segment" must be entered on that tab (those items are then carried over to the data tab).

The 2027 Rate Filing Exhibits include controls intended to facilitate the efficient processing of the data being submitted as well as to ensure that the playing field is level. These Exhibits should not be "unlocked" for the purposes of modifying them in any way.

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). Contact information may be redacted.

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

Exhibit 13A - Numerical Summary and Rate Indication Calculation, Exhibit 13B - Narrative Summary, 13C – Average Premium Details, and 13C Supplement – Distribution by Rating Tiers

Exhibit 13 has been split into four separate Exhibits (13a, 13b, 13c, and 13c Supplement). The Numerical Summary portion (Exhibit 13a) includes the "Requested Rate Adjustment" percentage that will be posted on our website, as well as a "Rate Indication Calculation" which will not be made available to the public. Exhibit 13b is a placeholder for the "Narrative Summary". The Narrative Summary is intended to be a plain English description of, and rationale for, the rate change being requested. Exhibit 13c shows the development of the weighted average premiums that are reported in Exhibit 13a.

Regarding 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:

Exhibit 13a

A. 2026 and 2027 Weighted Average Base Premium Rates:

These are required fields whose values are to be determined as the subscriber weighted average (not member month weighted) using the single adult premium rates as selected by the subscribers for each applicable metal level specified in Rows 31 and 32 (Columns G-K) of Exhibit 13a. These values should come from the appropriate cells of Exhibit 13c (Row 32, Columns L-P, and Columns U-Y of Exhibit 13c).

B. Weighted Average Annual Percentage Adjustments (2026 to 2027):
The Weighted Average PMPM Rates for 2026 and 2027 are required fields. These numbers should come from Exhibit 13c (Cells Q-74 and Z-74 of Exhibit 13c).

C. Weighted Average Annual Percentage Adjustments (Prior Years):
These are required fields (to the extent the Company participated in the relevant years). Note that values reported in this Section should be consistent with what was publicly reported (and approved) on the DFS website.

D. Average Medical Loss Ratios for 2023-2025, Projected 2026, and Projected 2027:
The MLRs reported in this Section should be calculated as total Incurred Claims (Net of federal risk adjustment) divided by Earned Premium for the applicable calendar year. Claim and premium amounts should be consistent with Exhibit 17. Federal risk adjustment amounts should be based on final amounts for 2023 and 2024, and Interim results for 2025. Cells have been added for Projected 2026 and 2027 MLRs.

E. Claim Trend Rates and Ratios to Earned Premiums (2025-2027):

E 1 Claim Trend Rates (2025-2027):
Enter the claim trend rates associated with 2026 and 2027 as reported in the "Expected" columns of the Company's Exhibit 18 Supplement. For 2025, enter the claim trend rate as reported in the "2025 Actual" column of Exhibit 18 Supplement. If not applicable, enter "N/A".

E 2 Ratios to Earned Premiums (2025-2027):
Enter the relevant ratios associated with 2026 and 2027 as reported in the "Expected" columns of the Company's Exhibit 18 Supplement. For 2025, enter the relevant ratios as reported in the "2025 Actual" column of Exhibit 18 Supplement. If not applicable, enter "N/A".

Note that Exhibit 18 Supplement does not specifically illustrate the ratios for Pre-Tax Profit provision. This item is to be determined as the sum of the Post Tax Profit provision plus the components for State and Federal taxes.

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

G. For purposes of this Exhibit (13A and 13C), "Base" Premiums means the rate charged for a single adult (i.e., prior to application of Standardized Rating Tier Factors).

H. All weighted averages in Exhibits 13A and 13C should be calculated using membership as of 3/31/2026.

Exhibit 13c

A. The "Weighted Average Monthly Base Premiums" in rows 24-31 of Exhibit 13c, should be subscriber weighted averages calculated as the sum of the single adult rates (prior to the application of rating tier factors) multiplied by the number of subscribers for each plan divided by the total number of subscribers for each cell (combination of metal level and region). Note that there are three separate Sections where this calculation takes place (2026 Actual as of 3/31/2026, 2026 recalculated using only those subscribers that are enrolled in plans that will

continue to be available in 2027, and 2027 calculated using only those subscribers that are enrolled in 2026 plans that will continue to be available in 2027).

B. Rows 37-44, Columns C-G are to be populated with actual membership as of 3/31/2026.

C. Rows 37-44, Columns L-P are to be populated with the subset of members in (B) above that are enrolled in plans that will continue to be offered in 2027 (i.e., if the Company is not retiring/discontinuing any plans, the membership in Columns C-G and L-P will be the same). If membership in Columns L-P is not the same as membership in Columns C-G, then Exhibit 15a should be submitted for each product that is being discontinued.

D. For each of the three sets of columns, the accompanying Conversion factors needed to convert the Weighted Average Monthly Base Premiums to PMPM rates must be reported in Cells C-47, L-47, and U-47 (i.e., the reciprocal of the factor needed to convert PMPM rates to Base rates).

Exhibit 13c Supplement

This Exhibit is intended to collect Weighted Average Monthly Premium, Subscriber, and Membership information by Rating Tier.

A. The "Weighted Average Monthly Tier Premiums" in rows 28-32 of the Exhibit 13c Supp Tab should be populated with the subscriber weighted average premiums calculated as the sum of the monthly premiums the subscribers would actually be charged (**Base premium times the appropriate rating tier factor**) multiplied by the number of subscribers for each plan, divided by the total number of subscribers for each cell (combination of metal level and rating tier). Columns C-G should be based on the actual number of subscribers as of 3/31/2026. Columns L-P and U-Y should be based on the subset of the actual number of subscribers as of 3/31/2026 that are enrolled in plans that will continue to be offered in 2027.

B. For Rows 38-42, Columns C-G are to be populated with the actual number of subscribers enrolled in each metal level and rating tier as of 3/31/2026. Columns L-P are to be populated with the subset of subscribers reported in Columns C-G who are enrolled in plans that will continue to be available in 2027 (i.e., if the Company is not retiring/discontinuing any plans, the subscribers in Columns C-G and L-P will be the same).

C. For Rows 48-52, Columns C-G are to be populated with the actual number of members enrolled in each metal level and rating tier as of 3/31/2026. Columns L-P are to be populated with the subset of members reported on Columns C-G that are enrolled in plans that will continue to be offered in 2027 (i.e., if the Company is not retiring/discontinuing any plans, the members in Columns C-G and L-P will be the same).

Additional instructions are included within the Exhibit 13a, 13c, and 13c Supp tabs.

This Exhibit is applicable to Prior Approval Adjustment filings only.

Exhibit 14: Summary of Requested Percentage Changes:

This Exhibit provides details of the premium rate changes between 2027 requested and 2026 approved rates.

Information is requested (a) by Product, (b) by Metal Level, (c) by Rating Region, (d) by Effective Date of the premium rates, and (e) by the range of the requested rate change.

Effective dates are 1/1/2027 for all Individual plans, and 1/1/2027, 4/1/2027, 7/1/2027 or 10/1/2027 for Small Group plans.

Additional required information includes Lowest, Highest, and Weighted Average requested percentage rate changes, as well as details regarding the distribution of the requested change.

Please note:

- The Total Number of Members and Subscribers in Cells H-24 and I-24 of Exhibit 14 should equal the totals in Cells Q-45 of Exhibit 13c and Cells Q-43 of Exhibit 13c-Supplement respectively (i.e., Only those members/subscribers currently enrolled in plans that will continue to be offered in 2027 should be reported); and
- The Total Annualized Premium in Cell G-24 of this Exhibit should equal the total in Cell Q-61 of Exhibit 13c.

Exhibit 14 applies to Individual and Small Group Plans (**Calculations must be based on membership as of 3/31/2026**).

This Exhibit is applicable to Prior Approval Adjustment filings only.

Exhibit 15A: Discontinuance Certification

The rate adjustment submission must include a written certification with respect to any comprehensive medical expense products that the issuer intends to discontinue for 2027. A certification must be provided for each product to be discontinued for 2027. The certification must be signed by an officer of the issuer with knowledge of the issuer's comprehensive medical expense products and the laws and regulations applicable to those products. The certification shall be submitted as Exhibit 15a.

The certification must include:

1. The policy form numbers and marketing name of the product to be discontinued.
2. A statement that a planned product discontinuance will affect NYSOH Plans, if applicable.
3. A statement that a planned product discontinuance has been subject to the analysis set forth at 45 CFR 147.106(e) and DFS guidance distinguishing a product discontinuance from a uniform modification.
4. The basis for determining the change to a product constitutes a discontinuance and is not a uniform modification, which can only be one of the following:
    - The product is offered by a different health insurance issuer that is not a member of the same controlled group.
    - There is a change to the product's network type.
    - The change results in the product covering less than the majority of the service area for the product.
    - There is a change to the product's cost sharing structure, or a plan within the product has a different cost-sharing structure. Any variation in cost sharing solely related to changes in cost and utilization of medical care or to maintain metal level does not constitute a discontinuance.
    - There is a change to the benefits that cumulatively impacts the premium rate for any plan within a product by more than 2 percent (either + or -).

In addition to providing the certification as part of the rate adjustment submission, an issuer planning to discontinue a comprehensive medical expense product in 2027 must also follow the instructions posted to the DFS website for formally notifying the Superintendent of a planned discontinuance at least 30 business days prior to mailing any notices of discontinuance to policyholders and/or insureds.
NOTE: A "product" is defined under federal rules as a "discrete package of health insurance coverage benefits that are offered using a particular product network type (such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity) within a service area." A product is comprised of "plans" with the same characteristics (benefits, cost sharing and network structure, and service area). See 45 CFR 144.103.
A change to a single plan, a decision not to offer a particular plan, or adding a plan to a product would not, by itself, constitute a product discontinuance unless the change exceeds the scope of a uniform modification for the product. See Uniform Modification and Plan/Product Withdrawal FAQ (June 15, 2015), available at

https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/uniform-mod-and-plan-wd-FAQ-06-15-2015.pdf

See guidance on DFS website at:

https://www.dfs.ny.gov/apps_and_licensing/health_insurers/uniform_modification_policy_changes_guid

Uniform modifications should be communicated to enrollees in renewal notices.

To satisfy this requirement, insurers should complete the Exhibit 15A template that is available on our website.

Exhibit 15B: MHPAEA Certification
With respect to Non-Standard plans, all insurers are required to complete the Exhibit 15B template to certify compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and the various testing that is required under that Act. The template is available on our website.

Exhibit 16 - Summary of Policy Form and Product Changes
The purpose of this Exhibit is to provide a summary of all benefit and rate changes filed after the initial rate filing that could potentially impact the rates in this filing.

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

Exhibit 17 – Historical Claim Experience Data by Policy Forms
This exhibit illustrates the premiums and claims experience for the prior two (2) calendar years (2024 and 2025) by policy form.

For each market, the experience reported in Exhibit 17 should be representative of the risk that is expected to comprise the risk pool in 2027.

Individual: All of the Company's 2024 and 2025 Individual experience (including the experience of catastrophic plans) should be included in this Exhibit.

Small Group: For each applicable year, this Exhibit should include all experience associated with those specific groups that were considered "small" in the relevant calendar year (i.e., regardless of

whether a group was considered "large" in a different year). The information provided in this Exhibit should be consistent with what was reported in the Company's New York Supplement.

The policy forms covered by this Exhibit are those for all ACA compliant plans, as described in the table below, providing comprehensive benefits for hospital, medical and prescription drugs charges. This Exhibit should **not** include non-ACA compliant plans (e.g., grandfathered plans, indemnity plans, etc.). Note that discontinued/retired plans are **not** to be excluded. 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 2027 premium rates for "On" and "Off" Exchange plans for both Individual and Small Group business.

a. The format of this Standard Exhibit is fixed; populate as many rows as needed.

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 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.

d. 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.)

e. Column 3 Effective Date of Last Rate Change: Indicate the date on which the latest approved rate scale became effective (e.g., 1/1/2026 for individual ACA-Compliant plans).

f. Column "5A. Rating Region" was recently added. All 2025 and 2024 experience must be broken out by rating region.

g. 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, 2025.

h. Experience Data: The experience entered for the two (2) indicated experience periods is the New York statewide experience for the indicated base medical policy form plus all associated riders.

i. Each experience period is 12 months (or shorter if a new form).

j. The 2025 experience period runs from 1/1/2025 – 12/31/2025. The 2024 experience period runs from 1/1/2024 – 12/31/2024.

k. The incurred claims for both experience periods must be reported on a consistent basis. Columns 14.6 and 15.6 must represent only those claims paid during the relevant calendar year. Columns 14.6a and 15.6a must represent only those claims paid during the months of January and February of the year following the relevant calendar year on claims incurred during the relevant calendar year. Columns 14.6b and 15.6b must represent total estimated future remaining claims for the relevant calendar year that are not already reflected in the previous two columns. **Note that for the 2024 experience period, such estimate should reflect all known claims through the current date (i.e., Insurers should not simply copy the 2024 experience that was reported in Exhibit 17 last year).**

l. The Actuarial Memorandum must provide a clear description of how incurred claims were developed for each experience period. Incurred claims in the Columns referenced in this section should not be adjusted for commercial reinsurance, or federal risk adjustment payments/receipts.

m. Standardized earned premiums should not reflect adjustments for MLR rebates.

n. 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 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**.**

o. **Column 14.6c**: "Rx Rebates associated with claims reported in Columns 14.6 and 14.6a (enter as a positive value) ($)"

p. **Column 14.6d:** "Estimated Rx Rebates associated with claims reported in Column 14.6b or not otherwise included in 14.6c (enter as a positive value) ($)"

q. **Column 15.6c:** "Rx Rebates associated with claims reported in Columns 15.6 and 15.6a (enter as a positive value) ($)"

r. **Column 15.6d:** "Estimated Rx Rebates associated with claims reported in Column 15.6b or not otherwise included in 15.6c (enter as a positive value) ($)"

As noted in the column headings, any Rx Rebate values should be entered as positive numbers as they will be subtracted from non-Rx paid and incurred claims in Columns 14.7 and 15.7 to arrive at "Total Incurred Claims".

s. **Experience should be broken out as follows:**

Market	Description	Market Segment (Entry for Exhibit 17, Column 4)	Group Definition	Counting Method	Notes	Standardized Premium Scale
Individual	ACA Compliant Individual Plans	Individual-ACA	N/A	N/A	Issued on or after 1/1/2024	2026 Rates
Catastrophic	ACA Compliant Catastrophic Plans	Catastrophic	N/A	N/A	Issued on or after 1/1/2024	2026 Rates
Small Group	Experience of ACA Compliant Small Group Plans (Excluding Healthy New York plans) that were written or renewed on or after 1/1/2023	SG-ACA-FTE	1-100	Current New York (FTE)	All relevant experience in the calendar year	4th Quarter 2026 for rolling; 2026 for non-rolling
Small Group - HNY	Experience of Small Group Healthy New York Plans that were written or renewed on or after 1/1/2023	SG-ACA-HNY-FTE	1-50	Current New York (FTE)	All relevant experience in the calendar year	4th Quarter 2026 for rolling; 2026 for non-rolling

This Exhibit is applicable to Prior Approval Adjustment filings only.

Exhibit 18 - Index Rate /Plan Design Adjustment Worksheet

Exhibit 18 applies to all filings and must be prepared on a PMPM basis.

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

For Companies that participated in the relevant Market during calendar year 2025:

a1. For lines 10, 10A, and 10B, plan level 2025 earned premium, claim, and exposure data should be entered for each distinct plan. Data for multiple plans should not be combined into one column.

All insurers must use actual 2025 experience as the starting point for the Index Rate regardless of credibility. Cell D-30 (Line 10A, Column D) should equal the Market total reported in Column 15.7 of Exhibit 17. Cell D-31 (Line 10B, Column D) should equal the Market total reported in Column 15.3 of Exhibit 17. Any adjustments that may be necessary to account for lack of credibility are to be included in Line 20 and must be fully explained and justified in the Actuarial Memorandum. Line 10C (Average PMPM Incurred Claims) will be calculated as line 10A divided by Line 10B.

a2. The Average Pricing Actuarial Value for all in-force plans combined is to be entered in Line 11, Column D. The value in Line 12, Column D will be carried to all other columns for use as the starting point for all plans (unless a particular plan is no longer being offered).

a3. Plan level 2025 allowed claims should be entered for each distinct plan. Data for multiple plans should not be combined into one column.

a4. Go to step b.

For Companies that did not participate in the relevant Market during calendar year 2025:

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.) Because of the way the Exhibit is designed, the relevant data should be entered in the "Plan 1" column.

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 impact of trend must be shown on Line 18 of Exhibit 18 and should be consistent with the annual trend reported in Exhibit 18 Supplement. The expense and profit provisions in lines 49-52 must be consistent with Exhibit 18 Supplement.

a6. Go to step b.

For all Companies regardless of whether they participated in the relevant market in calendar year 2025:

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. Regarding Lines 24 – 27 ("Other"), because additional rows cannot be added, if more than four additional adjustments are necessary, such additional adjustments should be combined and included in "Other 4" (Line 27). All "Other" adjustments should be fully explained and justified (as well as itemized) in the Actuarial Memorandum.

c. The value in Line 28, Column D is calculated as the product of Lines 13 through 27 of Column D. The value in Line 28, Column D is carried to all other columns in Line 28 and used for all relevant plans.

d. Factors for any relevant Plan Level Adjustments as described in 45 CFR 156.80(d)(2) are to be entered in Lines 30 through 46 as appropriate for each plan. Regarding Lines 46a – 46d ("Other"), because additional rows cannot be added, if more than four additional adjustments

are necessary, such additional adjustments should be combined and included in "Other 4" (Line 46d). All "Other" adjustments should be fully explained and justified (as well as itemized) in the Actuarial Memorandum. The combined impact of plan specific values in Line 47 is calculated as the product of Lines 30 through 46 for each specific plan. The overall "Impact of Plan Wide Adjustments" in Line 47, Column D is calculated as the weighted average of the plan specific values.

e. Line 43: "Premium Curve Adjustment"

Premium Curve (Slope) and CSR Loading Adjustments (Individual only):

2027 premium rates should be developed in the same manner as years past with the following exceptions:

1. Insurers should review their final premiums with any CSR Loading removed to determine if a Slope Adjustment (see below) is necessary. The Slope Adjustment (Line 43 of Exhibit 18) should occur as the second to last step (i.e., prior to applying a factor to Line 44 to account for the loss of CSR funding).
2. The CSR Loading adjustment should occur as the final step in the process so that CSR loading does not impact the premium slope.

Premium Curve (Slope) Adjustment:

Prior to finalizing rates, insurers should perform a check to determine if a Slope Adjustment is necessary. Final individual premium rates, prior to any adjustment for the loss of CSR funding, must conform to the following table:

	Minimum Relativity to Silver	Average Relativity to Silver	Maximum Relativity to Silver
Bronze	0.710	0.740	0.770
Silver	1.000	1.000	1.000
Gold	1.205	1.250	1.295
Platinum	1.460	1.520	1.580

To the extent that the Company's individual premium rates (adjusted to remove any CSR loading) do not conform to the above table, an adjustment will need to be made and incorporated into Line 43 of Exhibit 18. For purposes of determining whether a slope adjustment is necessary, the following should be considered:

1. For each of the Company's Bronze, Silver, Gold, and Platinum tiers, calculate the relativity of each plan's single adult premium rate to that of the most appropriate corresponding silver plan premium rate. This should be done by using appropriately comparable plans across metal tiers (e.g., plans that are comparable per the categories listed in Columns 9 – 21 of Exhibit 23). To the extent a comparable plan in a particular metal level does not exist, an appropriate interpolation will need to be made. Any such interpolation should be fully explained and actuarially justified in the Actuarial Memorandum. All other things being equal, the relativity between a non-silver plan to the corresponding silver plan should fall into the ranges prescribed in the table above. To the extent this is not the case, a factor will need to be included in Line 43 of Exhibit 18. For a given plan, the magnitude of the factor should represent the adjustment that

is necessary to bring the slope of the plan into minimal compliance (i.e., any adjustments should result in differentials that represent one of the endpoints of the applicable range).

a. For purposes of this aspect of the calculation:

i. Tiered network plans should be handled separately (i.e., the relativity between a tiered network bronze plan should maintain a relativity between 0.710 and 0.770 to a tiered network silver plan, all other things being equal).

ii. For HSA plans, any deviation from the prescribed relativities to Silver should be fully explained and actuarially justified in the Actuarial Memorandum.

iii. The Actuarial Memorandum should include a listing of any plans that have been excluded from the company's slope analysis as well as the rationale for doing so.

2. Apply a uniform factor to all the Company's premium rates that eliminates any rate impact which results from applying Step 1. This adjustment should also be included in Line 43 of Exhibit 18 and should result in Cell D-82 (Line 43 Column D) being equal to 1.0000.

f. Line 44: "Adjustment to add CSR Payments on the Plan Level (A common factor to be applied uniformly to all silver plans only - if applicable)"

The impact of the loss of CSR funding should be applied uniformly to all silver plans in Line 44 of Exhibit 18. **This factor should be applied as the final step in the rate development process so that the slope adjustment is not impacted by this step.**

IMPORTANT NOTE: The impact of CSR loading should be removed from the 2025 experience data in Line 13A of Exhibit 18. Therefore, this step does **not** need to be performed on a revenue neutral basis as was required in past years.

g. Line 45 is intended to account for distribution by rating region of a particular plan. This line is intended to ensure that the weighted average PMPM value in Line 56 Column D (Cell D-112) matches the value in Cell Z-74 of Exhibit 13c.

h. Expenses should be split by fixed versus variable as indicated in Column C of the "Expenses" Section. Fixed expenses should be expressed as a PMPM value and variable expenses should be expressed as a percentage of overall premium. See Item 2 in the "Additional Notes" Section below.

i. Line 54 should be populated with actual 2026 PMPM rates for each of the respective plans and Line 55 should be populated with actual membership as of 3/31/2026.

j. The values in Line 56 are determined as: (Line 49 + Line 50) / (1- Line 51 – Line 52)

Additional Notes

1. Additional benefits (e.g., OON, Non-EHB) should be backed out of the experience data by entering an adjustment factor in Line 13. **The adjustment should be fully explained and justified in the Actuarial Memorandum.**

2. Information in Lines 50 - 52: Administrative Expense and Profit: Any variable expenses should be expressed as a constant percentage value that is the same for all plans. Likewise, any fixed expenses should be expressed as a constant PMPM value that is the same for all plans. Additionally, all expense and profit must be reflected in Lines 50 – 52, and must be consistent with Exhibit 18 Supplement.
3. See Appendices A and B for additional details regarding the general rate development process.

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

Exhibit 18 – Supplemental Exhibit

The purpose of the supplemental Exhibit is to provide additional details and support for the "Expenses" Section of the "18" tab.

This Exhibit requests both actual and proposed expense data from past years for comparison purposes.

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 2026 to calendar year 2027; and
b. From calendar year 2025 to calendar year 2026; and
c. From calendar year 2024 to calendar year 2025.

As noted on the Instructions tab of this Exhibit, actual allowed amounts are requested for 2025. These 2025 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 2024 to 2025, 2025 to 2026, and 2026 to 2027) 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.

Exhibit 21 will not be posted on our website.

Consistent with Exhibits 17 and 18, Small Group Healthy New York experience should be included.

This Exhibit is applicable to Prior Approval Adjustment filings only.

Exhibit 22 - Medical and Hospital Utilization:

This Exhibit has been modified to ensure more consistent reporting across insurers to better isolate the various cost drivers.

a. The Exhibit now includes separate tabs for "Non-Capitated-Setting", "Non-Capitated-Service", "Capitated-Setting", and "Capitated-Service" claims. Non-Capitated claims should be reported separately from Capitated claims in the respective tabs.

b. The “Non-Capitated” tabs of the Exhibit should be populated using the Company’s 2025 and 2024 EDGE data (i.e., companies should not simply copy the 2024 values from last year).

c. For purposes of populating Columns 6-8 and 15-17 in the ”Non-Capitated-Service” tab of the Exhibit, the SQL code provided by DFS should be used. This code can be found on our website in the same location as the 2027 Exhibits.

d. For purposes of populating Columns 6-9 and 16-19in the “Non-Capitated Setting” tab of the Exhibit, the SQL code provided by DFS should be used. This code can be found on our website in the same location as the 2027 Exhibits.

e. Any capitated claims should be reported in the “Capitated…” tabs of the Exhibit in a manner that is consistent with how the amounts were determined (e.g., allocated based on membership to any relevant Column 5 categories).

    - Insurers should first separate allowed amounts using the SQL code (as a reference), then as a second step, develop “Number of Services” counts in a manner that results in the service counts being consistent with how the allowed amounts were separated into the various categories.

f. The member months reported in cells J3/T3 (Setting tabs) and I3/R3 (Service tabs) should represent the Company's total member months for each respective year.

This exhibit requires details regarding the medical/hospital services provided in the Individual and Small Group Markets, separately for calendar years 2025 and 2024.

Information requested includes:

a. Number of Claims (Setting tabs only)
b. Number of Services
c. Amounts of Allowed Charges
d. Amounts of Paid Charges
e. Member Months

All other data fields in the exhibit are calculated with formulas.

Consistent with Exhibits 17 and 18, Small Group Healthy New York experience should be included.

This Exhibit is applicable to (a) Prior Approval Adjustment filings only.

Exhibit 23 - Summary of Requested 2027 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 as well as to facilitate the mapping of premium rates in the Rate Manuals to the premium rates in the Binder filings. This Exhibit is applicable to both (a) Rate and Form filings and (b) Prior Approval Adjustment filings.

Information requested includes:

a. Company Name; and
b. NAIC Code; and
c. SERFF Filing Number; and
d. Market (i.e., Individual or Small Group); and
e. HIOS ID Number (16 Digit), both current and previous if applicable **(Note that any change in HIOS numbers needs to be explained in the Actuarial Memorandum)**; and
f. Metal Level (Including Catastrophic plans); and

g. "On" or "Off" Exchange/CSR Type; and
h. Standard or Non-Standard plan design; and
i. Limiting age (i.e., 26 or 30); and
j. Domestic Partner coverage indicator; and
k. Family Planning coverage indicator; and
l. Pediatric Dental coverage indicator; and
m. Out of network coverage benefits indicator; and
n. Additional benefits in addition to EHB indicator; and
o. Healthy New York indicator; and
p. Child-Only Plan indicator; and
q. Tiered Network indicator; and
r. HSA indicator; and
s. PNDS identifier; and
t. Company Network identifier; and
u. Premium Rates by Standardized Rating Region (2024 - 2027); and
v. Member Months by Standardized Rating Region by calendar year (2024 and 2025); and
w. Actual member counts as of 3/31/2026 – all members; and
x. Actual member counts as of 3/31/2026 – only those members currently enrolled in 2026 plans that will continue to be offered in 2027; and
y. Actual member counts as of 3/31/2026 – only those members currently enrolled in 2026 plans. **Item (y) applies to Small Group Only.**

Regarding Items (s) and (t) above:

1. Column 20: "PNDS Identifier" – This field should be populated with the 4-digit code used to identify the network associated with the plan in question as reported in New York's PNDS system.
2. Column 21: "Company Network Identifier" – This field should be populated with the specific network identifier used internally by the Company.

These fields are intended to help us understand how many distinct networks are used by the Company, as well as to identify which plans are associated with each specific network. We will use these fields as an additional tool for which to evaluate the Company's premium slope.

For Individual plans, the premium rates are the requested 2027 calendar year rates for the Single Adult Rating Tier only.

For Small Group plans, the premium rates are the first quarter requested 2027 rates for the Single Adult (Subscriber) Rating Tier.

All plans are to be included in this Exhibit (as opposed to just the base plans).

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

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions for the Filing of 2027 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, standardized rating regions, 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 risk adjustment program (However, for most Exhibits claims should be reported ignoring federal risk adjustment).

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, 2027 and is expected to be revised for January 1, 2027. The rate applicability period for this table is January 1, 2027 through December 31, 2027.

   (ii) Example 2 (Small Group Plans): A quarterly rolling rate table is developed for issues and renewals in January – March 2027 and incorporates a 12-month rate guarantee period. The rate applicability period for this table is January 1, 2027 through March 31, 2027.

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 (e.g., 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).

APPENDIX A

General Overview of Pricing Development:

For purposes of developing individual and small group premium rates, the following process must be followed. Additional details are provided in Appendix B below.

1. For each In-force plan-design, determine the applicable Metal Level, using the HHS AV Calculator.
2. For each In-force plan design, determine the AV Pricing Value with the restrictions mentioned in Section H (Induced Demand) above.
3. 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.
4. For all in-force plans combined, determine the Average PMPM Incurred Claims for the latest experience period (without any adjustment for Healthy New York Stop-Loss Reimbursements or any other reinsurance/stop-loss arrangements).
5. Project the average PMPM Incurred Claims in (4) 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 2027).
6. 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.
7. 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 (6) 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
8. Determine the PMPM rates for each plan based on (7) 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.
9. The process described above is simplified and does not discuss details by (a) Rating Tiers, (b) Rating Regions, and (c) Applicable Effective Quarters. These items are addressed in Appendix B.

APPENDIX B

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 is included in Appendix A (note the restriction on Induced Demand). This process includes:

1. Average PMPM Incurred Claims for the latest experience period (1/1/2025 – 12/31/2025, 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 Appendix C below. The Actuarial Memorandum must explain how the Company developed its adjustment for the Federal Risk Adjustment.
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 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. Administrative Expense and Profit values may not vary by plan level, Metal Tier, or 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 rating tiers 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 Rating Tier factors in Section M 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 rating tiers 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 2027 are determined by applying the appropriate trend rate.

APPENDIX C – Market-Wide and Plan-Level Adjustments:

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:

1. Impact of adjusting experience period data to EHB (Essential Health Benefits) level (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).
2. Adjustment to remove CSR payments.
3. 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.
4. Impact of provider fee schedule changes.
5. Impact of utilization management changes.
6. Market wide adjustment for impact on claim costs from quality improvement and cost containment initiatives.
7. Impact of medical inflation (i.e., trend).
8. Total expected market-wide payments and charges under the federal risk adjustment.
9. Impact of adjustments for the experience period claim data not being sufficiently credible.
10. Impact of anticipated changes in the distribution of membership in the risk pool across the standard rating regions.
11. Change in morbidity not reflected in the experience data that is known and quantifiable at the time of the rate filing.
12. Impact of Covered Lives Assessment.
13. Adjustment to add the 200-250% FPL population (which is expected to return for all of 2027).
14. Impact of GLP-1 Drugs (Expected change in costs between experience period and pricing period. Note that amounts reflected in this line should NOT be included in the trend reported in Line 19 to avoid double-counting).
15. Impact of NYS Legislative changes (only those not reflected in the experience data already).
16. Impact of the expiration of enhanced Premium Tax Credit (ePTC) subsidies.
17. Adjustments that may be necessary to account for the fact that the final 2027 NBPP was different from what was originally proposed that are not already reflected elsewhere).

Plan-Level Adjustments:

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

1. The actuarial value and cost-sharing design of the plan (e.g., based on the various Pricing AV Values).

2. The Company's provider network, delivery system characteristics, and utilization management practices specific to that plan beyond what is reflected in the index rate.
3. Impact on claim costs from quality improvements and cost containment initiatives.
4. 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.
5. Impact of eligibility categories (Catastrophic plans only).
6. Addition of Out-of-Network Benefit Option (e.g. POS or PPO).
7. The anticipated Stop Loss reimbursements from New York State for Small Group Healthy New York plans (Small Group only).
8. The impact of the inclusion or non-inclusion of common plan variations (i.e., Family planning, dental, coverage to age 29, domestic partner coverage).
9. Expenses - Administrative costs and provisions for Profit or Contribution to Surplus margins (See the "Expenses" Section of Exhibit 18).
10. Impact of any necessary adjustments to the Premium Curve. Any necessary factors should be included in this line to ensure that appropriately comparable plans across metal tiers (e.g., plans that are comparable per the categories listed in Columns 9 – 21 of Exhibit 23) comply with the prescribed slope requirements.

(a) Impact of loss of CSR Funding – This should be a uniform factor that is applied to silver plans only.

(b) Rating Region Factor – This line is intended to capture plan distribution differences across regions that would otherwise result in the value in Line 56, Column D (Cell D 112) of Exhibit 18 being different from Cell Z-74 of Exhibit 13c (i.e., Cell D-112 of Exhibit 18 should be the same as Cell Z-74 of Exhibit 13c).

APPENDIX D – Instructions for Creating Searchable AV Screen Shots:

First, from the **Page Layout** ribbon, click **Orientation**, and then select **Landscape**

The next step is to choose a method of creating text-searchable PDF files. It depends on whether or not Adobe Acrobat Professional is installed.

Method 1:

If Adobe Acrobat Professional is not installed, print only **the AV Calculator sheet** (not Output sheets, which are images) as a text-searchable PDF file by the following steps,

1. Go to **File**, then **Print.**
2. Select **Microsoft Print to PDF** from **Printer.**
3. Set the scaling option to **Fit Sheet on One Page.**
4. Click **Print.**
5. In **the Save Print Output As** dialog box, specify a filename and location for the PDF.
6. Click **Save** to create the PDF.

Method 2:

If Adobe Acrobat Professional is installed, the options for creating text-searchable PDFs are available from **the Acrobat ribbon in Excel** as follows:

1. From the **Acrobat** ribbon, select **Create PDF**.
2. In the **Acrobat PDFMaker** dialog box, select **Sheet(s)** in **Conversion Range**, add the **AV Calculator** sheet or the **Output** sheets in **Sheet Selection**, select **Fit Worksheet to a single page** in **Conversion Options**, then click **Convert To PDF**.
3. In the **Save Adobe PDF File As** dialog box, specify a filename and location for the PDF.
4. Click **Save** to create the PDF.

If Acrobat Ribbon is not available in Office 2016 or Office 365 applications on Windows, please search for "**Troubleshoot Acrobat PDFMaker issues in Microsoft Office on Windows**" in Adobe Help Center (https://helpx.adobe.com/support.html).

Requirements for the AV Screenshot document

1. Only text-searchable PDFs generated from the **AV Calculator** sheet or **output** sheet are needed. Please do not add a cover page or a table of contents page
2. Plan HIOS ID must be entered in **cell E40** (right to the Plan HIOS ID cell) in the **AV Calculator** sheet.
    a. When entering multiple HIOS IDs in cell E40, the HIOS IDs are separated by space or comma.

b. The last HIOS ID should not cross the right border of the calculator, otherwise it will be truncated in the output sheet.

3. No additional information should be added to the AV Calculator sheet, except in the following circumstances:

   a. A health plan's design is not compatible with the AV Calculator. To enter the actuarial value for such a plan, enter below Row 53 of the AV Calculator sheet the information beginning with the word "**Adjusted Actuarial Value:**" and then followed by the actuarial value in percentage format.

   b. Enter more HIOS IDs below Row 53 of the AV Calculator sheet. The entry should begin with "**Additional Plan HIOS ID:**" and follow by HIOS IDs, which are separated by space or comma, and the last HIOS ID should not cross the right border of the calculator.

   c. For these two circumstances, the text-searchable PDF of a screenshot must be generated only from the **AV Calculator** sheet.

4. The column width and font size in the AV Calculator sheet should not be changed.

5. The AV Screenshot page must not be rotated.

6. The naming convention for the filename should contain the following components:

   a. Company Name (a very short version is fine)

   b. Market (Ind or SG)

   c. Document Type (**AV Screenshot,** or **AV Certification** for the certification required by section 156.135 (b))

   d. As an example, for Anthem's Small Group filing, the filename for its AV Screenshots would **Anthem_SG_AV_Screenshot**, and the filename for its AV Certification would be **Anthem_SG_AV_Certification**.