

**NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES**

**Instructions for the Filing of 2017 Premium Rates  
Individual and Small Group – “On” and “Off” Exchange Plans**

**Table of Contents**

<b>A. General Introduction</b>	<b>Page 3</b>
<b>B. Essential Health Benefits</b>	<b>Page 3</b>
<b>C. Separate Rate Filings for On and Off Exchange Plans</b>	<b>Page 3</b>
<b>D. HHS Proposed Notice of Benefit and Payment Parameters for 2016</b>	<b>Page 3</b>
<b>D (a) Reinsurance Program for Individual Plans</b>	<b>Page 4</b>
<b>D (b) Patient-Centered Outcomes Research Institute (PCORI) Fees</b>	<b>Page 4</b>
<b>D (c) Changes in Deductibles and Maximum Out of Pocket Limits</b>	<b>Page 4</b>
<b>D (d) ACA Fees</b>	<b>Page 4</b>
<b>E. New York State Standard Benefit Design</b>	<b>Page 4</b>
<b>F. Actuarial Value (AV) Metal Values</b>	<b>Page 4</b>
<b>G. Actuarial Value (AV) Pricing Values</b>	<b>Page 5</b>
<b>H. Induced Demand</b>	<b>Page 5</b>
<b>I. Single Risk Pool / Index Rate</b>	<b>Page 6</b>
<b>J. Market-Wide Index Rate Adjustments</b>	<b>Page 6</b>
<b>K. Plan-Level Adjustments</b>	<b>Page 7</b>
<b>L. Standardized Rating Regions</b>	<b>Page 7</b>
<b>M. Claims Experience Data</b>	<b>Page 7</b>
<b>M (a) Small Group Exchange Plans</b>	<b>Page 7</b>
<b>M (b) Individual Exchange Plans</b>	<b>Page 8</b>
<b>N. Small Group Healthy New York Plans</b>	<b>Page 8</b>
<b>O. Standardized Census Tiers</b>	<b>Page 8</b>
<b>P. Child Only Plans (Individual Exchange Plans Only)</b>	<b>Page 8</b>
<b>Q. HHS Rate Filing Requirements</b>	<b>Page 9</b>
<b>R. General Overview of Pricing Development</b>	<b>Page 9</b>
<b>S. Material to be Included in Rate Filing</b>	<b>Page 10</b>
<b>(a) Exhibit 11</b>	<b>Page 10</b>
<b>(b) Exhibits 13A-13c</b>	<b>Page 10</b>
<b>(c) Exhibit 14</b>	<b>Page 10</b>
<b>(d) Exhibit 16</b>	<b>Page 10</b>
<b>(e) Exhibit 17</b>	<b>Page 10</b>
<b>(f) Exhibit 18 (and Exhibit 18 Supplement)</b>	<b>Page 10</b>
<b>(g) Exhibit 19</b>	<b>Page 10</b>
<b>(h) Exhibits 21A-21B</b>	<b>Page 10</b>
<b>(i) Exhibit 22</b>	<b>Page 10</b>
<b>(j) Exhibit 23</b>	<b>Page 10</b>
<b>(k) Exhibit 25</b>	<b>Page 10</b>
<b>(l) AV Calculations (Snapshots)</b>	<b>Page 10</b>
<b>(m) Quality Improvements</b>	<b>Page 11</b>
<b>T. Actuarial Memorandum</b>	
<b>T(a) Process in Development of Index Rates and Premium Rates</b>	<b>Page 11</b>
<b>T(b) Supporting Details on the Material Assumptions</b>	<b>Page 12</b>

<b>U. Rate Manuals</b>	
<b>U (a) Premium Rate Manuals – General Instructions</b>	<b>Page 14</b>
<b>U (b) Premium Rate Manuals – Required Items</b>	<b>Page 14</b>
<b>U (c) Premium Rate Manuals – Prescription Drug Premium Rates</b>	<b>Page 15</b>
<b>U (d) Premium Rate Manuals - Adjustments for the Age 29 Rider</b>	<b>Page 15</b>
<b>U (e) Premium Rate Manuals - Adjustments for Pediatric Dental</b>	<b>Page 15</b>
<b>U (f) Premium Rate Manuals –Presentation</b>	<b>Page 15</b>
<b>V. Actuarial Memorandum - Actuarial Qualifications</b>	<b>Page 15</b>
<b>W. Actuarial Certification</b>	<b>Page 16</b>
<b>X. Objection Letters</b>	<b>Page 16</b>
<b>Y. Additional Requirements</b>	<b>Page 16</b>
<b>Y (a) Filing Type Codes</b>	<b>Page 16</b>
<b>Y (b) Format of Attachments</b>	<b>Page 17</b>
<b>Y (c) SERFF/HHS Requirements</b>	<b>Page 17</b>
<b>Y (d) Filing Amendments</b>	<b>Page 17</b>
<b>Z. Other Miscellaneous Items</b>	
<b>Z (a) Membership Survey as of 3/1/2015</b>	<b>Page 17</b>
<b>Z (b) Minimum Loss Ratio</b>	<b>Page 18</b>
<b>Z (c) Minor/Major Changes in Benefits</b>	<b>Page 18</b>
<b>Z (d) Uniform Rate Review Template (URRT)</b>	<b>Page 18</b>
<b>Z (e) Rate Review Detail Data (R2D2)</b>	<b>Page 19</b>
<b>Z (f) Dental Coverage</b>	<b>Page 19</b>
<b>Instructions – Definitions</b>	<b>Page 20</b>
<b>Additional Instructions regarding Exhibits to be Included in Rate Filings</b>	
<b>General</b>	<b>Page 21</b>
<b>Exhibit 11 General Information about the Rate Filing</b>	<b>Page 21</b>
<b>Exhibit 13A-13C Numerical Summary, Rate Indication Calculation, etc.</b>	<b>Page 21</b>
<b>Exhibit 14 Summary of Requested Percentage Changes</b>	<b>Page 23</b>
<b>Exhibit 16 Summary of Policy Form and Product Changes</b>	<b>Page 23</b>
<b>Exhibit 17 Historical Claim Experience Data by Policy Forms</b>	<b>Page 23</b>
<b>Exhibit 18 Index Rate /Plan Design Adjustment Worksheet</b>	<b>Page 26</b>
<b>Exhibit 18 Supplement</b>	<b>Page 28</b>
<b>Exhibit 19 Summary of Claim Trends, Admin. Costs and Profit Margins</b>	<b>Page 28</b>
<b>Exhibit 21 Hospital Unit Cost Development</b>	<b>Page 30</b>
<b>Exhibit 22 Medical and Hospital Utilization</b>	<b>Page 30</b>
<b>Exhibit 23 Summary of Requested 2016 Premium Rates</b>	<b>Page 31</b>
<b>Exhibit 25 Adjustment Factors for Major Variations from the Base Plan</b>	<b>Page 32</b>
<b>Filing Types</b>	<b>Page 32</b>
<b>Required Exhibits by Filing Type</b>	<b>Page 33</b>

## NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

These instructions apply to all rate filings submitted in calendar year 2016 for premium rates effective in calendar year 2017 for Individual and Small Group plans, both “On” and “Off” Exchange.

**For companies with 2016 rates on file in a particular market (i.e., Individual or Small Group), rate filings for calendar year 2017 are to be submitted pursuant to § 3231(e)(1) or § 4308(c) (Prior Approval Adjustment filings) for that market. Additional requirements, as specified by those Sections apply (e.g., notices of proposed rate changes to impacted policyholders at the time the rate filing is submitted, a notice of the approved rates to impacted policyholders 60 days prior to the effective date of renewal, specified time limits, etc.) Notices of proposed changes may be sent to policyholders after DFS has posted the rate applications. Note that for filings of this type, if the existing forms are being modified or if new plans are being introduced, then a separate Form Filing must be submitted. Both filings (i.e. the separate Rate and Form filings) must clearly reference each other by SERFF Filing Number.**

**For companies that do not have 2016 rates on file in a particular market, rate filings for calendar 2017 are to be submitted pursuant to § 3231(d) or § 4308(b) (Rate and Form filings) for that market.**

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

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

Note that the 2017 version of the rate filing exhibits released on 3/11/2016 must be used as they include updates from the previous year.

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

Companies must provide the Essential Health Benefits specified by the New York State Department of Health (DOH) for calendar year 2017.

### **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 (this is a departure from last year).

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.

### **Proposed Notice of Benefit and Payment Parameters for 2017:**

Generally speaking, HHS final requirements for 2017 are similar to 2016 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.

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

(1) Because the reinsurance program ends at the end of 2016, there should not be any provision for that program included in 2017 premium rates (i.e., in the form of expected reimbursements or fees);

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

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

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

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

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

For 2016, the HHS prescribed self-only coverage MOOP limit is \$7,150, and the family limit is \$14,300.

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

ACA fees include:

- (1) Risk Adjustment User fee of \$1.56 per member per year (or \$0.13 PMPM) in 2017; and
- (2) There should be no explicit fees for Exchange funding as the NYSOH is being funded using the existing HCRA mechanism.
- (3) Note that the ACA tax has been suspended for 2017. As such, this tax must not be reflected in 2017 Individual rates. With regard to Small Group, this tax may be reflected to the extent that policies written or renewed in 2017 roll into 2018 and to the extent that such amounts have not already been collected on the similar portion of business associated with policies written or renewed in 2016 that rolled into 2017.

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

Due to the changes in the Deductible and Maximum out of Pocket Limit provisions noted in Section D(c) above, several Standard Benefit Designs will require revision in order to meet the required AV criteria. We will notify plans of these changes in the near future.

**F. Actuarial Value (AV) Metal Values:**

Except for the impact of cost-sharing reduction subsidies, each product must fall within one of the following specified actuarial value (AV) levels based on cost sharing features of the product and determined using the HHS AV Calculator (2017 version must be used).

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

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

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

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

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

The AV Metal Values determine what metal level a particular plan-design belongs in, and the 2017 HHS Actuarial Value Calculator must be used in the calculation of these AV Metal Values.

The final version of the 2017 AV Calculator and accompanying documentation can be found in the following locations:

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-AV-Calculator-2017.xlsm>

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-AV-Methodology-012016.pdf>

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

(Within these Instructions, the actuarial values developed using the HHS Actuarial Value Calculator are referred to as the AV Metal Values, while the actuarial values developed for pricing are referred to as the AV Pricing Values.)

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

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

**Note: This is for pricing purposes only. All ACA Compliant plans must fall within the AV Metal Values using the 2017 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 2017 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 market as applicable. This requirement applies to health plans both inside and outside the Exchange for each of these markets. HHS regulations require each Company to determine the 'index rate' for the risk pool and make permissible adjustments, both Market-Wide (uniform for all plans) and Plan-Level (varying at the plan-design level) to the index rate.

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

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

Accordingly, the pricing basis used must be consistent with the assumption that the Individual, Small Group, or Catastrophic Market is one standard population, and that the entire population of that Market enrolls in a particular plan (i.e., The rating differential between plan-designs in a given metal tier or a given rating region cannot, in whole or in part, be based upon differences due to age, sex, occupation or health status among the actual or assumed enrollees in a particular plan-design).

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

#### **J. Market-Wide Index Rate Adjustments:**

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

- (a) Impact of compliance with Essential Health Benefits (e.g., some in-force plans may not include all of the required Essential Health Benefits, and some additional benefits may need to be eliminated);

- (b) Impact of changes in the provider network, fee schedule levels, or utilization management that apply to the entire market-wide risk pool not included in the claim trend;
- (c) Market wide adjustment for impact on claim costs from quality improvement and cost containment initiatives;
- (d) Impact of anticipated changes in the risk characteristics of the expected covered membership of the market-wide risk pool;
- (e) Impact of anticipated changes in the distribution of membership in the risk pool across the standard rating regions;
- (f) Total expected market-wide payments and charges under the Federal risk adjustment;
- (g) Impact of adjustments for the experience period claim data not being sufficiently credible;
- (h) Impact of other changes that affect the entire market-wide risk pool as detailed by the Company's actuary.

**K. Plan-Level Adjustments:**

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

- (a) The actuarial value and cost-sharing design of the plan (e.g., based on the various Pricing AV Values);
- (b) The Company's provider network, delivery system characteristics, and utilization management practices specific to that plan beyond what is reflected in the index rate;
- (c) Impact on claim costs from quality improvements and cost containment initiatives;
- (d) Benefits provided under the plan that are in addition to the Essential Health Benefits. Such additional benefits must be pooled with similar benefits and the associated claims experience utilized to determine the rate variations for plans that offer those additional benefits;
- (e) Administrative costs and provisions for Profit or Contribution to Surplus margins;
- (f) Addition of Out-of-Network Benefit Option (e.g. POS or PPO);
- (g) The anticipated Stop Loss reimbursements from New York State for Small Group Healthy New York plans;
- (h) Impact of other Plan-Level adjustments, as detailed by the Company's actuary.

**L. Standardized Rating Regions:**

The ACA requires standardized rating regions. The Standardized Rating Regions for New York have not changed for 2017. Companies may vary premiums between standardized rating regions in accordance with HHS regulations.

**M. Claims Experience Data:**

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

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

The Index Rate for Small Group must incorporate the claims experience of all of the Company's Small Group business including Small Group Healthy New York experience. Additional details are provided in the Instructions for Exhibit 17.

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

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

**M (b) Individual Plans:**

For companies currently participating in the Individual market, the premium rates for Individual plans should be based on the claims experience of the company's 2015 ACA Compliant Non-Grandfathered Individual (including catastrophic) plans only.

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

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

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

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

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

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

**O. Standardized Census Tiers:**

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

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

Census tier factors for calendar year 2017 are unchanged from 2016.

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

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

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

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

**Q. HHS Rate Filing Requirements:**

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

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

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

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

- (a) For each In-force plan-design, determine the applicable Metal Level, using the HHS AV Calculator.
- (b) For each In-force plan-design, determine the AV Pricing Value with the restrictions mentioned in Section H above.
- (c) For all in-force plans, determine the weighted-average “AV Pricing Value” and the weighted-average “Induced Demand” factor, using member months as weights (for the most recent experience period as submitted in Exhibit 17). The weighted-average AV Pricing Value should include the Induced Demand component.
- (d) For all in-force plans combined, determine the Average PMPM Incurred Claims for the latest experience period (without any adjustment for the 3Rs, Healthy New York Stop-Loss Reimbursements, or any other reinsurance/stop-loss arrangements).
- (e) Project the average PMPM Incurred Claims in (d) above for the impact of claim cost trend, from the mid-point of the experience period to the midpoint of the period for which the rates will be in effect (i.e., it should be assumed that individual rates will be in effect for a full calendar year and that small group rates will be in effect through the first quarter of 2017).
- (f) For all in-force plans combined, determine the “Index” PMPM applicable to all plans (“On” and “Off” Exchange) combined. This step reflects all Market-Wide adjustments.
- (g) Determine the provision for incurred claims for each plan (to be sold both “On” and “Off” Exchange) based on the Index PMPM Rate determined in (f) above, times (A) over (B), where (A) and (B) are:
  - A. The AV Pricing Value determined for each plan; and
  - B. The Average AV Pricing Value (per (c) above) for all in-force plans
- (h) Determine the PMPM rates for each plan based on (g) above, plus Plan-Level adjustments for administrative costs and profit margins and all other Plan-Level changes, not already reflected, as discussed above. Note that such adjustments may vary at the plan level.

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

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

To determine which Exhibits must be submitted with each of the two categories of “Filing Types”, refer to the “Required Exhibits by Filing Type” section of these instructions. Supplementary instructions are provided in subsequent pages for all Exhibits.

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

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

**(c) Exhibit 14 - Summary of Requested Percentage Changes:** Provides details as to the changes in premium rates between the approved 2016 premium rates and the requested 2017 premium rates as well as details regarding the distribution of rate changes.

**(d) Exhibit 16 – Summary of Policy Form and Product Changes:** Provides a summary of all benefit and rate changes filed after the initial rate filing which impact the rate tables in this filing.

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

**(f) Exhibit 18 (and Exhibit 18 Supplements) - Index Rate/Plan Design Level Adjustment Worksheet:** Summarizes all market wide and plan-level adjustments used in the development of the premium PMPMs for each plan to be sold. This Exhibit also summarizes the information in Exhibit 19 and compares actual to expected expenses for past years.

**(g) Exhibit 19 - Summary of Average Claim Trend and Administrative Expenses and Profit Margin:** Requires details supporting assumptions used for claim trend, administrative costs, and profit margin on a percent of premium basis. Two sets of assumptions are required, including the current set of assumptions for use in the determination of the 2017 premium rates, and those used to determine 2016 premium rates.

**(h) Exhibits 21A-21B - Hospital Unit Cost Development:** Requires details on average changes in the level of hospital charges, separately for the last three calendar years (2013-15), by provider, and separately for Inpatient services (Exhibit 21A) and for Outpatient Services (Exhibit 21B). These exhibits also require information on allowed claims.

**(i) Exhibit 22 - Small Groups Medical and Hospital Utilization Data:** Requires details for number of services, allowed charges and membership for the last three calendar years (2013-2015), by type of service.

**(j) Exhibit 23 - Requested 2017 Premium Rates:** Requires information on 2014-2017 premium rates and membership for all plans. Information is requested separately for Small Group and Individual plans by metal level and rating region.

**(k) Exhibit 25 – Adjustment Factors for Major Variations from the Base Plan:** The purpose of this Exhibit is to provide the factors used to add/subtract major plan variations and provide a summary of the experience split out by the various rating factors

**(l) AV Calculations (Snapshots):** As an attachment to the Actuarial Memorandum, provide printouts of all AV calculation pages (snapshots) using the final HHS 2017 AV Calculator for all plans

covered by the rate filing. Each page should clearly indicate the HIOS ID so that DFS can cross check the calculator input to the cost sharing parameters for that particular plan-design.

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

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

**(m) Quality Improvements:**

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

**T. Actuarial Memorandum:**

This section is divided into two subsections:

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

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

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

1. Average PMPM Incurred Claims for the latest experience period (1/1/2015 – 12/31/2015, with 2 months of claim run-out) for all non-grandfathered in-force plans combined. Discuss whether any particular products were excluded and the rationale for doing so.
2. Average AV Pricing Value determined for all in-force plans in effect during the latest experience period, based on member-months in the experience period for each in-force plan. Note that this average AV Pricing Value reflects the impact of Induced Demand.
3. Average Induced Demand Adjustment factor determined based on member-months in the experience period for each in-force plan. Note that this should be the value that has already been reflected in step (2) above.
4. Assumptions for all components of claim trend, including inflation, utilization, leverage, and other factors.
5. The factor used to project the assumed underlying claim trend from the midpoint of experience period to midpoint of the period for which the proposed rates will be in effect.
6. Projected Average PMPM Incurred Claims determined from steps (1) and (5) above.
7. Market-wide index rate adjustments as discussed in Section J above. The Actuarial Memorandum must explain how the Company developed its adjustment for the Federal Risk Adjustment.

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. Plan-Level Adjustments for Administrative Expense and Profit Margin per Exhibit 19. Note that such adjustments may vary at the plan level and by Metal Tier, but not by rating region.
12. Determine preliminary PMPM Premium Rate for each plan ((12) = {(10) / [1.00 – (11)]}).
13. Calculate final premium rates (for all Regions combined) for the various rating tiers that are required in New York: A conversion factor (i.e., to convert PMPM rates to Individuals/Employees premium rates, etc.) must be developed and fully explained in the Actuarial Memorandum. Such conversion factor must be based on the distribution of members and subscribers (individuals/employees) by census cells during the experience period used in step (1) above as modified by the Market-Wide Index Rate Adjustment for such anticipated changes with support for such anticipated changes included in the Actuarial Memorandum.
14. Calculate final premium rates (all regions combined) for all plans based on the Standardized Census Tier factors in Section O above. The Actuarial Memorandum must clearly outline the development of the conversion factor used to convert preliminary rates to final rates. Such conversion factor must be based on the distribution of enrollees by census cells during the experience period as modified by the Market-Wide Index Rate Adjustment for such anticipated changes with support for such anticipated changes included in the actuarial memorandum.
15. Final Premium rates for Small Group plans for subsequent quarters in calendar year 2017 are determined by applying the appropriate trend rate (such trend rate should be consistent with the trend rate in Exhibit 19).

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

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

1. Assumptions used for **trend**, all components, including inflation, utilization, leverage impact and other factors as applicable, including (if available) information on claim trend rates for allowed charges;
2. Justification for the assumed utilization, unit cost and composite annual trend factors. Discuss the impact and provide justification for any case mix change, intensity of service change,

population/demographic (aging) change, adverse selection, or deductible leveraging component incorporated into the utilization and/or unit cost trend factor components that is not part of the Market-Wide Index Rate Adjustments;

3. Assumptions used for **administrative expense**, including (a) an explanation of changes in Exhibit 19 expense components from the prior year, and (b) a reconciliation with information on administrative costs reported in latest financial statements;
4. Assumptions for **profit** and contribution to surplus, including a discussion pertaining to Return on Equity;
5. Details regarding **adjustments to Actuarial Values** produced by the HHS AV Calculator;
6. Details regarding **conversion factors** used to convert Preliminary PMPM Rates to actual premium rates for each of the Standardized Census Tiers prescribed by DFS. This should include information on the distribution of both individuals/subscribers and members by the various census cells.
7. Details regarding how premium rates are determined for **standardized rating regions**. Companies must determine factors for all applicable standardized rating regions to arrive at premium rates by rating region and address the following:
  - a. Details must be provided in support of the regional factors.
  - b. Confirm that such regional factors are in compliance with HHS regulations must be provided (i.e., that they do not reflect regional differences in age, sex, occupation or health status. Regional factors may reflect differences in Provider Network Characteristics, Delivery System Characteristics, and Utilization Management Practices).
8. Details regarding how the Company determined its AV Pricing Values, including but 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.
9. Support for adjustments to the premium rates for the impact of **Federal risk adjustment**.
10. Details supporting any **material pricing ratios used for morbidity**.
11. There should be no inconsistencies between the information in the Actuarial Memorandum and the information contained in Exhibit 18 (Index Rates).
12. Support for adjustment factors used for **Out-of-Network benefits**.
13. Support for any **significant premium rate differences** between plans in the same metal level.
14. Details must be provided on any **Propriety Studies** used to develop or modify premiums rates covered by this filing.
15. Details need to be provided on any adjustments introduced under the category of **"Management Adjustments"**, including justification that such adjustments are in compliance with HHS regulations.
16. Details and support for any **other adjustments** deemed necessary by the Company's actuary.
17. 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.

## **U. Rate Manuals:**

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

Rate manuals must be submitted with the rate filings.

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

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

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

The rate manuals must include premium rates for standard and non-standard plans, all applicable Standardized Census Tiers, and all applicable Rating Regions. Small Group rate manuals must include premium rates for all quarters during calendar year 2017.

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

Rate manuals must include the following items:

1. Table of Contents;
2. Insurer/corporation name on each consecutively numbered rate page;
3. Identification by form number of each policy, rider or endorsement to which the
4. rates apply;
5. Commission Schedule and/or Fees;
6. An expected loss ratio page. The expected loss ratio is to be calculated using the
7. traditional New York State methodology (not the Federal rebate methodology) as outlined in Circular Letter 15 from 2011:  
[http://www.dfs.ny.gov/insurance/circltr/2011/cl2011\\_15.pdf](http://www.dfs.ny.gov/insurance/circltr/2011/cl2011_15.pdf);
8. 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);
9. A detailed description of the cost sharing provisions applicable to each plan-design, including details on prescription drugs;
10. The base premium rate for a plan with the following characteristics:
  - a. with “Coverage through Age 26 only”; and
  - b. with “Family Planning Coverage”; and
  - c. with “Domestic Partner Coverage”; and
  - d. without “Pediatric Dental Coverage”.
11. Factors must be provided for the following major variations:
  - a. with “through Age 29 Coverage”; and
  - b. without “Family Planning Coverage”; and
  - c. without “Domestic Partner Coverage”; and
  - d. with “Pediatric Dental Coverage”.
12. The Standardized Census Tiers and accompanying factors as prescribed by DFS must be included.
13. Factors for Geographic Rating Regions must be included.

14. A listing of the counties included in each region in which the Company plans to market each of its products;
15. Other information as applicable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**V. Actuarial Memorandum - Actuarial Qualifications:**

- (a) 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.

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

- (a) The filing is in compliance with all applicable laws and regulations of the State of New York;
- (b) The filing is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including but not limited to:
  - ASOP No. 5, Incurred Health and Disability Claims
  - ASOP No. 8, Regulatory Filings for Health Plan Entities
  - ASOP No. 12, Risk Classification
  - ASOP No. 23, Data Quality
  - ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
  - ASOP No. 41, Actuarial Communications
  - 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.

**X. Objection Letters:**

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

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

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

**Y. Additional Requirements:**

**Y (a) Filing Type Codes**

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

Prior Approval Rate Adjustment Filings (Companies with 2016 rates on file):

“2017 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. This is a departure from previous years.

Rate and Form Filings (Companies that do not have 2016 rates on file):

“Exchange Forms & Rates” for “On” Exchange plans; and

“Off Exchange Forms & Rates” for “Off” Exchange plans.

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

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

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

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

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

**Y (d) Filing Amendments:**

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

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

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

**Z. Other Miscellaneous Items:**

**Z (a) Membership Survey as of March 31, 2016:**

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

**Z (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:

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

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

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

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

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

**Z (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 2016, 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 2016, rate filings for premium rates to be effective in calendar year 2017 will be handled as Rate and Form filings under Insurance Law § 3231(d) or § 4308(b), as described in Section A (General Introduction) above.

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

Care should be exercised in the preparation of 2017 filings to ensure consistency between values for the items noted above.

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

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

In the past, DFS has raised several objections with regard to 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 PMPM rates (they should be expressed as annualized premium rates);
- (5) Screen shows “N/A” under “Forms, Affected Forms and Other Affected Forms”; items must be left blank if they do not apply (i.e., making an entry implies the form is impacted);
- (6) Requested Rate Period data is all 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 2017 premium rate filings, the Rate Review Detail must be completed in a manner that is consistent with prior years.

**Z (f) Dental Coverage**

Instructions for Dental filings will be available on our website.

**NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES**

**Instructions for the Filing of 2017 Premium Rates**

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

**Instructions – Definitions:**

- a. **ACA Compliant** data means the data associated with plans which are subject to the market reforms that went into effect on 1/1/2014 such as the EHB, Metal Tiers, AV, etc. By Non-ACA Compliant, we mean those plans that are Non-Grandfathered which are not subject to the market reforms that went into effect on 1/1/2014.
- b. **Company** refers to the licensed entity (distinct NAIC Number) providing the insurance coverage reflected in the rate filing.
- c. A Company’s **commercial book of business** includes all of the following: large group, Small Group, Individual, Healthy New York, and Medicare Supplemental. It excludes all government programs, such as, Medicare, Medicaid, Family Health Plus, and Child Health Plus.
- d. **Loss ratio** refers to incurred claims divided by earned premiums for a given period of time. Incurred claims include the covered lives assessments, and the HCRA surcharge. Incurred claims do not include any administrative expenses, including “quality improvement expenses” or “community benefit expenses”. Earned premiums do not include any adjustment for assessments or taxes. For ACA compliant plans, incurred claims include the impact of the federal reinsurance and risk adjustment programs (However, for most Exhibits claims should be reported ignoring the 3Rs).
- 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, 2017 and is expected to be revised for January 1, 2018. The rate applicability period for this table is January 1, 2017 through December 31, 2017.
  - (ii) Example 2 (Small Group Plans): A quarterly rolling rate table is developed for issues and renewals in January – March 2017 and incorporates a 12 month rate guarantee period. The rate applicability period for this table is January 1, 2017 through March 31, 2018.
- 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).

**NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES**

**Instructions for the Filing of 2017 Premium Rates  
Individual and Small Group,  
“On” and “Off” Exchange Plans**

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

**General**

Summary information was provided in the Instructions above. Additional instructions for each Exhibit are provided in this section regarding their applicability to Individual and Small Group filings.

Instructions are also provided at the end of this section regarding required exhibits for Rate and Form filings.

**For a given Market, 2017 proposed rates for “On” and “Off” Exchange business must be submitted as a combined filing as opposed to submitting two separate filings. This is a departure from previous years.**

**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. This is a departure from previous years.**

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

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

This exhibit provides general information about the rate filing.

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

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

**Exhibit 13A - Numerical Summary and Rate Indication Calculation, Exhibit 13B - Narrative Summary and 13C – Average Premium Details**

Exhibit 13 has been split into three separate Exhibits (13a, 13b and 13c). The Numerical Summary portion (Exhibit 13a), which includes a high-level rate indication calculation. Exhibit 13b is a placeholder for the “Narrative Summary”. The Narrative Summary is intended to be a plain English description of the rate change and the reasons for such. Exhibit 13c shows the development of the weighted average premiums.

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

Additional Details:

A. Average 2016 and 2017 Base Premium Rates:

This information needs to be completed for all rate filings, separately for both Individual and Small Group plans. The average premium rates are to be determined as the member weighted average (not member month) of all premium rates for the applicable metal level plan described

in Lines 31 and 32 of Column L of Exhibit 13a (i.e., These values should come from the appropriate cells in Exhibit 13c), for all plans, both On and Off, and for all regions combined.

B. Weighted Average Annual Percentage Adjustments (2016 to 2017):

This information needs to be completed for all rate filings, for both Individual and Small Group plans. This information comes from Exhibit 13c as indicated in cell j-38 of Exhibit 13a.

C. Weighted Annual Percentage Adjustments (Prior Years):

This information needs to be completed for both Individual and Small Group filings. Note that calculation of rate adjustments between years 20XX and 20XX+1 should be based on membership as of 12/31/20XX.

D. Average Medical Loss Ratios for 2013-15:

For Small Group plans, enter the MLRs as illustrated in the current year Exhibit 17. For Individual plans, the 2013 value should be provided to the extent available, the actual 2014 value should be provided, and an estimated 2015 value should be provided (estimates should be consistent with the information provided within the 2017 rate filing).

E. Claim Trend Rates and Ratios to Earned Premiums (2015-2017):

E 1 Claim Trend Rates (2015-2017):

For Individual and Small Group plans, enter the claim trend rates used for 2017 and 2016 as illustrated in the current year Exhibit 19. For 2015, enter the claim trend rate for 2015 as illustrated in Exhibit 19 of the Prior Approval rate filing submitted in calendar year 2014 for premium rates effective in 2015. If not applicable, enter "N/A".

E 2 Ratios to Earned Premiums (2015-17):

For Individual and Small Group plans, enter the various ratios as illustrated in the current year Exhibit 19, for 2016 and 2017; for 2015, enter the ratios in Exhibit 19 of the Prior Approval rate filing submitted in calendar year 2014 for premium rates effective in calendar year 2015. If not applicable, enter "N/A".

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

F. This Exhibit is only applicable to Prior Approval Adjustment filings. 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:

- a. With "Through Age 26" coverage; and
- b. With Family Planning coverage; and
- c. With Domestic Partner coverage; and
- d. Without Pediatric Dental coverage.

H. All weighted averages in Exhibits 13A and 13C should be calculated using membership as of 3/31/2016.

I. Additional instructions are included within the Exhibit.

**As noted above, 2017 proposed "On" and "Off" Exchange rates must be submitted together as one filing within a given market (i.e., Individual and Small Group). 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. This is a departure from previous years.**

**Exhibit 14: Summary of Requested Percentage Changes:**

This exhibit provides details as to the changes in premium rates between the approved 2016 and requested 2017 premium rates. Note that this Exhibit has been modified from last year to also include the distribution of the rate change (i.e., it has been merged with what used to be Exhibit 15 which has been eliminated).

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

Effective dates are 01/01/2017 for all Individual plans, and 01/01/2017, 04/01/2017, 07/01/2017 or 10/01/2017 for Small Group plans.

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

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

Exhibit 14 applies to Individual and Small Group Plans (**Calculations must be based on membership as of 3/31/2016**).

This Exhibit is only applicable to Prior Approval Adjustment filings. Note that “On” and “Off” Exchange rate filings have been combined this year (i.e., DFS is not requiring that the changes in premium rates be identified separately for “On” vs. “Off” Exchange plans).

**As noted above, 2017 proposed “On” and “Off” Exchange rates must be submitted together as one filing within a given market (i.e., Individual and Small Group). 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. This is a departure from previous years.**

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

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

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

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

This exhibit illustrates the premiums and claims experience for the prior two (2) calendar years (2014-2015) by policy form. **Note that only the experience associated with ACA compliant plans should be included in this Exhibit. This includes only those plans written or renewed on or after 1/1/2014 that are subject to the federal Market Reforms that went into effect on that date. This is a departure from previous years.**

The policy forms covered are those for all plans (as described in the table below) providing comprehensive benefits for hospital, medical and prescription drugs charges. As noted above, some policy forms previously included in Insurance Law § 3231(e)(1) or § 4308(c) Prior Approval Adjustment

filings must be excluded (i.e., Individual Healthy New York plans, Individual Direct Pay plans, Sole Proprietor plans, hospital only plans, medical only plans, limited benefit plans, plans supplementing Medicare benefits, and other discontinued or closed group policy forms should be excluded). Note that discontinued plans are not to be excluded. Small Group Healthy New York experience written on or after 1/1/2014 must be included in this Exhibit (as well as in Exhibit 18) with the Company's Small Group experience. This Exhibit will be used in our analysis of the claims experience for prior years and to assist in our evaluation of the Company's development of 2017 premium rates for "On" and "Off" Exchange plans for both Individual and Small Group business.

- a. The format of this Standard Exhibit is fixed; insert additional rows as needed. Use only the second tab for data entry.
- b. Policy Form: Use a separate row for each base medical policy form. Data is to be shown for each policy form as described in the table below.
- c. Columns 1a, 1b, and 1c: Indicate the Company Name, NAIC Code and SERFF Filing number.
- d. Columns 1d, 1e and 1f: Indicate the form number for each base medical policy form, the product name as in the rate manual, and the street product name.
- e. Column 2 "Filing Type": This field should indicate the Section of the Insurance Law under which the rates are being submitted (or which they were last submitted) (e.g., § 3231(e)(1), § 4308(c), etc.)
- f. Column 3 Effective Date of Rate Change: Indicate the date on which the latest approved rate scale became effective (e.g., 1/1/2016 for individual ACA-Compliant plans).
- g. Columns 4 through 7: Identify the Market Segment, Product Type, Rolling/Non Rolling rate structure and whether or not the policy form is open or closed (i.e., Open/Closed).
- h. Columns 8 and 9: Enter the number of policyholders (number of Small Group accounts) and the number of covered lives (members) affected by this rate filing, as of December 31, 2015.
- i. 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.
- j. Each experience period is 12 months (or shorter if a new form).
- k. The ending date of the most recent experience period is December 31, 2015. For most Companies, this experience period will be from January 1, 2015 through December 31, 2015.
- l. The first prior experience period is the immediately prior 12 month experience period or shorter period if a new form).
- m. 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 claims for the relevant calendar year that are not already reflected in the previous two columns (Note that for the first prior experience period, such estimate should reflect all known claims through the current date). 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, Federal Reinsurance, Risk Adjustment or Risk Corridors payments/receipts.

- n. Loss ratio report refunds or refunds/payments pursuant to Regulation 146 are to have no impact on the earned premiums or standardized premiums shown. Such refunds do not impact earned or standardized earned premiums.
- o. Standard Premiums: The Actuarial Memorandum must clearly describe how standardized earned premiums for each experience period were developed from the earned premiums for the applicable experience period. A numerical example illustrating the development methodology for one non-rolling rate product and one rolling rate product included in the rate filing must be included as part of the Actuarial Memorandum, as applicable. The same standard rate level must be used for all of the experience periods. The appropriate Standardized Premium Scale represents the latest scale that was approved by DFS as described in the last column of the table below

**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 (Excluding CSR variations that will move to BHP in 2016 and December Health Republic Enrollees)	Individual-ACA	N/A	N/A	Issued on or after 1/1/2014	2016 Rates
Individual	BHP - CSR variations of ACA Compliant Individual Plans that will move to BHP in 2016 (Excluding December Health Republic Enrollees)	Individual-ACA-BHP	N/A	N/A	Issued on or after 1/1/2014	2016 Rates
Individual	Former Health Republic Members who enrolled in 2015 for the month of December - (Excluding CSR variations that will move to BHP in 2016)	Individual-HR	N/A	N/A	Issued during the month of December 2015	2016 Rates
Individual	Former Health Republic Members who enrolled in 2015 for the month of December - (Plans that will move to BHP in 2016)	Individual-HR-BHP	N/A	N/A	Issued during the month of December 2015	2016 Rates
Small Group	ACA Compliant Small Group Plans (Excluding Healthy New York plans)	SG-ACA	1-50	Current New York	Issued on or after 1/1/2014	4th Quarter 2016 for rolling; 2016 for non-rolling
Small Group	ACA Compliant Small Group Healthy New York Plans	SG-ACA-HNY	1-50	Current New York	Issued on or after 1/1/2014	4th Quarter 2016 for rolling; 2016 for non-rolling
Large Group	Current Large Group business that would be classified as Small Group assuming a	LG-100	51-100	Current New York	All experience for calendar years	4th Quarter 2016 for rolling; 2016 for non-rolling

	small group definition of 1-100 with the New York Counting Methodology not already counted above					
Catastrophic	ACA Compliant Catastrophic Plans	Catastrophic	N/A	N/A	Issued on or after 1/1/2014	2016 Rates

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

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

**As noted above, 2017 proposed “On” and “Off” Exchange rates must be submitted together as one filing within a given market (i.e., Individual and Small Group). 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. This is a departure from previous years.**

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

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

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

Information on Lines 1 through 9 must be entered for each plan (i.e., 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 2015:**

a1. For lines 10A and 10B, information for all Plans should be entered in column D (Only the experience of plans written or renewed on or after 1/1/2014 that are subject to the federal Market Reforms that became effective on that date should be included. This is the case for both Markets). This information should be consistent with Exhibit 17. Line 10C (Average Incurred Claims) will be calculated as line 10A divided by Line 10B. All other columns associated with Lines 10A through Line 11 are to be left blank.

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

a3. Go to step b.

**For Companies that did not participate in the relevant Market during calendar year 2015:**

- a1. For lines 10A and 10B, information must be entered in Column D, based on premium rate development which must be specifically identified in the Actuarial Memorandum, including any relevant sources (e.g. publications, preparing organizations, consultants, etc.)
- a2. Information on lines 10A and 10B must correspond to the experience period for which the proposed rates are based, excluding any projection for trend, and excluding any provision for expenses and profit margin. The annual claim trend used must be shown in the appropriate column in Exhibit 19, and the impact of any claim trend must be shown on line 23 of Exhibit 18. The expense and profit provisions in lines 36 and 37 must be consistent with those shown in Exhibit 19.
- a6. Go to step b.

**For all Companies regardless of whether they participated in the relevant market in calendar year 2015:**

- b. Lines 13 through 27 are intended to represent the Market-Wide Adjustments described in 45 CFR 156.80(d)(1). Relevant factors that are appropriate for all plans combined are to be entered in Column D. All other columns in Lines 13 through 27 are to be left blank. Note that for Individual filings, Column D of Exhibit 18 should match Column G of the "18 Supp-Ind" tab for these specific Lines. For Small Group filings, Column D of Exhibit should match Column F of the "18 Supp-SG" tab for these specific lines. With regard to Lines 25 – 27 ("Other"), because additional rows cannot be added, if more than three additional adjustments are necessary, such additional adjustments should be included in "Other 3". All "Other" adjustments should be fully explained and justified (as well as split out) in the Actuarial Memorandum. c. The value in Line 28, Column D is to be calculated as the product of Lines 13 through 27 of Column D. The value in Line 28, Column D must be carried to all other columns in Line 28 and must be used for all plans.
- d. Factors for any relevant Plan Level Adjustments as described in 45 CFR 156.80(d)(2) are to be entered in Lines 29 through 44 for Columns E and subsequent as appropriate for each plan. With regard to Lines 41 – 44 ("Other"), because additional rows cannot be added, if more than four additional adjustments are necessary, such additional adjustments should be included in "Other 4". All "Other" adjustments should be fully explained and justified (as well as split out) in the Actuarial Memorandum. The values in Line 45 are to be calculated as the product of Lines 29 through 44 for all columns (i.e., for each specific plan).
- f. The value in Line 46, Column D is intended to be used in Line 5 of Exhibit 13a for purposes of the Rate Indication Calculation.
- g. Line 47 should be populated with actual 2016 rates (i.e., first quarter of 2016 for Small Group) for each of the respective plans and Line 48 should be populated with actual membership as of 3/1/2016.
- h. The values in Line 49 are determined as the product of Lines 12, 28 and 45.

**Additional Notes**

- 1. Additional benefits (e.g., OON, Non-EHB, should be backed out of experience data prior to it being built back in via Plan Level Adjustments.

2. **No additional rows or columns should be added to this Exhibit.** If additional lines are deemed necessary, then the Actuary should contact the Department.
3. Information in Lines 36 and 37 (Expense and Profit) must be provided for each specific plan (i.e. average values may not be used).
4. Values in Lines 36 (Administrative Expense) and 37 (Profit and Contribution to Surplus) must be consistent with the relevant values in Exhibit 19.
  - a. For example, if the Administrative Expense and Profit values in Exhibit 19 are 13.0% and 2.0% respectively, then the Factors on Lines 36 and 37 should be 1.1529 ( i.e. the ratio of 98% to 85%, where 98% is 100% less 2.00%, and 85% is 100% less 13.00% less 2.00%), and 1.0204 ( i.e., the ratio of 100% to 98%, where 98% is 100% less 2.00%, and 100% is given) respectively.
5. Lines 36 and 37 may **not** be reported as 1.000, with the provisions for expenses and profit reflected elsewhere in this Exhibit. Additionally, all expense and profit must be reflected in Lines 36 and 37.

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

**As noted above, 2017 proposed “On” and “Off” Exchange rates must be submitted together as one filing within a given market (i.e., Individual and Small Group). 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. This is a departure from previous years.**

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

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

Note that there is a separate supplemental Exhibit for Individual and Small Group filings. (There is only one base Exhibit 18 template for both Individual and Small Group filings). For Individual business, the values in Column D, for Lines 10-28 of Exhibit 18 should be consistent with the values in Column I, Lines 10-28 of the “18 Supp-Ind” tab. For Small Group business, the values in Column D, for Lines 10-28 of Exhibit 18 should be consistent with the values in Column F, Lines 10-28 of the “18 Supp-SG” tab.

This Exhibit also requests a summary of the information contained in Exhibit 19 and also requests both actual and proposed expense data from past years for comparison purposes.

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

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

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

Regulatory fees, including New York State 206 (formerly Section 332) assessment as well as fees associated with the Federal Reinsurance and Risk Adjustment programs should be entered in columns 6.1 and 16.1. All other State and Federal taxes and fees should be entered in columns 6.5 and 16.5.

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

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

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

- a. Column A: Company Name.
- b. Column B: NAIC Code.
- c. Column C: SERFF Filing Number.
- d. Column D: Market (Individual, Small Group or Catastrophic).
- e. Column 1: Enter Metal Tier.
- f. Column 2: Indicate whether the specific category is "On" or "Off" Exchange, as well as whether it is "Standard" or "Non-Standard" (e.g., Enter "Exchange STD", "Exchange-NonSTD", "OffExchange-STD" or OffExchange-NonSTD").
- g. Column 3: Enter Membership at mm/dd/yyyy, excluding Pre ACA members. Note that this number should be estimated for 2017.
- h. Columns 4.1 - 4.2: Enter the applicability period.
- i. Column 5: The average claim trend is the average annualized claim trend rate to adjust source data forward to the applicable applicability period.
- j. Columns 6.1 through 6.7: The administrative expense components must reflect the anticipated expenses for applicability in calendar year 2017.
- k. Columns 7 through 10: The profit margins components must reflect the provision for profit margin required for applicability in calendar year 2017.
- l. Both the administrative expenses and the profit margins are to be entered as percentages of premiums in columns 6.1 through 11.
- m. Columns 14.1 through 21 must be proposed on a basis consistent with the basis used for columns 4.1 through 11.

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

**As noted above, 2017 proposed "On" and "Off" Exchange rates must be submitted together as one filing within a given market (i.e., Individual and Small Group). 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. This is a departure from previous years.**

**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 2016 to calendar year 2017; and
- b. From calendar year 2015 to calendar year 2016; and
- c. From calendar year 2014 to calendar year 2015.

As noted on the Instructions tab of this Exhibit, actual allowed amounts are requested for 2015. These 2015 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 2014 to 2015, 2015 to 2016, and 2016 to 2017) can be determined.

Exhibit 21A applies to Inpatient Services.

Exhibit 21B applies to Outpatient Services.

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

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

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

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

**As noted above, 2017 proposed “On” and “Off” Exchange rates must be submitted together as one filing within a given market (i.e., Individual and Small Group). 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. This is a departure from previous years.**

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

This exhibit requires details regarding the medical/hospital services provided in the Individual and Small Group Markets, separately for calendar years 2015 and 2014.

Information requested includes:

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

The information in this Exhibit 22 may be redacted.

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

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

**As noted above, 2017 proposed “On” and “Off” Exchange rates must be submitted together as one filing within a given market (i.e., Individual and Small Group). 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. This is a departure from previous years.**

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

The purpose of this exhibit is to provide the actual distribution of all base Premium Rates for all Metal Tiers and Rating Regions 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, Small Group or Catastrophic); and
- e. HIOS ID Number (14 Digit), both current and previous if applicable; and
- f. Metal Level (Excluding Silver CSR plans); and
- g. "On" or "Off" Exchange; 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. Premium Rates by Standardized Rating Region (2014 - 2017); and
- q. Member Months by Standardized Rating Region by calendar year (2014 and 2015); and
- r. Actual member counts as of 3/31/2016 – all members; and
- s. Actual member counts as of 3/31/2016 – only those members currently enrolled in 2016 plans that will continue to be offered in 2017; and
- t. Actual member counts as of 3/31/2016 – only those members currently enrolled in 2016 plans. **Item (t) applies to Small Group Only.**

For Individual plans, the premium rates are the requested 2017 calendar year rates for the Individual Only Census Tier only.

For Small Group plans, the premium rates are the first quarter requested 2017 rates for the Employee Only Census Tier.

**Unlike past years, we are now requesting all plans to be provided 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.

**As noted above, 2017 proposed "On" and "Off" Exchange rates must be submitted together as one filing within a given market (i.e., Individual and Small Group). 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. This is a departure from previous years.**

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

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

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

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

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

For purposes of this Exhibit, “Paid Claims” means actual amounts paid through 2/29/2016 (regardless of the year), exclusive of federal risk adjustment, reinsurance, risk corridors, commercial reinsurance, commercial stop-loss payments, Healthy New York reimbursements, etc.

For purposes of the Exhibit, “Incurred Claims” means “Paid Claims” as defined above plus a proportional amount of the actual reserve held for all outstanding claims associated with the given calendar year.

For purposes of this Exhibit, “Special Enrollment Period” means any enrollment that is outside of “Open Enrollment”. The Special Enrollment portion of the Exhibit applies only to Individual experience.

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

**As noted above, 2017 proposed “On” and “Off” Exchange rates must be submitted together as one filing within a given market (i.e., Individual and Small Group). 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. This is a departure from previous years.**

**Filing Types:**

As discussed in Section A (General Introduction), most filings for premium rates effective in calendar year 2017 will be of the Prior Approval Adjustment type (Insurance Law § 3231(e)(1) and § 4308(c)), as most companies submitted rate filings in 2015 for premium rates effective in calendar year 2016. **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.**

- SERFF Filing Type: “2017 Prior Approval ACA Rates”

For companies that did not submit a rate filing in 2015 for premium rates effective in calendar year 2016, a Rate and Form filing (Insurance Law § 3231(d) and § 4308(b)) is required for premium rates effective in calendar year 2017.

The required Exhibits for “Prior Approval” and “Rate and Form” filings, applicable to filings applicable to both the Individual and Small Group Markets, are described below.

- SERFF Filing Types:
  - “Exchange Forms & Rates” for “On” Exchange plans; and
  - “Off Exchange Forms & Rates” for “Off” Exchange plans.

#### **Required Exhibits by Filing Type:**

**Companies that participated in a particular Market during calendar year 2015 (or did not participate in 2015 but filed rates for 2016 in a particular Market) and wish to modify rates for that Market are subject to § 3231(e)(1) and § 4308(c), Prior Approval, and must provide the following Exhibits for both Individual and Small Group rate filings (SERFF Filing Type: “2017 Prior Approval ACA Rates”):**

- 2017 Rate Filing Checklist
- Exhibit 11: General Information;
- Exhibit 13 (A,B, and C): Narrative Summary, Numerical Summary, and Average Premium Details;
- Exhibit 14: Requested Percentage Changes;
- Exhibit 16: Summary of Policy Form Changes;
- Exhibit 17: Claims Experience Data;
- Exhibit 18: Index Rate/Plan Design Level Adjustment;
- Exhibit 19: Claim Trend and Administrative Expenses;
- Exhibit 21 (A and B): Hospital Unit Costs;
- Exhibit 22: Medical and Hospital Utilization Data;
- Exhibit 23: Summary of Requested 2017 Premium Rates and HIOS Product Mapping;
- Exhibit 25: Adjustment Factors for Major Variations from the Base Plan.

**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. This is a departure from previous years.**

**Companies that did not participate in a particular Market during calendar year 2015 and do not have 2016 rates filed for that Market are subject to § 3231(d) and § 4308(b), Rate and Form Filings, and must provide the following Exhibits for both Individual and Small Group rate filings (SERFF Filing Types: “Exchange Forms & Rates” or “Off Exchange Forms & Rates”):**

- 2017 Rate Filing Checklist
- Exhibit 11: General Information;
- Exhibit 16: Summary of Policy Form Changes;
- Exhibit 18: Index Rate/Plan Design Level Adjustment;
- Exhibit 19: Claim Trend and Administrative Expenses;
- Exhibit 23: Summary of Requested 2017 Premium Rates and HIOS Product Mapping;
- Exhibit 25: Adjustment Factors for Major Variations from the Base Plan.