NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions for the Filing of 2018 Premium Rates
Individual and Small Group – "On" and "Off" Exchange Plans

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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

A. General Introduction:

These instructions apply to all comprehensive medical rate filings submitted in calendar year 2017 for premium rates effective in calendar year 2018, for Individual and Small Group plans, both "On" and "Off' Exchange.

For companies with 2017 rates on file in a particular market (i.e., Individual or Small Group), rate filings for calendar year 2018 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 2017 rates on file in a particular market, rate filings for calendar 2018 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.

B. Essential Health Benefits:

Companies must provide the Essential Health Benefits as specified in the model language 2018.

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

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

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

Rate manuals can include rates for both "On" and "Off" Exchange plans as long as there is a separate section for each (i.e., Only "On" Exchange rates are shown in the Exchange Section and only "Off" Exchange rates are shown in the "Off" Exchange Section). Separate rate manuals within the combined "On" and "Off" Exchange Rate filing may also be provided.

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

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

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

- **Redacted documents must be clearly marked as such by including the word "Redacted" in the filename.**
- **In instances where we receive redacted versions of a rate filing document, the redacted version will be posted on our website (otherwise, the non-redacted version will be posted).**
- **Insurers should exercise caution when redacting files. Instances where files are over-redacted may result in the un-redacted version being posted. If there are any questions regarding whether a particular item may be redacted, please contact us.**
- **The Rate Manual (i.e., all pages) should also be provided in both PDF and Excel format.**

D. Notice of Benefit and Payment Parameters for 2018:

Generally speaking, HHS final requirements for 2018 are similar to 2017 as they apply to rates. There is no change with regard to the requirements for the Index Rate or Single Risk Pools. However, as noted below, some changes have been introduced.

(a) Reinsurance Program for Individual Plans:

Because the federal reinsurance program ended on 12/31/2016, there should not be any provision for that program included in 2018 premium rates (i.e., in the form of expected reimbursements or fees). Claim amounts reported in the various Exhibits should not reflect any federal reinsurance receipts.

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

Premium rates should reflect the PCORI fee as appropriate. 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

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

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

For 2018, the HHS prescribed self-only coverage MOOP limit is $7,350, and the family limit is $14,700.

(d) Other Fees:

ACA fees include:

1. Based on the rules as currently written, the ACA tax has been reinstated for the 2018 plan year (i.e., it will be collected in 2018 based on the 2017 data year). As such, insurers should include a provision for this tax in their 2018 premium rates. Such provision should reflect differences in aggregate 2018 projected premium levels relative to 2017. Additionally, for Small Group, that provision should take into consideration any amounts that will be collected in 2018 on policies that were written or renewed in 2017. Note that certain thresholds may apply for smaller blocks of business. For more information, please refer to the following link:

   https://www.irs.gov/businesses/corporations/health-insurance-provider-fee-2017-moratorium-questions-and-answers

   The Actuarial Memorandum should clearly indicate the percentage of total premium represented by the ACA tax.

2. Per the 2018 Final NBPP, the Risk Adjustment User fee will be $1.68 per **billable member** per year (or $0.14 PMPM) in 2018; and

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

E. New York State Standard Benefit Design:

Standard benefit designs should conform to the set of designs to be circulated by DFS.

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 (2018 version must be used).

Bronze:	60% AV (de minimis range of -4%/+2%; or -4/+5% if one major service covered prior to the deductible)
Silver:	70% AV (de minimis range of -4%/+2%)
Gold:	80% AV (de minimis range of -4%/+2%)
Platinum:	90% AV (de minimis range of -4%/+2%)

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

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%/+ 1% AV is permissible.

The AV Metal Values determine what metal level a particular plan-design belongs in, and the 2018 HHS Actuarial Value Calculator must be used in the calculation of these AV Metal Values.

The final version of the 2018 AV Calculator and accompanying documentation can be found in the following locations:

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Revised-Final-2018-AV-Calculator-41317.xlsm

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Revised-Final-2018-AV-Methodology-41317.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 2018 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 2018 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).

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) Impact of provider fee schedule changes;

(d) Impact of utilization management changes;

(e) Market wide adjustment for impact on claim costs from quality improvement and cost containment initiatives;

(f) Impact of medical inflation (i.e., trend);

(g) Total expected market-wide payments and charges under the federal risk adjustment, including the expected impact of New York's adjustment to federal risk adjustment associated with the Emergency Amendment to Regulation 146 (i.e., the Emergency Amendment to Regulation 146 impact, which will be the same for all insurers, should be incorporated into Line 19 of Exhibit 18);

(h) Impact of adjustments for the experience period claim data not being sufficiently credible.

(i) Impact of anticipated changes in the distribution of membership in the risk pool across the standard rating regions;

(j) Post/Pre ACA: Impact on risk pool of changes in expected covered membership risk characteristics (Small Group Only);

(k) Adjustment for change in Small Group Definition (Small Group Only);

(l) Adjustment to reflect the difference in counting method used for the experience provided compared to the FTE method that will be required in 2016 (Small Group only).

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) Impact of eligibility categories (Catastrophic plans only);

(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 (Small Group only);

(h) The impact of the inclusion or non-inclusion of common plan variations (i.e., Family planning, dental, coverage to age 29, domestic partner coverage);

(i) Expenses - Administrative costs and provisions for Profit or Contribution to Surplus margins (See the newly added "Expenses" Section of Exhibit 18).

L. Standardized Rating Regions:

The ACA requires standardized rating regions. The Standardized Rating Regions for New York have not changed for 2018. Companies may vary premiums between standardized rating regions in accordance with HHS regulations.

M. Claims Experience Data:

(a) Small Group Plans:

For Companies currently participating in the Small Group market, premium rates for "On" and "Off" Exchange plans should be based on recent claims experience for ACA compliant Non-Grandfathered plans only (The impact of non-ACA compliant business should be reflected in Lines 22 and 23 of Exhibit 18).

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.

(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 2016 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:

Small Group Healthy New York plans may be offered "Off" Exchange only and must be designed 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 Rating Tiers:

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

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

Rating tier factors for calendar year 2018 are **unchanged** from 2017.

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

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

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

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

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. Rate Filings - Materials that must be Included:

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

(a) SERFF Filing Types:

- "2018 Prior Approval ACA Rates" – To be used if the legal entity for which the filing is being made currently has 2017 rates on file with DFS in the applicable market.
- "Exchange Forms & Rates" – To be used if the legal entity for which the filing is being made does not currently have 2017 rates on file with DFS in the applicable market, and plans will be sold both "On" and "Off" the Exchange.
- "Off Exchange Forms & Rates" - To be used if the legal entity for which the filing is being made does not currently have 2017 rates on file with DFS in the applicable market, and plans will be sold "Off" Exchange only.

(b) <u>Required Exhibits by Filing Type:</u>
Filings submitted under the SERFF Filing Type "2018 Prior Approval ACA Rates" must include the following Exhibits:

- 2018 Rate Filing Checklist;
- Exhibit 11: General Information;
- Exhibit 13 (A): Numerical Summary and Rate Indication Calculation;
- Exhibit 13 (B): Narrative Summary;
- Exhibit 13 (C): Average Premium Details;
- Exhibit 14: Summary of Requested Percentage Changes;
- Exhibit 16: Summary of Policy Form and Product Changes;
- Exhibit 17: Historical Claims Data by Policy Forms included in Rate Adjustment Filing;
- Exhibit 18: Index Rate/Plan Design Level Adjustment Worksheet;
- Exhibit 19: Summary of Average Claim Trend and Administrative Expenses and Profit Margin;
- Exhibit 21 (A): Hospital Unit Cost Development – Inpatient Services;
- Exhibit 21 (B): Hospital Unit Cost Development – Outpatient Services;
- Exhibit 22: Medical and Hospital Utilization Data;
- Exhibit 23: Summary of Requested 2018 Premium Rates;
- Exhibit 25: Summary of Experience by Material Rating Variables.

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

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

- 2018 Rate Filing Checklist;
- Exhibit 11: General Information;
- Exhibit 16: Summary of Policy Form and Product Changes;
- Exhibit 18: Index Rate/Plan Design Level Adjustment Worksheet;
- Exhibit 19: Summary of Average Claim Trend and Administrative Expenses and Profit Margin;
- Exhibit 23: Summary of Requested 2018 Premium Rates;
- Exhibit 25: Summary of Experience by Material Rating Variables.

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

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

<u>(e) AV Calculations (AV Snapshots):</u>
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.

(f) Quality Improvement Strategy:

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

S. Actuarial Memorandum:

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

1. For purposes of documenting the market wide adjustment for risk adjustment, the following information should be included in the Actuarial Memorandum:
    a. Any sources (e.g., CMS Interim Reports, Wakely study results, etc.) that were used to develop the market wide adjustment factor.
    b. A clear explanation and accompanying demonstration of how those sources were used to develop the market wide adjustment factor included in the filing.
    c. A clear explanation and accompanying demonstration of how the market wide adjustment factor would change if actual 2016 results differ from the sources used to develop that factor.
        i. The above mentioned demonstrations should clearly show how the various estimates used translate to the Company's expected 2016 payment or charge. The demonstrations should also show how differences between the actual and expected 2016 results would impact the Company's expected results for 2018, as well as how those differences would impact the accompanying market-wide adjustment included in the 2018 rate application. **These demonstrations should be provided in spreadsheet format and include all applicable formulas (as opposed to simply providing hard-coded values).**
    d. In the event that there are material differences between a company's actual and expected 2016 risk adjustment results, DFS may use this information to make an objective determination as to how the Company's rates should be modified. Such adjustments may increase or decrease the Company's initially filed rates.
2. Assumptions used for **trend:** All components, including inflation, utilization, leverage impact and other factors as applicable, including (if available) information on claim trend rates for allowed charges.
    a. The Actuarial memorandum should include an explicit breakdown of the various components of the trend factor used to develop the 2018 premium rates. Such

breakdown should include but not necessarily be limited to support for the unit cost, utilization, deductible leveraging, and projection components of the trend factor used in Exhibit 18. The breakdown should also address changes in provider contracts that impact trend.

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

3. Justification for the assumed utilization, unit cost and composite annual trend factors. Discuss the impact and provide justification for any case mix change, intensity of service change, population/demographic (aging) change, adverse selection, or deductible leveraging component incorporated into the utilization and/or unit cost trend factor components that is not part of the Market-Wide Index Rate Adjustments;
4. Assumptions used for **administrative expense**, including (a) an explanation of changes in Exhibit 19 expense components from the prior year, and (b) a reconciliation with information on administrative costs reported in latest financial statements;
5. Assumptions for **profit** and contribution to surplus, including a discussion pertaining to Return on Equity;
6. Details regarding **adjustments to Actuarial Values** produced by the HHS AV Calculator;
7. Details regarding **conversion factors** used to convert Preliminary PMPM Rates to actual premium rates for each of the Standardized Rating Tiers prescribed by DFS. This should include information on the distribution of both individuals/subscribers and members by the various rating tiers.
8. 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).
9. Details regarding how the Company determined its AV Pricing Values, including but not limited to justification for differences between AV Pricing Values versus values produced by the AV Calculator and sources for any external data sources that were utilized.
10. Support for adjustments to the premium rates for the impact of **Federal risk adjustment**.
11. Details supporting any **material pricing ratios used for morbidity**.
12. There should be no inconsistencies between the information in the Actuarial Memorandum and the information contained in Exhibit 18 (Index Rates).
13. Support for adjustment factors used for **Out-of-Network benefits**.
14. Support for any **significant premium rate differences** between plans in the same metal level.
15. Details must be provided on any **Propriety Studies** used to develop or modify premiums rates covered by this filing.

16. Details need to be provided on any adjustments introduced under the category of **"Management Adjustments"**, including justification that such adjustments are in compliance with HHS regulations.

17. Details and support for any **other adjustments** deemed necessary by the Company's actuary.

18. Data sources that are not based on the actual claim experience of the Company's 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.

19. **Description of Payments Related to Advanced Primary Care Payments**:
    If insurers include PT or CC payments in their MLR calculation, they should include the amounts of those payments and a description of the particular primary care programs they are associated with, in the actuarial memorandum. Insurers will be allowed to include this information in a supplement to the actuarial memorandum if it is proprietary or confidential, and it should be marked as such.

    DFS is working with DOH and health insurers to ensure attainment of the Triple Aim in New York State: better care for patients, better health for our communities, and lower costs through improvement of the health delivery system. New York State is in receipt of Federal support through a State Innovation Model Testing Cooperative agreement to test an Advanced Primary Care model as a means of achieving the Triple Aim. NY's Advanced Primary Care model (APC) leverages and builds on past successes such as the Patient Centered Medical Home and assumes a supportive reimbursement structure.

    Multi-payer involvement is essential as it ensures adequate financial support for practices to make fundamental changes to their care delivery. Further, when payers share cost, utilization, and quality data with practices at regular intervals, it facilitates practices' ability to manage their patient population's health, leading to smarter spending, better care, and healthier people. APC will be regionally based with practice transformation support targeted to those regions in which payers are most likely to support this care delivery model through an evolved payment structure that moves from Fee-for-Service to a value-based strategy that supports team-based care and incents quality and value.

    In support of the SHIP initiative, the State is asking insurers to voluntarily make "practice transformation" (PT) and "care coordination" (CC) payments to qualifying primary care providers (as defined by SIM-funded NYS Practice Transformation vendors and validated by an independent entity) starting in 2018. These payments are designed to help primary care practices build infrastructure and coordinate care in furtherance of the SIM goals of raising the quality of care and controlling costs in the future.

    To recognize insurers' PT and CC payments, DFS will allow insurers to adjust the pricing medical loss ratio formula (MLR) for prior approval rate applications for 2018 premium rates. Currently the pricing MLR is the ratio of claims to premiums. Under the new formula, the pricing MLR will be the ratio of claims plus PT and CC payments to premiums. Insurers should therefore calculate the ratio of (1) the total projected PT and CC payments for 2018, to (2) the total projected premiums for 2018 when determining whether or not their target MLRs are projected to be met. For instance, if projected PT and CC payments are 0.4% of 2018 projected claims, the pricing formula may reflect that claims are expected to be 0.4% higher than they would have otherwise been. For purposes of 2018 rate applications, these costs shall not be passed on to policyholders.

If insurers include PT or CC payments in their MLR calculation, they should include the amounts of those payments and a description of the particular primary care programs they are associated with, in the actuarial memorandum. Insurers will be allowed to include this information in a supplement to the actuarial memorandum if it is proprietary or confidential, and it should be marked as such.

For the purposes of credits related to PT or CC payments:

"Practice Transformation or PT Payments" shall include any payments made to primary care physicians or practices, to offset productivity losses to the practice as they develop the capacity and expertise to adopt an APC -qualified contract. Practice transformation payments must be monetary and can include direct payments to practices, increased reimbursement rates and increased monthly capitation payments, but do not include in-kind support in expertise, IT, etc. Practice transformation payments include prospective payments, but do not include retrospective payments such as shared savings or pay for performance programs. Practice transformation payments shall not include any claims payments, including visit-based or procedure-base claims payments.

"Care Coordination or CC Payments" shall include any payments made to primary care physicians or practices under an APC-qualified contract to offset the cost of hiring or paying for care coordination staff and related practice investments (e.g., technology, specialized resources, etc.). Care coordination payments must be monetary and can include direct payments to practices, increased reimbursement rates and increased monthly capitation payments, but do not include in-kind support in expertise, IT, etc. Care coordination payments include prospective payments, but do not include retrospective payments such as shared savings or pay for performance programs. Practice transformation payments shall not include any claims payments, including visit-based or procedure-base claims payments.

"APC-qualified contract" is a primary care participating provider contract that substantially complies with the APC model established by DOH and DFS, including but not limited to practice transformation payments, care coordination payments, and use of a common set of APC quality measures. Final determination of whether a contract is APC-qualified will be made by DOH and DFS.

T. Rate Manuals:

(a) Premium Rate Manuals – General Instructions:

Rate manuals must be submitted with the rate filings.

Premium rates for Small Group, "On" and "Off" Exchange 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 Rating Tiers, and all applicable Rating Regions. Small Group rate manuals must include premium rates for all quarters during calendar year 2018.

(b) Premium Rate Manuals – Required Items:

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

1. Table of Contents;
2. Insurer/corporation name on each consecutively numbered rate page;
3. **Identification by HIOS ID and form number of each policy, rider or endorsement to which the rates apply;**
4. Commission Schedule and/or Fees;
5. An expected loss ratio page. The expected loss ratio is to be calculated using the
6. 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;
7. 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);
8. A detailed description of the cost sharing provisions applicable to each plan-design, including details on prescription drugs;
9. Base premium rates for each plan along with any factors that may be applicable to differentiate the following characteristics:
    a. "Coverage through Age 26 only" vs "Coverage through Age 29"; and
    b. whether or not the plan includes "Family Planning Coverage"; and
    c. whether or not the plan includes "Domestic Partner Coverage"; and
    d. whether or not the plan includes "Dental Coverage".
10. The Standardized Rating Tiers and accompanying factors as prescribed by DFS must be included.
11. Factors for Geographic Rating Regions must be included.
12. A listing of the counties included in each region in which the Company plans to market each of its products;
13. Other information as applicable.

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

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

1. Variations by geographical regions: If medical premium rates for region X are set at 15% above medical premium rates for region Y, then prescription drug premium rates for region X must be set at 15% above prescription drug premium rates for region Y;
2. Prescribed rating 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.

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

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

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

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

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

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

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

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

(f) Premium Rate Manuals – Presentation:

In past years, many companies have submitted items such as pages of premium rates and summary of benefit charts that were 'reduced' to such an extent that DFS was not able to review them. In such cases, DFS actuaries had to increase the magnification to 200% or even 300%, which resulted in headings and line designations being lost. Companies must submit 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.

U. 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.

V. 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.

W. Objection Letters:

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

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

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

X. Additional Requirements:

(a) Filing Type Codes

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

Prior Approval Rate Adjustment Filings (Companies with 2017 rates on file):

"2018 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 2017 rates on file):

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

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

(b) Format of Attachments:

Each attachment to the rate adjustment filing must be compatible with the following software: Microsoft Word 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.

(c) SERFF/HHS Requirements:

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

(d) Filing Amendments:

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

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

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.

Y. Other Miscellaneous Items:

(a) Membership Survey as of March 31, 2017:

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.

(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;

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.

(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 2017, 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 2017, rate filings for premium rates to be effective in calendar year 2018 will be handled as Rate and Form filings under Insurance Law § 3231(d) or § 4308(b), as described in Section A (General Introduction) above.

(d) Uniform Rate Review Template (URRT):

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

In the past, DFS has raised objections 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 2018 filings to ensure consistency between values for the items noted above.

(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 2018 premium rate filings, the Rate Review Detail must be completed in a manner that is consistent with prior years.

(f) Dental Coverage

Instructions for Dental filings will be available on our website.

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

2018 Rate Filing Exhibit Instructions

General

For a given Market, 2018 proposed rates for "On" and "Off" Exchange business must be submitted as a combined filing as opposed to submitting two separate filings. Only Individual experience data should be included within Exhibits submitted with Individual rate filings and only Small Group experience data should be included within Exhibits submitted with Small Group filings.

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

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

The 2018 Rate Filing Exhibits include controls intended to facilitate the efficient processing of the data being submitted as well as to ensure that the playing field is level. These Exhibits should not be "unlocked" for the purposes of modifying them in any way.

Exhibit 11 - General Information about the Rate Filing

This Exhibit provides general information about the rate filing.

Information must be provided for a general Contact Person as well as an Actuarial Contact (i.e., the identification of the actuary responsible for the preparation of the rate filing, including telephone number and e-mail address). 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) includes the "Requested Rate Adjustment" percentage that will be posted on our website, as well as a "Rate Indication Calculation" which will not be made available to the public. Exhibit 13b is a placeholder for the "Narrative Summary". The Narrative Summary is intended to be a plain English description of, and rationale for, the rate change being requested. Exhibit 13c shows the development of the weighted average premiums that are reported in Exhibit 13a.

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 2017 and 2018 Weighted Average Base Premium Rates:
   These are required fields. These values are to be determined as the subscriber weighted average (not member month weighted) using the single adult premium rates as selected by the subscribers for each applicable metal level specified in Rows 31 and 32 (Columns G-K) of Exhibit 13a (i.e., These values should come from the appropriate cells of Exhibit 13c).

B. Weighted Average Annual Percentage Adjustments (2017 to 2018):
   The Weighted Average PMPM Rates for 2017 and 2018 are required fields. These numbers should come from Exhibit 13c (Cells Q-72 and Z-72).

C. Weighted Average Annual Percentage Adjustments (Prior Years):

These are required fields (to the extent the Company participated in the relevant years). Note that values reported in this Section should be consistent with what was publicly reported on the DFS website.

D. Average Medical Loss Ratios for 2014-2016:

The MLRs reported in this Section should be calculated as total Incurred Claims (Net of federal risk adjustment and reinsurance) divided by Earned Premium for the applicable calendar year. Claim and premium amounts should be consistent with Exhibit 17. Federal risk adjustment and reinsurance amounts should be based on final amounts for 2014 and 2015, and Interim results for 2016.

E. Claim Trend Rates and Ratios to Earned Premiums (2016-2018):

E 1 Claim Trend Rates (2016-2018):

Enter the claim trend rates used for 2018 and 2017 as illustrated in the current year Exhibit 19. For 2016, enter the claim trend rate for 2016 as illustrated in Exhibit 19 of the Prior Approval rate filing submitted in calendar year 2015 for premium rates effective in 2016. If not applicable, enter "N/A".

E 2 Ratios to Earned Premiums (2016-17):

For Individual and Small Group plans, enter the various ratios as illustrated in the current year Exhibit 19, for 2018 and 2017; for 2016, enter the ratios in Exhibit 19 of the Prior Approval rate filing submitted in calendar year 2015 for premium rates effective in calendar year 2016. If not applicable, enter "N/A".

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

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

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

H. All weighted averages in Exhibits 13A and 13C should be calculated using membership as of 3/31/2017.

Additional Notes Regarding Exhibit 13c

A. The "Weighted Average Monthly Base Premiums" in rows 22-29 of Exhibit 13c, should be calculated as the sum of the single adult rates (prior to the application of rating tier factors) multiplied by the number of subscribers for each plan divided by the total number of subscribers for each cell (combination of metal level and region). Note that there are three separate Sections where this calculation takes place (2017 Actual as of 3/31/2017, 2017 recalculated using only those subscribers that are enrolled in plans that will continue to be available in 2018, and 2018 calculated using only those subscribers that are enrolled in 2017 plans that will continue to be available in 2018).

B. Rows 35-42, Columns C-G are to be populated with actual membership as of 3/31/2017.

C. Rows 35-42, Columns L-P are to be populated with the subset of members in (B) above that are enrolled in plans that will continue to be offered in 2018 (i.e., if the Company is not discontinuing any plans, the membership in Columns C-G and L-P will be the same).

D. For each of the three sets of columns, the accompanying Conversion factors needed to convert the Weighted Average Monthly Base Premiums to PMPM rates must be reported in Cells C-45, L-45, and U-45 (i.e., the reciprocal of the factor needed to convert PMPM rates to Base rates).

Additional instructions are included in both Exhibits 13a and 13c.

This Exhibit is applicable to Prior Approval Adjustment filings only.

Exhibit 14: Summary of Requested Percentage Changes:

This Exhibit provides details of the premium rate changes between 2018 requested and 2017 approved rates.

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

Effective dates are 01/01/2018 for all Individual plans, and 01/01/2018, 04/01/2018, 07/01/2018 or 10/01/2018 for Small Group plans.

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

Exhibit 14 applies to Individual and Small Group Plans (**Calculations must be based on membership as of 3/31/2017**).

This Exhibit is applicable to Prior Approval Adjustment filings only.

Exhibit 16 - Summary of Policy Form and Product Changes

The purpose of this Exhibit is to provide a summary of all benefit and rate changes filed after the initial rate filing that could potentially impact the rates in this filing.

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

Exhibit 17 – Historical Claim Experience Data by Policy Forms

This exhibit illustrates the premiums and claims experience for the prior two (2) calendar years (2015 and 2016) by policy form.

For each market, the experience reported in Exhibit 17 should be representative of the risk that is expected to comprise the risk pool in 2018.

Individual:

The 2015 experience of individuals that moved to the Basic Health Plan in 2016 should not be reported in the 2015 experience period.

Small Group:

Note that this Exhibit should include the experience associated with those specific groups that were considered “small” or “large” groups in calendar years 2015 and/or part of 2016 that were considered “small” groups after the change in counting method that became effective on 1/1/2016.

- The experience of any groups that were classified as "small" before and after the change in counting method should be included in both experience periods (Calendar years 2015 and 2016).

- **EXAMPLE:** A group of size 45 (using the "Eligibiles" counting method) was first written on 7/1/2015, and that group renewed on 7/1/2016 as size 72 (using the FTE counting method). The experience from 7/1/2015-12/31/2015 should be reported in 2015 with a "Market Segment" of "SG-ACA" and "Group Definition" of "1-50"; the experience from 1/1/2016-6/30/2016 should be reported in 2016 with a "Market Segment of "SG-ACA" and "Group Definition of "1-50"; the experience from 7/1/2016-12/31/2016 should be reported in 2016 with a "Market Segment" of "SG-ACA-FTE" and "Group Definition" of "1-100.

- The experience of any groups that were classified as "large" before and "small" after the change in counting method should be included (the "large" and "small" components should be reported in their respective categories per the above table). The experience of such groups should be included in both experience periods to the extent it is available.
    - **EXAMPLE:** A group of size 75 (using the "Eligibiles" counting method) was first written on 7/1/2015, and that group renewed on 7/1/2016 as size 95 (using the FTE counting method). The experience from 7/1/2015-12/31/2015 should be reported in 2015 with a "Market Segment" of "LG-100" and "Group Definition" of "1-100"; the experience from 1/1/2016-6/30/2016 should be reported in 2016 with a "Market Segment of "LG-100" and "Group Definition of "1-100"; the experience from 7/1/2016-12/31/2016 should be reported in 2016 with a "Market Segment" of "SG-ACA-FTE" and "Group Definition" of "1-100.
- The experience of any groups that were classified as "small" before and "large" after the change should be removed from both experience periods.
    - Note that had the group in either of the above examples renewed in 2016 with a size of 101 or larger based on the FTE counting method, then the experience of that group should not be reported in either calendar year of Exhibit 17.

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. Some policy forms previously included in Insurance Law § 3231(e)(1) or § 4308(c) Prior Approval Adjustment filings must be excluded in addition to the exclusions mentioned above (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 (unless otherwise excluded as indicated above). Small Group Healthy New York experience written on or after 1/1/2015 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 2018 premium rates for "On" and "Off" Exchange plans for both Individual and Small Group business. **Note that while the experience associated with the "non-ACA compliant" 51-100 portion of 2016 experience (i.e., the pre-renewal portion) should be reported in Exhibit 17 as indicated above, that particular portion should not be included in Exhibit 18 as any adjustment needed to adjust that portion of the experience should be made via Market Wide Adjustment Factors in that Exhibit.**

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

b. Policy Form: Use a separate row for each base medical policy form. Data is to be shown for each policy form as described in the table below.

c. Columns 1d, 1e and 1f: Indicate the form number for each base medical policy form, the product name as in the rate manual, and the street product name.

d. Column 2 "Filing Type": This field should indicate the Section of the Insurance Law under which the rates are being submitted (or which they were last submitted) (e.g., § 3231(e)(1), § 4308(c), etc.)

e. Column 3 Effective Date of Last Rate Change: Indicate the date on which the latest approved rate scale became effective (e.g., 1/1/2017 for individual ACA-Compliant plans).

f. 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).

g. Columns 8 and 9: Enter the number of policyholders (number of Small Group accounts) and the number of covered lives (members) affected by this rate filing, as of December 31, 2016.

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

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

j. The 2016 experience period runs from 1/1/2016 – 12/31/2016. The 2015 experience period runs from 1/1/2015 – 12/31/2015.

k. The incurred claims for both experience periods must be reported on a consistent basis. Columns 14.6 and 15.6 must represent only those claims paid during the relevant calendar year. Columns 14.6a and 15.6a must represent only those claims paid during the months of January and February of the year following the relevant calendar year on claims incurred during the relevant calendar year. Columns 14.6b and 15.6b must represent total estimated future remaining claims for the relevant calendar year that are not already reflected in the previous two columns. **Note that for the 2015 experience period, such estimate should reflect all known claims through the current date (i.e., Insurers should not simply copy the 2015 experience that was reported in Exhibit 17 last year).**

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

m. Standardized earned premiums should not reflect adjustments for MLR rebates, premium credits pursuant to Regulation 146, etc.

n. Standard Premiums: The Actuarial Memorandum must clearly describe how standardized earned premiums for each experience period were developed from the earned premiums for the applicable experience period. A numerical example illustrating the development methodology for one non-rolling rate product and one rolling rate product included in the rate filing must be included as part of the Actuarial Memorandum, as applicable. The same standard rate level must be used for all 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	Individual-ACA	N/A	N/A	Issued on or after 1/1/2015	2017 Rates
Catastrophic	ACA Compliant Catastrophic Plans	Catastrophic	N/A	N/A	Issued on or after 1/1/2015	2017 Rates
Small Group	Experience of ACA Compliant Small Group Plans (Excluding Healthy New York plans) that were written or renewed prior to 1/1/2016	SG-ACA	1-50	Previous New York (Based in "Eligibles")	All relevant experience in the calendar year	4th Quarter 2017 for rolling; 2017 for non-rolling
Small Group	Experience of ACA Compliant Small Group Plans (Excluding Healthy New York plans) that were written or renewed on or after 1/1/2016	SG-ACA-FTE	1-100	Current New York (FTE)	All relevant experience in the calendar year	4th Quarter 2017 for rolling; 2017 for non-rolling
Small Group - HNY	Experience of Small Group Healthy New York Plans that were written or renewed prior to 1/1/2016	SG-ACA-HNY	1-50	Previous New York (Based in "Eligibles")	All relevant experience in the calendar year	4th Quarter 2017 for rolling; 2017 for non-rolling
Small Group - HNY	Experience of Small Group Healthy New York Plans that were written or renewed on or after 1/1/2016	SG-ACA-HNY-FTE	1-50	Current New York (FTE)	All relevant experience in the calendar year	4th Quarter 2017 for rolling; 2017 for non-rolling
Large Group	The Large Group portion of the experience of groups that were large in 2015 (and part of 2016) and renewed as small in 2016	LG-100	1-100	Previous New York (Based in "Eligibles")	All relevant experience in the calendar year	4th Quarter 2017 for rolling; 2017 for non-rolling

This Exhibit is applicable to Prior Approval Adjustment filings only.

Exhibit 18 - Index Rate /Plan Design Adjustment Worksheet

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

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

For Companies that participated in the relevant Market during calendar year 2016:

a1. For lines 10A and 10B, plan level claim and exposure data should be entered for each distinct plan. **Data for multiple plans should not be combined into one column.** Note that only the 2016 experience associated with ACA compliant plans written or renewed on or after 1/1/2015 should be reported in Lines 10A and 10B (i.e., Experience in Exhibit 17 with a "Market Segment" of "LG-100" should not be included in Exhibit 18. Any adjustments needed to reflect the "LG-100" portion should be made via "Market Wide Adjustments" in the "18" tab of Exhibit 18 in Lines 21-23). This information should be consistent with the appropriate categories reported in Exhibit 17. Line 10C (Average PMPM Incurred Claims) will be calculated as line 10A divided by Line 10B.

a2. The Average Pricing Actuarial Value for all in-force plans combined is to be entered in Line 11, Column D. The value in Line 12, Column D will be carried to all other columns for use as the starting point for all plans (unless a particular plan is being discontinued).

a3. Go to step b.

For Companies that did not participate in the relevant Market during calendar year 2016:

a1. For lines 10A and 10B, information must be entered in Column D, based on premium rate development which must be specifically identified in the Actuarial Memorandum, including any relevant sources (e.g. publications, preparing organizations, consultants, etc.) Because of the way the Exhibit is designed, the relevant data should be entered in the "Plan 1" column.

a2. Information on lines 10A and 10B must correspond to the experience period for which the proposed rates are based, excluding any projection for trend, and excluding any provision for expenses and profit margin. The impact of trend must be shown on Line 18 of Exhibit 18 and should be consistent with the annual trend reported in Exhibit 19. The expense and profit provisions in lines 49-52 must be consistent with Exhibit 19.

a6. Go to step b.

For all Companies regardless of whether they participated in the relevant market in calendar year 2016:

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. Note that for Small Group filings, Column D of the "18" tab should match Column F of the "18 Supp-SG" tab for these specific lines. With regard to Lines 24 – 27 ("Other"), because additional rows cannot be added, if more than four additional adjustments are necessary, such additional adjustments should be combined and included in "Other 4". All "Other" adjustments should be fully explained and justified (as well as itemized) in the Actuarial Memorandum.

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

d. Factors for any relevant Plan Level Adjustments as described in 45 CFR 156.80(d)(2) are to be entered in Lines 30 through 46 as appropriate for each plan. With regard to Lines 44 – 46 ("Other"), because additional rows cannot be added, if more than three additional adjustments are necessary, such additional adjustments should be combined and included in "Other 3". All "Other" adjustments should be fully explained and justified (as well as itemized)

in the Actuarial Memorandum. The combined impact of plan specific values in Line 47 are calculated as the product of Lines 30 through 46 for each specific plan. The overall "Impact of Plan Wide Adjustments" in Line 47, Column D is calculated as the weighted average of the plan specific values.

e. Expenses should be split by fixed versus variable as indicated in Column C of the "Expenses" Section. Fixed expenses should be expressed as a PMPM value and variable expenses should be expressed as a percentage of overall premium. This is new for 2018 and is intended to more accurately reflect expense structures used in practice.

f. Line 54 should be populated with actual 2017 PMPM rates for each of the respective plans and Line 55 should be populated with actual membership as of 3/31/2017.

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

Additional Notes

1. Additional benefits (e.g., OON, Non-EHB) should either be backed out of the experience data prior to being reported in Line 10A, or the corresponding factors reported in the "Plan Level Adjustments" section should only represent changes to such benefits from the prior year. **The method used should be explicitly stated in the Actuarial Memorandum.**
2. Information in Lines 50 - 52 (Administrative Expense and Profit) must be provided for each specific plan (i.e. average values may not be used) and must be consistent with Exhibit 19. Any variation by plan must be fully explained and justified in the Actuarial Memorandum.
3. Lines 50 – 52 may **not** be reported as zero (or negative) with the provisions for expenses and profit reflected elsewhere in this Exhibit. Additionally, all expense and profit must be reflected in Lines 50 - 52.
4. See Appendices A and B for additional details regarding the general rate development process.

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

Exhibit 18 – Supplemental Exhibits

The purpose of these supplemental Exhibits is to provide additional details and support for the "Expenses" Section of the "18" tab, as well as to provide details regarding necessary experience period adjustments for small group related to the changes in counting method and small group definition (Note that the "18 Supp-Ind" tab only includes the "Expense Data" Section).

There is a separate supplemental Exhibit for Individual and Small Group filings and there is only one base Exhibit 18 template for both Individual and Small Group filings (i.e., the "18" tab). For Small Group business, Lines 10A – 28 of the "18-Supp-SG" tab is intended to provide additional support for the adjustments included in Lines 21-23 of the "18" tab. As indicated above, Lines 10A and 10B of the "18" tab must be populated with ACA Compliant plan by plan experience, and any adjustments needed to reflect non-ACA experience should be made in Lines 21-23 of the "18" tab.

The "Expense Data" Sections of these supplemental tabs provide a summary of the information contained in Exhibit 19 and also request 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.

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"). One of the "Exchange" options should be used for plans sold both "On" and "Off" Exchange.
g. Column 3: Enter Membership at mm/dd/yyyy, (Total membership should be equal to the 3/31/2017 membership survey total).
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 2018.
k. Columns 7 through 10: The profit margins components must reflect the provision for profit margin required for applicability in calendar year 2018.
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.

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 2017 to calendar year 2018; and

b. From calendar year 2016 to calendar year 2017; and

c. From calendar year 2015 to calendar year 2016.

As noted on the Instructions tab of this Exhibit, actual allowed amounts are requested for 2016. These 2016 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 2015 to 2016, 2016 to 2017, and 2017 to 2018) 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 Prior Approval Adjustment filings only.

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 2016 and 2015.

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.

For purposes of completing Row 7:

Primary Care – Includes all costs associated with medical services provided in any setting, including inpatient care, urgent care and walk-in care by a primary care provider. Primary care providers include pediatricians, internists, family practitioners, general practitioners, obstetrician/gynecologists, physician extenders (PA, NP, CNW, etc.) and nurses who are acting as independent practitioners.
The following associated costs and payment arrangements are included:

- Salaries including fringe benefits paid to physicians for delivery of medical services;

- Capitated payments paid by the plan to physicians or clinics for delivery of medical services to plan subscribers; and
- Fees paid by the plan to physicians on a fee-for-service basis for delivery of medical services to plan subscribers.

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

Exhibit 23 - Summary of Requested 2016 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 **(Note that any change in HIOS numbers needs to be explained in the Actuarial Memorandum)**; 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. Child-Only Plan indicator – NEW for 2018.
q. Premium Rates by Standardized Rating Region (2015 - 2018); and
r. Member Months by Standardized Rating Region by calendar year (2015 and 2016); and
s. Actual member counts as of 3/31/2017 – all members; and
t. Actual member counts as of 3/31/2106 – only those members currently enrolled in 2017 plans that will continue to be offered in 2018; and
u. Actual member counts as of 3/31/2017 – only those members currently enrolled in 2017 plans. **Item (t) applies to Small Group Only.**

For Individual plans, the premium rates are the requested 2018 calendar year rates for the Single Adult Rating Tier only.

For Small Group plans, the premium rates are the first quarter requested 2018 rates for the Single Adult (Subscriber) Rating 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.

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. DFS recognizes that insurers may use different combination of benefits for their base plans. In completing the "Adjustment Factors" Section, as an example, if in 2015 an insurer used 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 Dental coverage.

Then, cells F25 – F28 would be populated with the value 1.000 and cells F29-32 would be populated with the factors necessary to convert 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 Dental coverage.

For purposes of this Exhibit, **"Paid Claims"** means actual amounts paid through 2/29/2017 (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.

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

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions for the Filing of 2018 Premium Rates
Individual and Small Group,
"On" and "Off" Exchange Plans

Instructions – Definitions:

a. **ACA Compliant** data means the data associated with plans which are subject to the market reforms that went into effect on 1/1/2014 such as the EHB, Metal Tiers, AV, standardized rating regions, etc. By Non-ACA Compliant, we mean those plans that are Non-Grandfathered which are not subject to the market reforms that went into effect on 1/1/2014.

b. **Company** refers to the licensed entity (distinct NAIC Number) providing the insurance coverage reflected in the rate filing.

c. A Company's **commercial book of business** includes all of the following: large group, Small Group, Individual, Healthy New York, and Medicare Supplemental. It excludes all government programs, such as, Medicare, Medicaid, Family Health Plus, and Child Health Plus.

d. **Loss ratio** refers to incurred claims divided by earned premiums for a given period of time. Incurred claims include the covered lives assessments, and the HCRA surcharge. Incurred claims do not include any administrative expenses, including "quality improvement expenses" or "community benefit expenses". Earned premiums do not include any adjustment for assessments or taxes. For ACA compliant plans, incurred claims include the impact of the federal 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, 2018 and is expected to be revised for January 1, 2019. The rate applicability period for this table is January 1, 2018 through December 31, 2018.

   (ii) Example 2 (Small Group Plans): A quarterly rolling rate table is developed for issues and renewals in January – March 2018 and incorporates a 12-month rate guarantee period. The rate applicability period for this table is January 1, 2018 through March 31, 2019.

g. **Standardized earned premiums** are the earned premiums for the period adjusted to assume that all premiums for the period are payable at the most current approved rate level, reflecting rate increases exclusive of rate changes due to contract language changes (i.e., excluding rate changes due to benefit revisions or members migrating to different plan-designs since the impact of such changes would be automatically reflected in the earned premiums and incurred claims once such a change becomes effective). Refunds payable (e.g., pursuant to a loss ratio report) have no impact on the earned premiums or standardized earned premiums shown in Exhibit 17 or in the rate development analysis.

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

APPENDIX A

General Overview of Pricing Development:

For purposes of developing individual and small group premium rates, the following process must be followed. Additional details are provided in Section T(a) below.

1. For each In-force plan-design, determine the applicable Metal Level, using the HHS AV Calculator.
2. For each In-force plan-design, determine the AV Pricing Value with the restrictions mentioned in Section H (Induced Demand) above.
3. For all in-force plans, determine the weighted-average "AV Pricing Value" and the weighted-average "Induced Demand" factor, using member months as weights (for the most recent experience period as submitted in Exhibit 17). The weighted-average AV Pricing Value should include the Induced Demand component.
4. For all in-force plans combined, determine the Average PMPM Incurred Claims for the latest experience period (without any adjustment for the 3Rs, Healthy New York Stop-Loss Reimbursements, or any other reinsurance/stop-loss arrangements).
5. 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 2018).
6. For all in-force plans combined, determine the "Index" PMPM applicable to all plans ("On" and "Off" Exchange) combined. This step reflects all Market-Wide adjustments.
7. Determine the provision for incurred claims for each plan (to be sold both "On" and "Off" Exchange) based on the Index PMPM Rate determined in (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
8. 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.
9. The process described above is simplified and does not discuss details by (a) Rating Tiers, (b) Rating Regions, and (c) Applicable Effective Quarters. These items are addressed in Section T(a).

APPENDIX B

Process in Development of Index Rates and Premium Rates:

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

1. Average PMPM Incurred Claims for the latest experience period (1/1/2016 – 12/31/2016, 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 rating tiers during the experience period used in step (1) above as modified by the Market-Wide Index Rate Adjustment for such anticipated changes with support for such anticipated changes included in the Actuarial Memorandum.
14. Calculate final premium rates (all regions combined) for all plans based on the Standardized Rating Tier factors in Section 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 rating tiers during the experience period as modified by the Market-Wide Index Rate Adjustment for such anticipated changes with support for such anticipated changes included in the actuarial memorandum.
15. Final Premium rates for Small Group plans for subsequent quarters in calendar year 2018 are determined by applying the appropriate trend rate (such trend rate should be consistent with the trend rate in Exhibit 19).