NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions for the Filing of 2021 Premium Rates
Individual and Small Group – "On" and "Off" Exchange Plans

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WHAT'S NEW FOR 2021?

This Section is intended to alert your attention to the more significant changes that are relevant to the 2021 rate filing process. Please note that this Section is not intended to be a comprehensive list of all changes and anyone who is involved in the preparation of a rate filing to which these instructions apply should review this entire document as there are additional changes.

1. **Risk Adjustment Guidance for 2021 Pricing:**

    a. **Regulation 146 Market Stabilization Pool:**

        i. Total expected market-wide payments and charges under the federal risk adjustment: For the purposes of developing 2021 premium rates in the individual and small group markets, insurers should assume that DFS will not make any adjustments to risk adjustment transfers or implement a market stabilization pool as authorized under the final amendments to Regulation 146 (11 NYCRR Part 361). DFS offers this guidance to assist insurers in using consistent assumptions for upcoming rate submissions for 2021. DFS retains full discretion to implement the market stabilization pool and make any or all adjustments authorized under the proposed or final amendment to Regulation 146 for each plan year, after reviewing the impact of the federal risk adjustment program on the individual and small group health insurance markets in New York, including payment transfers, the statewide average premiums, the ratio of claims to premiums, federal risk adjustment results, and carriers' risk adjustment assumptions included in the premium rates approved by the superintendent for the applicable plan year.

    b. **Risk Adjustment Data Validation (RADV):**

        i. Insurers may reflect up to +/- 1.0% of expected 2021 RADV transfers in their 2021 premium rates.

        ii. Any provision for RADV must be based on a prospective estimate of the expected 2021 RADV impact that is clearly explained and actuarially justified in the Actuarial Memorandum.

2. **Regional Premium Relativities:**

    a. For purposes of establishing regional relativities, the following guidelines are to be used and documented in the Actuarial Memorandum:

        i. Regional incurred claims net of regional risk adjustment transfers are to be used as the starting point to effectively remove health status.

        ii. To the extent that regional data is less than fully credible, an appropriate credibility procedure is to be used and must be fully explained in the Actuarial Memorandum

            1. Such procedure must be clearly defined and consistently applied (i.e., to all regions, all years, etc.)

            2. The procedure should clearly specify the insurer's standard for full credibility (e.g., in terms of the number of member months, or number of claims, etc.)

3. The procedure should also explain how the compliment of credibility is chosen. Such explanation should include the ranking of credibility compliments in situations where the insurer uses more than one option.

iii. Additional adjustments may be made to the extent they can be actuarially justified (e.g., to reflect regional differences in provider contracts, cost of living differences, pooling of the excess portion of high-cost claims across all regions, etc.) Any details included in the Actuarial Memorandum related to provider contracts may be redacted.

iv. Any instances where judgement is used to override an insurer's adopted credibility procedure must be fully explained in the Actuarial Memorandum.

v. All calculations associated with premium relativity determination should be provided in an Excel spreadsheet with all formulas included (i.e., there should be no "pasted values").

3. Healthy New York:

2021 Healthy New York Funding levels will be established to be consistent with a 17.5% reduction in claims for the program. For purposes of completing Line 39 of Exhibit 18, this is consistent with a factor of approximately 0.825. DFS will use this factor as the basis of determining the appropriate 2021 funding level.

4. Exhibits:

a. Exhibit 13c – Supplement: A new tab has been added to Exhibit 13 to capture premium, subscriber, and member information by metal level and rating tier. For additional information, see the "2021 Rate Filing Exhibit Instructions" Section of these instructions.

b. Exhibit 14 – The Exhibit instructions have been updated to clarify that:

i. The Total Number of Members and Subscribers in Cells H-24 and I-24 of that Exhibit should equal the totals in Cells Q-45 of Exhibit 13c and Cells Q-43 of Exhibit 13c-Supplement respectively (i.e., Only those members/subscribers currently enrolled in plans that will continue to be offered in 2021 should be reported); and

ii. The Total Annualized Premium in Cell G-24 of this Exhibit should equal the total in Cell Q-61 of Exhibit 13c.

c. Exhibit 15A: Discontinuance Certification: This Certification was introduced last year. For additional information, see the "2021 Rate Filing Exhibit Instructions" Section of these instructions.

d. Exhibit 15B: Mental Health Parity and Addiction Equity Act Certification: This Certification was introduced last year. For additional information, see the "2021 Rate Filing Exhibit Instructions" Section of these instructions.

e. Exhibit 18:

i. New Market-Wide Adjustments – the following Lines have been recently added:

1. Line 22: "Change in morbidity not reflected in the experience data that is known and quantifiable at the time of the rate filing": This adjustment is

intended to reflect information that is not reflected in the experience period data, related to events that have already occurred, which are known and quantifiable at the time the filing is submitted (e.g., significant membership changes between 12/31/2019 and 3/31/2020, etc.). This Line should not reflect any further projection of such change beyond what is actually known at the time of the filing. Any expected deterioration in morbidity in 2021 associated with Covid-19 may be reflected in Line 23c (see below).

2. **Line 23a:** "Impact of changes in New York State Law that are not reflected in the experience data": This Line is intended to capture the impact of new budget items, etc., that impact 2021 rates or that were introduced in the prior year for which the Company may not have experience due to the lag in pricing.

   Insurers should develop estimates as appropriate for any relevant items and develop a single factor that represents the combined impact of all such Items. Such factor is to be included in Line 23a of Exhibit 18. The Actuarial Memorandum should provide justification for each of the components of any factor that is included in Line 23a.

   Line 23b: 2020 Covid-19 Impact – Impact associated with state requirements that were intended to diagnose, treat, or avoid contact with Covid-19 which were imposed during the 2020 calendar year, but not included in 2020 pricing. Any such provision must be fully explained and actuarially justified in the Actuarial Memorandum. All relevant components of the factor should be separately itemized (e.g., SEP, waiving of cost sharing associated with testing of COVID-19, waiving of cost sharing associated with telehealth, waiving of preauthorization requirements, modifications to Rx supply restrictions, waiving of grace periods, etc.)

   Line 23c: 2021 Covid-19 Impact – Expected impact associated with worsening morbidity and other costs resulting from COVID-19 with respect to the 2021 calendar year. Any such provision must be fully explained and actuarially justified. No further projections (i.e., unrelated to COVID-19) of worsening morbidity beyond what is known at the time of the filing are to be included in the 2021 proposed rates.

Additionally, the Marketwide adjustment for the Health Insurance Providers Fee (ACA Provision 9010) has been removed.

ii. New Plan Level Adjustments (This was new for 2020):

1. A new line has been added (Line 45) to account for distribution by rating region of a particular plan. This line is intended to ensure that the weighted average PMPM value in Line 56 Column D (Cell D-104) matches the value in Cell Z-74 of Exhibit 13c.

f. Exhibit 19: This Exhibit has been eliminated.

g. Exhibit 22: This Exhibit has been modified to ensure more consistent reporting across insurers in an effort to better isolate the various cost drivers.

i. For 2021, we have provided additional SQL code which is to be used for purposes of populating the various columns that require service counts. This is in addition to the following changes that were introduced last year:

1. The Exhibit now includes separate tabs for "Non-Capitated" and "Capitated" claims (the tabs are otherwise identical. Non-Capitated claims should be reported separately from Capitated claims in the respective tabs.

2. The "Non-Capitated" tab of the Exhibit should be populated using the Company's 2019 and 2018 EDGE data (i.e., companies should not simply copy the 2018 values from last year).

3. For purposes of populating Columns 7 and 13 in the "Non-Capitated" tab of the Exhibit ("Amounts of Allowed Charges"), the SQL code provided by DFS should be used. This code can be found on our website in the same location as the 2021 Exhibits.

4. For purposes of populating Columns 6 and 12 in the "Non-Capitated" tab of the Exhibit ("Number of Services"), the SQL code provided by DFS should be used. This code can be found on our website in the same location as the 2021 Exhibits.

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

6. Insurers should first separate allowed amounts using the SQL code, then as a second step, develop "Number of Services" counts in a manner that results in the service counts being consistent with how the allowed amounts were separated in to the various categories.

ii. The new SQL code can be found on our website in the same zip file in which the Exhibits are found.

h. Exhibit 23 (these changes were introduced last year):

i. Two columns have been added to this Exhibit:

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

2. Column 21: "Company Network Identifier" – This field should be populated with the specific network identifier used internally by the Company.

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

5. **Commissions:**

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

    Insurance Circular Letter No. 20 (2017):

    https://www.dfs.ny.gov/insurance/circltr/2017/cl2017_20.htm

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

    https://www.dfs.ny.gov/insurance/circltr/2018/cl2018_s1_cl20_2017.htm

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

    https://www.dfs.ny.gov/insurance/health/faqs_cl2017_20_commissions.htm

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

    https://www.dfs.ny.gov/insurance/health/faqs_cl2017_20_oct18.htm

6. **2021 Filing Types:**

    a. **"2021 Prior Approval ACA Rates"** - If 2020 rates were filed in the relevant Market.

    b. **"Exchange Forms & Rates"** - If 2020 rates were not filed in the relevant Market.

    c. **"Off Exchange NG Forms & Rates"** - If 2020 rates were not filed in the relevant Market.

7. **2021 Rate Notice Templates:**

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

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

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

8. **2021 Standard Plan Documents:**

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

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

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

A. General Introduction:

These instructions apply to all comprehensive medical rate filings submitted in calendar year 2020 for premium rates effective in calendar year 2021, for Individual and Small Group plans, both "On" and "Off' Exchange.

For companies with 2020 rates on file in a particular market (i.e., Individual or Small Group), rate filings for calendar year 2021 are to be submitted pursuant to § 3231(e)(1) or § 4308(c) (Prior Approval Adjustment filings) for that market. Additional requirements, as specified by those Sections apply (e.g., notices of proposed rate changes to impacted policyholders at the time the rate filing is submitted, a notice of the approved rates to impacted policyholders 60 days prior to the effective date of renewal, specified time limits, etc.) Notices of proposed changes should be sent to policyholders after DFS has posted the rate applications (DFS will send a blast email to let insurers know when the posting has occurred). Note that for filings of this type, if the existing forms are being modified or if new plans are being introduced, then a separate Form Filing must be submitted. Both filings (i.e. the separate Rate and Form filings) must clearly reference each other by SERFF Filing Number.

For companies that do not have 2020 rates on file in a particular market, rate filings for calendar 2021 are to be submitted pursuant to § 3231(d) or § 4308(b) (Rate and Form filings) for that market.

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

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

B. Essential Health Benefits:

Companies must provide the Essential Health Benefits as specified in the 2021 model language.

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

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

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

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

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

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

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

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

D. Notice of Benefit and Payment Parameters for 2021:

Generally speaking, HHS final requirements for 2021 are expected to be similar to 2020 as they apply to rates. There is no change with regard to the requirements for the Index Rate or Single Risk Pools. However, as noted below, some changes have been introduced.

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

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

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

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

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

For 2021, the HHS prescribed self-only coverage MOOP limit is $8,550, and the family limit is $17,100.

(c) ACA Fees:

Affordable Care Act Provision 9010 - Health Insurance Providers Fee:

This fee has been repealed and therefore should not be reflected in 2021 premium rates.

Risk Adjustment User Fee:

Per the 2021 Proposed NBPP, the Risk Adjustment User fee will be $0.19 **per member per month**.

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

E. New York State Standard Benefit Design:

Standard benefit designs 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 (2021 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:
	Individual: -0%/+2%
	Small Group: -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.

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

The AV Metal Values determine what metal level a particular plan-design belongs in, and the 2021 HHS Actuarial Value Calculator must be used in the calculation of these AV Metal Values.

The final version of the 2021 AV Calculator and accompanying documentation can be found in the following locations:

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2021-AV-Calculator.xlsm

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2021-AV-Calculator-Methodology.pdf

G. Actuarial Value (AV) Pricing Values:

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

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

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

Note: This is for pricing purposes only. All ACA Compliant plans must fall within the AV Metal Values using the 2021 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 2021 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 (including Catastrophic) experience.

Accordingly, the pricing basis used must be consistent with the assumption that the Individual, Small Group, or Catastrophic Market is one standard population (i.e., The rating differential between plan-

designs in a given metal tier or a given rating region cannot, in whole or in part, be based upon differences due to age, sex, occupation or health status among the actual or assumed enrollees in a particular plan-design).

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

See Appendix C for additional details.

J. Standardized Rating Regions:

The ACA requires standardized rating regions. The Standardized Rating Regions for New York have not changed for 2021. Companies may vary premiums between standardized rating regions in accordance with HHS regulations and DFS Guidance.

K. Claims Experience Data:

(a) Small Group Plans:

For Companies currently participating in the Small Group market, premium rates for "On" and "Off" Exchange plans should be based on recent claims experience as reported in the appropriate categories of Exhibit 17.

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.

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

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

(b) Individual Plans:

For companies currently participating in the Individual market, the premium rates for Individual plans should be based on the claims experience of the company's 2019 ACA Compliant Non-Grandfathered Individual (including catastrophic) plans only.

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

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

L. Small Group Healthy New York Plans:

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

2021 Healthy New York Funding levels will be established to be consistent with a 17.5% reduction in claims for the program. For purposes of completing Line 39 of Exhibit 18, this is consistent with a factor of approximately 0.825. DFS will use this factor as the basis of determining the appropriate 2021 funding level.

M. Standardized Rating Tiers:

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

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

Rating tier factors for calendar year 2021 are **unchanged** from 2020.

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

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

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

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

O. HHS Rate Filing Requirements:

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

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

P. Rate Filings - Materials that must be Included:

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

(a) SERFF Filing Types:

- "2021 Prior Approval ACA Rates" – To be used if the legal entity for which the filing is being made currently has 2020 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 2020 rates on file with DFS in the applicable market, and plans will be sold both "On" and "Off" the Exchange.
- "Off Exchange NG Forms & Rates" - To be used if the legal entity for which the filing is being made does not currently have 2020 rates on file with DFS in the applicable market, and plans will be sold "Off" Exchange only.

(b) Required Exhibits by Filing Type:

Filings submitted under the SERFF Filing Type "2021 Prior Approval ACA Rates" must include the following Exhibits:

- 2021 Rate Filing Checklist;
- Exhibit 11: General Information;
- Exhibit 13 (A): Numerical Summary and Rate Indication Calculation;
- Exhibit 13 (B): Narrative Summary;

- Exhibit 13 (C): Two tabs: Average Premium Details and Distribution by Rating Tiers;
- Exhibit 14: Summary of Requested Percentage Changes;
- Exhibit 15a: Product Discontinuance Certification;
- Exhibit 15b: Mental Health Parity and Addiction Equity Act (MHPAEA) Certification;
- Exhibit 16: Summary of Policy Form and Product Changes;
- Exhibit 17: Historical Claims Data by Policy Forms included in Rate Adjustment Filing;
- Exhibit 18: Index Rate/Plan Design Level Adjustment Worksheet;
- Exhibit 21 (A): Hospital Unit Cost Development – Inpatient Services;
- Exhibit 21 (B): Hospital Unit Cost Development – Outpatient Services;
- Exhibit 22: Medical and Hospital Utilization Data;
- Exhibit 23: Summary of Requested 2021 Premium Rates;

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

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

- 2021 Rate Filing Checklist;
- Exhibit 11: General Information;
- Exhibit 15b: Mental Health Parity and Addiction Equity Act (MHPAEA) Certification;
- Exhibit 16: Summary of Policy Form and Product Changes;
- Exhibit 18: Index Rate/Plan Design Level Adjustment Worksheet;
- Exhibit 23: Summary of Requested 2021 Premium Rates;

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

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

(e) AV Calculations (AV Snapshots):

As an attachment to the Actuarial Memorandum, provide printouts of all AV calculation pages (snapshots) using the final HHS 2021 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 the HHS MLR report and the Supplemental Health Care Exhibit.

Q. 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 2019 results differ from the sources used to develop that factor.
        i. The above mentioned demonstration should clearly show how the various estimates used translate to the Company's expected 2019 payment or charge. The demonstration should also show how differences between the actual and expected 2019 results would impact the Company's expected results for 2021, as well as how those differences would impact the accompanying market-wide adjustment included in the 2021 rate application.
        ii. **This demonstration 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 2019 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 2021 premium rates. Such breakdown should include support for the unit cost, utilization, deductible leveraging, and projection components of the trend factor used in Exhibit 18. The breakdown should also address changes in provider contracts that impact trend.
    b. The Actuarial Memorandum should explicitly address any offsets to deductible leveraging which result from plan design modifications that are necessary 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 18 Supplement expense components from the prior year, and (b) a reconciliation with information on administrative costs reported in latest financial statements;
5. Assumptions for **profit** and contribution to surplus, including a discussion pertaining to Return on Equity;
6. Details regarding **adjustments to Actuarial Values** produced by the HHS AV Calculator;
7. Details regarding the **conversion factors** (Cells C-47, L-47 and U-47 of Exhibit 13c) used to convert Preliminary PMPM Rates to actual premium rates for each of the Standardized Rating Tiers prescribed by DFS. This should include information on the distribution of both individuals/subscribers and members by the various rating tiers. Additionally, any inconsistencies between the actual conversion factors used and the information contained in Exhibit 13c and 13c Supplement should be explained.

8. Regional Premium Relativities:

a. For purposes of establishing regional relativities, the following guidelines are to be used and documented in the Actuarial Memorandum:

i. Regional incurred claims net of regional risk adjustment transfers are to be used as the starting point to effectively remove health status.

ii. To the extent that regional data is less than fully credible, an appropriate credibility procedure is to be used and must be fully explained in the Actuarial Memorandum

1. Such procedure must be clearly defined and consistently applied (i.e., to all regions, all years, etc.)
2. The procedure should clearly specify the insurer's standard for full credibility (e.g., in terms of the number of member months, or number of claims, etc.)
3. The procedure should also explain how the compliment of credibility is chosen. Such explanation should include the ranking of credibility compliments in situations where the insurer uses more than one option.

iii. Additional adjustments may be made to the extent they can be actuarially justified (e.g., to reflect regional differences in provider contracts, cost of living differences, pooling of the excess portion of high-cost claims across all regions, etc.) Any details included in the Actuarial Memorandum related to provider contracts may be redacted.

iv. Any instances where judgement is used to override an insurer's adopted credibility procedure must be fully explained in the Actuarial Memorandum.

v. All calculations associated with premium relativity determination should be provided in an Excel spreadsheet with all formulas included (i.e., there should be no "pasted values").

9. 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 **Proprietary Studies** used to develop or modify premiums rates covered by this filing.
16. Details and support for any **other adjustments** that were made.
17. Data sources that are not based on the actual claim experience of the Company's ACA Compliant Non-Grandfathered plans must be clearly highlighted (e.g., the publication, organization, or specific consultant), and the applicability of the source must be justified.
18. **Description of Payments Related to Advanced Primary Care Payments**:
    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). 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 2021 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 2021, to (2) the total

projected premiums for 2021 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 2021 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 2021 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.

R. Rate Manuals:

(a) Premium Rate Manuals – General Instructions:

Rate manuals must be submitted with the rate filings.

Premium rates for Small Group, "On" and "Off" Exchange 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 2021.

(b) Premium Rate Manuals – Required Items:

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

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

   https://www.dfs.ny.gov/insurance/circltr/2011/cl2011_15.htm;

6. An explanation of how the premium rate for a specific plan design is determined, including an example of the actual rate calculation (i.e. showing how the rate tables and formulas included in the rate manual are used to determine the final rate for a given plan design);
7. A detailed description of the cost sharing provisions applicable to each plan-design, including details on prescription drugs;
8. 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".
9. The Standardized Rating Tiers and accompanying factors as prescribed by DFS must be included.
10. Factors for Geographic Rating Regions must be included.
11. A listing of the counties included in each region in which the Company plans to market each of its products;
12. Other information as applicable.

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

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

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

S. Actuarial Memorandum - Actuarial Qualifications:

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

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

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

(a) The filing is in compliance with all applicable laws and regulations of the State of New York;

(b) The filing is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including but not limited to:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Plan Entities
- ASOP No. 12, Risk Classification

- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 41, Actuarial Communications
- ASOP No. 42, Determining Health and Disability Liabilities other than Liabilities for Incurred Claims
- ASOP No. 45, The Use of Health Status Based Risk Adjustment Methodologies
- ASOP No. 50, Determining Actuarial Value and Minimum Value under the ACA

(c) These rates have been established to produce an expected loss ratio that meets the minimum requirement of the State of New York;

(d) The benefits are reasonable in relation to the premiums charged; and

(e) The premiums are not unreasonable, excessive, inadequate, or unfairly discriminatory.

U. Objection Letters:

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

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

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

V. Additional Requirements:

(a) Filing Type Codes

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

Prior Approval Rate Adjustment Filings (Companies with 2020 rates on file):
"2021 Prior Approval ACA Rates" - Note that there is only one filing type under this category as "On" and "Off" Exchange rate filings must be combined.

Rate and Form Filings (Companies that do not have 2020 rates on file):

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

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

(b) Format of Attachments:

Each attachment to the rate adjustment filing must be compatible with the following software: Microsoft Word 2013 (or higher), Microsoft Excel 2013 (or higher), or Adobe Acrobat 9.

When an attachment is submitted via SERFF in a format other than an Adobe Acrobat PDF, another copy of that attachment is to also be included in Adobe Acrobat PDF file format. This can occur when one of the standard exhibits is required to be submitted as an Excel workbook,

or when an appendix/attachment to the Actuarial Memorandum is submitted in other than PDF format. Failure to include a PDF version of each attachment will result in a notification letter being sent for the missing material.

(c) SERFF/HHS Requirements:

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

(d) Filing Amendments:

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

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

W. Other Miscellaneous Items:

(a) Membership Survey as of March 31, 2020:

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.htm;

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

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

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

(c) Minor/Major Changes in Benefits:

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

Major benefit changes (e.g., introduction of new plans not offered in 2020, 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 2020, rate filings for premium rates to be effective in calendar year 2021 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 and 18 related to Incurred Claims, Risk Sharing Adjustments, Expenses and Profit Provision, and other items.

Care should be exercised in the preparation of 2021 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 annual premium rates (they should be expressed as Annualized PMPM premium rates);

(5) Screen shows "N/A" under "Forms, Affected Forms and Other Affected Forms"; items must be left blank if they do not apply (i.e., making an entry implies the form is impacted);

(6) Requested Rate Period data is all zeroes in some cases, the projected premiums and claims required revisions to reflect projected membership, and/or Minimum, Maximum, and Average PMPM values were not provided.

Note that for 2021 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

2021 Rate Filing Exhibit Instructions

General

For a given Market, 2021 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 2021 Rate Filing Exhibits include controls intended to facilitate the efficient processing of the data being submitted as well as to ensure that the playing field is level. These Exhibits should not be "unlocked" for the purposes of modifying them in any way.

Exhibit 11 - General Information about the Rate Filing

This Exhibit provides general information about the rate filing.

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

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

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

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

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:

Exhibit 13a

A. 2020 and 2021 Weighted Average Base Premium Rates:

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

B. Weighted Average Annual Percentage Adjustments (2020 to 2021):
The Weighted Average PMPM Rates for 2020 and 2021 are required fields. These numbers should come from Exhibit 13c (Cells Q-74 and Z-74 of Exhibit 13c).

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

D. Average Medical Loss Ratios for 2017-2019:
The MLRs reported in this Section should be calculated as total Incurred Claims (Net of federal risk adjustment) divided by Earned Premium for the applicable calendar year. Claim and premium amounts should be consistent with Exhibit 17. Federal risk adjustment and reinsurance amounts should be based on final amounts for 2017 and 2018, and Interim results for 2019.

E. Claim Trend Rates and Ratios to Earned Premiums (2019-2021):

E 1 Claim Trend Rates (2019-2021):
Enter the claim trend rates associated with 2020 and 2021 as reported in the "Expected" columns of the Company's Exhibit 18 Supplement. For 2019, enter the claim trend rate as reported in the "2019 Actual" column of Exhibit 18 Supplement . If not applicable, enter "N/A".

E 2 Ratios to Earned Premiums (2019-2021):
Enter the relevant ratios associated with 2020 and 2021 as reported in the "Expected" columns of the Company's Exhibit 18 Supplement. For 2019, enter the relevant ratios as reported in the "2019 Actual" column of Exhibit 18 Supplement. If not applicable, enter "N/A".

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

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

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

H. All weighted averages in Exhibits 13A and 13C should be calculated using membership as of 3/31/2020.

Exhibit 13c

A. The "Weighted Average Monthly Base Premiums" in rows 24-31 of Exhibit 13c, should be subscriber weighted averages calculated as the sum of the single adult rates (prior to the application of rating tier factors) multiplied by the number of subscribers for each plan divided by the total number of subscribers for each cell (combination of metal level and region). Note that there are three separate Sections where this calculation takes place (2020 Actual as of 3/31/2020, 2020 recalculated using only those subscribers that are enrolled in plans that will

continue to be available in 2021, and 2021 calculated using only those subscribers that are enrolled in 2020 plans that will continue to be available in 2021).

B. Rows 37-44, Columns C-G are to be populated with actual membership as of 3/31/2020.

C. Rows 37-44, Columns L-P are to be populated with the subset of members in (B) above that are enrolled in plans that will continue to be offered in 2021 (i.e., if the Company is not retiring/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-47, L-47, and U-47 (i.e., the reciprocal of the factor needed to convert PMPM rates to Base rates).

Exhibit 13c Supplement

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

A. The "Weighted Average Monthly Tier Premiums" in rows 28-32 of the Exhibit 13c Supp Tab should be populated with the subscriber weighted average premiums calculated as the sum of the monthly premiums the subscribers would actually be charged (**Base premium times the appropriate rating tier factor**) multiplied by the number of subscribers for each plan, divided by the total number of subscribers for each cell (combination of metal level and rating tier). Columns C-G should be based on the actual number of subscribers as of 3/31/2020. Columns L-P and U-Y should be based on the subset of the actual number of subscribers as of 3/31/2020 that are enrolled in plans that will continue to be offered in 2021.

B. For Rows 38-42, Columns C-G are to be populated with the actual number of subscribers enrolled in each metal level and rating tier as of 3/31/2020. Columns L-P are to be populated with the subset of subscribers reported in Columns C-G who are enrolled in plans that will continue to be available in 2021 (i.e., if the Company is not retiring/discontinuing any plans, the subscribers in Columns C-G and L-P will be the same).

C. For Rows 48-52, Columns C-G are to be populated with the actual number of members enrolled in each metal level and rating tier as of 3/31/2020. Columns L-P are to be populated with the subset of members reported on Columns C-G that are enrolled in plans that will continue to be offered in 2021 (i.e., if the Company is not retiring/discontinuing any plans, the members in Columns C-G and L-P will be the same).

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

This Exhibit is applicable to Prior Approval Adjustment filings only.

Exhibit 14: Summary of Requested Percentage Changes:

This Exhibit provides details of the premium rate changes between 2021 requested and 2020 approved rates.

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

Effective dates are 1/1/2021 for all Individual plans, and 1/1/2021, 4/1/2021, 7/1/2021 or 10/1/2021 for Small Group plans.

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

Please note:

- The Total Number of Members and Subscribers in Cells H-24 and I-24 of Exhibit 14 should equal the totals in Cells Q-45 of Exhibit 13c and Cells Q-43 of Exhibit 13c-Supplement respectively (i.e., Only those members/subscribers currently enrolled in plans that will continue to be offered in 2021 should be reported); and
- The Total Annualized Premium in Cell G-24 of this Exhibit should equal the total in Cell Q-61 of Exhibit 13c.

Exhibit 14 applies to Individual and Small Group Plans (**Calculations must be based on membership as of 3/31/2020**).

This Exhibit is applicable to Prior Approval Adjustment filings only.

Exhibit 15A: Discontinuance Certification

The rate adjustment submission must include a written certification with respect to any comprehensive medical expense products that the issuer intends to discontinue for 2021. A certification must be provided for each product to be discontinued for 2021. The certification must be signed by an officer of the issuer with knowledge of the issuer's comprehensive medical expense products and the laws and regulations applicable to those products. The certification shall be submitted as Exhibit 15a.

The certification must include:

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

In addition to providing the certification as part of the rate adjustment submission, an issuer planning to discontinue a comprehensive medical expense product in 2021 must also follow the instructions posted to the DFS website for formally notifying the Superintendent of a planned discontinuance at least 30 business days prior to mailing any notices of discontinuance to policyholders and/or insureds.

NOTE: A "product" is defined under federal rules as a "discrete package of health insurance coverage benefits that are offered using a particular product network type (such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity) within a service area." A product is comprised of "plans" with the same characteristics (benefits, cost sharing and network structure, and service area). See 45 CFR 144.103.
A change to a single plan, a decision not to offer a particular plan, or adding a plan to a product would not, by itself, constitute a product discontinuance unless the change exceeds the scope of a uniform modification for the product. See Uniform Modification and Plan/Product Withdrawal FAQ (June 15, 2015), available at

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

See guidance on DFS website at:

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

Uniform modifications should be communicated to enrollees in renewal notices.

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

Exhibit 15B: MHPAEA Certification

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

Exhibit 16 - Summary of Policy Form and Product Changes

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

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

Exhibit 17 – Historical Claim Experience Data by Policy Forms

This exhibit illustrates the premiums and claims experience for the prior two (2) calendar years (2018 and 2019) 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 2021.

Individual: All of the Company's 2018 and 2019 Individual experience (including the experience of catastrophic plans) should be included in this Exhibit.

Small Group: For each applicable year, this Exhibit should include all experience associated with those specific groups that were considered "small" in the relevant calendar year (i.e, regardless of whether or not a group was considered "large" in a different year). The information provided in this Exhibit should be consistent with what was reported in the Company's New York Supplement.

The policy forms covered by this Exhibit are those for all ACA compliant plans, as described in the table below, providing comprehensive benefits for hospital, medical and prescription drugs charges. This

Exhibit should **not** include non-ACA compliant plans (e.g., grandfathered plans, Individual Direct Pay plans, indemnity plans, etc.). Note that discontinued/retired plans are **not** to be excluded. This Exhibit will be used in our analysis of the claims experience for prior years and to assist in our evaluation of the Company's development of 2021 premium rates for "On" and "Off" Exchange plans for both Individual and Small Group business.

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

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

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

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

e. Column 3 Effective Date of Last Rate Change: Indicate the date on which the latest approved rate scale became effective (e.g., 1/1/2020 for individual ACA-Compliant plans).

f. Column "5A. Rating Region" was recently added. All 2019 and 2018 experience must be broken out by rating region.

g. Columns 8 and 9: Enter the number of policyholders (number of Small Group accounts) and the number of covered lives (members) affected by this rate filing, as of December 31, 2019.

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 2019 experience period runs from 1/1/2019 – 12/31/2019. The 2018 experience period runs from 1/1/2018 – 12/31/2018.

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 2018 experience period, such estimate should reflect all known claims through the current date (i.e., Insurers should not simply copy the 2018 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.

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**.**

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

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

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

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

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

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

Market	Description	Market Segment (Entry for Exhibit 17, Column 4)	Group Definition	Counting Method	Notes	Standardized Premium Scale
Individual	ACA Compliant Individual Plans	Individual-ACA	N/A	N/A	Issued on or after 1/1/2018	2020 Rates
Catastrophic	ACA Compliant Catastrophic Plans	Catastrophic	N/A	N/A	Issued on or after 1/1/2018	2020 Rates
Small Group	Experience of ACA Compliant Small Group Plans (Excluding Healthy New York plans) that were written or renewed on or after 1/1/2017	SG-ACA-FTE	1-100	Current New York (FTE)	All relevant experience in the calendar year	4th Quarter 2020 for rolling; 2020 for non-rolling
Small Group - HNY	Experience of Small Group Healthy New York Plans that were written or renewed on or after 1/1/2017	SG-ACA-HNY-FTE	1-50	Current New York (FTE)	All relevant experience in the calendar year	4th Quarter 2020 for rolling; 2020 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 2019:

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

All insurers must use actual 2019 experience as the starting point for the Index Rate regardless of credibility. Cell D-30 (Line 10A, Column D) should equal the Market total reported in Column 14.7 of Exhibit 17. Cell D-31 (Line 10B, Column D) should equal the Market total reported in Column 14.3 of Exhibit 17. Any adjustments that may be necessary to account for lack of credibility are to be included in Line 20 and must be fully explained and justified in the Actuarial Memorandum. Line 10C (Average PMPM Incurred Claims) will be calculated as line 10A divided by Line 10B.

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

a3. Go to step b.

For Companies that did not participate in the relevant Market during calendar year 2019:

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

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

a6. Go to step b.

For all Companies regardless of whether they participated in the relevant market in calendar year 2019:

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. 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" (Line 27). All "Other" adjustments should be fully explained and justified (as well as itemized) in the Actuarial Memorandum.

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

d. Factors for any relevant Plan Level Adjustments as described in 45 CFR 156.80(d)(2) are to be entered in Lines 30 through 46 as appropriate for each plan. With regard to Lines 46a – 46d ("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 4" (Line 46d). All "Other" adjustments should be fully explained and justified (as well as itemized) in the Actuarial Memorandum. The combined impact of plan specific values in Line 47 is calculated as the product of Lines 30 through 46 for each specific plan. The overall "Impact of Plan Wide Adjustments" in Line 47, Column D is calculated as the weighted average of the plan specific values.

e. Line 43: "Premium Curve Adjustment"

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

2021 premium rates should be developed in the same manner as years past with the following exceptions:

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

Premium Curve (Slope) Adjustment:

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

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

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

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

between 0.710 and 0.770 to a tiered network silver plan, all other things being equal).

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

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

2. Apply a uniform factor to all of the Company's premium rates that eliminates any rate impact which results from applying Step 1. This adjustment should also be included in Line 43 of Exhibit 18 and should result in Cell D-75 (Line 43 Column D) being equal to 1.0000.

f. Line 44: "Impact of loss of CSR Funding (A common factor to be applied uniformly to all silver plans only - if applicable)"

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

Note that rates should be developed in the same manner as years past and this adjustment should be applied as a last step in the rate development process. ANY FACTORS INCLUDED IN LINE 43 MUST BE CALCULATED SUCH THAT THE OVERALL IMPACT IS REVENUE NEUTRAL.

g. A new line has been added (Line 45) to account for distribution by rating region of a particular plan. This line is intended to ensure that the weighted average PMPM value in Line 56 Column D (Cell D-104) matches the value in Cell Z-74 of Exhibit 13c.

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

i. Line 54 should be populated with actual 2020 PMPM rates for each of the respective plans and Line 55 should be populated with actual membership as of 3/31/2020.

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

Additional Notes

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

2. Information in Lines 50 - 52 (Administrative Expense and Profit) must be provided for each specific plan (i.e. average values may not be used) and must be consistent with Exhibit 18 Supplement. Note that any variable expenses should be expressed as a constant percentage value that is the same for all plans. Likewise, any fixed expenses should be expressed as a

constant PMPM value that is the same for all plans. Additionally, all expense and profit must be reflected in Lines 50 - 52.

3. See Appendices A and B for additional details regarding the general rate development process.

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

Exhibit 18 – Supplemental Exhibit

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

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

Exhibit 21 - Hospital Unit Cost Development:

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

a. From calendar year 2020 to calendar year 2021; and

b. From calendar year 2019 to calendar year 2020; and

c. From calendar year 2018 to calendar year 2019.

As noted on the Instructions tab of this Exhibit, actual allowed amounts are requested for 2019. These 2019 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 2018 to 2019, 2019 to 2020, and 2020 to 2021) can be determined.

Exhibit 21A applies to Inpatient Services.

Exhibit 21B applies to Outpatient Services.

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

Exhibit 21 will not be posted on our website.

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

This Exhibit is applicable to Prior Approval Adjustment filings only.

Exhibit 22 - Medical and Hospital Utilization:

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

a. The Exhibit now includes separate tabs for "Non-Capitated" and "Capitated" claims (the tabs are otherwise identical. Non-Capitated claims should be reported separately from Capitated claims in the respective tabs.

b. The “Non-Capitated” tab of the Exhibit should be populated using the Company’s 2019 and 2018 EDGE data (i.e., companies should not simply copy the 2018 values from last year).

c. For purposes of populating Columns 7 and 13 in the ”Non-Capitated” tab of the Exhibit (“Amounts of Allowed Charges”), the SQL code provided by DFS should be used. This code can be found on our website in the same location as the 2021 Exhibits.

d. For purposes of populating Columns 6 and 12 in the “Non-Capitated” tab of the Exhibit (“Number of Services”), the SQL code provided by DFS should be used. This code can be found on our website in the same location as the 2021 Exhibits.

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

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

This exhibit requires details regarding the medical/hospital services provided in the Individual and Small Group Markets, separately for calendar years 2019 and 2018.

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)).

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

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

Exhibit 23 - Summary of Requested 2021 Premium Rates:

The purpose of this exhibit is to provide the actual distribution of all base Premium Rates for all Metal Tiers and Rating Regions as well as to facilitate the mapping of premium rates in the Rate Manuals to the premium rates in the Binder filings. This Exhibit is applicable to both (a) Rate and Form filings and (b) Prior Approval Adjustment filings.

Information requested includes:

a. Company Name; and
b. NAIC Code; and
c. SERFF Filing Number; and
d. Market (i.e., Individual or Small Group); and
e. HIOS ID Number (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 (Including Silver CSR and Catastrophic 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; and
q. Tiered Network indicator; and
r. HSA indicator; and
s. PNDS identifier; and
t. Company Network identifier; and
u. Premium Rates by Standardized Rating Region (2018 - 2021); and
v. Member Months by Standardized Rating Region by calendar year (2018 and 2019); and
w. Actual member counts as of 3/31/2020 – all members; and
x. Actual member counts as of 3/31/2020 – only those members currently enrolled in 2020 plans that will continue to be offered in 2021; and
y. Actual member counts as of 3/31/2020 – only those members currently enrolled in 2020 plans. **Item (y) applies to Small Group Only.**

For Individual plans, the premium rates are the requested 2021 calendar year rates for the Single Adult Rating Tier only.

For Small Group plans, the premium rates are the first quarter requested 2021 rates for the Single Adult (Subscriber) Rating Tier.

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

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

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions for the Filing of 2021 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, 2021 and is expected to be revised for January 1, 2022. The rate applicability period for this table is January 1, 2021 through December 31, 2021.

   (ii) Example 2 (Small Group Plans): A quarterly rolling rate table is developed for issues and renewals in January – March 2021 and incorporates a 12-month rate guarantee period. The rate applicability period for this table is January 1, 2021 through March 31, 2022.

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

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

APPENDIX A

General Overview of Pricing Development:

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

1. For each In-force plan-design, determine the applicable Metal Level, using the HHS AV Calculator.
2. For each In-force plan-design, determine the AV Pricing Value with the restrictions mentioned in Section H (Induced Demand) above.
3. For all in-force plans, determine the weighted-average "AV Pricing Value" and the weighted-average "Induced Demand" factor, using member months as weights (for the most recent experience period as submitted in Exhibit 17). The weighted-average AV Pricing Value should include the Induced Demand component.
4. For all in-force plans combined, determine the Average PMPM Incurred Claims for the latest experience period (without any adjustment for the 3Rs, Healthy New York Stop-Loss Reimbursements, or any other reinsurance/stop-loss arrangements).
5. Project the average PMPM Incurred Claims in (4) above for the impact of claim cost trend, from the mid-point of the experience period to the midpoint of the period for which the rates will be in effect (i.e., it should be assumed that individual rates will be in effect for a full calendar year and that small group rates will be in effect through the first quarter of 2021).
6. For all in-force plans combined, determine the "Index" PMPM applicable to all plans ("On" and "Off" Exchange) combined. This step reflects all Market-Wide adjustments.
7. Determine the provision for incurred claims for each plan (to be sold both "On" and "Off" Exchange) based on the Index PMPM Rate determined in (6) above, times (A) over (B), where (A) and (B) are:
    A. The AV Pricing Value determined for each plan; and
    B. The Average AV Pricing Value (per (c) above) for all in-force plans
8. Determine the PMPM rates for each plan based on (7) above, plus Plan-Level adjustments for administrative costs and profit margins and all other Plan-Level changes, not already reflected, as discussed above. Note that such adjustments may vary at the plan level.
9. The process described above is simplified and does not discuss details by (a) Rating Tiers, (b) Rating Regions, and (c) Applicable Effective Quarters. These items are addressed in Appendix B.

APPENDIX B

Process in Development of Index Rates and Premium Rates:

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

1. Average PMPM Incurred Claims for the latest experience period (1/1/2019 – 12/31/2019, with 2 months of claim run-out) for all non-grandfathered in-force plans combined. Discuss whether any particular products were excluded and the rationale for doing so.
2. Average AV Pricing Value determined for all in-force plans in effect during the latest experience period, based on member-months in the experience period for each in-force plan. Note that this average AV Pricing Value reflects the impact of Induced Demand.
3. Average Induced Demand Adjustment factor determined based on member-months in the experience period for each in-force plan. Note that this should be the value that has already been reflected in step (2) above.
4. Assumptions for all components of claim trend, including inflation, utilization, leverage, and other factors.
5. The factor used to project the assumed underlying claim trend from the midpoint of experience period to midpoint of the period for which the proposed rates will be in effect.
6. Projected Average PMPM Incurred Claims determined from steps (1) and (5) above.
7. Market-wide index rate adjustments as discussed in Appendix C below. The Actuarial Memorandum must explain how the Company developed its adjustment for the Federal Risk Adjustment.
8. For all in-force plans combined, determine the "Index" PMPM Rate. This step reflects the Projected PMPM Incurred Claims per (6) above with Market-Wide adjustments prescribed by HHS regulation per step (7) above. Note that such adjustments may not vary by plan.
9. Determine the starting point PMPM Rate for each Non-Grandfathered Plan (both "On" and "Off" Exchange) by multiplying the Index PMPM Rate for all in-force plans combined per step (8) above by the ratio of (A) to (B), where (A) and (B) are:
    A. The AV Pricing Value for each Non-Grandfathered Plan, both "On" and "Off" Exchange, at each of the Metal Tier levels; and
    B. The Average AV Pricing Value per step (2) above for all in-force plans.

    The AV Pricing Values used in (A) and (B) are the total AV Pricing Values that reflect induced demand.
10. Plan-Level Adjustments for the various items described above. Full details must be provided in the Actuarial Memorandum for each such item (even if no adjustment is being made for a particular item). The adjustments, and accompanying results, must be indicated.
11. Administrative Expense and Profit values may not vary by plan level, Metal Tier, or rating region.
12. Determine preliminary PMPM Premium Rate for each plan ((12) = {(10) / [1.00 – (11)]}).
13. Calculate final premium rates (for all Regions combined) for the various rating tiers that are required in New York: A conversion factor (i.e., to convert PMPM rates to

Individuals/Employees premium rates, etc.) must be developed and fully explained in the Actuarial Memorandum. Such conversion factor must be based on the distribution of members and subscribers (individuals/employees) by rating tiers during the experience period used in step (1) above as modified by the Market-Wide Index Rate Adjustment for such anticipated changes with support for such anticipated changes included in the Actuarial Memorandum.

14. Calculate final premium rates (all regions combined) for all plans based on the Standardized Rating Tier factors in Section M above. The Actuarial Memorandum must clearly outline the development of the conversion factor used to convert preliminary rates to final rates. Such conversion factor must be based on the distribution of enrollees by rating tiers during the experience period as modified by the Market-Wide Index Rate Adjustment for such anticipated changes with support for such anticipated changes included in the actuarial memorandum.
15. Final Premium rates for Small Group plans for subsequent quarters in calendar year 2021 are determined by applying the appropriate trend rate.

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

Market-Wide Index Rate Adjustments:

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

1. Impact of 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);
2. 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;
3. Impact of provider fee schedule changes;
4. Impact of utilization management changes;
5. Market wide adjustment for impact on claim costs from quality improvement and cost containment initiatives;
6. Impact of medical inflation (i.e., trend);
7. Total expected market-wide payments and charges under the federal risk adjustment: For the purposes of developing 2021 premium rates in the individual and small group markets, insurers should assume that DFS will not make any adjustments to risk adjustment transfers or implement a market stabilization pool as authorized under the proposed or final amendments to Regulation 146 (11 NYCRR Part 361). DFS has previously indicated that it will consider a market stabilization pool for the 2019 and 2020 plan years, after it receives all relevant information. In light of the timing of receipt of information for those prior plan years, certain changes in the market and federal actions and inactions, DFS offers this guidance that insurers should not include an assumption for a New York market stabilization pool in 2021 rates solely to assist insurers in using consistent assumptions for upcoming rate submissions for 2021. DFS retains full discretion to implement the market stabilization pool and make any or all adjustments authorized under the proposed or final amendment to Regulation 146 for each plan

year, after reviewing the impact of the federal risk adjustment program on the individual and small group health insurance markets in New York, including payment transfers, the statewide average premiums, the ratio of claims to premiums, federal risk adjustment results, and carriers' risk adjustment assumptions included in the premium rates approved by the superintendent for the applicable plan year.

8. Impact of adjustments for the experience period claim data not being sufficiently credible.
9. Impact of anticipated changes in the distribution of membership in the risk pool across the standard rating regions.
10. Change in morbidity not reflected in the experience data that is known and quantifiable at the time of the rate filing.
11. Impact of ACA Provision 9010 - Health Insurance Providers Fee.
12. Impact of changes in New York State Law that are not reflected in the experience data.

Plan-Level Adjustments:

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

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

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

(b) Rating Region Factor – This line is intended to capture plan distribution differences across regions that would otherwise result in the value in Line 56, Column D (Cell D 104) of Exhibit 18

being different from Cell Z-74 of Exhibit 13c (i.e., Cell D-104 of Exhibit 18 should be the same as Cell Z-74 of Exhibit 13c).