# New Hampshire Individual and Small Group Rate Filing User Guide

***** This User Guide corresponds to version 6 of the Excel template *****

**PURPOSE OF THIS USER GUIDE:** This user guide and corresponding exhibits were developed to bring increased standardization and transparency to the rate review process in New Hampshire for the Individual and Small Group Markets. The rate exhibits also assist the state of New Hampshire in maintaining its effective rate review status. The purpose of this user guide is to provide guidance for both the carriers and the New Hampshire Insurance Department (NHID) on how to complete the corresponding set of exhibits. This user guide also provides information as to how the NHID will use and interpret each exhibit including areas where additional follow-up with the carrier may be necessary depending on the information provided by the carrier. It is expected that every time rates are filed a single set of exhibits will be provided for the corresponding market segment and corresponding legal entity.

It is assumed that the readers of this user guide possess knowledge of the New Hampshire health insurance market, New Hampshire health insurance rules and laws (RSA Chapter 420-G and NHCAR Part INS Chapter 4100), and knowledge of the Affordable Care Act (ACA), in particular the federal final rule on Health Insurance Issuer Rate Increases: Disclosure and Review Requirements (45 CFR 154).[1] In addition, the reader should be knowledgeable of the actuarial principles used to complete health care rate filings and be familiar with the following Actuarial Standards of Practice (ASOP's):

1. ASOP 5: Incurred Health and Disability Claims
2. ASOP 8: Regulatory Filings for Health Plan Entities
3. ASOP 12: Risk Classification (for All Practice Areas)
4. ASOP 23: Data Quality
5. ASOP 25: Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
6. ASOP 26: Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
7. ASOP 41: Actuarial Communications

Carriers should review the most recent set of Unified Rate Review instructions and template. As of the writing of this document, the latest version was posted by CMS in January 2019.[2]The NHID may request additional information beyond the items requested in this user guide if deemed necessary to complete their rate review.

Throughout the Excel-based exhibits specific items are shaded in blue, green or gray. Items in blue represent numerical inputs. Items in green represent text inputs. Items in gray represent pre-populated

[1] Federal Register—Health Insurance Market Rules; Rate Review (Feb. 27 final rule): http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf

[2] https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10379.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending

items, either as the result of a calculation from a formula or a direct input from another source within the rate filing.

**RATE FILING EXHIBITS**

The table below lays out each of the requested exhibits and indicates whether it is a public exhibit and whether it is requested in an Excel or PDF format. This table is also found in Exhibit A1: Cover Sheet. Two exhibits were modified in version 6 of the Excel template primarily based on changes to the Unified Rate Review Template (URRT.) This includes Exhibit A2a and Exhibit A2.

| Exhibit Name | Public? | Excel or PDF? |
|---|---|---|
| Exhibit A1: Cover Sheet | Y | Excel |
| Exhibit A2a: Modified URRT Worksheet 1 | Y except for detailed trend | Excel |
| Exhibit A2: Proposed Rate Change and Enrollment by Health Coverage Plan | Y | Excel |
| Exhibit A3: History of Rate Changes | Y | Excel |
| Exhibit A4: Distribution of Rate Changes | Y | Excel |
| Exhibit A5: Components of the Average Proposed Rate Change | Y | Excel |
| Exhibit A6: Narrative Description of Rate Change *(Non-Standardized Exhibit)* | Y | PDF |
| Exhibit B1: Plan Design and Plan Relativity Factors | Y | Excel |
| Exhibit B2: Support for AV Metal Values for Unique Plan Designs *(Non-Standardized Exhibit)* | Y | PDF |
| Exhibit C3: Support for Exhibit A2 and A2a- Other than Trend *(Non-Standardized Exhibit)* | Y | PDF |
| Exhibit C4: Support for URRT Worksheet 2- Other than AV Metal Values *(Non-Standardized Exhibit)* | Y | PDF |
| Exhibit D1: Description of Trend Assumptions *(Non-Standardized Exhibit)* | N | PDF |
| Exhibit D2: Supporting Schedules for Trend Development *(Non-Standardized Exhibit)* | N | PDF |
| Exhibit E2: Administrative Charges | Y | Excel |
| Exhibit E3: Retention Charges | Y | Excel |

| | | |
|---|---|---|
| Exhibit G1: Individual Market Example 1 *(Non-Standardized Exhibit)* | Y | PDF |
| Exhibit G2: Individual Market Example 2 *(Non-Standardized Exhibit)* | Y | PDF |
| Exhibit G3: Small Group Market Example 1 *(Non-Standardized Exhibit)* | Y | PDF |
| Exhibit G4: Small Group Market Example 2 *(Non-Standardized Exhibit)* | Y | PDF |
| Exhibit G5: Illustrative Rates | Y | Excel |
| Exhibit H1: Summary of Rating Factors | Y | Excel |
| Exhibit H2: Rating Factors *(Non-Standardized Exhibit)* | Y | PDF |
| Exhibit H3: Description of Rating Factors *(Non-Standardized Exhibit)* | Y | PDF |
| Exhibit H4: Expected Distribution of Rating Factors *(Non-Standardized Exhibit)* | Y | PDF |
| Exhibit M1: Medical Loss Ratio Exhibit for Individual Market | Y | Excel |
| Exhibit M2: Medical Loss Ratio Exhibit Small Group Market | Y | Excel |
| Exhibit M3: Description of Methodology for Projected Medical Loss Ratio *(Non-Standardized Exhibit)* | Y | PDF |

**A. <u>Proposed Rate Change Exhibits:</u>** The exhibits in this section provide information on the proposed rate change including the average rate change by health coverage plan, membership by health coverage plan, history of past rate changes, distribution of the proposed rate changes and breakdown of the components of the average rate change. This section also includes a cover sheet with high level information related to the rate filing.

**<u>Exhibit A1: Cover Sheet</u>**

**<u>Instructions:</u>** This exhibit contains two sections: Rate Filing Information and Rate Filing Exhibits. The first section contains a series of ~~several~~ items, some items with multiple sub-parts. The carrier is asked to state their name, NAIC Company Code, HIOS Issuer ID, SERFF Tracking ID, the

plan type or plan types (e.g. HMO, POS, PPO, Indemnity, etc.) being filed, market segment, rate effective date for this rate filing and the rate effective date for the most recently approved rate filing. The carrier is then asked to provide contact information for the person responsible for completing the filing. The carrier is also asked to indicate whether there have been any changes to the rating methodology or the benefits offered and, if so, to describe these changes. The carrier is asked to indicate if this is a new rate filing (i.e. new product filing) or a rate revision filing. The carrier is also asked to indicate if this filing represents an amendment to a previously submitted filing or not. Then the carrier is asked to indicate if this rate filing includes all of the carrier's health insurance rates for the applicable market segment and, if not, provide an explanation as to why. The carrier is also asked to indicate whether it intends to charge rates for subsequent renewal or issue dates by multiplying the rates within the rate filing by prospective trend adjustments. If yes, the carriers must indicate all the rate effective dates included with this filing and include the prospective trend adjustments in Exhibit A2a. The second section of this exhibit asks the carrier to indicate that all requested exhibits have been provided and are complete, noting that some exhibits are only applicable to one market segment (Exhibit G1-G4 and Exhibit M1-M2.)

**Exhibit Purpose:** This exhibit provides high-level information to the NHID related to the rate filing.

**Exhibit A2a: Modified URRT Worksheet 1**

**Instructions:** The top part of this exhibit mirrors the federal Unified Rate Review Template (URRT) Worksheet 1 as of January 2019. The carrier should complete this portion exactly as it would complete the URRT Worksheet per the federal instructions. The carrier should enter an expected risk adjustment receipt or reinsurance receipt as a POSITIVE number and an expected risk adjustment payment as a NEGATIVE number. This is consistent with the federal Part I instructions, but this will differ from how the information is requested in other parts of the NHID Excel template. Also note, consistent with the URRT, reinsurance and risk adjustment are PMPM values while exchange user fees are represented as a percentage.

The detailed trend information in this exhibit is deemed confidential. **In order for the carrier to comply with the instructions to maintain appropriate confidentiality, the trended EHB Allowed Claims PMPM must be manually entered into this exhibit (cell J29). Please see Section S of this User Guide for instructions for the carrier to complete to maintain confidentiality of the appropriate exhibits.** Carriers are asked to indicate how many months the time periods Year 1 and Year 2 represent (cells P23 and P24) so that an annualized trend can be calculated in cell J31. In many cases, it is expected that the Year 1 and Year 2 represent 12 month periods, but this may not be the case for quarterly Small Group filings.

Starting in row 49, there are several pieces of information requested in this exhibit in addition to the information requested as part of the federal URRT.
Item 1a and 1c requests the total annualized trend assumptions from this filing both including and excluding the impact of leverage. **The trend excluding the impact of leverage should be**

**consistent with the total utilization and cost trend based on the inputs above in the URRT section of this exhibit (cells E23 through H28.)** Items 2a and 2b requests the total annualized trend assumptions from the most recently approved filing both including and excluding the impact of claims leverage. If the carrier intends to charge rates for subsequent renewal or issue dates by multiplying the rates within this rate filing by prospective trend adjustments, the carrier will provide the monthly prospective trend adjustment in the table requested for item 3.[3] These trend adjustments should be entered as percentages. **These trend adjustments are NOT cumulative.** Please see the examples provided under Exhibit A2 for further clarification on how to complete the table.

**Exhibit Purpose:** This exhibit requires information directly from the federal URRT helping to facilitate the NHID's review and ensuring that the carriers can demonstrate the development of the health coverage plan rates from the market adjusted index rate in the subsequent Exhibit A2. The experience period information allows the NHID to understand the details of the experience used in the development of the market adjusted index rate. The NHID will use the trend information presented in this exhibit to compare among carriers to understand if there are any outliers. It can also be used to compare trend assumptions used over time to understand how a specific carrier's assumptions have changed. In addition, overall trend assumptions can be compared to actual requested rate changes, and variances can be investigated. It is important that the trend information presented in the subsequent Exhibits D1 and D2 clearly and directly provide the necessary detail for the NHID to understand the methodology used to develop the final trend assumptions presented in this exhibit. If any of the information is not clear or is not consistent with Exhibits D1 and D2, the NHID will follow-up with questions.

**Exhibit A2: Proposed Rate Change and Enrollment by Health Coverage Plan**

**Instructions:** This exhibit requests information by health coverage plan to illustrate rate change differences. In addition, the total weighted average rate change is calculated across all health coverage plans included in the rate filing. A row must be completed in this exhibit for each health coverage plan. Health coverage plan is defined as a benefit offering which has an associated health coverage plan rate that varies based on cost sharing provisions, specific benefits or other allowable modifiers and is associated with a unique HIOS Plan ID standard component. The plan type (e.g. HMO, POS, PPO, Indemnity, etc.) for each health coverage plan must be provided in column B. It is also expected that the carrier provides a plan name or code for each health coverage plan in column C. The carrier plan name or code in column C will correspond to an assigned plan index number in column A. **The carrier plan code or name requested in column C should match exactly to the carrier plan name or code provided in Exhibit B1.** The carrier will also provide the HIOS Plan ID (Standard Component) in column D for each health coverage plan.

[3] It is expected that Small Group rates can change quarterly but not monthly.

Health coverage plan rate PMPM's are requested for several different time periods: The health coverage plan rate PMPM from 12 months prior to the rate effective date (column K), the health coverage plan rate PMPM from the most recently approved rate period (column L), and the proposed health coverage plan rate PMPM for the rate effective date (column M0.) These health coverage plan rates should include all applicable components of the premium. **The health coverage plan rates requested for each plan is for a 21 year old (where the age factor equals 1.0) and for a non-tobacco user.** If the carrier intends to charge rates for subsequent renewal or issue dates by multiplying the rates within this rate filing by prospective trend adjustments, the carrier is asked to provide the rates for those subsequent renewal or issue dates using columns M1 through M11. If the rates will not be changed for subsequent renewal or issue dates, the carrier should leave these columns blank. Below are several examples:

1. If the first rate effective date in the filing is January 1, and the carrier intends to charge the same rates for February and March, the carrier must report the rate in columns M0, M1, and M2, leaving columns M3 through M11 blank. In Worksheet A2a, the carrier should enter 0% in the monthly prospective trend adjustment column for the rate effective date plus 1 month and plus 2 months (cells G78 and G79) and leave the other adjustments blank.
2. If the first rate effective date in the filing is January 1, and the carrier intends to charge the same rate for each month in the 12 month period, the carrier must report the rate in columns M0 through M11. In Worksheet A2a, the carrier should enter 0% in the monthly prospective trend adjustment columns for each of the rate effective dates (cells G78 through G88.)
3. If the first rate effective date in the filing is January 1, and the carrier intends to charge different rates for each quarter in the 12 month period, the carrier must report rates in columns M0 through M11. In Worksheet A2a, the carrier should enter the appropriate prospective trend adjustment in the monthly prospective trend adjustment columns for each of the rate effective dates (cells G78 through G88.)

The intent is for the NHID to be able to calculate the final premiums charged to a policyholder by utilizing the health coverage plan rate PMPM's in this exhibit and all applicable rating factors, as described in the rating formula. Total enrollment and impacted enrollment is also requested by health coverage plan. "Impacted" enrollment is defined as those members (or policyholders plus covered dependents), subscribers (or policyholders) and groups (where applicable) impacted by the proposed rate change in this rate filing. In cases where the carrier is intending to charge rates for subsequent renewal or issue dates by multiplying the rates within the rate filing by prospective trend adjustments, the impacted enrollment should reflect just the enrollment for the month of the first rate effective date. The enrollment information should be based on the carrier's most recent data. In cases of new rate filings and new health coverage plans, the number of <u>expected</u> members, subscribers and groups should be provided. The weighted average health coverage plan rate PMPM is automatically calculated using both the

impacted number of members and the total members. The weighted average rate changes are calculated by comparing the weighted average health coverage plan rate PMPM's from the applicable time periods. The average proposed rate change, using impacted members, from column N (cell AB12) should equal the reported weighted average rate change in SERFF. Similarly, the Prior Rate and Requested Rate Information in SERFF should correspond to rate information in column K and column M0. The carrier must explain any differences in the Appendix. The group information will only be applicable for a Small Group Market filing.

Information is also requested for the "Standard Health Coverage Plan". This is as defined in Exhibit B1. If this rate filing is for more than one plan type, the corresponding standard health coverage plan should be included in this exhibit for each plan type included in the filing.

In cases where a carrier is discontinuing a health coverage plan, the NHID would like to understand where the members are likely to transition. The NHID expects the carrier to make assumptions on the member migration from discontinued plans to new or existing plans. For each migration assumption, the carrier should include a row which includes the carrier plan code in column C. The carrier should report the health coverage plan rate of the discontinued plan in column K and the health coverage plan rate of the mapped plan (new or existing) in column M0. There may be multiple rows for one discontinued plan as members may be mapped to more than one new or existing plan. The enrollment information for the discontinued health coverage plan should only reflect those enrollees that are mapped from the discontinued plan to the new or existing plan. (In Exhibit B1, column BC, the carrier will indicate which health coverage plan the members are transitioning to.)

Carriers will input the allowable adjustments to the market adjusted index rate in columns R through columns Y to arrive at the health coverage plan rates. As defined in the URRT, the market adjusted index rate will already reflect the three market-wide adjustments (risk adjustment, reinsurance, and exchange user fees.) Exhibit A2 will then apply the allowable plan specific health coverage plan rate adjustments. The AV and cost sharing, provider network, benefits in addition to EHB and catastrophic plan adjustments should be entered as a multiplicative factor where a factor less than 1.000 represents a decrease to the market adjusted index rate and a factor greater than 1.000 represents an increase to the market adjusted index rate. The administrative expenses less exchange user fees, taxes and fees and profits & risk load will be entered as a percentage. Taxes and fees will exclude the exchange user fee.

Column AA checks that the health coverage plan rate adjustments applied to the and market adjusted index rate equals the health coverage plan rate entered in column M0. **Note that the health coverage plan rate is equivalent to the calibrated plan adjusted index rate as defined in the URRT.** The formula for calculating the calibrated plan adjusted index rate is as follows:

**Plan Adjusted Index Rate (PAIR):**

{(Market Adjusted Index Rate) * (AV and Cost Sharing Factor) * (Provider Network Adjustment Factor) * (Benefits in addition to EHB Factor) * (Cat Plan Adjustment Factor)}

**/**

{1 - (Administrative Expenses less Exchange Fees Percentage) - (Taxes and Fees Percentage)- (Profit & Risk Load Percentage)}

**Calibrated Plan Adjusted Index Rate** = PAIR * Calibration Adjustment

There are several additional pieces of ACA related information requested in this exhibit for each health coverage plan. This includes the level of coverage (i.e. Platinum, Gold, Silver, Bronze or Catastrophic), indication as to whether the plan design is a "Unique Plan Design"[4], indication as to whether the health coverage plan is offered on the exchange, off the exchange or offered both on and off the exchange, the AV metal value and the percentage of the health coverage plan rate that is for EHB.

**Exhibit Purpose:** This exhibit allows NHID to understand the weighted average rate change as well as variation in the changes in each health coverage plan rate. NHID can identify possible outliers that may warrant further investigation. In addition NHID can place more emphasis on its review of health coverage plans that have significant enrollment versus health coverage plans that have minimal enrollment. This exhibit also requires carriers to demonstrate that the health coverage plan rates are developed directly from the market adjusted index rate which will facilitate NHID's review of the single risk pool requirement.

**Exhibit A3: History of Rate Changes**

**Instructions:** This exhibit requests historical rate changes on an annual basis by the rate effective month for the past three years. The rate changes entered in this exhibit should be based on the weighted average rate change using total enrollment from each time period, which is one of the methods utilized in Exhibit A2 to calculate the weighted average rate change. Both the proposed and approved rate changes are requested for each time period.

**Exhibit Purpose:** Exhibit A3 allows the NHID to compare the proposed rate change to historical rate changes to understand if there is significant difference or fluctuation over time. If there is, this will highlight the need to understand what is driving the difference in this rate filing versus past rate filings. NHID will also be able to compare the proposed and past rate changes among carriers to understand if the rate changes are consistent over time or if there are any outliers.

[4] A "unique plan design" is a health plan design that is not compatible with the federal AV calculator in accordance with 45 CFR 145.135.

**Exhibit A4: Distribution of Rate Changes**

**Instructions:** Using the weighted average health coverage plan rate changes and any changes to the rating factors, an overall rate change can be calculated for each policyholder. These rate changes should be based on the impacted membership using the carrier's most recent data. The rate changes calculated for this exhibit should not include the impact of changing rating cells. For example, it should not reflect aging. Each policyholder will be bucketed into one of the following eight ranges:

1. Reduction of 15% or more
2. Reduction of 10.01% to 14.99%
3. Reduction of 5.01% to 10.00%
4. Reduction of 0.01% to 5.00% AND NO CHANGE
5. Increase of 0.01% to 5.00%
6. Increase of 5.01% to 10.00%
7. Increase of 10.01% to 14.99%
8. Increase of 15.00% or more

In the Individual Market rate changes are determined based on the policyholder. Each policyholder should be categorized into one of the ranges shown above and all covered dependents associated with the policyholder should be counted in the same range. Therefore, all policyholders and covered dependents within a policy will have the same rate change. In the Small Group Market, since the rate changes are determined based on the employer group, each group should be categorized into one of the ranges shown above with the corresponding subscribers and members included in the same range. The enrollment information in this exhibit should only include those who are impacted by the rate changes proposed in this rate filing. The totals from each of these columns should tie to the totals in Exhibit A2 columns H through J. The overall minimum and maximum rate change is also requested. This should be calculated in a similar manner as the rate changes in the rate distribution table described above.

In the cases where plans are being discontinued within a filing, we expect carriers to make assumptions on members migrating from discontinued plans to new or existing plans and plans. We expect carriers to calculate what the policyholders/groups would experience by comparing the final rate of the new plan to the prior rate. This rate increase will reflect changes in rating factors and changes in product or plan. This rate increase should not reflect changes in rating cells.

**Exhibit Purpose**: This exhibit allows the NHID to analyze the variance in the proposed rate changes. This distribution, along with the average proposed rate change, will give a clearer picture of who is impacted and to what degree. This information allows the NHID to perform some high-level reasonability checks on the information presented in the rate filing. For example, if the average proposed rate change from Exhibit A2 is 5% but the distribution from this exhibit suggests something higher, there may be a disconnect.

**Exhibit A5: Components of the Average Proposed Rate Change**

**Instructions:** This exhibit breaks out the average proposed annual rate change into several components, each of which is described in further detail below.

1. Utilization (including mix): This component is the overall impact that changes in utilization have on the average annual proposed rate change. The utilization change should include the impact of changes due to the severity, service and provider mix (collectively referred to as "mix.") Some carriers' current rating practice may not include a calculation of an overall utilization change. The NHID recognizes that there are different methodologies to calculate average utilization change, since there are different types of services with different types of counting metrics (e.g. inpatient admissions, physician office visits, pharmacy prescriptions, etc.) One suggested methodology is to weight the utilization change assumption for each type of service by the PMPM for that service category. The NHID requests that whatever methodology chosen, it is based on actuarial principles and generates results that are reasonable in light of the underlying assumptions used in the rate filing. Any benefit changes that impact utilization trend assumptions should be included here.
2. Unit Cost: This component is the overall impact that changes in unit cost have on the average proposed rate change. The unit cost price changes shown should exclude the impact of changes due to the severity, service and provider mix (collectively referred to as "mix.") This suggests that the unit cost price change represents a pure unit cost trend and that the trend analysis was based on a common basket of services from both the proposed and prior period. Similar guidance applies to unit cost price change as was made for the utilization change, in that some carriers' rating practice may not include a calculation of an overall unit cost price change. One suggested approach would be to weight the expected unit cost price change for each service category by the PMPM for that service category. The NHID requests that whatever methodology chosen, it is based on actuarial principles and it generates results that are reasonable in light of the underlying assumptions used in the rate filing. Any changes in capitated payments or other provider payments that can be attributed to changes in unit cost or price should also be included in this category. Any benefit changes that impact unit cost or price assumptions should be included here.
3. Change in cost sharing: This component should include the overall impact on the average proposed rate change due to changes in cost sharing to the plans included in the filing. This change will also include the impact of mapping members from discontinued plans to new plans.
4. Changes in benefits required by law: Benefit changes required by law could include benefit changes required either by state or federal mandates including changes due to essential health benefit requirements (e.g. coverage for pediatric vision.) Note that since this calculation is based on a weighted average of all health coverage plans

included in the filing, if there are only benefit changes to some of the health coverage plans, this calculation should appropriately calculate the effect of those changes spread over all health coverage plans.

5. Changes in benefits NOT required by law: Benefit changes not required by law include any instances where the carrier is removing or adding benefits for the health coverage plans covered in this filing. Note that since this calculation is based on a weighted average of all health coverage plans included in the filing, if there are only benefit changes to some of the health coverage plans, this calculation should appropriately calculate the effect of those changes spread over all health coverage plans.
6. Changes in the provider network: This component should include the overall impact on the average proposed rate change due to change in provider networks. This does not include changes to unit cost, which is captured in a separate item, rather it includes changes due to either addition or deletion of providers, or implementation of limited network or tiered network products.
7. Population risk morbidity: This component should be consistent with the definition of population risk morbidity from the federal Part I instructions and includes the impact on the average proposed rate change for changes in morbidity of the underlying population.
8. Reinsurance fee: This represents the impact on the average proposed rate change for reinsurance program fees including a state reinsurance program if applicable.
9. Reinsurance recovery: This represents the impact on the average proposed rate change for expected reinsurance recoveries including a state reinsurance program if applicable.
10. ACA Insurer Fee: This component should include the impact to the average proposed rate change of the ACA insurer fee, also referred to as the health insurance tax (HIT.)
11. PCORI Fee: This component should include the impact to the average proposed rate change of the patient-centered outcomes research institute (PCORI) fee.
12. Exchange User Fee: This component should include the impact to the average proposed rate change of the exchange user fee.
13. Risk Adjustment User Fee: This component should include the impact to the average proposed rate change of the risk adjustment user fee.
14. Risk Adjustment Receipts/Payment: This component should include the impact to the average proposed rate change of the projected risk adjustment charge or payment. Risk adjustment receipts are positive. Risk adjustment payments are negative. If the current year risk adjustment receivable/payable minus the prior year risk adjustment receivable/payable is positive, this is an increase to the average proposed rate change and if it is negative, then this is a decrease to the average proposed rate change. This amount should be gross of the risk adjustment user fees.
15. Contribution to Surplus/Profit/Reserve: This component should include the impact to the average proposed rate change of the contribution to surplus/profit/reserve.
16. All Other Retention: This component should include the impact to the average proposed rate change of any other retention component, including the administrative charge and the investment income component.

17. Over/Understatement of Prior Rates: The impact of the over/understatement of prior rates can be developed by recalculating the expected revenue requirement for the prior period using the most recent claims experience and updated pricing assumptions. The variance from this reevaluated rate and the actual charged rate is the over/understatement adjustment. Note that this line item is not suggesting that the proposed average rate change should include any "recoupments" or "refunds" based on past losses or gains, rather it is meant to reflect that actual experience may be different from what was anticipated in prior periods, and therefore will impact future rates.
18. Other: This "Other" category is included as a "catch-all" for other items not specifically addressed in the above four categories. If this amount is greater than 0.5% then the exhibit requests an explanation of what is included in this amount. This category may include, but is not limited to, the following:
    i. Impact due to the leverage impact of fixed cost sharing
    ii. Impact due to changes in global capitated arrangements or any other provider payments such as provider payment incentives that cannot be attributed to one of the items listed above
    iii. Impact due to any rating factor changes that are not revenue neutral

Below is an illustration of the "Total" calculation within this exhibit:

| | |
|---|---|
| Utilization (including mix) | 3.0% |
| Unit Cost | 4.0% |
| *Etc.* | |
| All Other Retention | 0.5% |
| Over/Understatement of Prior Rates | -1.0% |
| Other | 1.0% |
| **Overall Average Rate Change** | **7.6%** |

*Where **7.6%** = [ (1 + 3.0%) * (1 + 4.0%) *(1 + 0.5%) * (1 – 1.0%) * (1 + 1.0%)] -1*

Note that the overall average rate change from this exhibit should correspond to the average annual proposed rate change reported in Exhibit A2 column N weighted by total enrollment. Also note that this total rate change would include the impact of any benefit changes. The exhibit does continue on to calculate the average proposed rate change excluding benefit changes and cost-sharing changes.

**Exhibit Purpose:** The information in this exhibit provides an overview of the major components driving the average proposed annual rate change. This will be a useful exhibit to compare among carriers and over time to understand if there are any outliers or if the magnitude of the various components has changed over time. The NHID will be able to identify what portion of the rate change is due to benefit changes. In addition, the exhibit allows the NHID to compare rate changes among carriers excluding the impact of benefit changes. The information in this

exhibit will also allow the NHID to understand how unit cost and utilization trend assumptions affect the rate change. Any outliers in these assumptions can be further investigated and also compared to the trend information provided in Exhibit A2a. If the overstatement or understatement of prior rates is a significant driver of the rate change, the NHID could request an actual to expected claims analysis on historical claims to review this impact further. Finally, benefit change information provided in this exhibit can be compared to the information in Exhibit B1 to ensure consistency. For example, if the information in this exhibit shows that benefit changes do not have a material impact on the average proposed annual rate change, but the information presented in Exhibit B1 suggests that there have been significant benefit changes made to the plans offered, there may be a disconnect that needs to be explored further.

**Exhibit A6: Supporting Documentation and Narrative Description of Rate Change**

**Instructions:** This is a written response with no corresponding Excel exhibit. The carrier is required to provide a narrative description of all the significant drivers of the average proposed rate change. This exhibit should correspond to the numerical information provided in Exhibit A5.

**Exhibit Purpose:** This exhibit will provide the NHID with information about the average proposed rate change to supplement the information from Exhibit A4 and Exhibit A5.

**B. Plan Design and Plan Relativity Factors:** This exhibit provides information on cost sharing elements and the health coverage plan rate adjustments.

**Exhibit B1: Plan Design and Plan Relativity Factors**

**Instructions:** There are five different B1 tabs provided; one for each plan type (HMO, POS, PPO, Indemnity or Other.) The carrier should complete a B1 tab for each plan type included in the filing. Health coverage plan is defined as a benefit offering which has an associated health coverage plan rate that varies based on cost sharing provisions or specific benefits. A row must be completed in the B1 exhibit(s) for each health coverage plan corresponding to a HIOS Plan ID (standard component). **The carrier plan code or name in this exhibit must correspond exactly to the carrier plan code and name reported in Exhibit A2. Please ensure that the health coverage plan naming conventions are the same for each exhibit so that fields can be automatically populated such as the number of members.** The carrier plan name or code in column B will correspond to an assigned plan index in column A.

Cost sharing information is requested for specific service categories. The cost sharing information requested is not meant to be comprehensive. However, it should capture cost

sharing elements that have the greatest impact on rates. If there is additional information on any of these health coverage plans the carrier feels is relevant to the rate filing review and would like to include, those can be included in the Appendix. Most of the cost sharing categories are meant to correspond to the categories requested in the federal plan & benefit templates. If a service has no cost sharing, then leave that item blank. If a service is not covered, then indicate that in the space provided. If the health coverage plan has multiple in-network tiers, please indicate this in column AB. The deductible and out-of-pocket maximum information should be provided for in-network, Tier 1, single tier type policies only. If the plan has an integrated medical and pharmacy deductible, this should be indicated in column U and the integrated deductible should be entered in the medical deductible column (column W.) Coinsurance percentages should represent the member portion of the coinsurance. The out-of-pocket maximum should include any deductibles, where applicable.

The Plan Relativity Factors requested in this exhibit are defined as a factor that represents the relative value of cost-sharing and benefits and other allowable modifiers against a standardized set of benefits. The plan relativity factor is the relative value between each health care coverage plan rate and the rate for the Standard Health Coverage Plan (defined below.) **The plan relativity factor can also be calculated by taking the ratio of the total health coverage plan rate adjustment for each plan to the total health coverage plan rate adjustment for the Standard Health Coverage Plan from Worksheet A2.**

The Reinsurance Pool in New Hampshire has developed four benefit plans, one for each of the four plan types, that ceding carriers must use to adjudicate claims: an indemnity plan, a PPO plan, a POS plan and an HMO plan.[5] These four plan types are referred to as the "Standard Health Coverage Plans." The plan design information for the standard health coverage plans is provided in the "Standard Health Coverage Plans" tab and is pre-populated. If the rate filing includes health coverage plans for more than one plan type, then a separate Exhibit B1 must be completed for each plan type. The carrier is required to provide the plan relativity factors for the applicable standard health coverage plan which should be calculated in a manner consistent with the carrier's other plan relativity factors. The standard health coverage plans are not expected to change over time. Plan relativity factors must be provided for the rate effective date and for the twelve months prior to the rate effective date. The plan relativity factor will reflect any differences in retention by health coverage plans. There is also a question asking if there have been any changes in benefits or cost sharing in the prior twelve months where a "Y" or "N" response is required. If the answer is "Y", there is text field in column AT where the carrier must provide the details on what plan design items have changed. If there is a change of more than 5% in the plan relativity factor, actuarial justification must be provided in column BB.

[5] http://www.nh.gov/insurance/media/bulletins/2005/documents/ins05039method.pdf

Additional information is also requested for each health coverage plan: policy form number, whether it is open or closed to new membership, grandfathered or non-grandfathered per the ACA definition, renewability, general marketing methods, issue age limit, and if this health coverage plan is "new." A health coverage plan is "new" if this rate filing is the first time rates are being filed.

Consistent with the instructions for Exhibit A2, in cases where a carrier is discontinuing a health coverage plan the NHID would like to understand where the members are likely to transition. NHID expects the carrier to make assumptions on the member migration from discontinued plans to new or existing plans. For each migration assumption, the carrier should include a row which includes the plan code for the discontinued health coverage plan in column B and the plan code of the mapped health coverage plan (new or existing) in column BC. The carrier should report the plan relativity factor of the discontinued plan in column AR and the plan relativity factor of the mapped plan (new or existing) in column AQ. There may be multiple rows for one discontinued plan as membership may be mapped to more than one new or existing plan. The benefits and cost sharing should reflect the benefits and cost sharing in effect for the discontinued plan.

**Exhibit Purpose:** The information in this exhibit allows the NHID to understand how carriers price various benefit offerings in the market. This information can be used to make comparisons among carriers and within a carrier over time. Comparing plan relativity factors across carriers may not be straightforward since each carrier may use a different scale to calculate their plan relativity factors. (For example, some carriers may use a scale of 0.0 to 1.0 where a 1.0 represents a plan with no cost sharing, while another carrier may use a scale where their most popular plan is represented by a 1.0, so the plan relativity factor for a plan with richer benefits can be more than 1.0.) By requesting the plan relativity factors for a pre-defined standard health coverage plan, the plan relativity factors for each carrier can be normalized to a similar scale so more direct comparisons can be made. By showing both the plan relativity factors for the rate effective date and the prior twelve months, the NHID can easily identify any health coverage plans with a material change to their plan relativity factor and then investigate this change as it pertains to the requested rate change in the filing. For example, if a carrier files a significant reduction in a plan relativity factor, NHID may want to apply further scrutiny to this health coverage plan as a reduction in one year could lead to significant increases the next. The information in this exhibit can also provide NHID insight on "benefit buy down" as it relates to trend assumptions. The NHID recognizes that there is no standard methodology for developing plan relativity factors and each carrier may use different methods. Given this, after adjusting for different scales, there is still an expectation that plan relativity factors with similar benefits would be within a reasonable range of each other. Membership information is automatically populated from Exhibit A2 which allows the NHID to consider materiality as they focus on the health coverage plans with the greater membership.

In addition, this exhibit can highlight where rate variations among health coverage plans may exceed the maximum possible differences given the benefits. The NHID can further investigate if, for example, the difference is due to expected utilization differences due to plan design.

**Exhibit B2: Support for AV Metal Values for Unique Plan Designs**

**Instructions:** In any cases where the health coverage plan rate is considered a unique plan design[6] and the carrier has to certify the AV metal value, the carrier should provide documentation as to why the plan design is considered "Unique" and how the carrier determined the AV metal value. This exhibit is not requested in a standardized format.

**Exhibit Purpose:** This exhibit will provide the NHID with information to support the AV metal value in cases of a unique plan design.

**C. Historical Experience and Credibility:** The exhibits in this section provide support for the information on the experience used in the rate development and support for the various pieces of the URRT Worksheet 1 and Worksheet 2.

**Exhibit C3: Support for Exhibit A2a and Exhibit A2 (Other Than Trend)**

**Instructions:** This is a written response with no corresponding Excel exhibit. The carrier is expected to provide the actuarial support for the following items as it relates to Exhibit A2 and Exhibit A2a:

1. Development of the Morbidity Adjustment, Demographic Shifts, Plan Design Changes and Other factors used in Exhibit A2a to develop the market adjusted index rate;
2. Development of experience period premiums;
3. Development of the experience period incurred claims, allowed claims and estimates of incurred but not yet paid claims;
4. Administrative expense loads;
5. Manual rate experience used (if applicable);
6. Credibility percentage applied to allowed claims experience;
7. Risk Adjustment Payments and Receipts;
8. A cross-walk between the administrative expenses, taxes and fees and profit & risk load from Exhibit A2 to the information in Exhibits E2 and E3.
9. If there has been a change in the source of the data used in the rate development from the most recently approved rate filing, the carrier should note the change and provide an explanation. For example, if the carrier used the plan type-specific experience for

[6] A "unique plan design" is a health plan design that is not compatible with the federal AV calculator in accordance with 45 CFR 145.135.

the rate development in the prior filing, but this filing is using a blend of the manual rate and the plan type experience, this should be noted and explained;

10. If the carrier is filing a new health coverage plan or new plan type, the carrier should include a brief explanation as to how the rate was developed and the data source;
11. Any other information required in the federal Part III Actuarial Memorandum to support the information in URRT Worksheet 1 that is not already requested elsewhere.

**Exhibit Purpose:** This exhibit will provide further background to the NHID on the appropriateness of the data used in the rate development for this rate filing. For example, if a carrier used nationwide experience they should provide a logical explanation for why nationwide experience was used and if reasonable adjustments were made to reflect New Hampshire specific utilization, price levels or other regional specific attributes. The NHID will also be able to determine if there has been a change in the source of the experience used in the rate development from prior rate filings and follow-up with further questions if that change does not appear justified. The NHID will also be able to reference past rate filings to determine the varying levels at which carriers assume full credibility and identify possible outliers. This exhibit also provides specific support to items within Exhibit A2a and Exhibit A2 which is requested as of part of the federal Part III Actuarial Memorandum.

**Exhibit C4: Support for URRT Worksheet 2 (Other than AV Metal Values)**

**Instructions:** The carrier is requested to provide actuarial support for the information in the URRT Worksheet 2 that is not already specifically requested in other exhibits. Note that the URRT Worksheet 2 itself is not required as part of the NHID Excel template, but the supporting documentation is required. This exhibit is not requested in a standardized format. The carrier is expected to provide actuarial support for the following items:

1. Membership projections by health coverage plan;
2. Plan adjustment factors including AV and Cost Sharing Design of Plan, Provider Network Adjustment, Benefits in Addition to EHB, Administrative Expenses, Taxes and Fees and Profit & Risk Load factors;
3. Calibration Factors;
4. Information that shows how members are mapped from discontinued plans to new plans in cases when new plans designs are being created to meet the ACA requirements for policy years beginning on or after 1/1/2014;
5. Any other information required in the federal Part III Actuarial Memorandum to support the URRT Worksheet 2 that is not already requested elsewhere.

**Exhibit Purpose:** This exhibit will provide the NHID with information to support the information within the URRT Worksheet 2 as specifically requested within the federal Part III Actuarial Memorandum instructions.

**D. Trend:** The exhibits requested in this section provides background on how the trend assumptions were developed, supporting data for the trend assumptions and a discussion on how the trend assumptions have changed since the most recently approved filing. The two exhibits in the section are confidential along with the trend detail requested in Exhibit A2a. **Please see Section S of this User Guide for instructions for the carrier to complete to maintain confidentiality of the appropriate exhibits.**

**Exhibit D1: Description of Trend Development**

**Instructions:** This is a written response with no corresponding Excel exhibit. This document should include an explanation of the development of trend assumptions and how they were developed based on generally accepted actuarial principles. This document should address the items listed below if they are applicable to how the carrier developed their trend assumptions. Note that specific numbers are not being requested for each of these items, rather a written discussion on if and how these items were considered in the trend development.

1. Description of the data source used to develop the trend assumptions, specifically pointing out if any information outside of the New Hampshire market was used, such as company-wide information or consultant survey data;
2. The differences in methodology used to project utilization versus unit costs trends along with any differences in methodology by type of service (e.g. medical versus pharmacy);
3. Leverage on trend from fixed cost sharing;
4. Capitation payments and other provider payments;
5. Provider reimbursement and contracting strategy;
6. Care management programs;
7. Large claims;
8. If the trend assumptions have changed since the most recently approved rate filing, this should be pointed out and a brief explanation should be provided as to the drivers of this change. (Exhibit A2a asks for the carrier to report the annualized trend assumption from the most recently approved rate filing.);
9. A clear and direct explanation as to how the supporting documentation information provided in Exhibit D2 relates to the final trend assumptions in Exhibit A2a;

**Exhibit Purpose**: This exhibit is instrumental in providing the necessary background to understand how the trend assumptions were developed and if they are reasonable in light of the information provided in the rate filing. While there is no standard format required, it is important that the carrier provide enough information so that the NHID can understand the narrative in this exhibit and how it relates to Exhibits D2 and the trend information in Exhibit A2a. If any of the items listed above are not addressed or answered clearly, the NHID may make further inquiries.

**Exhibit D2: Supporting Schedules for Trend Development**

**Instructions:** The carrier is expected to provide supporting schedules to support the trend assumptions used in the rate development. There should be enough detail provided in this exhibit along with the narrative description in Exhibit D1, so that the NHID can clearly understand how the final trend assumptions presented in Exhibit A2a were developed. The information provided in this exhibit should clearly document the data used in the trend development. Note that this information is not requested in a standardized format.

**Exhibit Purpose:** Similar to Exhibit D1, this exhibit is instrumental to providing necessary background to the NHID so that they can understand how the trend assumptions were developed and if they are reasonable in light of the information provided in the filing. While there is no standard format required, it is important that the carrier provide enough background information so that the NHID can review the data along with the information in Exhibits D1 and the trends in Exhibit A2a. If any of the information is not clear or is not consistent with the narrative from Exhibit D1, the NHID will follow-up with questions.

**E. Components of Retention:** The exhibits in this section request retention charges used in the past and the proposed rate filing. The carrier is also asked to provide an explanation on any significant changes to retention or administrative costs assumed in the proposed rate filing compared to prior periods.

**Exhibit E2: Administrative Charges**

**Instructions:** This exhibit requests the average administrative charge included in rates for three time periods: the administrative charge from 12 months prior to the rate effective date, the administrative charge from the most recently approved rate period, and the proposed administrative charge for the rate effective date. If the charges vary by health coverage plan, by group size or by some other variable, the amounts entered in this exhibit should be based on a weighted average of total members, consistent with how the information is requested in Exhibit A2. **Similar to Exhibit A2the administrative charges are requested based a 21 year old (where the age factor equals 1.0) and for a non-tobacco user.** The following components of the administrative charge are requested:

1. Health care quality and improvement costs
2. All other administrative costs

This exhibit utilizes the inputs and calculates the change by comparing the proposed administrative charge to the administrative charge from the two prior periods. Also, ratios are calculated by comparing the proposed administrative charges to the weighted average health coverage plan rate from Exhibit A2. There is also a text response required in this exhibit. The text response requires the carrier to provide a brief explanation of the drivers of change where the percentage difference between the proposed administrative charge and each of the prior administrative charges is more than 2.5%.[7]

[7]The 2.5% is based on the Northeast Medical CPI as of June 2013. http://www.bls.gov/xg_shells/ro1xg01a.htm

**Exhibit Purpose:** This exhibit allows the NHID to compare the proposed administrative charge to administrative charges from the most recently approved rate filing as well as earned premiums. In addition, NHID can make comparisons among carriers to identify outliers and can follow-up with questions on the development of the administrative charge.

**Exhibit E3: Retention Charges**

**Instructions:** This exhibit requests the average retention charges on a PMPM basis for three time periods: The retention charge from 12 months prior to the rate effective date, the retention charge from the most recently approved rate period, and the proposed retention charge for the rate effective date. The information is requested to be separated into several categories:

1. Administrative Costs (The administrative costs are pre-populated from Exhibit E2.)
2. Investment Income Credit
3. Contribution to Surplus or Profit or Reserve
4. Reinsurance Fee
5. ACA Insurer Fee
6. PCORI Fee
7. Exchange User Fee
8. Risk Adjustment User Fee
9. All Other Federal and State Taxes and Assessments
10. All Other Retention

These categories largely correspond to the retention categories in Exhibit A5 and further explanation of these categories is provided in that section of this user guide.

If the retention charges vary by health coverage plan health coverage plan, the amounts entered in this exhibit should be based on a weighted average of total members, consistent with how the information is requested in Exhibit A2. **Similar to Exhibit A2, the retention charges are requested based on a 21 year old (where the age factor equals 1.0) and for a non-tobacco user.**

This exhibit utilizes the inputs and calculates the retention charge change by comparing the proposed retention charge to the two prior periods. In addition, a retention percentage is calculated by comparing the proposed retention charge to the proposed weighted average health coverage rate from Exhibit A2. There are also two text responses required in this exhibit. The first requires the carrier to provide a brief explanation if the change in the proposed retention charge compared to either of the prior periods is greater than 2.5%.[8] In addition, a response is required if the proposed contribution to surplus or profit as a percentage of the average health coverage plan rate is greater than 2%. Note that contribution to surplus or profit as a percentage of the weighted average health coverage plan rate is not a rate filing approval criterion, rather this information is being collected to understand overall market statistics and benchmarks across carriers.

[8] Ibid.

**Exhibit Purpose:** This exhibit allows the NHID to make comparisons of the retention charge which can then be used to compare among carriers or within a carrier over time. This information can be tracked over a period of time to determine typical retention charges and more easily identify possible outliers or rate filings that may require additional follow-up.

**G. Illustrative Rates:** This exhibit is for the carrier to provide the final rates and details on the rating methodology for two illustrative cases. The two cases for the Individual Market and the two cases for the Small Group Market are presented below. These examples may change in future user guides.

**Exhibit G1-G4: Individual/Small Group Market Rating Examples**

**Instructions:** The carrier is requested to present the rate calculation for rates for two hypothetical cases. Rates should be provided as of the effective date in the rate filing. The final rates should be provided for each member within the group. We would expect that the carrier would start with the health coverage plan rate from Exhibit A2 and apply the appropriate rating factors (as detailed in H1 and H2.) There is no pre-defined format required for this exhibit. The methodology and references to other exhibits should be clear throughout. The final rates for each example should be provided in Exhibit G5.

**Exhibit G1: Individual Market Example 1**: Single policy with a 50 year old male; tobacco user; lowest costing Silver Plan off-exchange.

**Exhibit G2: Individual Market Example 2:** Family policy where the subscriber is a 35 year old female, spouse is a 39 year old male, and two dependents age 4 and age 12.; all members on the policy are non-tobacco users; lowest costing Bronze Plan off-exchange.

**Exhibit G3: Small Group Market Example 1:** Member census in Example 1 (also provided in Excel as part of Exhibit G5); lowest costing Silver Plan off-exchange.

**Small Group Example 1 Census:**

***Employee #5 is a tobacco user and Child #2 for Employee #7 is a tobacco user (highlighted in yellow)***

| | Employee Age | Spouse Age | Number of Children | Child #1 Age | Child #2 Age | Child #3 Age |
|---|---|---|---|---|---|---|
| Employee #1 | 19 | n/a | 1 | 0 | | |
| Employee #2 | 24 | n/a | 0 | | | |
| Employee #3 | 32 | 34 | 2 | 3 | 1 | |
| Employee #4 | 37 | 32 | 3 | 5 | 7 | 9 |
| Employee #5 | 40 | n/a | 0 | | | |
| Employee #6 | 47 | 45 | 0 | | | |
| Employee #7 | 52 | n/a | 2 | 18 | 20 | |
| Employee #8 | 59 | 57 | 0 | | | |
| Employee #9 | 61 | n/a | 0 | | | |
| Employee #10 | 64 | 63 | 0 | | | |

**Exhibit G4: Small Group Market Example 2:** Member census in Example 2 (also provided as part of Excel Exhibit G5); lowest costing Bronze Plan off-exchange.

**Small Group Example 2 Census:**

***Employee #3 and the spouse of Employee #3 are a tobacco users (highlighted in yellow)***

| | Employee Age | Spouse Age | Number of Children | Child #1 Age | Child #2 Age | Child #3 Age |
|---|---|---|---|---|---|---|
| Employee #1 | 49 | n/a | 1 | 10 | | |
| Employee #2 | 50 | n/a | 0 | | | |
| Employee #3 | 52 | 50 | 3 | 16 | 19 | 20 |
| Employee #4 | 55 | 54 | 0 | | | |

**Exhibit G5: Illustrative Rates**

**Instructions:** Final rates for each of the two examples specific to the market segment for which rates are being filed should be provided in this exhibit.

**Exhibits Purpose:** The rate calculation in Exhibits G1-G4 and the final rates in G5 allow the NHID to understand how the information in the filing is used to calculate premium rates. If the source of any of these rate development inputs is unclear, the NHID will follow-up with the carrier. Since the illustrative rating characteristics are the same for all carriers, if the rate effective dates are the same, the final rates in these exhibits can be directly compared among carriers to understand the range of variability. It is noted that if one carrier has the highest (or lowest) final rate under one rating example, this does not mean that the same carrier has the highest (or lowest) final rate in all cases. This exhibit also allows the NHID to focus on comparing absolute rate levels across carriers, where many of the other exhibits in the rate filing are focused on comparing and explaining rates of change.

**H. Rating Factors**: This exhibit provides the NHID with all proposed rating factors and requires the carrier to list out all rating factors used in their rating formula, indicating which of the factors (if any) have changed since the most recently approved filing. If a rating factor has changed since the most recently approved rate filing, the carrier must provide an actuarial justification for the change.

**Exhibit H1: Summary of Rating Factors**

**Instructions**: In column A, the carrier should select whether the rating factor applies to the filed rates within the rate filing. The responses are either "Yes" or "No". In column B, the carrier is asked to indicate if the rating factor has changed since the last approved rate filing. The responses are either "Unchanged", "Changed" or "Not Used Previously." If the carrier uses a factor that is not listed in this exhibit, the carrier is asked to list out the rating factor and provide answers to the questions in column A and column B, along with providing a brief description of the rating factor in column C. For each rating factor, the carrier is also asked to calculate the ratio of the highest rate factor to the lowest rate factor in column D. This is referred to as the "rating band."

**Exhibit Purpose:** This exhibit provides the NHID with a clear view of the rating factors used in this rate filing along with which factors have changed. If a rating factor is referred to elsewhere in the filing and is not listed in this exhibit, the NHID will follow-up with the carrier. If a rating factor is listed under "Other" that is not allowed under NH law, the NHID will follow-up with the carrier. The rating band information will also allow the NHID to easily understand the range of factors for each rating characteristic.

**Exhibit H2: Rating Factors**

**Instructions:** Since each carrier may use different rating factors and/or these rating factors may vary in how they are categorized, the carrier may choose the best format to present this information. The name of the rating factor should be clearly labeled on the top of each page in this exhibit. For each rating factor indicated in the rating formula in Exhibit H1, the carrier should provide rating factor tables. Rate factors should be provided even if there are no changes from the last rate filing.

**Exhibit Purpose:** This exhibit provides the NHID will all relevant rating factors for this rate filing. This information, along with other information in the rate filing, should allow the NHID to easily replicate a rate provided to policyholders for any Individual or Small Group. For example, the NHID should be able to apply the rate factors in this filing to the health coverage plan rates in Exhibit A2. In addition these rate factors should be referenced in the illustrative rating examples in Exhibit G1-G4. The NHID will also check that the age factors for non-grandfathered plans as of 1/1/2014 match the federal age factors.

**Exhibit H3: Description of Rating Factors**

**Instructions:** This is a written response with no corresponding Excel exhibit. The carrier is asked to provide answers to the following questions:

1. If there has been a change to any of the rating factors, provide a brief explanation providing actuarial justification for the change. The rating factors in effect prior to the change should also be provided. If the rating factor change is revenue neutral, this should be indicated and a demonstration of how the change is revenue neutral should be provided. If the change is not revenue neutral, this should be indicated and the impact reflected in the "Other" line in Exhibit A5.
2. Provide a written explanation of how the rating factors are compliant with NHCAR Part INS Chapter 4100 and RSA Chapter 420-G.

**Exhibit Purpose:** If there has been a change to the rating factors since the most recently approved rate filing, the information in this exhibit will provide the NHID with an explanation on why and how the rating factors have changed. The carrier will indicate whether or not any of the rating factor changes are revenue neutral. This exhibit should also clearly explain how the rate factors in this rate filing are compliant with the applicable laws and regulations, and if this is not clear the NHID can investigate further.

**Exhibit H4: Expected Distribution of Rating Factors**

**Instructions:** There is no standardized format for this exhibit. The carrier is asked to provide an expected membership distribution by rating factor for each of their allowable rating factors including their tier or conversion factors.

**Exhibit Purpose:** The purpose of this exhibit is to understand how the expected distribution of rating factors has changed over time and to compare among carriers.

**M. Projected Medical Loss Ratio:** These exhibits are for the carrier to demonstrate their projected medical loss ratio and compare it to historical medical loss ratios. The carrier is also asked to describe the assumptions used in the projected medical loss ratio development.

**Exhibit M1: Medical Loss Ratio for Individual Market**

**Instructions:** This exhibit requests anticipated medical loss ratio information for the Individual Market plan type(s) for which the rates are being filed. The numerator of the medical loss ratio is defined as incurred claims plus quality improvement expenses, plus federal transitional reinsurance recoveries (where recoveries are entered as a negative number), plus risk corridor payments or receipts (where a payment is listed as a positive number and a receipt is listed as a negative number) plus risk adjustment payments or receipts (where a payment is listed as a positive number and a receipt is listed as a negative number.) The denominator of the medical loss ratio is defined as earned premium net of rebates minus adjustments to earned premium. These terms are defined in the federal regulation 45 CFR 158.

The historical information should begin at the inception date of the plan type(s) and continue through to the most recent data available, allowing for the appropriate amount of run-out. The data should be grouped by calendar year time periods. In instances where the inception date and/or the end date of the experience period is during the calendar year, data may be grouped by partial years. In addition to medical loss ratio information, the exhibit also requests the present value of both the incurred claims plus quality improvement expenses the earned premium minus adjustments to earned premium as of the rate effective date. The interest rate assumptions used in this calculation should be entered in the field provided. The interim time period is meant to be the time between the end date of the "Most Recent Data Available" and the rate effective date. The future time periods should start at the rate effective date. In cases where the first future period does not correspond to a full calendar year, a partial year may be displayed. The lifetime loss ratio calculation should be calculated over a period that is at least as great as the anticipated policy lifetime and that does not exceed 20 years. The incurred claims in this exhibit should include all FFS and non-FFS claims and also include any other payments made to providers. The details on the development of the projected incurred claims and earned premium will be provided by the carrier in Exhibit M3.

**Exhibit Purpose**: This exhibit allows the NHID to understand both the historical and projected medical loss ratios for the Individual Market plan types(s) being filed. If the projected medical loss ratio does not comply with NHCAR Part INS Chapter 4100, the NHID will follow-up with the carrier. If there is a wide variation in the most recent historical medical loss ratios compared to the projected medical loss ratios that is not adequately explained in Exhibit M3 then the NHID will follow-up with the carrier to understand the drivers of this change. If the proposed rate

change in this rate filing does not appear consistent with the information in this exhibit, then the NHID will follow-up with the carrier. For example, if the projected medical loss ratio is significantly greater than the historical medical loss ratios, but the carrier is requesting a large rate increase, then there may be an inconsistency in the filing that requires the NHID to ask additional questions. In addition, the NHID will also be able to compare historical and projected medical loss ratios across carriers to understand the range of outcomes in light of the projected rate changes to determine any inconsistencies or outliers. The NHID may want to refer to the information presented in Exhibit C3 regarding the credibility of the experience for the plan types(s) in this filing.

**Exhibit M2: Medical Loss Ratio for Small Group Market**

**Instructions:** This exhibits requests information for the Small Group Market plan type for which the rates are being filed. The carrier is asked to input the historical and projected information for the twelve months immediately following the rate effective date. The numerator of the medical loss ratio is defined as incurred claims plus quality improvement expenses, plus risk corridor payments or receipts (where a payment is listed as a positive number and a receipt is listed as a negative number) plus risk adjustment payments or receipts (where a payment is listed as a positive number and a receipt is listed as a negative number.) The denominator of the medical loss ratio is defined as earned premium net of rebates minus adjustments to earned premium These terms are defined in the federal regulation 45 CFR 158.

**Exhibit Purpose:** The information in this exhibit will allow the NHID to understand the future projected medical loss ratios for the Small Group Market plan type(s). If the projected medical loss ratio does not comply with NHCAR Part INS Chapter 4100, the NHID will follow-up with the carrier. If there is a wide variation in the recent historical medical loss ratios compared to the projected medical loss ratios that is not adequately explained in Exhibit M3 then the NHID will follow-up with the insurer to understand the drivers of this change. If the proposed rate change in this rate filing does not appear consistent with the information in this exhibit, then the NHID will follow-up with the carrier. In addition, the NHID will also be able to compare historical and projected medical loss ratios across carriers to understand the range of outcomes in light of the projected rate changes to determine any inconsistencies or outliers. The NHID may want to refer to the information presented in Exhibit C3 regarding the credibility of the experience for the plan type(s) in this filing.

**Exhibit M3: Description of Methodology for the Projected Medical Loss Ratio**

**Instructions:** There is no pre-defined format required for this exhibit, so the carrier may choose the best format in which to present. This document should explain how the projected medical loss ratio was developed for either Exhibit M1 (Individual Market) or M2 (Small Group Market) based on generally accepted actuarial principles. This document should at a minimum address the following items:

a. Identify the starting time period for the projected medical loss ratios, if not already clearly labeled in Exhibit M1 or Exhibit M2.
b. Identify the data source used in the base projections. Depending on the credibility of the plan type, this may be based on the plan type's actual historical experience or some other data source. (The carrier may want to reference information provided

in Exhibit C3 regarding the credibility of the experience for the plan type(s) in this filing.)

c. Describe the assumptions used in both the projected incurred claims and projected earned premiums. For example, this should include the lapse assumption if applicable. References to assumptions presented elsewhere in the filing should be made, where applicable. For example, it is assumed that a trend assumption consistent with what is presented in Exhibit D3 is used as part of the projected claims.
d. Describe the basis for the interest rate assumption used in the present value calculations.

**Exhibit Purpose:** This exhibit will be used in conjunction with the information in Exhibit M1 or M2 to allow the NHID to understand how the projected medical loss ratios are developed and the key assumptions driving the medical loss ratios. If any of the information is not clear or not adequately explained, then the NHID will follow-up with additional questions. If any of the assumptions used in the projected medical loss ratio calculation do not appear consistent with the information presented elsewhere in the rate filing, the NHID will follow-up with additional questions.

**O. <u>Actuarial Certification:</u>**

Each rate filing submission must include an actuarial certification signed by a member of the American Academy of Actuaries stating the following:

(1) A statement indicating that the filing conforms to generally accepted actuarial principals;

(2) A statement that the entire filing is in compliance with all applicable laws and rules;

(3) A certification that the projected index rate is:

i. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 (d)(1));

ii. Developed in compliance with the applicable Actuarial Standards of Practice;

iii. Reasonable in relation to the benefits provided and the populations anticipated to be covered;

iv. Neither excessive or deficient;

(4) A statement that the premiums are not inadequate, excessive, unfairly discriminatory, or unreasonable in relation to the benefits;

(5) A statement that variations in health coverage plan rates:

i. Shall not exceed the maximum possible difference in benefits unless they are based on the following:

1. Expected utilization differences attributable to the plan design
2. Expected administrative costs differences attributable to plan design
3. Provider Reimbursement variances attributable to plan design.

ii. Do not vary based on the health status/morbidity or other demographics of the populations electing the varying plans.

(6) A statement indicating that premium rates are calculated from health coverage plan rates and that premium rates vary from health coverage plan rates using only allowable rating factors;

(7) A statement that benefits are neither excluded nor vary by any of the allowable rating factors;

(8) A statement indicating that the health plan coverages for which rates are being filed are being actively marketed and are available to both new issues and renewing policyholders;

(9) A statement that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates;

(10) A statement that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice; and

(11) A statement stating that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans except those specified in the certification. If an alternate methodology was used to calculate the AV Metal Value for at least one plan offered, a copy of the actuarial certification required by 45 CFR Part 156, §156.135 must be included. The certification must be signed by a member of the

American Academy of Actuaries, and must indicate that the values were developed in accordance with generally accepted actuarial principles and methodologies.

**P.** **Actuarial Memorandum:** The Actuarial Memorandum will consist of the following exhibits described in this user guide:

a. Exhibit A1: Cover Sheet
b. Exhibit A2a: Modified URRT Worksheet 1
c. Exhibit A2: Proposed Rate Change and Enrollment by Plan Type
d. Exhibit A3: History of Rate Changes
e. Exhibit A4: Distribution of Rate Changes
f. Exhibit A5: Components of the Average Proposed Rate Change
g. Exhibit A6: Narrative Description of the Rate Change
h. Exhibit B1: Plan Design and Plan Relativity Factors
i. Exhibit B2: Support for AV Metal Values for Unique Plan Designs
j. Exhibit C3: Support for Exhibit A2 and A2a- Other than Trend
k. Exhibit C4: Support for URRT- Worksheet 2 Other AV Metal Values
l. Exhibit D1: Description of Trend Assumptions
m. Exhibit D2: Supporting Schedules for Trend Development
n. Exhibit E2: Administrative Charges
o. Exhibit E3: Retention Charges
p. Exhibit G1: Individual Market Example 1
q. Exhibit G2: Individual Market Example 2
r. Exhibit G3: Small Group Market Example 1
s. Exhibit G4: Small Group Market Example 2
t. Exhibit G5: Illustrative Rates
u. Exhibit H1: Summary of Rating Factors
v. Exhibit H2: Rating Factors
w. Exhibit H3: Description of Rating Factors
x. Exhibit H4: Expected Distribution of Rating Factors
y. Exhibit M1: Medical Loss Ratio for Individual Market
z. Exhibit M2: Medical Loss Ratio for Small Group Market
aa. Exhibit M3: Description of Methodology for the Projected Medical Loss Ratio

**Q.** **Appendix:** There are several instances throughout this user guide where it is noted that the carrier may provide additional information for the NHID in the Appendix. In addition, there may be other instances, not specifically pointed out in this user guide, where the carrier may choose to provide additional information in order to aid the NHID in their review. This type of information may also be included in the Appendix. It is expected that all information included in the Appendix be clearly labeled and that appropriate references to other exhibits be provided, so that the NHID may clearly understand the purpose of the information in the Appendix.

## S. CONFIDENTIALITY:

Per NHCAR Part INS Chapter 4100, the trend detail and supporting documentation (parts of Exhibits A2a, and the entire Exhibits D1 and D2) are deemed confidential. Exhibit A2a is a worksheet within the rate filing Excel template. In order to ensure confidentiality of the appropriate exhibits and documents, we are proposing the following process for filings submitted with the version 5 of the rate filing Excel template:

1. Within the "Supporting Documentation" category in SERFF, insurers will create two new sub-categories, one labeled "Confidential" and one labeled "Public." (Currently there are several default sub-categories within the "Supporting Documentation" category including "Actuarial Memorandum with Rates", "PPACA Filing Requirements", "Compliance Certification", etc.)
2. Within the "Confidential" sub-category, insurers will submit any supporting trend documentation that is confidential (Exhibits D1 and Exhibits D2) along with the fully completed rate filing Excel template.
3. Within the "Public" sub-category, insurers will submit files that are considered public (e.g. any cover letters, the actuarial certification and other non-trend related supporting documentation.) In addition, carriers will submit a copy of the rate filing Excel template with the following modifications: Deletion of trend information in Exhibit A2a (cells E23 through H28).