2024 Plan Year
Individual and Small Group Market
Rate Filing Template Instructions



State of New Mexico
Office of Superintendent of Insurance

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Overview

The New Mexico ACA Rate Filing Template (the Template) must be submitted by carriers for all non-grandfathered individual and small group rate filings sold on or off the Exchange, effective January 1, 2024, and later. The Template must be submitted for both new and existing products. The objective of the Template is to facilitate the rate review process, standardize inputs supporting a rate filing, and allow for data collection that provides an overview of the individual and small group markets. The data collected in the Template includes information related to enrollment, experience data, the development of the index rate, and risk adjustment transfer payments. In addition, the Rate Filing Summary form has been incorporated into the "Data" tab of the Template.

It is intended that the information reported in the Template is consistent with current State or Federal laws and regulations. If any subsequent changes are made to State or Federal law and/or guidance that conflict with these instructions, the revised laws/guidance will supersede these instructions.

Cell Shading: Green and purple cells should be populated. Please see the following:


Cells shaded green represent Manual Input – Free Form cells.


Cells shaded pink represent Manual Input – Dropdown List cells.


Cells shaded blue do not require inputs and should not be changed.

Once populated with the required information, the Template should be submitted in Excel format in SERFF on the Supporting Documentation tab of the rate filing.

For the purposes of completing the Template, please note:

- Allowed Claims are after the removal of any duplicates, claims for noncovered services or COB, and after the application of provider discounts, but prior to reduction for any member cost sharing.
- Incurred Claims are after the removal of any duplicates, claims for noncovered services or COB, and after the application of provider discounts and reduction for any member or HHS (as applicable) cost sharing. This field also includes runout after the incurred date as well as an appropriate adjustment for claims incurred but not yet paid (IBNP) as of the reporting date.
- Do not adjust allowed or incurred claims for non-medical items (e.g., quality improvement expenses) that can be added to the numerator in the federal Medical Loss Ratio (MLR) calculation. The treatment of any claims processed outside of the claims system should be consistent (inclusion or exclusion) with how such claims were handled in pricing. The actuarial memorandum should include documentation of any adjustments made for non-system claims.

- The HIOS Plan ID field should be populated using the Standard Component Plan ID assigned in HIOS. The required information should include data for all non-grandfathered policies underlying the single risk pool included in the filing, including data for plans that were active during the experience period but are or will be terminated by the rate effective date.
- When completing sections of the template where the number of rows a carrier can enter is variable, enter all subsequent rows in a continuous manner; do not leave any blank rows between the records.

Do not attempt to alter the format of the worksheets or workbook in any way, including adding/copying sheets. Alteration may cause tools to not work properly, in which case the carrier may be required to resubmit the Template.

The Template must be submitted under the 'Supporting Documentation' tab in SERFF. Please use the following standard naming convention:

CarrierName_MMDDYYYYmkt_ **Exchangetype**_v#_"RFT.xls"

• CarrierName: Up to 6 Characters which identify the carrier

• MMDDYYYY: e.g., 010123 for filings effective January 1, 2023

• mkt: "i" for individual "s" for small group filings

• Exchangetype: indicate one of the following
    - MedOn (Medical On-Exchange)
    - MedOff (Medical Off-Exchange)

• v#: v followed by the version number (increment for each update to the filing)

As an example, for "ABC Health insurance Company", the initial version of the template filed in SERFF for the individual market single risk pool may be named:
ABCHIC_01012023i_MedOn_v1_RFT.xls

1. Data

A. Identifying Information

- **Carrier Name:** Enter the name of the legal entity submitting the filing.
- **NAIC Number:** Enter the legal entity's NAIC number.
- **SERFF Tracking Number:** Enter the SERFF Tracking Number for the Form/Rate Filing.
- **Product(s):** Enter the product(s) included in the filing (HMO, PPO, etc.)
- **Market Segment:** Drop down indicating either individual or small group.
- **Projected Rating Period (mm/dd/yyyy):** Enter the first effective date of the rating period. For individuals this must be January 1, 20XX; for small group, this should be the beginning of the first calendar quarter for which the filed rates apply.
- **Experience Period (mm/dd/yyyy)** Once the Projected Rating Period is entered, these cells will auto-populate with beginning dates two years prior. This field may be overwritten if the auto-populated dates are not accurate.
- **Manual Experience Period:** Enter the first and last date of the manual experience period, if applicable.
- **Most Recent Membership Date:** Enter the date as of which the current membership will be reported, consistent with the URRT.
- **Current Period:** Do not enter any values. This field will auto-populate with a date that begins on the first day of the current calendar year and ends on the most recent membership date, which is March 31 of the current calendar year.

B. Notes

Enter information that would help the reviewer understand the information presented. Please indicate the SERFF number for the associated binder filing. Other examples of notes to add in this field are brief explanations relating to the manual experience data, or a list of the changes made to the current version of the Template.

C. Rate Filing summary

This section is intended to provide a general overview of the rate filing. Please fill out all sections as applicable.

- **Preliminary Information:**
    - **SERFF Tracking Number:** Do not enter any values. This field will be populated automatically.
    - **Name of Company:** Do not enter any values. This field will be populated automatically.
    - **PPACA Type:** Use the drop down to choose either 'Non-Grandfathered' or 'Grandfathered'

- **Rate Request:** Enter the required information regarding the rate increase which includes the requested rate change in percentage format, effective date, type of insurance, number of policy holders that will be affected, and the number of New Mexicans that will be affected.
- **Basis for the Rate Request:** Provide an explanation for the requested rate change.
- **Form Changes (if applicable):** Provide and explanation for any changes that have occurred on the related forms.
- **Expected N.M. Medical Loss Ratio (if applicable):** If applicable, enter the current year, last year, 2nd prior year, and 3rd prior year MLRs for each block of business. In addition, please provide information as to how the blocks of business will meet the requirements for medical loss ratio in state and federal law, using the green space provided.
- **Medical Costs (if applicable):** If applicable, enter information on premium reserves, claim history, losses, and reserves for each block of business for the given years.
- **All Products Lines Sold in New Mexico (in aggregate):** Enter actual or estimated expected incurred but unpaid (IBNP) reserves and surplus in aggregate for the indicated years.
- **Changes in Administrative and Medical Costs:** Enter the changes in medical and administrative costs for the given years.
- **Open vs. Closed Blocks of Business (or Plans closed to new issue):** For each plan, indicate the required and filed rate increases, form number, number of members, and whether the block of business was open or closed.

Please attach an electronic copy of the company's most recent Annual Statement (NAIC) to the first filing after March 1 of each year and refer to its SERFF Tracking Number in subsequent filings on this form until the following March 1.

2. Enrollment – On Exchange

This worksheet captures On-Exchange ACA enrollment separately by rating area, metal tier, subsidy level, and tobacco for the experience period, current period, and projected period. Please note the current period begins on the first day of the current calendar year to the most recent membership date provided on tab '1. Data'. All enrollment used for this worksheet should be On-Exchange.

A. Membership by Metal Level: For the Covered Lives column, enter the total number of covered lives by metal tier as of the last day of the current period, for the metal tier (Platinum, Standardized Gold, Non-Standardized Gold, Standardized Silver, Non-Standardized Silver, Standard Bronze, Expanded Bronze, and Catastrophic) indicated. For new carriers, enter "0" in all cells. For the Member Months columns, enter the total number of member months for the experience period, current period, and projection period. For new carriers, enter "0" for the Experience Period and Current Period. Non-credible carriers should still provide the Experience

period member months unless they did not participate in the Experience period at all, in which case enter “0” for the Experience period member months.

B. Membership by Cost Sharing Subsidy Level:

Please note that this table includes membership information for both the ACA CSR variants and the New Mexico Healthcare Affordability Fund (HCAF) variants discussed in the Policy Manual Marketplace Affordability Program.

- **Covered Lives:** Enter the total number of covered lives by cost sharing subsidy level. Please note that the HCAF variants should not be used in this section because there are not members currently in these variants.
- **Member months:** For the Member Months columns, enter the total number of member months for the experience period, current period, and projection period. For new carriers, enter “0” in the Experience Period and Current Period columns. Non-credible carriers should still provide the Experience period member months unless they did not participate in the Experience period at all, in which case enter “0” for the Experience period member months. **Information for the HCAF variants should only be completed for the current and projection periods.** In the projection period please enter members where it is most appropriate. Please input the Total expected member months for each category and for the total membership. For APTC Non-CSR, please include all members receiving premium subsidies but are not included in the CSR categories.

C. Tobacco Use Membership:

Individual Market: Because rating for tobacco use is not allowed in the individual market, please include all members as non-tobacco users (i.e., leave this table blank) for the individual market.

Small Group Market: Enter the tobacco use membership under the ‘Covered Lives’ column, respectively for each age group. For new carriers, enter “0” in all cells. For the ‘Member Months’ section, enter the total number of member months for the experience period, current period, and projection period by age. For new carriers, enter “0” in the Experience Period and Current Period columns. Non-credible carriers should still provide the Experience period member months unless they did not participate in the Experience period at all, in which case enter “0” for the Experience period member months.

D. Experience Period Member Months Age: Enter the membership in the experience period for each rating area by age. For new carriers, enter “0” in all cells. Non-credible carriers should still provide the Experience period member months unless they did not participate in the Experience period at all, in which case enter “0” for the Experience period member months.

E. Current Period Member Months by Age: Enter the membership for the current period for each rating area by age. For new carriers, enter “0” in all cells.

F. Projected Member Months by Age: Enter the projected membership for each rating area by age. This section is required to be populated by all carriers.

G. Covered Lives – As of Last Day of Current Period: Enter the total number of covered lives as of the last day of the current period, for the age and rating area indicated. For new carriers, enter "0" in all cells.

H. Total Membership by Age: Do not enter any values. All fields in this section will be populated automatically.

I. Total Membership by Geographic Area: Do not enter any values. All fields in this section will be populated automatically.

3. Enrollment – Off Exchange

This worksheet captures Off-Exchange ACA enrollment separately by rating area, metal tier, , and tobacco for the experience period, current period, and projected period. All enrollment used for this worksheet should be Off-Exchange. For a description of each section, please see 2. Enrollment – On Exchange above. **Do not enter any data in the Cost Sharing by Subsidy Level on this tab.**

4. Monthly Experience – Trend

For dollar entries where the carrier is reporting no experience, 0 should be entered. New carriers should complete sections B, D, and F.

Complete the table in G5:J9, adding a description for the Runout Period, Large Incurred Claim Threshold, and Metal Levels in Prior Periods.

A. Annual Adjustments: This section deals with experience based on New Mexico only data for the single risk pool filed. Enter the required components for each incurred year listed in this section. Descriptions are below.

- **Private Reinsurance Recoverable:** Enter the net adjustment to claims as a result of reimbursements received from private reinsurance arrangements. Enter amounts recoverable from private reinsurance arrangements as positive values.
- **Federal High-Cost Risk Pool Payment Amount**: Enter the actual/expected receivable from the federal high-cost risk pool program consistent with the HHS Summary Report.
- **Federal Risk Adjustment State Payment Transfer Amount Catastrophic:** Enter the actual/expected net amounts payable to or from the federal risk adjustment program, including any risk adjustment user fees, consistent with the HHS Summary Report for the Catastrophic Pool.

- **Federal Risk Adjustment State Payment Transfer Amount Non-Catastrophic:** Enter the actual/expected net amounts payable to or from the federal risk adjustment program, including any risk adjustment user fees, consistent with the HHS Summary Report for the Non-Catastrophic Pool.
- **Federal Risk Corridor:** Enter the amounts paid by the federal risk corridor program as a positive number. Do not include any amounts that may be owed to a carrier but have not yet been paid. Enter any amounts paid or payable by a carrier as a negative value.
- **Adjustment for Large Claims:** Enter the total amount of incurred claims for all large claimants incurred in the applicable period. The value entered should include actual runout plus an estimate of IBNP, if applicable.
- **Other Adjustments:** Enter any other adjustments to claims for the applicable period. Amounts that reduce a carrier's liability should be entered as a positive value.
- **Non-EHB portion Allowed Claims:** Enter the amount of non-EHB portion allowed claims.
- **Total Allowed EHB Capitation:** Enter the amount of total allowed EHB capitation.
- **Total Allowed Non-EHB Capitation:** Enter the amount of total allowed non-EHB capitation.

The Trend Summary table (N13:T19) will automatically populate.

B. Annual Adjustments – Alternate Data Source: This section collects experience similar to that in section A but based on an alternate data source. For a description of each column, please see the section above.

The Trend Summary – Alternate Data Source table (AK13:AP19) will automatically be populated.

C. Description of Data: Enter a description of the data used for trend development.

D. Description of Data – Alternate Data Source: Enter a description of the data used for trend development.

E. Experience Data by Month: This section collects experience data for all New Mexico policies in the single risk pool for the applicable period. This section should be completed by all carriers with policies in the single risk pool during any part of the period. If the New Mexico experience of the single risk pool included in the filing is less than 100% credible, section F must also be completed. Carriers with no New Mexico experience in the single risk pool filed should leave this section unpopulated.

- **Earned Premium:** Enter the amount of earned premium for the indicated month.
- **Paid Claims:** Enter the total amount of paid claims, net of CSR recoveries, for the indicated month.
- **Completion Factors:** Enter completion factors for the indicated month. Express this as a percentage.
- **Incurred Claims:** Do not enter a value. This field will be populated automatically.

- **# Members:** Enter the number of members for each indicated month.
- **Incurred Claims PMPM:** Do not enter a value. This field will be populated automatically.
- **Large Incurred Claims:** Enter the amount of large, incurred claims for the indicated month.
- **Cost Sharing - Member:** Enter the amount of cost sharing paid by a member for the indicated month.
- **Cost Sharing - HHS (CSR):** Enter the amount of cost sharing (APTC) paid by HHS for the indicated month.
- **RX Rebates:** Enter the amount of Rx Rebates for the indicated month.
- **Allowed Claims:** Enter the total amount of allowed claims. Express Prescription Drug Rebates as a negative number.
- **Allowed PMPM:** Do not enter a value. This field will be populated automatically.
- **Loss Ratio:** Do not enter a value. This field will be populated automatically.
- **Average Normalization Factors:** The normalization factors are not required to be the same as the factors used in setting premiums; however, a common set of factors must be used for all 36 months in the experience period so that changes in the average normalization factors reflect changes in the population and not in the factors themselves. The factors should be determined based on all covered members, not just those with incurred claims.
    - **Age/Gender:** Enter the average age/gender factor (weighted by membership) for the membership that was in force for the applicable month. If the Risk /Morbidity normalization factor (discussed below) incorporates the portion of risk related to age and gender, this field should be populated with 1.00.
    - **Benefit Richness:** Enter the average factors related to the underlying cost sharing benefits (weighted by membership) for the membership that was in force for the applicable month. This should reflect an estimate of the average incurred to allowed ratio, plus induced utilization, across all plans.
    - **Risk /Morbidity:** Enter the average risk score or morbidity factor (weighted by membership) that represents the estimated morbidity for the membership that was in force for the applicable month. The value entered may be the HHS risk score used for risk adjustment, but it is not required to be the HHS risk score. The most recent risk adjustment model (weighted by membership).
    - **Geographic Area:** Enter the average geographic factor (weighted by membership) for the membership that was in force for the applicable month.
    - **Tobacco:** Enter the average tobacco factor (weighted by membership) for the membership that was in force for the applicable month. If the carrier does not propose utilizing rates based on tobacco use, this field should be populated with a 1.00.
    - **Other:** Enter the average 'other' factor (weighted by membership) for the membership that was in force for the applicable month. This estimate should

reflect the normalization of the claim costs for any other dynamics that impact cost and are not better reflected in one of the above categories. At a minimum this would include factors related to network management and benefits provided in addition to EHB which correspond to the rating factors described in 45 CFR Part 156.80(d)(2)(ii) and(iii).

F. Experience Data by Month – Alternate Data Source: This section collects experience data similar to what is collected in Section E but based on an alternate data source. This worksheet captures the historical claims data entered in worksheets 8a through 8f that was used to support the carrier's trend assumption. If the New Mexico experience of the single risk pool included in the filing (i.e., the same experience as that shown in section is considered 100% credible and was used as the basis for developing the trend assumption, this section may be left unpopulated. If other experience was used to support the trend assumption, enter the experience for this alternate population in this section. For descriptions of the required fields, please see section E above.

5. Rate Development

A. Development of the Projected Index Rate, Market-Adjusted Index Rate, and Total Allowed Claims: The following manual entries should be entered under Actual Experience Data and Manual Data if applicable.

- **Experience Period PMPM (Allowed EHB + Capitation EHB - Rx Rebates):** This figure should match the corresponding item on Worksheet 1 of the URRT for Experience Period Index Rate PMPM Total.
- **Trend Projection Factor:** Enter the factor calculated from Worksheet 1 of the URRT. This is calculated as the Trended EHB Allowed Claims PMPM Total amount divided by the Experience Period Index Rate PMPM total.
- **Morbidity Adjustment:** Enter the value as defined in the URRT instructions. This item should match the Morbidity Adjustment factor on Worksheet 1 of the URRT. For the Manual entry, if applicable, enter the value used in the development of the manual rate which is included in the Actuarial Memorandum and supporting documentation.
- **New Mexico HCAF Adjustment:** Please enter any adjustment related to the implementation of the New Mexico Healthcare Affordability Fund. All adjustments should be explained narratively and quantitatively in the accompanying actuarial memorandum.
- **Demographic Shift, Plan Design Changes, Other:** Enter the value(s) from Worksheet 1 of the URRT as defined in the URRT instructions. For the Manual entries, if applicable, enter the values used in the development of the manual rate which is included in the Actuarial Memorandum and supporting documentation.

- **Credibility Factors:** Enter the amount of credibility assigned to Actual Experience Data. This should match the value on Worksheet 1 of the URRT. The Manual Data credibility will auto-populate.
- **Projected Paid to Allowed Ratio:** Enter the Paid to Allowed Ratio in the Projection Period as defined in the URRT Instructions. This should match the figure on Worksheet 1 of the URRT.

The following manual entries should be entered for the market-wide adjusted index rate.

- **Projected Risk Adjustment PMPM:** Payments should be negative, and receipts should be positive. Value should be net of risk adjustment user fees. This entry should match the corresponding value on Worksheet 1 of the URRT.
- **Projected Paid Exchange User Fees PMPM:** Enter the expected Exchange User Fee based on the amount specified by the NMHIX, if applicable. This entry should match the corresponding value on Worksheet 1 of the URRT. For 2023, this amount should be $0, since the NMHIX pays user fees out of a broad assessment, which is included in item C below.

The Market-Adjusted Index Rate will populate automatically.

B. Small Group Projected Index Rate with Quarterly Trend: Please refer to the URR Instructions under "Quarterly Submissions" for more information. Please provide members renewing in each quarter, for on-exchange and off-exchange separately. The Months of Trend and Annualized Quarterly Trend will auto populate but can be changed if necessary. The Annualized Quarterly Trend should be the quarterly pricing trend on an annualized basis, not on a quarterly basis. If the trend varies by quarter, please provide narrative and quantitative support in the actuarial memorandum.

C. Retention: Values should be entered under % of Premium, Projection Period PMPM, and Experience Period PMPM in columns C, D, and E, respectively. Total Administrative Expenses, Taxes and Fees, and Retention will be populated automatically.

The following are allowed entries under Administrative Expenses and the total should equal the Administrative Expense Load on the URRT:

- General and Claims
- Agent/Broker Fees and Commissions
- Private Reinsurance
- Quality Improvement Initiatives
- Other (Provide additional detail in memorandum)

The following are allowed entries under Taxes and Fees and the total should equal Taxes and Fees on the URRT:

- PCORI Fees

- NM Premium Tax (if applicable).
- Federal Income Tax
- NM HIX assessment
- Risk Adjustment Fee
- Other (Provide additional detail in memorandum)

The after-tax Profit/Contingency should be included which equal the Profit & Risk Load on the URRT WS2.

For the Commissions included in the Administrative Expenses section discussed above, provide a breakout of projected commissions for new business, renewals, and special enrollment period as a % of premium and PMPM.

D. Projected MLR: The following manual entries are required:

- **MLR:** Provide the projected one-year medical loss ratio incorporating the federal MLR numerator and denominator adjustments. This amount should be consistent with the expected MLR in the Rate Filing Summary.
- **Projected incurred claims PMPM:** This item includes projected incurred claims as well as adjustments for projected Rx rebates, risk adjustment transfer payments and (if applicable) reinsurance recoveries.
- **Average Single Risk Pool Premium PMPM:** This item includes adjustment for certain projected taxes and fees.

6. Plan Level Adjustments

A. Calibration Factors: Enter the values for the calibration factors, which must match the calibration factors shown on Worksheet 2 of the URRT. For more information on calibration factors, see below. The Aggregate Calibration Factor (row 17) will populate automatically. The Reciprocal of Projected Calibration Factor and Difference columns will also populate automatically.

- **Age Calibration Factor:** Enter the age calibration factor using the federal age curve and projected membership. Carriers are expected to demonstrate the calculation of this factor in an exhibit in Excel format with working formulas, and any differences the carrier's calibration factor input in cell C 14 and the factor in cell D 14, based on the calculation in Tab 7, should be explained.
- **Geographic Calibration Factor:** Enter the geographic calibration factor using the geographic factors and projected membership for each geographic rating area. Carriers are expected to demonstrate the calculation of this factor in an exhibit in Excel format with working formulas, and any differences the carrier's calibration factor input in cell C 15 and the factor in cell D 15, based on the calculation in Tab 7, should be explained.

- **Tobacco Calibration Factor:** Enter the tobacco calibration factor using the tobacco factors and projected membership for each age. Carriers are expected to demonstrate the calculation of this factor in an exhibit in Excel format with working formulas, and any differences the carrier's calibration factor input in cell C 16 and the factor in cell D 16, based on the calculation in Tab 7, should be explained. (See)

B. Plan-Level Information: This section contains the component factors of the plan level adjustments (actuarial value/cost sharing, network and management, non-EHB coverage, catastrophic adjustment, and administrative costs excluding Exchange fees) at the plan level for both the current and projection periods, along with other information for the plan such as metal level, wellness indicator, membership by rating area, and whether the plan will be sold on the Exchange. Information on each column is listed below. For items that are shown in the URRT, the entries in the template must match the URRT.

- **Column B: HIOS Plan ID (Standard Component):** Enter the Standard Component Plan ID for all plans associated with the rate filing, including plans that were included in the most recently approved rate filing but will be terminated prior to the effective date of this filing and new plans that will be first offered on the effective date of this filing. These should be the same plans entered in the URRT.
- **Column C: Plan Type:** Enter the Network Description associated with the product. Allowable entries are the following: 'HMO' (health maintenance organization), 'POS' (point of service), 'PPO' (preferred provider organization), 'EPO' (Exclusive Provider Organization), 'Indemnity' (indemnity), and 'Other' (other).
- **Column D: Current Year Plan Marketing Name:** Enter the Marketing name used for the plan in the current period.
- **Column E: Projected Year Plan Status:** Select one of the following allowable entries depending on the status of the plan for this filing – Enter 'N' for new plans, 'T' for plans that will not be offered in the projected period, 'R' for the issuer's plans that will be renewed in the projected period and 'R-CG' for renewed plans previously offered by another issuer within the controlled group.
- **Column F: Projected Year Plan Marketing Name:** Enter the Marketing name that will be used for the discontinued plan that will be mapped to a new or existing plan in the projected period.
- **Column G: Metallic Tier:** Enter the metal level that corresponds with the Metal AV. Allowable entries are the following: 'P' (Platinum), 'G' (Gold), 'S' (Silver), 'Std. B' (Standard Bronze), 'Exp. B' (Expanded Bronze), and 'C' (Catastrophic).
- **Column H: Metallic Tier Actuarial Value:** Enter the actuarial value as calculated by HHS' AV Calculator. If the plan has a unique plan design that required the actuary to make an adjustment to HHS' AV Calculator value as allowed under 45 CFR156.135(b)(2) or (b)(3), the adjusted value that was certified should be entered.

- **Column I: AV Basis:** If the plan's AV was calculated using HHS AV Calculator without adjustment, enter 'Std'. If the plan has a unique plan design that required the actuary to make an adjustment to HHS' AV Calculator value as allowed under 45 CFR156.135(b)(2), enter 'Unique – 2'. If the plan has a unique plan design that required the actuary to make an adjustment to HHS' AV Calculator value as allowed under 45 CFR156.135(b)(3), enter 'Unique – 3'.
- **Column J: Exchange Indicator:** Identify whether the plan is (or is expected) to be sold on the Exchange ('Yes') or off the Exchange ('No'). For terminated plans, indicate whether the plan was sold on or off the Exchange.
- **Column K: Standardized Plan Indicator:** Identify whether the plan fulfills the New Mexico Standardized Plan requirements ('Yes') or not ('No').
- **Column L: Wellness Indicator:** An indicator of whether the plan offers participation in a wellness program as part of its rating provisions. Allowable field entries are 'Y' and 'N.' For small group filings, if premium rates vary based on tobacco use status, this field must be populated with a 'Y'. For the individual market this field should be 'N' for all entries.
- **Column M: Pediatric Dental Indicator:** An indicator of whether or not the plan provides coverage for an embedded pediatric dental benefit. Allowable field entries are 'Y' and 'N.'
- **Column N: Non-EHB Services Indicator:** An indicator of whether or not the plan includes non-EHB services. Allowable field entries are 'Y' and 'N.'
- **Current Period Market Adjusted Index Rate:** Enter the Market Adjusted Index Rate used in the approved rate filing from the current period in cell R19.
- **Current Rating Factors:** For plans that are offered for the first time, enter a zero in the 'Current' rating factors section. The 'Current' factors should reflect those factors that the carrier employed in its most recently approved rate filing.
    - **Column O: Induced Utilization:** Enter the multiplicative factors that are applied in rating to reflect the anticipated changes in utilization due to cost sharing differences. This entry refers to the plan level adjustment allowed under 45 CFR 156.80 (D)(2)(i) due to the anticipated changes in utilization due to cost sharing differences. This factor should not reflect differences in health status.
    - **Column P: CSR Load:** Enter the required 1.44 CSR Load per OSI Guidance for individual On-Exchange Silver plans.
    - **Column Q: Cost-Sharing Design:** Enter the multiplicative factors that are applied in rating to reflect the relative value of the plan's cost sharing provisions. These factors should reflect anticipated differences in plan liabilities under different cost sharing provisions for each plan relative to the adjusted index rate but should not include the anticipated changes in utilization due to cost sharing differences. This entry refers to the plan level adjustment allowed under 45 CFR 156.80 (D)(2)(i) which reflects the relative value of the plan's cost sharing

differences without regard to the differences in utilization. This item should reflect an adjustment to remove the impact of the CSR benefits already included in the experience level claims. A separate exhibit should be provided which splits out the components of this factor, and a detailed explanation should be included in the actuarial memorandum.

- **Column R: Provider Network:** Enter the multiplicative factors that are applied in rating to reflect the relative value of the plan's provider network, delivery system characteristics, and utilization management practices. These factors should reflect these cost differences for each plan relative to the adjusted index rate. This entry refers to the plan level adjustment allowed under 45 CFR 156.80 (D)(2)(ii).
- **Column S: Benefits in addition to EHB:** Enter the multiplicative factors that are applied in rating to reflect the value of all of the plan's benefits in addition to the required EHBs. These factors should reflect the non-EHB cost differences for each plan relative to the adjusted index rate. This entry refers to the plan level adjustment allowed under 45 CFR 156.80 (D)(2)(iii).
- **Column T: Catastrophic Eligibility:** Enter the multiplicative factors that are applied in rating to reflect the effect of specific eligibility categories for catastrophic plans. These factors should reflect the cost differences for each plan relative to the adjusted index rate. This entry refers to the plan level adjustment allowed under 45 CFR 156.80 (D)(2)(v).

- **Column U: Current Premium Before Retention Load and Calibration:** Do not enter a value. This field will be automatically populated.
- **Column V: Current Admin Costs:** Enter the total administrative expense as a percentage of premium.
- **Column W: Current Taxes & Fees (Not Including Exchange Fees):** Enter the total for taxes and fees (not including Exchange fees but including the NMHIX assessment) as a percentage.
- **Column X: Current Profit or Contingency:** Enter the total amount allocated for profit and risk charge as a percent of premium.
- **Column Y: Current Plan Adjusted Index Rate:** Do not enter a value. This field will be automatically populated.
- **Column Z: Total Current Covered Lives:** Enter the total number of lives associated with each plan in the current period.
- **Column AA: Current Year Calibrated Plan Adjusted Index Rate PMPM:** Enter the calibrated plan adjusted index rate by plan for the current period.
- **Projected Year Market Adjusted Index Rate:** Do not enter a value. This field will be automatically populated from Tab 5.
- **Proposed Rating Factors:**

- **Column AC: Induced Utilization:** For both individual and small group plans, enter the multiplicative factors that are applied in rating to reflect the anticipated changes in utilization due to cost sharing differences. This entry refers to the plan level adjustment allowed under 45 CFR 156.80 (D)(2)(i) due to the anticipated changes in utilization due to cost sharing differences. This factor should not reflect differences in health status.
- **Column AD: CSR Load:** Enter the required 1.44 CSR Load per OSI Guidance for individual On-Exchange Silver plans.
- **Column AE: Cost-Sharing Design:** Enter the multiplicative factors that are applied in rating to reflect the relative value of the plan's cost sharing provisions. These factors should reflect anticipated differences in plan liabilities under different cost sharing provisions for each plan relative to the adjusted index rate but should not include the anticipated changes in utilization due to cost sharing differences. This entry refers to the plan level adjustment allowed under 45 CFR 156.80 (D)(2)(i) which reflects the relative value of the plan's cost sharing differences without regard to the differences in utilization.
- **Column AF: Provider Network:** Enter the multiplicative factors that are applied in rating to reflect the relative value of the plan's provider network, delivery system characteristics, and utilization management practices. These factors should reflect the cost differences for each plan relative to the adjusted index rate. This entry refers to the plan level adjustment allowed under 45 CFR 156.80 (D)(2)(ii).
- **Column AG: Benefits in addition to EHB:** Enter the multiplicative factors that are applied in rating to reflect the value of all the plan's benefits in addition to the required EHBs. These factors should reflect the non-EHB cost differences for each plan relative to the adjusted index rate. This entry refers to the plan level adjustment allowed under 45 CFR 156.80 (D)(2)(iii).
- **Column AH: Catastrophic Eligibility:** Enter the multiplicative factors that are applied in rating to reflect the effect of specific eligibility categories for catastrophic plans. These factors should reflect the cost differences for each plan relative to the adjusted index rate. This entry refers to the plan level adjustment allowed under 45 CFR156.80 (D)(2)(v).

- **Column AI: Projected Premium Before Retention Load and Calibration:** Do not enter a value. This field will be automatically populated.
- **Column AJ: Proposed Admin Costs:** Enter the total administrative expense as a percentage of premium.
- **Column AK: Proposed Taxes & Fees (Not Including Exchange Fees):** Enter the total for taxes and fees (not including Exchange fees but including the NMHIX assessment) as a percentage.

- **Column AL: Proposed Profit or Contingency:** Enter the total amount allocated for profit and risk charge as a percent of premium.
- **Column AM: Projected Plan Adjusted Index Rate:** Do not enter a value. This field will be automatically populated.
- **Column AN: Total Projected Member Months:** Enter the projected member months for each plan.
- **Column AO: Projected Year Calibrated Plan Adjusted Index Rate PMPM:** Do not enter a value. This field will be automatically populated.
- **Column AP: Change in Plan Adjusted Index Rate:** Do not enter a value. This field will be automatically populated.
- **Column AQ: Change in Calibrated Plan Adjusted Index Rate:** Do not enter a value. This field will be automatically populated.
- **Columns AR-AV: Number of Members by Rating Area:** Enter the number of members for each plan, by rating area as of the most recent membership date. The Total will be calculated automatically in column AV.

7. Calibration Factors

A. Age and Tobacco Factors: Enter the Proposed Tobacco Factor and Current Tobacco Factor for age 18+ in columns D and E, respectively. The fields Factor Change, Projected Non-Tobacco Use Member Months, Projected Tobacco Use Member Months, and Projected Total Member Months will be populated automatically.

B. Geographic Factors: Enter the Proposed Area Factor and Current Area Factor for all five rating areas. If no plans are being offered in the rating area, enter 'NA'. The Factor Change, Member Months, and Projected Geographic Calibration fields will populate automatically.

8. Rate Change & Plan Mapping

A. Estimated Components of Calendar Year 20XX Rate Change: Enter the impact of each component listed in the first section. These should match the estimated component impacts detailed in the URRT and supporting documentation. The Mult. Factor and Total Impact will be populated automatically.

B. Mapping of Renewal Plans: All plans included in the single risk pool for the most recently approved rate filing, even if the plan has been terminated or will be terminated before the effective date of this filing, must be included in this tab. Carriers with no membership in the single risk pool for the current period should skip this worksheet. However, do not delete this worksheet from the workbook. Information on each column is listed below.

- **Current Period HIOS Plan ID:** Enter the HIOS Plan ID from the current period.

- **Current Period Metal Tier:** Choose C, Std. B, Exp. B, S, G, or P from the drop-down menu, respectively to represent Catastrophic, Standard Bronze, Expanded Bronze, Silver, Gold or Platinum metal tier.
- **Current Enrollment:** Enter the number of members enrolled in the current period.
- **Projected Period HIOS Plan ID:** Enter the HIOS Plan ID from the Projection period.
- Projected Year Metal: Choose C, Std. B, Exp. B, S, G, or P from the drop-down menu, respectively to represent Catastrophic, Standard Bronze, Expanded Bronze, Silver, Gold or Platinum metal tier.
- **Year Over Year % Change – Rating Area XX:** Enter the rate change for rating areas 1 – 5 as a percentage in columns G – K. Carriers are expected to submit detailed documentation of the method used to determine the amounts entered in this field in the actuarial memorandum. Carriers will also need to provide an exhibit demonstrating the calculation of this item in an Excel spreadsheet with formulas intact. For Small Group filings, these exhibits will need to incorporate a weighted average by renewal quarter.
- **Year Over Year % Change – All Rating Areas:** Enter the total rate change for all rating areas as a percentage. Carriers are expected to submit detailed documentation of the method used to determine the amounts entered in this field in the actuarial memorandum. Carriers will also need to provide an exhibit demonstrating the calculation of this item in an Excel spreadsheet with formulas intact.
- **Plan Status Indicator:** From the drop-down, choose "T" for plans that will not be offered in the projected period, "R" for plans that will be offered in projected period and "R-CG" for plans offered by another issuer within the controlled group in and that will be renewed in projected period by the submitting issuer.

9. Risk Adjustment

This worksheet collects information related to the calculation of the risk adjustment transfer payment amounts payable to or by the carrier under the federal risk adjustment program. The methodology used to determine the estimated risk adjustment transfer payment amounts must also be supported by a detailed narrative in the actuarial memorandum explaining how each element of the calculation of the risk adjustment transfer payment was determined as well as an exhibit demonstrating the calculation in Excel format with working formulas.

A. Statewide Factors: This section provides actual and projected components of the statewide factors used in the risk adjustment transfer payment formula.

- Actual Columns:
    - The information for 2019 through 2021 is provided by OSI and cannot be changed.
    - The 2022 column should be completed by the issuer once that information is provided by CMS, usually during the rate review process.
- Projected Columns:
    - These columns should be completed with the estimated factors used in the 2022 through 2024 rate filings, as applicable.

B. Issuer Factors: This section provides actual and projected components of the issuer-specific factors used in the risk adjustment transfer payment formula.

- Actual Columns:
    - The factors entered must match the factors included in each issuer's Transfer Payment Issuer Report (TPIR) provided by CMS for the applicable year not the factors from a third-party vendor.
    - The 2022 column should be completed once that information is provided by CMS, which is usually after the initial filing but during the review process.
- Projected Columns:
    - These columns should be completed with the estimated factors used in the 2022 through 2024 rate filings, as applicable.

C. Estimated Risk Adjustment Transfer Payment Information From Rate Filings:

- These columns must be populated with the estimated member months and transfer payment amounts from the rate filing for the applicable year.

D. Actual Risk Adjustment Transfer Payment Information From CMS TPIR reports:

- These columns must be populated with the actual billable member months and transfer payment amounts from the CMS TPIR reports for the applicable year, before and after any RADV adjustments.

E. Summary of Risk Adjustment Calculation for 2024 Premiums:

Do not enter any values. This table will be automatically populated.

Regardless of the methodology used, carriers are expected to provide detailed support for each element of the calculation of the risk adjustment transfer payments in the actuarial memorandum.