

2018 ACA-Compliant Health Insurance Rate Filing Guidance

Nevada Rate Filing Template Instructions

Nevada Division of Insurance

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Instructions for Completing the 2018 Nevada Rate Filing Template

Overview

Carriers are required to complete and submit the 2018 Nevada Rate Filing Template (the Template) for all non-grandfathered individual and small group rate filings sold on or off the Exchange, with effective dates of January 1, 2018 and later, regardless of whether the filing is for new or existing products. The data captured in the Template includes information related to enrollment, the development of the index rate, rating factors, risk adjustment transfer payments, experience data and quality measures.

The information reported in the Template is intended to be consistent with current State and Federal laws and other regulatory guidance. If any subsequent changes are made to State or Federal law and/or guidance that are in conflict with these instructions, the revised laws/guidance will supersede these instructions. In particular, unless otherwise notified due to a change in federal law, the Division expects that the rates filed for the 2018 benefit year will be in compliance with the Affordable Care Act (ACA).




The Template is an Excel based workbook designed to streamline the data collection process in order to meet the Division's long-term goals for a more efficient rate review process.

The Template consists of the following worksheets:

- Worksheet 1 – Enrollment – Off Exchange
- Worksheet 2 – Enrollment – On Exchange
- Worksheet 3 – Plan Mapping & Rate Change
- Worksheet 4 – Index Rate Development
- Worksheet 5 – Plan Level Adjustments
- Worksheet 6 – Rating Factors
- Worksheet 7 – Risk Adjustment
- Worksheet 8 – Experience by Month – Trend Justification
- Worksheet 9 – Nevada Experience Data
- Worksheet 10 – Tracking Quality Measures

Once populated with the required information, the Template should be submitted in Excel format with working formulas, in the "Supporting Documentation" tab of the NAIC's System for Electronic Rate and Form Filing (SERFF).

For purposes of completing the Template, please note the following:

- **Cell Shading:** All shaded cells are required to be populated. Except where specifically noted, in general, cells shaded green  are for the experience period, cells shaded pink  are for the current period and cells shaded blue  are for the projected rating period, as indicated in the instructions for these fields. Cells that are not shaded are calculated and as such do not require any input.
- **Incurred Claims** are claims after the removal of any duplicates, claims for non-covered services, or coordination of benefits (COB), and after the application of provider discounts and reduction for any cost sharing payable by the member or a governmental agency. 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.

Please note the following when completing the Template:

- **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 Standard Component Plan ID field should be populated using the Standard Component Plan ID assigned in the Health Insurance Oversight System (HIOS).

The required information should contain data for all policies in the single risk pool (SRP) included in the submitted filing, including data for plans that existed during the experience period but are or will be terminated by the effective date (except where specifically noted throughout these instructions). This applies to all worksheets except for Worksheets 4 and 8, which may be populated with experience data other than that of the single risk pool when such other experience is used to develop the manual rate or to support trend assumptions used in the filing.

When completing sections of the template where the number of rows a carrier may enter is variable, please enter the first row of data in the first row of colored cells. Enter all subsequent rows of data in a continuous manner; do not leave any blank rows between the records.

Do not attempt to alter the format of the worksheets in any way since alteration may impact the efficacy of the Division's analytical tools.

Worksheet 1: Enrollment – Off Exchange

Worksheet 1 captures enrollment off the ACA Exchange in member months separately by rating area, metal tier, gender and age for the experience period, current period and projected rating period. The information entered in this worksheet will provide information related to changes in the demographic make-up of the single risk pool over time and any expected changes that may be reflected in the submitted rate filing. This information will allow the reviewer to better understand the nature of related actuarial adjustments made in the rate filing.

Header: This section includes basic identifying information. All information entered in this section will be automatically imported to the other worksheets in the workbook.

- **Company Name:** Enter the name of the legal entity submitting the filing.
- **HIOS Issuer ID:** Enter the Health Insurance Oversight System (HIOS) ID affiliated with the issuer submitting the filing.
- **NAIC Number:** Enter the Company Code number assigned by the National Association of Insurance Commissioners (NAIC).
- **Market:** Indicate whether the filing is for policies offered in the individual or small group market by entering “Individual” or “Small Group”, respectively.

Section I - Membership by Rating Area: This section captures off-Exchange enrollment for each of the four rating areas. Enter the total member months for the experience period (2016), current period (January 1, 2017 through March 31, 2017) and projected rating period (2018), respectively for each rating area. For new carriers, enter “0” in the ‘Experience Period’ and ‘Current Period’ columns.

Section II - Membership by Gender: This section captures off-Exchange enrollment, in member months, by gender. Enter the total member months for the experience period, current period and projected rating period separately for males and females. For new carriers, enter “0” in the ‘Experience Period’ and ‘Current Period’ columns.

Section III - Membership by Metal Level: This section captures off-Exchange enrollment by metal tier. For each metal tier (Platinum, Gold, Silver, Bronze, Expanded Bronze and Catastrophic), enter the total member months for the experience period (2016), current period (January 1, 2017 through March 31, 2017) and projection periods (2018). For new carriers, enter “0” in the ‘Experience Period’ and ‘Current Period’ columns.

Section IV – Membership by Renewal Quarter – Small Group Only: This section captures enrollment by renewal quarter for small group single risk pools only. For small group single risk pools, this information will be used to verify the calculation of trend factors which will be applied to the allowed claims to calculate the index rate. For small group, enter the projected member months for the indicated quarter. **For individual (non-group) single risk pool submissions, this entry should be left blank.**

Section V - Member Months by Age – Experience Period: This section captures off-Exchange enrollment by age for the experience period. Enter the total member months for the experience period, for the age band indicated. For new carriers, enter “0” in all rows.

Section VI - Member Months by Age – Current Period: This section captures off-Exchange enrollment by age for the current period (January 1, 2017 through March 31, 2017). Enter the total member months for the current period, for the age band indicated. For new carriers, enter “0” in all rows.

Section VII - Member Months by Age – Projected Rating Period: This section captures off-Exchange enrollment by age for the projected period. Enter the total number of member months for the projected period, for the age band indicated. **This column is required to be populated by all carriers.**

Worksheet 2: Enrollment – On Exchange

Worksheet 2 captures Exchange enrollment in member months separately by rating area, metal tier, gender and age for the experience period, current period and projected rating period. The information entered in this worksheet will allow the reviewer to better understand changes in the demographic make-up of the single risk pool over time and any expected changes that may be reflected in the submitted rate filing. Carriers with no Exchange plans should simply leave this worksheet blank. Do not delete this worksheet from the workbook.

Section I - Membership by Rating Area: This section captures Exchange enrollment for each of the four rating areas. Enter the total member months for the experience period, current period (January 1, 2017 through March 31, 2017) and projected rating period, respectively for each rating area. For new carriers, enter “0” in the ‘Experience Period’ and ‘Current Period’ columns.

Section II - Membership by Gender: This section captures Exchange enrollment, in member months, by gender for the experience period, current period (January 1, 2017 through March 31, 2017) and projection periods, respectively. Enter the total member months for the experience period, current period and projected rating period separately for males and females. For new carriers, enter “0” in the ‘Experience Period’ and ‘Current Period’ columns.

Section III - Membership by Metal Level: This section captures Exchange enrollment by metal tier. For each metal tier (Platinum, Gold, Silver, Bronze, Expanded Bronze and Catastrophic), enter the total member months for the experience period, current period (January 1, 2017 through March 31, 2017) and projection periods. For new carriers, enter “0” in the ‘Experience Period’ and ‘Current Period’ columns.

Section IV - Membership by Cost Sharing Reduction Level: **This section should be completed only for individual (non-group) single risk pools.** This section captures Exchange enrollment, in member months, by cost sharing level for the experience period, current period (January 1, 2017 through March 31, 2017) and projection periods, respectively. Enter the total member months for the experience

period, current period and projected rating period separately for each cost sharing level indicated. For new carriers, enter “0” in the ‘Experience Period’ and ‘Current Period’ columns.

Section V - Membership by Renewal Quarter - Small Group Only: This section captures Exchange enrollment by renewal quarter for small group single risk pools only. For the small group single risk pool, this information will be used to verify the calculation of trend factor which will be applied to the allowed claims to calculate the index rate. For small group, enter the projected member months for the indicated quarter. **For individual (non-group) single risk pool submissions, this entry should be left blank.**

Section VI - Member Months by Age – Experience Period: This section captures Exchange enrollment by age for the experience period. Enter the total member months for the experience period (2016), for the age band indicated. For new carriers, enter “0” in all rows.

Section VII - Member Months by Age – Current Period: This section captures Exchange enrollment by age for the current period (January 1, 2017 through March 31, 2017). Enter the total member months for the current period, for the age band indicated. For new carriers, enter “0” in all rows.

Section VIII - Member Months by Age – Projected Rating Period: This section captures Exchange enrollment by age for the projected period (2018). Enter the total number of member months for the projected period, for the age band indicated. This column is required to be populated by all carriers.

Worksheet 3: Plan Mapping & Rate Change

The purpose of this worksheet is to capture the mapping of all 2017 plans that have been modified in accordance with the uniform plan modification rules¹ or have been discontinued to plans being offered in the market for 2018 and to capture the rate change by plan. Complete this worksheet for Individual plans only. **Carriers with no membership in the individual single risk pool for 2017 should skip this worksheet. However, do not delete this worksheet from the workbook.**

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.

- **2017 HIOS ID:** Enter the 2017 HIOS Plan ID.
- **2017 Metal Tier:** Enter C, B, S, G, P, respectively to represent Catastrophic, Bronze, Silver, Gold or Platinum metal tier.
- **3/31/2017 Current enrollment:** Enter the number of members enrolled as of 3/31/2017.
- **2018 HIOS Plan ID:** Enter the 2018 HIOS Plan ID
- **2018 Metal Tier:** Enter C, Exp. B, B, S, G, P, respectively to represent Catastrophic, Expanded Bronze, Bronze, Silver, Gold or Platinum metal tier.

¹ 45CFR 146.152, 147.106, and 148.122

- **Calendar Year % Change – Rating Area 1:** Enter the rate change for rating area 1 as a percentage. Carriers are expected to provide 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.
- **Calendar Year % Change – Rating Area 2:** Enter the rate change for rating area 2 as a percentage. Carriers are expected to provide 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.
- **Calendar Year % Change – Rating Area 3:** Enter the rate change for rating area 3 as a percentage. Carriers are expected to provide detailed documentation of the method used to determine the amounts entered in this field in the actuarial memorandum. Carriers will also need to provide the calculation of this item in an Excel spreadsheet with formulas intact.
- **Calendar Year % Change – Rating Area 4:** Enter the rate change for rating area 4 as a percentage. Carriers are expected to provide 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.
- **Calendar Year % Change – Total:** Enter the total rate change for **all rating areas** as a percentage. Carriers are expected to provide 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.
- **Indicator for 2017 Plan Status Indicator:** Enter "T" for 2017 plans that will not be offered in 2018, "R" for 2017 plans that will be offered in 2018 and "R-CG" for plans offered by another issuer within the controlled group in 2017 and that will be renewed in 2018 by the submitting issuer.

Worksheet 4: Index Rate Development

This worksheet is intended to provide a standardized format for carriers to demonstrate that their index rates are in compliance with the ACA rate development framework. This worksheet is required to be completed in order to facilitate the Division's review and to reduce the number of follow-up questions from the Division's reviewers. However, since State and Federal regulations do not prescribe the exact formula that must be used in the development of the index rate, the Division recognizes that other methods may be used as long as they meet all regulatory requirements. If a carrier uses a different method to develop the index rate, a similar exhibit (in excel format with formulas intact), documenting the actual method used to calculate the index rate will also need to be provided along with a detailed description of the methodology used.

This worksheet requires carriers to report claims and adjustments at the major service category levels. The definitions for these categories should be consistent with what the carrier reports in Worksheet 1 of the Unified Rate Review Template (URRT). Sections I, II, III, V, VII, VIII, IX and X of this worksheet will be populated for all returning carriers. Additionally, sections IV and VI will need to be completed if a manual rate is being used. New carriers will need to ensure that sections I, II, IV, VI, VII, VIII, IX and X are populated.

The worksheet collects the following information in eleven sections:

Section I. Rate Development Basis – Data Source: This section describes the source of the data used for the development of the index rate.

- **Base Experience Start Date:** Enter the starting incurred date for the base period experience. This field must be completed for all returning carriers, without regard for the credibility of the data. This entry should match the beginning of the experience period defined in Worksheet 1 of the URRT.
- **Base Experience End Date:** Enter the ending incurred date for the base period experience. This field must be completed for all returning carriers, regardless of the credibility of the data. This entry should match the end of the experience period defined in Worksheet 1 of the URRT.
- **Manual Rate Experience Start Date:** Enter the starting incurred date for the claims data used to develop the manual rate. If a manual rate is not used, leave this field blank.
- **Manual Rate Experience End Date:** Enter the ending incurred date for the claims data used to develop the manual rate. If a manual rate is not used, leave this field blank.
- **Rate Basis:** Enter basis used for the development of the index rate. Enter “NV-SRP” if the index rate is calculated based on claims data for the experience period defined in Worksheet 1 of the URRT. Enter “Manual” if the index rate is calculated based on a manual rate using data from an alternate source.
- **Description:** Describe the underlying data used in rate development. For example, this description may state that the submitting carrier used experience data for the experience period defined in Worksheet 1 of the URRT and which is exclusively based on the legal entity’s policies issued in Nevada for the single risk pool included in the filing. If a manual rate is being utilized, enter a description of the data used to develop the manual rate.

Section II. Experience Data – Member Months and Earned Premium: This section collects membership and earned premium for the experience period.

- **Member Months:** In the ‘Base Period’ column, enter the total member months that underlie the claims reported for the base period experience reported in Section III of this Worksheet. In the ‘Manual Rate’ Column, enter the total member months that underlie the claims reported in Section IV upon which the manual rate is based.
- **Earned Premium:** In the ‘Base Experience’ column, enter the total earned premium for policies included in the base period experience reported in Section III of this worksheet. In the ‘Manual

Rate' column, enter the total earned premium for policies included in the experience reported in Section IV and upon which the manual rate is based.

Section III. Historical claim Cost – Base Experience: This section contains base period utilization per 1,000, the average allowed cost per service/script, and incurred claims PMPM for policies issued in Nevada by the carrier for the single risk pool included in the filing for the experience period defined in Worksheet 1 of the URRT. The net impact of pooling and private reinsurance must be separately reported by service category. All returning carriers are required to complete this section. New carriers should leave this section blank.

- **Utilization per 1,000:** Enter the annualized utilization per thousand enrollees for each of the service categories. The utilization should be reflective of both EHB and non-EHB services present in the base period experience. The unit of measure for medical services should be consistent with the measurement units reported in the URRT and on Worksheet 9.
- **Avg. Cost per Service/Script:** Enter the average allowed cost per service/script that corresponds with the utilization measures reported in this column. The average unit costs should be reflective of the both EHB and non-EHB services present in the base period experience.
- **Allowed Claims PMPM:** This is a calculated field. Do not enter a value.
- **Paid to Allowed Ratio:** Enter the ratio of paid to allowed claims. Carriers are expected to include in the actuarial memorandum a demonstration of the development of this ratio along with detailed support for the methodology used to determine the paid to allowed ratio.
- **Incurred Claims PMPM:** This is a calculated field. Do not enter a value.
- **Net Impact of Pooling:** Enter the estimated net increase or reduction in plan liability as a result of any large claim pooling methodology (netting pooled claims against a corresponding pooling charge). If large claim pooling is not employed in the rate development, enter zero in this field for all service categories. Carriers are expected to include in the actuarial memorandum a demonstration of the development of these adjustments along with detailed support for the methodology used to determine the adjustments using historical pooling data and other relevant information.
- **Net Impact of Private Reinsurance:** Enter the net adjustment to claims as a result of any private reinsurance arrangement utilized during the base period. As with large claim pooling, carriers are expected to demonstrate and justify the appropriateness of any adjustments in the actuarial memorandum.

Section IV - Historical Claim Cost – Manual Rate: This section contains base period utilization per 1,000, the average allowed cost per service/script, and incurred claims PMPM based on the data used in the development of the manual rate. The net impact of pooling and private reinsurance must be separately reported by service category. Complete this section only if a manual rate is used.

- **Utilization per 1,000:** Enter the annualized utilization per thousand enrollees for each of the service categories. The utilization should be reflective of both EHB and non-EHB services present in the manual rate experience period defined in Section I. The unit of measure for medical

services should be consistent with the measurement units reported in the URRT and on Worksheet 9.

- **Avg. Cost per Service/Script:** Enter the average allowed cost per service/script that corresponds with the utilization measures reported in this column. The average unit costs should be reflective of the both EHB and non-EHB services present in the manual rate experience period defined in Section I.
- **Allowed Claims PMPM:** This is a calculated field. Do not enter a value.
- **Paid to Allowed Ratio:** Enter the ratio of paid to allowed claims. Carriers are expected to include in the actuarial memorandum a demonstration of the development of this ratio along with detailed support for the methodology used to determine the paid to allowed ratio.
- **Incurred Claims PMPM:** This is a calculated field. Do not enter a value.
- **Net Impact of Pooling:** Enter the estimated net increase or reduction in plan liability as a result of any large claim pooling methodology (netting pooled claims against a corresponding pooling charge). If large claims pooling is not employed in the development of the manual rate, enter zero in this field for all service categories. Carriers are expected to include in the actuarial memorandum a demonstration of the development of these adjustments and justify the magnitude of these adjustments using historical pooling adjustments and other relevant information.
- **Net Impact of Private Reinsurance:** Enter the net adjustment to claims as a result of any private reinsurance arrangement used by the carrier during the base period. As with large claim pooling, carriers are expected to demonstrate the appropriateness of any adjustments in the actuarial memorandum.

Section V – Projection Factors – Base Experience: This section contains projection factors by service category, including those that apply to utilization and unit cost, to project base period claims to the projection period, as well as any additive adjustments. Carriers are expected to include in the actuarial memorandum, detailed support for each of the adjustments detailed below.

For all multiplicative adjustments, enter the cumulative trend from the base period to the projection period, and not an annualized average amount. Multiplicative trends should be entered as 1 + the trend percentage. Entering a 1.00 indicates a 0% change in these entries. Do not leave blank, and do not enter zero. Include each adjustment in the category that best characterizes the change, ensuring that components of an adjustment are only reflected in one category to avoid double counting the impact.

Utilization Adjustments

- **Utilization per 1,000 Trend:** Enter the multiplicative utilization trend factor to project services from the base period to the projection period, for a constant population.
- **Benefit Plan Change:** Enter the multiplicative adjustment factor to reflect expected utilization changes between the base period and the projection period based on aggregate plan design changes. This adjustment can reflect changes in benefit mix (i.e., distribution of enrollment across different plans) as well as changes in specific plan designs (i.e., cost sharing).

- **Demographic Change:** Enter the multiplicative adjustment factor to reflect expected utilization changes between the base period and the projection period based on expected changes in the demographic mix of covered policyholders. It should not include changes that are reflected elsewhere. For example, if the carrier writes a number of new small groups that are younger than its average group effective during the base period and select plans with higher cost sharing than the average group, then the demographic change factor should reflect the groups' relative youth while the benefit plan change reflects the relative utilization change from the cost sharing designs of the new policyholders.
- **Morbidity Change:** Enter the multiplicative adjustment factor to reflect expected utilization changes between the base period and the projection period based on expected changes in the morbidity of the covered policyholders. This adjustment should not include changes that are reflected elsewhere. For example, if changes in risk scores are used as a proxy for changes in morbidity, the demographic component of the risk score must only be reflected once, either in Morbidity Change or in Demographic Change. For example, if the carrier acquires a block of small groups that it knows has a higher risk score and lower member cost sharing than its average small group, then the morbidity change factor should reflect the relative health of the population change while the benefit plan change reflects the relative utilization from cost sharing of the new policyholders.
- **Other Change:** Enter the multiplicative adjustment factor for other expected utilization changes that are not reflected elsewhere. In addition to the required support for the adjustment factor, the actuary should include a detailed description of the components of this factor in the actuarial memorandum.

Unit Cost Adjustments

- **Provider Payment or Discount Change:** Enter the multiplicative adjustment factor to reflect expected changes in contracts with providers or PBMs between the base period and the projection period.
- **Benefit or Formulary Change:** Enter the multiplicative adjustment factor to reflect expected changes in average cost as a result of changes in benefit plans or formularies between the base period and the projection period. For example, if a carrier changes its benefit design from a four tier to a three tier formulary, an increase in the number of generic prescriptions as well as a corresponding change in generic costs may be expected. Carriers should enter such cost changes in this column. As with the utilization adjustments, do not include any changes in this adjustment field that are better reflected in another adjustment field.
- **Service Mix or Morbidity Change:** Enter the multiplicative adjustment factor to reflect expected changes in average cost as a result of changes in expected service mix or morbidity. For example, if the carrier acquires a block of small groups that it knows has a higher risk score, then the carrier should reflect any anticipated changes in service mix from this increased morbidity in the service mix or morbidity change field. Do not include any changes in this adjustment field that are better reflected in another adjustment field. For example, if the full impact of morbidity

change is reflected in the utilization adjustment for Morbidity Change, no additional service mix adjustment related to morbidity should be included here.

- **Other Change:** Enter the multiplicative adjustment factor for other expected utilization changes that are not reflected elsewhere. In addition to the required support for the adjustment factor, the actuary should include a detailed description of the components of this factor in the actuarial memorandum.

Additive Adjustments

- **Utilization per 1,000:** The additive adjustments are intended to reflect the introduction of new benefits or the removal of existing benefits. The utilization per 1,000 assumption should reflect the expected utilization of the benefit being added or removed. If a benefit is being removed from the base experience, the utilization adjustment should be reflected as a negative number. Also, any benefits that are removed should be reflected after adjustment for trend, morbidity, contracted reimbursement, etc. Entering a zero indicates no benefit change. **Do not leave blank.**
- **Unit Cost:** Additive adjustments are intended to reflect the introduction of new benefits or the removal of existing benefits relative to those covered in the base period. The unit cost assumption should reflect the expected cost of the benefit being added or removed. If the benefit is being removed from the base experience, the unit cost should be positive. Entering a zero indicates no benefit change. **Do not leave blank.**

Section VI Projection Factors – Manual Rate: This section contains projection factors by service category, including those that apply to utilization and unit cost, to project claims to the projection period, as well as any additive adjustments used in the development of the manual rate.

For all multiplicative adjustments, enter the cumulative trend from the manual rate experience period to the projection period, and not an annualized average amount. Multiplicative trends should be entered as 1 + the trend percentage. Entering a 1.00 indicates a 0% change in these entries. Do not leave blank, and do not enter zero. To avoid double counting, the actuary should include an adjustment in the category that best characterizes the change, ensuring that components of an adjustment are only reflected in one category.

Utilization Adjustments – Manual Rate

- **Utilization per 1,000 Trend:** Enter the multiplicative utilization trend factor to project services from the base period to the projection period, for a constant population.
- **Benefit Plan Change:** Enter the multiplicative adjustment factor to reflect expected utilization changes between the base period and the projection period based on aggregate plan design changes. This adjustment can reflect changes in benefit mix (i.e., distribution of enrollment across different plans) as well as changes in specific plan designs (i.e., cost sharing).
- **Demographic Change:** Enter the multiplicative adjustment factor to reflect expected utilization changes between the base period and the projection period based on expected changes in the demographic mix of covered policyholders. It should not include changes that are reflected

elsewhere. For example, if the carrier writes a number of new small groups that are younger than its average group effective during the base period and select plans with higher cost sharing than the average group, then the demographic change factor should reflect the groups' relative youth while the benefit plan change reflects the relative utilization change from the cost sharing designs of the new policyholders.

- **Morbidity Change:** Enter the multiplicative adjustment factor to reflect expected utilization changes between the base period and the projection period based on expected changes in the morbidity of the covered policyholders. This adjustment should not include changes that are reflected elsewhere. For example, if changes in risk scores are used as a proxy for changes in morbidity, the demographic component of the risk score must only be reflected once, either in Morbidity Change or in Demographic Change. As another example, if the carrier acquires a block of small groups that it knows has a higher risk score and lower member cost sharing than its average small group, then the morbidity change factor should reflect the relative health of the population change while the benefit plan change reflects the relative utilization from cost sharing of the new policyholders.
- **Other Change:** Enter the multiplicative adjustment factor for other expected utilization changes that are not reflected elsewhere. In addition to the required support for the adjustment factor, the actuary should include a detailed description of the components of this factor in the actuarial memorandum.

Unit Cost Adjustments – Manual Rate

- **Provider Payment or Discount Change:** Enter the multiplicative adjustment factor to reflect expected changes in contracts with providers or PBMs between the base period and the projection period.
- **Benefit or Formulary Change:** Enter the multiplicative adjustment factor to reflect expected changes in average cost as a result of changes in benefit plans or formularies between the base period and the projection period. For example, if a carrier changes its benefit design from a four tier to a three tier formulary, they might expect to see an increase in the number of generic prescriptions as well as a corresponding change in generic costs. Carriers should enter such cost changes in this column. As with the utilization adjustments, do not include any changes in this adjustment field that are better reflected in another adjustment field.
- **Service Mix or Morbidity Change:** Enter the multiplicative adjustment factor to reflect expected changes in average cost as a result of changes in expected service mix or morbidity. For example, if the carrier acquires a block of small groups that it knows has a higher risk score, then the carrier should reflect any anticipated changes in service mix from this increased morbidity in the service mix or morbidity change field. Do not include any changes in this adjustment field that are better reflected in another adjustment field. For example, if the full impact of morbidity change is reflected in the utilization adjustment for Morbidity Change, no additional service mix adjustment related to morbidity should be included here.
- **Other Change:** Enter the multiplicative adjustment factor for other expected utilization changes that are not reflected elsewhere. In addition to the required support for the adjustment factor,

the actuary should include a detailed description of the components of this factor in the actuarial memorandum.

Additive Adjustments – Manual Rate

- **Utilization per 1,000:** The additive adjustments are intended to reflect the introduction of new benefits or the removal of existing benefits. (For example, the carrier would employ these additive adjustments to reflect the introduction of EHBs to the historical benefit plan design.) The utilization per 1,000 assumption should reflect the expected utilization of the benefit being added or removed. If the benefit is being removed from the base experience, it should reflect a negative utilization. Also, any benefits that are removed should be reflected after adjustment for trend, morbidity, contracted reimbursement, etc. Entering a zero indicates no benefit change. **Do not leave blank if a manual rate is used.**
- **Unit Cost:** The additive adjustments are intended to reflect the introduction of new benefits or the removal of existing benefits relative to those covered in the base period. The unit cost assumption should reflect the expected cost of the benefit being added or removed. If the benefit is being removed from the base experience, the unit cost should be positive. Entering a zero indicates no benefit change. **Do not leave blank if a manual rate is used.**

Section VII: Projected Experience – NV SRP: This section calculates the projected allowed cost per member per month by major service category based on information entered in sections III and V. These are all calculated fields. **Do not** enter any information in this section.

Section VIII: Projected Experience – Manual Rate and Credibility: This section calculates the manual rate utilization per 1,000 and average cost per service/script for the projection period, projected allowed cost per member per month by major service category based on information entered in sections IV and VI. This section also requires input of the credibility weight, reported separately by service category.

- **Credibility Weights:** Enter the expected credibility weight by service category as a percentage. Carriers are allowed to vary the credibility weights by service category (e.g., because of the presence of capitation or the introduction of a new benefit). The carriers should be prepared to support any variation in the credibility weights by category as well as the implied aggregate credibility weight. The credibility weights should not exceed 100%, and if the base experience is fully credible, the credibility weights should be entered as 100%.

Section IX - Projected Index Rate: This section contains the index rate calculation, index rate adjustments (risk adjustment, Exchange user fees), and the average member cost sharing.

- **Allowed Claims:** This is a calculated field. Do not enter a value.
- **Non-EHB Services:** Enter the projected allowed costs associated with any non-EHB services included in the projection. These projected costs should be reflected on a PMPM basis.
- **Index Rate:** This is a calculated field. Do not enter a value.
- **Member weighted quarterly trend factor (small group only):** Enter the member-weighted trend factor for small group single risk pools only.

- **Risk Adjustment:** Enter the expected charge to or payment from the risk adjustment program, including any risk adjustment user fees. The amount should be reflected on an allowed cost PMPM basis. For 2018, this field includes the net impact of the high cost enrollee risk pool. Carriers that expect to receive a net payment from the risk adjustment program should enter a negative amount.
- **Exchange User Fees:** Enter the expected Exchange user fees as determined by the Silver State Health Insurance Exchange for the applicable year. For 2018, this fee is 3.15% of premium. The payment should be reflected on an allowed cost PMPM basis as a positive amount.
- **Adjusted Index Rate:** This is a calculated field. Do not enter a value.
- **Member/HHS Cost Sharing:** Enter the expected average cost sharing (Member and HHS) for the projection period. The adjustment should be reflected as a positive value, on a PMPM basis.
- **Paid Claims:** This is a calculated field. Do not enter a value.
- **Administrative Expenses:** Enter the administrative expenses as a percentage of revenue that the carrier anticipates in the projection period for all products included in the SRP. This administrative load should not include any profit, risk, taxes, or fees included in the following two categories.
- **Profit and Risk:** As a percentage of revenue, enter the profit and risk that the carrier anticipates in the projection period for all products considered in the filing. This should reflect the target underwriting gain/loss anticipated in the projection period and any explicit risk margin.
- **Taxes & Fees:** As a percentage of revenue, enter the taxes and fees that the carrier anticipates in the projection period for all products considered in the filing. This could include premium tax, insurer tax and patient centered outcomes research fee assessments mandated under the Affordable Care Act, or any other taxes and fees the carrier is required to pay. Do not include any user fees assessed by the Exchange or under the risk adjustment program.
- **Gross EHB Premium:** This is a calculated field. **Do not** enter a value.

Section X - Retention: This section collects information related to administrative expenses, taxes and fees. All entries should be represented as a percentage of premiums.

- **Administrative Expenses**
 - **General Administration and Claims:** Enter the total costs related to the general administration of the business as a percentage of premiums.
 - **Agent/Broker Fees and Commissions:** Enter the total costs related to payments made to brokers or agents for their service in facilitating sales or services of policyholders. Do not include any Exchange user fees in this category.
 - **Quality Improvement Initiatives:** Enter the total costs, as a percentage of premium, related to quality improvement and fraud detection. Include only those amounts that can be added to the numerator for purposes of calculating the Federal medical loss ratio (MLR).
 - **Other Expenses:** For any expense items that have not already been included above, enter the total non-claim expenses as a percentage of premium.

- Taxes and Fees
 - **PCORI Fee:** Enter the total amount of the fee for the Patient-Centered Outcomes Research Institute (PCORI) as a percentage of premium. Also enter the dollar amount of the PCORI fee in cell L76.
 - **NV Premium Taxes:** Enter the total costs, as a percentage of premium, related to payments made to a state or municipality based on premiums paid by insured individuals or groups.
 - **Federal Income Tax:** Enter the total cost for fees paid related to federal income taxes as a percentage of premium.
 - **Health Insurance Providers Fee (ACA Tax):** Enter the total cost for fees paid related to the health insurers providers' fee, as a percentage of premium.
 - **Other Taxes:** Enter the total costs related to payments made to a state or municipality based on other, non-premium taxes. Include only those amounts that can be subtracted from the premium for purposes of calculating the Federal MLR.
 - **Profit/Risk:** Enter the total amount earmarked for profit and risk charge, as a percentage of premium.

Worksheet 5: Plan Level Adjustments

This worksheet collects information relating to allowable plan level adjustments for the applicable single risk pool.

Section I – Calibration Factors: This section contains the calibration factors.

- **Age Calibration factor:** Enter the age calibration factor using the 2018 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.
- **Geographic Calibration Factor:** Enter the geographic calibration factor using the 2018 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.
- **Tobacco Calibration Factor:** Enter the tobacco calibration factor using the 2018 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.
- **Aggregate Calibration Factor:** This is a calculated field. Do not enter a value.

Section II – 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 and whether the plan will be sold on the Exchange.

- **HIOS Plan ID:** Enter the Standard Component Plan ID (assigned in HIOS) 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.
- **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).
- **1/1/2017 Plan Marketing Name:** Enter the Marketing name used for the plan in 2017.
- **Plan Status:** Enter one of the following allowable entries depending on the status of the plan for this filing – Enter 'N' for new plans, 'T' for 2017 plans that will not be offered in 2018, 'R' for the issuer's 2017 plans that will be renewed in 2018 and 'R-CG' for renewed plans previously offered by another issuer within the controlled group.
- **1/1/18 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 2018.
- **Metallic Tier:** Enter the metal level that corresponds with the Metal AV. Allowable entries are the following: 'P' (Platinum), 'G' (Gold), 'S' (Silver), 'B' (Bronze), 'Exp. B' (Expanded Bronze), and 'C' (Catastrophic).
- **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.
- **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 – 1'. 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 – 2'.
- **Exchange Indicator:** Identify whether the plan is or is expected to be sold on the Exchange ('On/Off') or off the Exchange ('Off').
- **Wellness Indicator:** An indicator of whether or not 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.
- **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.'
- **Non-EHB Services Indicator:** An indicator of whether or not the plan includes non-EHB services. Allowable field entries are 'Y' and 'N.'
- **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.

- **Actuarial Value 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. This entry refers to the plan level adjustment allowed under 45 CFR 156.80 (D)(2)(i) and should reflect anticipated changes in utilization due to cost sharing differences. This factor **should not** reflect differences in health status.
- **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).
- **Benefits in Addition to Essential Health Benefits (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).
- **Administrative Costs Excluding Exchange Fees:** Enter the additive administrative costs that are applied in rating to reflect the administrative cost components associated with each plan. While this adjustment is not required to be developed on a PMPM basis or reflect the same amount PMPM for each plan, the value must be converted to a PMPM basis for populating the Template. By including this factor as an additive adjustment, it will allow the Division to assess administrative costs across all carriers regardless of their average benefit design. These factors should not include Exchange User Fees, but should include amounts for risk and profit margin. This entry refers to the plan level adjustment allowed under 45 CFR 156.80 (D)(2)(iv).
- **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).
- **Proposed Rating Factors:** For plans that will be terminated prior to the effective date of this filing, leave the following six fields blank. Enter the appropriate factor for all other plans.
 - **Actuarial Value 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. This entry refers to the plan level adjustment allowed under 45 CFR 156.80 (D)(2)(i) and should reflect anticipated changes in utilization due to cost sharing differences. This factor **should not** reflect differences in health status.

- **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).
 - **Benefits in Addition to Essential Health Benefits (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).
 - **Administrative Costs Excluding Exchange Fees:** Enter the additive administrative costs that are applied in rating to reflect the administrative cost components associated with each plan. While this adjustment is not required to be developed on a PMPM basis or reflect the same amount PMPM for each plan, the value must be converted to a PMPM basis for populating the Template. By including this factor as an additive adjustment, it will allow the Division to assess administrative costs across all carriers regardless of their average benefit design. These factors should not include Exchange User Fees, but should include amounts for risk and profit margin. This entry refers to the plan level adjustment allowed under 45 CFR 156.80 (D)(2)(iv).
 - **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).
- **Premium before Retention Load and Calibration:** This is a calculated field. Do not enter a value.
 - **Administrative Costs:** Enter the total administrative expense as a percentage of premium.
 - **Taxes and Fees (Not Including Exchange Fees):** Enter the total for taxes and fees (not including Exchange fees) as a percentage.
 - **Profit or Contingency:** Enter the total amount allocated for profit and risk charge as a percent of premium.
 - **Total Current Member Months:** Enter the total member months associated with membership from January 1, 2017 through March 31, 2017.
 - **Total Projected Member Months:** Enter the total member months associated with membership for the projection period.
 - **2017 Calibrated Plan Adjusted Index Rate PMPM:** Enter the 2017 calibrated plan adjusted index rate by plan.
 - **2018 Calibrated Plan Adjusted Index Rate PMPM:** This is a calculated field. Do not enter a value.

Worksheet 6: Rating Factors

This worksheet collects information relating to the carrier's rating factors as well as the quarterly trend rate for small group carriers. Carriers are expected to demonstrate the calculation of these factors separately in Excel format with working formulas and provide detailed documentation of the methodology used to determine these factors in the actuarial memorandum.

Section I - Network Factors: The network factors entered in the 'Experience' column should equal the network factors used in the rate filing approved for the experience period as defined in the Unified Rate Review Template (URRT). The network factors entered in the 'Current' column should equal the network factors used in the most recently approved rate filing. For the 'Proposed' rating factors, the network factor should represent the proposed factors used in the submitted rate filing.

Section II - Geographic Adjustment Factors: The geographic adjustment factors entered in the 'Experience' column should equal the geographic adjustment factors used in the experience period as defined in the Unified Rate Review Template (URRT). The geographic adjustment factors entered in the 'Current' column should equal the geographic adjustment factors used in the most recently approved rate filing. For the 'Proposed' rating factors, the geographic adjustment should represent the proposed factors used in the submitted rate filing.

Section III - Quarterly Trend rate: This section should be completed for the small group single risk pool filing only. Enter the annualized trend rate for each quarter.

Section IV - Age and Tobacco Factors:

- **Age Factor:** Nevada uses the default federal age curve. The age factors for both the 'Experience Period' and the 'Current Period' columns have been populated with the federal default age factors which have been used for the 2014 through 2017 calendar years. The age factors for the 'Projected period' column have been populated with the new 2018 age factors. Do not change these factors.
- **Tobacco Factor:** The tobacco use adjustment factors entered in the 'Experience Period' column should represent the factors used in the experience period as defined in the URRT. The tobacco use adjustment factors in the 'Current' column should represent the factors used in the most recently approved rate filing. For the 'Proposed' rating factors, the tobacco use adjustment should represent the proposed factors used in this submitted rate filing.

Worksheet 7: Risk Adjustment

This worksheet collects information relating to the calculation of the risk adjustment transfer payment amounts payable to or by the carrier under the federal risk adjustment program. This worksheet allows for three alternatives to providing detailed information relating to the estimation of the risk adjustment transfer payment amounts. Sections II and III offer two alternative standardized approaches to

estimating the risk adjustment transfer payment amounts. Alternatively, carriers may choose to use a non-standardized approach which must be supported by a detailed narrative in the actuarial memorandum as well as a numerical demonstration of the calculation submitted in Excel format with working formulas.

Section I - Approach Used: This section must be completed. Enter 'Alt. 1' if the approach shown in Section II is used and complete Section II. Enter 'Alt. 2' if the approach used in Section III is used and complete Section III. Enter 'Other' if a non-standardized approach (neither Section II nor Section III) is used. If 'Other' is chosen, do not complete the rest of this worksheet and provide a separate excel spreadsheet (with working formulas) with numerical demonstration of the methodology used.

Section II - Risk Adjustment Transfer Payment Components – Alternative 1: Enter the components of Risk Adjustment Transfer Payment Formula for the appropriate time period as indicated by the column header. Do NOT complete both sections II and III.

- **2015 Actual:** The amounts entered in the '2015 Actual' column should represent the actual components of the risk adjustment transfer payment formula amounts reported by CMS for the 2015 benefit year.
- **2016 Pricing Estimate:** The amounts entered in the '2016 Pricing Estimate' column should represent the components of the risk adjustment transfer payment formula used to determine the adjustment to the index rate in the January 1, 2016 rate filing.
- **2016 Actual:** The amounts entered in the '2016 Actual' column should represent the actual components of the risk adjustment transfer payment formula amounts reported by CMS for the 2016 benefit year.
- **2016 Annual Statement Estimate:** The amounts entered in the '2016 Annual Statement Estimate' column should represent the estimated components of the risk adjustment transfer payment formula used to develop the estimated payable or receivable amounts for Nevada as reported on the carrier's 12/31/2016 annual statement.
- **2017 Pricing Estimate:** The amounts entered in the 'Current Period Pricing Estimate' column should represent the components of the risk adjustment transfer payment formula used to determine the adjustment to the index rate for the 2017 benefit year.
- **2018 Pricing Estimate:** The amounts entered in the '2018 Pricing Estimate' column should represent the components of the risk adjustment transfer payment formula used to determine the adjustment to the index rate for the 2018 benefit year.

Section III - Risk Adjustment Transfer Payment Buildup – Alternative 2: This section offers a second standardized approach for carriers to demonstrate the estimation of the risk adjustment transfer payment. Do NOT complete both sections II and III.

- **2015 (Actual):** Enter the actual 'Issuer Relative Risk Score', 'Statewide Relative Risk Score', 'Statewide Average Premium' PMPM and the 'Risk Transfer PMPM' amounts as calculated by CMS for the 2015 benefit year.

- **2016 (Estimate/Actual):** Enter the 'Issuer Relative Risk Score', 'Statewide Relative Risk Score', 'Statewide Average Premium' PMPM and the 'Risk Transfer PMPM' amounts for the 2016 benefit year. These values may be entered on an estimated or final basis. The actuarial memorandum should clearly indicate the basis. Additionally, if these amounts are estimated, a separate exhibit demonstrating the development of this number should be provided along with detailed support in the actuarial memorandum.
- **2017 Risk Adjustment Formula Changes:** Enter adjustments to the Issuer Relative Risk Score and the Statewide Relative Risk Score to reflect the changes in the risk adjustment formula from 2016 to 2017.
- **2017 Change in Risk:** Enter adjustments to the Issuer Relative Risk Score and the Statewide Relative Risk Score to reflect the changes in risk between 2016 and 2017.
- **2017 Statewide Average Premium Trend:** Enter a percentage in the statewide average premium column to reflect the estimated trend for the statewide average premium.
- **2017 Projected Risk Adjustment:** This is a calculated field. Do not enter a value.
- **2018 Risk Adjustment Formula Changes:** Enter adjustments to the 'Issuer Relative Risk Score' and the 'Statewide Relative Risk Score' to reflect the changes in the risk adjustment formula from 2017 to 2018.
- **2018 Change in Risk:** Enter adjustments to the 'Issuer Relative Risk Score' and the 'Statewide Relative Risk Score' to reflect changes in risk between 2017 and 2018.
- **2018 Administrative Cost Adjustment:** This field has already been populated in accordance with the Notice of Benefit and Payment Parameters for 2018 which may be accessed at the following link: <https://www.gpo.gov/fdsys/pkg/FR-2016-12-22/pdf/2016-30433.pdf>. **Do not** enter a value.
- **2018 Statewide Average Premium Trend:** Enter a percentage in the statewide average premium column to reflect the estimated trend for the statewide average premium.
- **2018 Base Experience Risk Adjustment PMPM:** This is a calculated field. **Do not** enter a value.
- **2018 Credibility %:** Enter a percentage (between 0.0% and 100.0%). If the base experience is fully credible, the credibility percentage should be entered as 100.0%.
- **2018 Manual Rate Risk Adjustment PMPM:** Enter the manual rate risk adjustment transfer payment amount prior to adjustment for the 2018 user fee and amounts recoverable from the high risk pool.
- **2018 Projected Risk Adjustment:** This is a calculated field. **Do not** enter a value.
- **2018 Risk Adjustment Fee:** Enter the 2018 risk adjustment user fee as a negative number.
- **2018 Net High Risk Pool Impact:** Enter the estimated impact (PMPM) of the high risk pool described in the Notice of Benefit and Payment Parameters for 2018 which may be accessed at the following link: <https://www.gpo.gov/fdsys/pkg/FR-2016-12-22/pdf/2016-30433.pdf>.
- **2018 Projected Risk Transfer:** This is a calculated field. **Do not** enter a value.

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.

Worksheet 8: Experience by Month - Trend Justification

The information collected in this worksheet is intended to provide support for the trend assumptions included in this filing.

For dollar entries where the carrier is reporting no experience, the carrier should enter zero. New carriers should complete sections II, III and V. The worksheet collects the following information in five sections:

Section I. Annual Adjustments – NV SRP: This section collects information related to annual adjustments that may need to be made to experience data before it can be used to determine a trend assumption. This section deals with experience based on Nevada-only data for the single risk pool filed.

- **Federal Reinsurance Recoverable:** Enter the net adjustment to claims as a result of reimbursements received from the federal transition reinsurance program. Enter amounts recoverable from the federal reinsurance program as positive values.
- **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 Risk Adjustment:** Enter the actual/expected net amounts payable to or from the federal risk adjustment program, including any risk adjustment user fees. Amounts payable to the carrier should be entered as a positive value.
- **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 (2014, 2015, 2016 and January 1, 2017 through March 31, 2017). 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.

Section II: Description of Basis Used for Trend Development: Enter a description of the data used for trend development.

Section III. Annual Adjustments – Alternate Data Source: This section collects information related to annual adjustments that may need to be made to the experience data before it can be used to determine a trend assumption. This section collects experience similar to that in Section I but based on an alternate data source.

- **Federal Reinsurance Recoverable:** Enter the net adjustment to claims as a result of reimbursements received from the federal transition reinsurance program. Enter amounts recoverable from the federal reinsurance program as positive values.

- **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 Risk Adjustment:** Enter the actual/expected net amounts payable to or from the federal risk adjustment program, including any risk adjustment user fees. Amounts payable to the carrier should be entered as a positive value.
- **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 (2014, 2015, 2016 and January 1, 2017 through March 31, 2017). 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.

Section IV. Experience Data by Month - NV SRP: This section collects experience data for all Nevada policies in the single risk pool (SRP) for the applicable period. This worksheet captures the historical claims data that was used to support the carrier's trend assumption and should be completed by all carriers with policies in the SRP during any part of the period. If the Nevada experience of the single risk pool included in the filing is considered to be less than 100% credible section V must also be completed. Carriers with no Nevada experience in the SRP filed should leave this section unpopulated.

- **Earned Premium:** Enter the total premium that was earned from members during the indicated month.
- **Paid Claims:** Enter the total claims paid, including runout for incurral dates during the indicated month. These amounts are reported net of cost sharing amounts payable by HHS under the cost sharing reduction program.
- **Completion Factors:** Enter completion factors for the indicated month
- **Incurred Claims:** This is a calculated field. Do not enter a value.
- **Large Incurred Claims:** Enter the amount of large claims incurred for the applicable month. This amount will be removed from the trend calculation.
- **Members:** Enter the number of member months applicable for that month
- **Incurred Claims PMPM:** This is a calculated field. Do not enter a value.
- **Cost Sharing - Member:** Enter the member cost sharing amount associated with services that were incurred for the Month. The estimate should only include costs for which the member is liable (i.e., it should be net of any cost sharing subsidies paid by HHS). Include estimates for claims incurred but not yet paid. This item should be entered as a positive value.
- **Cost Sharing - HHS (CSR):** Enter the HHS portion of cost sharing associated with services that were incurred for the Month. Include estimates for claims incurred but not yet paid (IBNP).
- **RX Rebates:** Enter the total amount of prescription drug rebates that are paid directly by the manufacturer to the carrier. If the carrier does not receive rebate reports at the product, plan

and month level, the carrier should allocate the rebates and be prepared to support the allocation if the Division requests it. Estimates of rebates anticipated to be received but have not yet been received should be included. These estimates should be documented and provided to the Division upon request. This value should be entered as a negative number.

- **Allowed Claims:** Enter the amount of claims after the removal of any duplicates, claims for non-covered services, or COB, and after the application of provider discounts and HHS cost sharing, but prior to reduction for any member cost sharing. Include actual runout as well as an estimate of claims incurred but not yet paid.
- **Allowed PMPM:** This is a calculated field. Do not enter a value.
- **Loss Ratio:** This is a calculated field. Do not enter a value.
- **Average Normalization Factors:** This section reports average normalization factors, so that changes in the characteristics of the population over time may be removed from trend analysis to determine a secular trend. 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).

Section V. Experience Data by Month – Alternate Data Source: This section collects experience data similar to what is collected in Section IV but based on an alternate data source. This worksheet captures the historical claims data that was used to support the carrier’s trend assumption. If the Nevada experience of the single risk pool included in the filing (i.e., the same experience as that shown in section IV) 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 as described below.

- **Earned Premium:** Enter the total premium that was earned from members during the indicated month.
- **Paid Claims:** Enter the total claims paid, including runout for incurral dates during the indicated month. These amounts are reported net of cost sharing amounts payable by HHS under the cost sharing reduction program.
- **Completion Factors:** Enter completion factors for the indicated month
- **Incurred Claims:** This is a calculated field. Do not enter a value.
- **Large Incurred Claims:** Enter the amount of large claims incurred for the applicable month. This amount will be removed from the trend calculation.
- **Members:** Enter the number of member months applicable for that month
- **Incurred Claims PMPM:** This is a calculated field. Do not enter a value.
- **Cost Sharing - Member:** Enter the member cost sharing amount associated with services that were incurred for the month. The estimate should only include costs for which the member is liable (i.e., it should be net of any cost sharing subsidies paid by HHS). Include estimates for claims incurred but not yet paid. This item should be entered as a positive value.
- **Cost Sharing - HHS (CSR):** Enter the HHS portion of cost sharing associated with services that were incurred for the month. Include estimates for claims incurred but not yet paid (IBNP).
- **RX Rebates:** Enter the total amount of prescription drug rebates that are paid directly by the manufacturer to the carrier. If the carrier does not receive rebate reports at the product, plan and month level, the carrier should allocate the rebates and be prepared to support the allocation if the Division requests it. Estimates of rebates anticipated to be received but have not yet been received should be included. These estimates should be documented and provided to the Division upon request. This value should be entered as a negative number.
- **Allowed Claims:** Enter the amount of claims after the removal of any duplicates, claims for non-covered services, or COB, and after the application of provider discounts and HHS cost sharing, but prior to reduction for any member cost sharing. Include actual runout as well as an estimate of claims incurred but not yet paid.
- **Allowed PMPM:** This is a calculated field. **Do not enter a value.**
- **Loss Ratio:** This is a calculated field. Do not enter a value.
- **Normalization Factors:** This section reports average normalization factors, so that changes in the characteristics of the population over time may be removed from trend analysis to determine a secular trend. 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).

Worksheet 9: Nevada Experience Data

This worksheet collects Nevada experience data by rating area for categories of service which are consistent with the categories shown on worksheet 1 of the URRT. New carriers should leave this worksheet blank.

Section I – Member Months by Rating Area: This section collects total member months for 2014, 2015 and 2016 associated with the experience data collected in the fields below. The values for 2016 are imported from worksheets 1 and 2. Therefore, no inputs are required for 2016. For 2014 and 2015, please enter the member months associated with the experience data in section II for each rating area.

Section II: This section collects experience data by rating area separately for 2014, 2015 and 2016.

- **Admissions per 1,000:** Enter the total number of inpatient hospital admissions per 1,000 for the indicated year for each rating area.
- **Length of Stay:** Enter number of inpatient days for enrollees admitted to inpatient facilities for the year indicated and for each rating area.
- **Utilization per 1,000:** Enter the annualized utilization per thousand enrollees for each of the service categories (Inpatient Facility, Outpatient Facility, Professional, Other Medical, Capitation, and Prescription Drugs) by rating area. The utilization should be reflective of both EHB and non-EHB services present in the base period experience. The unit of measure for medical services should be consistent with the measurement units reported in the URRT and on Worksheet 9.
- **Allowed Average Charge:** Enter the average allowed charge by service category for each rating area. Allowed Claims are claims after the removal of any duplicates, claims for non-covered services, or COB, and after the application of provider discounts.

Worksheet 10 – Tracking Quality Measures:

This section collects information relating to a carrier's quality measures for major medical coverage in Nevada for the most recent full calendar year. New carriers should leave this worksheet blank. The information provided on this worksheet should reflect the carrier's experience for their entire commercial membership and should not vary by market. Upon request by the Division, carriers should be prepared to provide documentation to support the information provided.

- **Breast Cancer Screening:** Enter the percentage of women aged 40 to 69 who had a mammogram for breast cancer every 2 years.
- **Follow-Up after Hospitalization for Mental Illness:** Enter the percentage of patients (ages 6+) who received a follow-up with a health care provider within 7 days of being discharged from the hospital for mental illness.
- **Comprehensive Diabetes Care - Hemoglobin A1c(HbA1c) Testing:** Enter the percentage of members 18 to 75 who had this test.
- **Access to Care (CAHPS):** Percentage of patients (adults and children) who thought they received appointments and care when they needed them.
- **Developmental Screening in the first three years of life:** Enter the percentage of children who were screened for risks of developmental, behavioral and social delays using standardized screening tools in the 12 months preceding their first, second or third birthday.