

Division of Insurance

Plan Year 2018 Rate Filing Guidance



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Future Webinars

- May 18th at 9:00AM Open Q&A
- June 1st at 9:00AM Open Q&A
- June 29th at 9:00AM Open Q&A



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Filing Submission Deadlines

	Rates	Forms	Binders
New Carriers - all	May 17th	May 17th	June 12th
Existing QHP Carriers	June 12th	June 12th	June 12th
Existing Non-QHP Carriers	July 17th	June 12th	June 12th
Stand-alone Dental plans	June 12th	June 12th	June 12th



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NV Rate Review Process for 2018

- All rate filings will be reviewed by consulting actuaries
- DOI staff will also review certain aspects
- Final decision by the Commissioner
- Guidance for Review:
 - State rating standards - NRS 686B
 - Compliance with federal rating standards, actuarial standards of practice (ASOPs)
 - Requirements for effective rate review
 - Actuarially equivalent EHB substitutions
 - Plan Actuarial Value



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Rate Review Timeline – New Carriers

- May 17th Rate filings due
- June 1st DOI sends first objection letter*
- June 8th Carrier response due in SERFF
- June 15th DOI sends second objection letter *
- June 22th Carrier response due in SERFF
- June 29th DOI sends third objection letter *
- July 6th Carrier response due in SERFF
- July 11th DOI sends fourth objection letter*
- July 14th Carrier response due in SERFF
- July 31st DOI makes final rate determinations

* If needed



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Rate Review Timeline – Existing QHP Carriers

- May 1st Submit EDGE server RATEE files
- June 12th Rate filings due
- June 21st DOI sends first objection letter*
- June 28th Carrier response due in SERFF
- July 5th DOI sends second objection letter*
- July 10th Carrier response due in SERFF
- July 13th DOI sends third objection letter*
- July 18th Carrier response due in SERFF
- July 31st DOI makes final rate determinations

*If needed



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Rate Review Timeline – Off Exchange Carriers

- May 1st Submit EDGE server RATEE files
- July 17th Rate filings due
- July 31st DOI sends first objection letter*
- August 7th Carrier response due in SERFF
- August 14th DOI sends second objection letter *
- August 21st Carrier response due in SERFF
- August 24th DOI sends third objection letter *
- August 29th Carrier response due in SERFF
- September 13th DOI makes final rate determinations

* If needed



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Division of Insurance Website

- The Division will not post proposed 2018 rates
- Approved 2018 rates will be posted on October 2nd
- Clean copies of the Schedule of Benefits and Evidence of Coverage for each approved plan must be submitted for display on the DOI website no later than 10/20/17
- The approved schedule of benefits and evidence of coverage for each plan will be posted by November 1st
- Website will generally use “Plan Marketing Name” from Plans & Benefits Template



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Basis for 2018 Filings

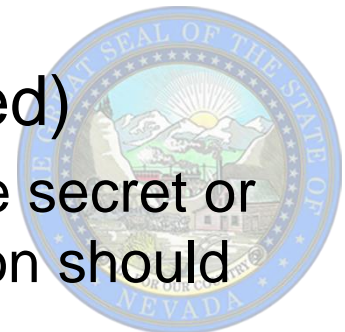
- The Affordable Care Act (ACA)
- Market Stabilization final rule
- Actuarial Value (AV) Calculator for 2018
- Final Notice of Benefit and Payment Parameters for 2018
- 2018 Nevada rate filing template and instructions
- 2018 Unified Rate Review (URR) Instructions



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Submission Requirements

- Supporting Documents tab of SERFF
 - 2018 Unified Rate Review Template (URRT) - Part I (confidential)
 - Consumer Disclosure – Part II
 - Actuarial Memorandum - Part III, with exhibits (confidential)
 - Format must follow the order of the 2018 URR instructions
 - Actuarial Memorandum – Part III (redacted)
 - Public version - any information that is a trade secret or confidential commercial or financial information should be redacted



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Submission Requirements, Cont'd

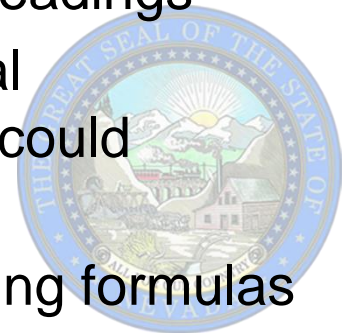
- Rate Data Template
- Plan & benefits template
- AV Calculator screen shots and support for unique plan designs
- 2018 Nevada rate filing template
- Documentation for \$ limit substitutions



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Formula for Timely Approvals

- Compliance with 2018 federal and state guidance
- Complete, well-documented filings:
 - URRT completed in accordance with federal guidelines
 - Actuarial memorandum: Detailed description of methods and assumptions, including changes since prior year, with supporting exhibits
 - Format in order of URR instructions, with same headings
 - Provide sufficient detail in narrative and numerical demonstrations so that another qualified actuary could evaluate the submission
 - Provide all supporting exhibits in Excel with working formulas



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Formula for Timely Approvals, Cont'd

- Review previous years' objection letters and ensure that issues are addressed in current filing
- Consistency across all information submitted for the single risk pool
 - URRT
 - Consumer disclosure (Part II)
 - Actuarial memorandum (Part III)
 - Plan management templates
- Any questions, contact the DOI



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Common Areas of Objections - 2017

- Provide numerical demonstration of:
 - Rate increase calculation, components of rate increase
 - Trend development, other projection factors
 - Manual rate development
 - Paid to allowed ratio
 - Geographic factor development
 - Risk adjustment
 - Plan level adjustments



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Nevada's Rating Parameters

- Age curve 3:1 federal default (2018 version)
- Geographic rating areas:
 1. Clark and Nye counties
 2. Washoe county
 3. Carson City, Lyon, Douglas and Storey counties
 4. All other counties
- Maximum tobacco rating factor allowed - 1.5
 - may vary by age
- Separate individual and small group risk pools



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2018 Exchange Fee

- Exchange Fee of 3.15 percent of premium for QHPs and SADPs
- No change from 2017



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Major Changes for 2018

- Change in de minimus ranges for AV metal tiers
- New Expanded bronze metal level
- New federal age curve
- Tobacco factors now included in calibration
- Modifications to risk adjustment methodology:
 - Adjustment for partial year enrollment;
 - Use prescription drug data to predict actuarial risk
 - New high cost enrollee risk pooling
 - Recalibration of risk adjustment model



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Major Changes for 2018, Cont'd.

- Plan Mapping/Uniform Modification guidance for companies in the same controlled group
- ASOP 50 added to actuarial certification
- AV Calculator Modifications



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Actuarial Value Changes

- New expanded bronze metal level
 - Covers and pays for at least one major service, other than preventive services, before the deductible; or
 - Meets the requirements for a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2)
 - De minimus range: -4 percentage points to +5 percentage points
- Broader de minimus range for standard metal levels
 - -4 percentage points to +2 percentage points
- CSR variations – no change to de minimus range



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Allowable AV Ranges (2018)

Metal Level	AV Requirements	Allowable AV Range
Platinum	90%	86% to 92%
Gold	80%	76% to 82%
Silver	70%	66% to 72%
Bronze	60%	56% to 62%
Expanded Bronze	60%	56% to 65%
Catastrophic*	Not specified by law	N/A

* Catastrophic Plans: available in the individual market only to 1) individuals below the age of 30 at the beginning of the plan year or 2) individuals who have received a certificate of hardship exemption.



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Actuarial Value – AV Calculator

- Actuarial support should include:
 - A description and explanation of any differences between results from the Plans & Benefits template and stand-alone AV calculator for unique plan designs
 - A description of any features not included in the AV calculator
 - Actuarial certification of AV calculator results



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Actuarial Value - Unique Plan Design

- Actuarial support should include:
 - Reasons plan design incompatible with AV calculator
 - Design differences cited must be material
 - Identification of alternative method pursuant to:
 1. 45 CFR 156.135(b)(2) or
 2. 45 CFR 156.135(b)(3)
 - Standardized plan population data used
 - Description of data, assumptions and methods used
- May use the FFM's Unique Plan Design Supporting Documentation and Justification form



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Plan / Product

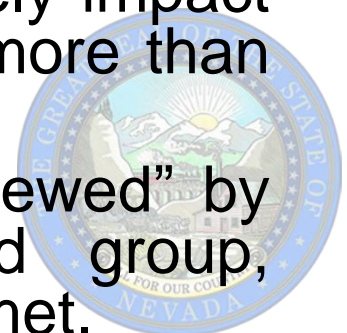
- Any set of plans that share a network type and a set of benefits is a product
 - Benefit variability within a product will not be allowed
 - Plans within a product vary by cost sharing structure, network, formulary or service area
 - More than one cost-sharing structure within a plan will not be allowed
- Cost sharing reduction (CSR) variations (silver)
 - Same premium, benefits, network as standard plan
 - More generous cost sharing, subsidized by federal government



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Uniform Modification Guidelines

- A plan is considered to be “Renewing” (as opposed to “New”) if:
 - Plan continues to cover at least a majority of the same service area
 - Plan continues to cover a majority (at least 50%) of the same provider network
 - Plan has same cost-sharing structure except for:
 - Changes in cost and utilization of care
 - Changes to maintain the same metal tier level
 - Changes in product benefits that cumulatively impact rate for any plan within the product by no more than 2%
 - Plan terminated by existing carrier but “renewed” by new carrier within the same controlled group, assuming all other requirements above are met.



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URRT Plan Mapping Guidance

- Issuers must identify plans as New, Renewing or Terminating
- Plan mapping instructions have been updated to reflect changes in recent federal guidance
- The following four slides provide examples of sample scenarios
 - See URR instructions for further detail on these scenarios and for additional scenarios



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Example: New Plan

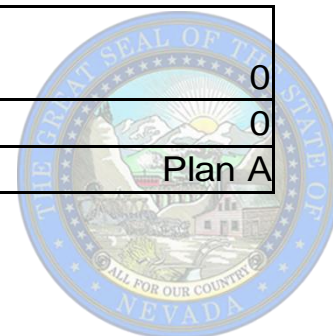
Example: Plan A is created and no existing members are mapped to it.

Year	Plans Available
2016	
2017	
2018	A

Section I: General Product and Plan Information

Plan Name	Plan A
Plan Category	New
Effective Date of Proposed Rates	01/01/2018
Rate Change % (over prior filing)	0
Cum'tive Rate Change % (over 12 mos prior)	0

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)	0
Section III: Experience Period Information	0
Section IV: Projected (12 months following effective date)	Plan A



Plan A is an entirely new plan with no existing members being mapped into the plan.

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Terminating Plans to a New Plan

Example: Plans A, B, and C are terminating and being mapped to a new Plan D.

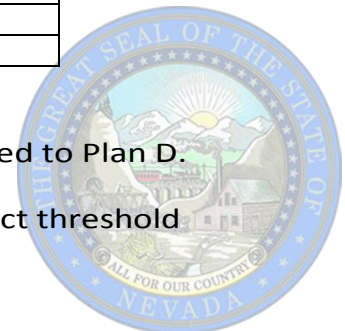
Year	Plans Available		
2016	A	B	C
2017	A	B	C
2018	D	D	D

Plan Name	Plan D	Terminated	Terminated
Plan Category	New	Terminated	Terminated
Effective Date of Proposed Rates	01/01/2018	01/01/2017	01/01/2017
Rate Change % (over prior filing)	Plans A,B,C =>	0	0
Cum'tive Rate Change % (over 12 mos prior)	Plans A,B,C =>	0	0

Section II: Components of Premium Increase <i>(DMPM Dollar)</i>			
Section III: Experience Period Information	Plan A	Plan B	Plan C
Section IV: Projected (12 months following)	Plan D	0	0

Plan A is shown as mapped to Plan D because Plan A has the highest enrollment of plans mapped to Plan D.

Rate Change is based on weighted average of Plans A,B,C to Plan D; but will not trigger a product threshold increase review because Plan D is new.



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Terminating Plans to Renewing Plan

Example: Plans A, and B are being mapped to renewing Plan C.

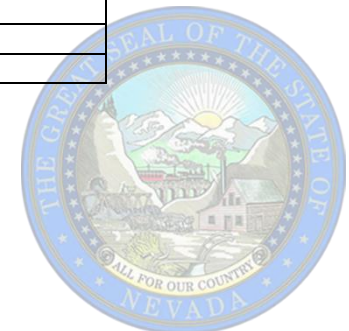
Year	Plans Available		
2016	A	B	C
2017	A	B	C
2018	C	C	C

Section I: General Product and Plan Information

Plan Name	Terminated Plan A	Terminated	Plan C
Plan Category	Terminated	Terminated	Renewing
Effective Date of Proposed Rates	01/01/2017	01/01/2017	01/01/2018
Rate Change % (over prior filing)	0	0	C => C
Cum'tive Rate Change % (over 12 mos prior)	0	0	C => C

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)	0	0	C => C
Section III: Experience Period Information	Plan A	Plan B	Plan C
Section IV: Projected (12 months following	0	0	Plan C*

Plan C* projection information would include mapped members from Plans A and B.



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Renewing to a new issuer in the same Controlled Group

Example: Issuer A's Plan 1 is being mapped to Issuer B's Plan 1 Issuers A and B are both members of the same controlled group.

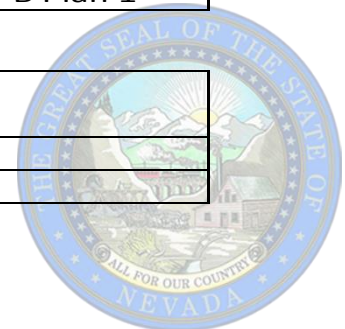
Year	Plans Available
2016	Issuer A Plan 1
2017	Issuer A Plan 1
2018	Issuer B Plan 1

Section I: General Product and Plan Information

Plan Name	Issuer B Plan 1
Plan Category	Renewing
Effective Date of Proposed Rates	01/01/2018
Rate Change % (over prior filing)	Issuer A Plan 1 => Issuer B Plan 1
Cum'tive Rate Change % (over 12 mos prior)	Issuer A Plan 1 => Issuer B Plan 1

Section II: Components of Premium Increase (PMPM Dollar	
Section III: Experience Period Information	Issuer A Plan 1
Section IV: Projected (12 months following effective date)	Issuer B Plan 1

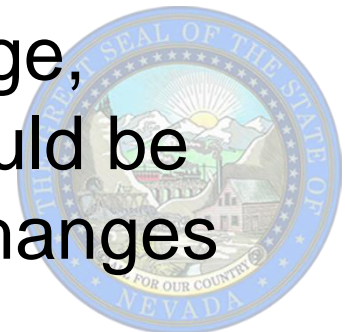
Issuer A and Issuer B are part of the same issuer's "Controlled Group."



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Calculating the Threshold Rate Increase

- Measure the premium change based on an issuer's current population compared to that same population if the new rates were implemented
- Not intended to capture demographic changes, such as a member aging up or moving to a new geographic location
- Changes to all rating factors, including age, rating area and tobacco use factors, should be captured in the calculation of plan rate changes



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Calculating the Threshold Rate Increase, Cont'd

- Include all plans, even those with no rate change or with rate decreases
- Calculate average change weighted by premium



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Example: Calculating the Threshold Rate Increase

Plan	Current Annual Premium	Annual Premium Based on Proposed Rates	Rate Change
A	\$10,000,000	\$11,000,000	10.00%
B	\$20,000,000	\$19,000,000	-5.00%
C	\$15,000,000	\$18,000,000	20.00%
D	\$ 5,000,000	\$ 5,000,000	0.00%
Total	\$50,000,000	\$53,000,000	6.00%

Weighted average rate change: $(\$53M/\$50M)-1 = 6.00\%$



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Components of Rate Change

- At a minimum, include the following components of the rate change:
 - Change in experience
 - Trend
 - Change in credibility weighting
 - Change in morbidity
 - Change in benefits
 - Change in plan level adjustments (list each change separately)
 - Change in risk adjustment



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Components of Rate Change, Cont'd

- Change in admin & profit
- Change in taxes & fees
- Change in calibration
- Change in area factors
- Change in tobacco factor
- Change in age factors



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Risk Adjustment

- Clearly document the methodology, data, assumptions used to determine the estimated adjustment to the index rate
- Reflect planned changes to the risk adjustment program
 - High-cost enrollee risk pooling; recoveries net of assessments should be reflected in estimated payment transfer amounts



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Index Rate Development Process



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Index Rate Development

Experience period allowed claims for the single risk pool

- Nevada experience for all non-grandfathered plans in existence during experience period
- Prior to adjustments
- Allowed claims include claims incurred but not paid (IBNP), does not include adjustments for premium stabilization plans
 - Describe methodology for estimating IBNP, including completion factors and adjustments
 - Provide a reconciliation of experience period claims shown on the URRT starting from the claims shown on the 2016 Supplemental Healthcare Exhibit (SSHCE). Provide support for any adjustments made to the data shown on the 2016 SSHCE.
- Use Nevada experience only



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Index Rate Development

- Projected claims adjustments:
 - Commercial reinsurance
 - Large claim pooling
- Projection factors:
 - Trend by service category (Excel Exhibit)
 - Medical and Rx separately
 - Change in morbidity
 - Demographic changes
 - Benefit changes



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Development of Credibility Manual Rate

- If Nevada base period experience is not fully credible, other experience may be used to develop manual rate
- Describe methodology, data, adjustments, assumptions used to develop manual rate
- Provide an exhibit with numerical demonstration of the manual rate development



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Credibility

- Provide support for the credibility % applied to the projected experience of the single risk pool
- Consider ASOP #25
 - Not sufficient to use “informed actuarial judgment” rationale without additional support
 - Traditional 2,000 life credibility threshold is not necessarily appropriate



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Projected Index Rate

Defined as the EHB portion of an issuer's estimated total projected allowed claims experience PMPM of the non-grandfathered plans within a market

- Demonstrate development of projected index rate from credibility adjusted claims



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Market Adjusted Index Rate

Allowed market-wide adjustments:

- Risk adjustment
 - Provide support for estimated risk transfer payments
 - Include estimated receipts under new....
- Exchange fees
 - Based on 3.15% fee and projected Exchange enrollment



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Plan Level Rate Adjustment

Demonstrate plan level adjustments to the market adjusted index rate:

- Cost sharing design
- Provider networks, utilization management
- Induced demand (should not reflect health status differences)
- Benefits in excess of EHBs
- Catastrophic plan adjustment
- Non-benefit expenses



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Consumer Adjusted Premium Rate

- Calibration of Plan Adjusted Index Rate for age, geography and tobacco (new in 2018)
 - Provide demonstration of calibration
- Rating factors Applied:
 - Age (new 2018 federal age curve)
 - Tobacco
 - Variation by age is allowed, must be supported
 - Geography
 - Should be based on differences in unit cost, not on health status differences



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Actuarial Certifications

- Metal AV
- Appropriateness of the EHB portion of premium (provided on 2nd tab of URRT and Plan Attributes section of the Plans and Benefits Template)
- Projected Index rate
- Plan adjusted index rate
- EHB Substitutions
- Geographic factors
- Compliance with state and federal laws and regulations
- Compliance with ASOPs



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ASOP Certification

The actuary must certify that each rate filing has been prepared in accordance with the relevant ASOPs. At a minimum, the following need to be referenced:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Rates and Financial Projections for Health Plans
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
- ASOP No. 41, Actuarial Communications
- ASOP No.50, Determining Minimum Value and Actuarial Value Under the Affordable Care Act



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Small Group Issues

- Tobacco rating: applied separately, on a per-member basis
- Quarterly rate updates allowed:
 - Standardized rate effective dates (January 1, April 1, July 1, October 1). No monthly trend adjustments
- Filings due the 15th of the 4th month prior to effective date
 - Include in the rate filing:
 - New URRT – Part I
 - New Actuarial Memorandum- Part III
 - HIOS submission of Parts I and III
 - Rate Data Template
 - Plans may be added or removed quarterly

