



## North Carolina Department of Insurance

### Instructions for Completing the North Carolina Data Submission Template

#### Overview

Carriers will be required to complete and submit a North Carolina Data Submission Template (the Template) for all single-risk pool non-grandfathered individual and small group rate filings, regardless of whether the filing is for new products or a change to rates for existing products, sold on or off the Exchange. The Template will capture information related to current and proposed rating factors, projected rate increase levels, historical and projected experience, and the development of the index rate (optional), as well as general company information.

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

The Template was designed with the North Carolina Department of Insurance's (NCDOI's) long-term goals for data collection and a streamlined rate review in mind. However, in the short-term, a number of elements included in the Template will be optional, or not required. These items are noted in the discussion that follows and are identified by pink cells in the Template. The Template is an Excel based workbook and can be downloaded at:

<https://www.ncdoi.gov/insurance-industry/form-and-rate-filings/life-and-health/health-insurance-industry/information-insurers#rate-filing-information>.

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The Template consists of the following worksheets:

- Worksheet 1 - General
- Worksheet 2 - Rate & Enrollment Distribution
- Worksheet 3 - Admin & Profit
- Worksheet 4 - Area Specific Experience
- Worksheet 5 – Monthly Experience
- Worksheet 6 – Med Claims
- Worksheet 7 – Rx Claims
- Worksheet 8 – Med Claims (Other Source)
- Worksheet 9 – Rx Claims (Other Source)
- Worksheet 10 - Index Rate Dev
- Summary Statistics
- Diagnostic Check

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

Worksheets 5 through 9 request information for 36 months of experience for all policies associated with the rate filing, including products that were offered during the period but will be terminated prior to the effective date of this filing. Throughout these instructions, reference to “terminated” products or plans means those that are no longer offered for new sales and will not be renewed once any policies currently in force reach the end of their current plan year. The information should reflect reasonably recent experience (i.e., as close as possible to the rate submission date with allowance for at least two months of claims payment runout) and represent the same 36 month period for all four worksheets.

For purposes of completing the Template, the following definitions apply:

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- **Cell Shading:** Cells shaded blue are required to be populated (except where specifically noted); cells shaded pink are optional as indicated in the instructions for these fields. Cells that are not shaded are calculated and as such do not require any input.  
**Allowed Claims** are claims after the removal of any duplicates, claims for non-covered services, or COB, and after the application of provider discounts, but prior to reduction for any member cost sharing.
- **Incurred Claims** are claims after removal of any duplicates, claims for non-covered services, or COB, and after the application of provider discounts and reduction for any member or HHS (as applicable) cost sharing.

Please employ 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 (inclusion or exclusion) any claims processed outside of the claims system should be consistent 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 HIOS.

The required information should include data for all policies underlying the single risk pool included in the filing, including data for plans that were active during the experience period but are or will be terminated by the effective date (except where specifically noted throughout these instructions). This applies to all worksheets except Worksheets 8 and 9, which are populated with experience other than that of the single risk pool when such other experience is used to support trend assumptions used in the filing. In addition, Section V of Worksheet 1 includes both grandfathered and non-grandfathered experience for the market.

All worksheets in the Template have been protected so that data entry is allowed only in the cells where applicable. This is primarily so that rows/columns are not accidentally

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inserted/deleted, and the format of the workbook is not altered. **Do not attempt to alter the format of the worksheets or workbook in any way. Alteration may cause the NCDOI’s analytical tools to not function properly, in which case the carrier may be required to resubmit the file.**

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.

For some sections of the workbook, the number of input rows is variable depending upon the number of regions and plans in which the carrier offers coverage (e.g., Worksheet 1, Section VII). For these sections, the workbook will allow data to be entered beyond all rows currently formatted with color, through the last row of the worksheets. In these sections, the carrier may first copy the last row that is formatted down as needed, prior to populating the data for that section. However, it is not required that the formatting be maintained in every row where the carrier has data if the carrier prefers to create a smaller file, as the additional formatting will cause the file size to be larger. It should be noted, however, that columns with formulas should have cells copied down to all additional rows.

### **Worksheet 1 – General**

Worksheet 1 captures general information about the carrier, summary rate increase metrics, contact/reference information, information related to the index rate and market level adjustments to the index rate, estimated MLR rebates for the most recently completed prior calendar year, and the current and proposed rating factors. The worksheet captures the following information in seven sections:

**Section I:** This section contains general information including the carrier and market identification, rate change effective dates, and summary rate increase amounts.

- **Company Legal Name:** Enter the name of the legal entity submitting the filing.
- **HIOS Issuer ID:** Enter the Health Insurance Oversight System ID affiliated with the issuer submitting the filing.
- **NAIC Number:** Enter the Company’s code number assigned by the National Association of Insurance Commissioners.

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- **Market:** Indicate whether the data reflected in the Template represents policies offered in the individual or small group market.
- **Rate Change Eff Date Start:** Enter the first effective date for which the proposed rates will be applied (must be January 1, 20XX for all individual business and the beginning of a calendar quarter for all small group business).
- **Rate Change Eff Date End:** Enter the last effective date for which the proposed rates will be applied (must be December 31, 20XX for all individual business). For small group this would be the last day on which the rates are intended to be issued or renewed. For example, if the filing has a July 1, 2023 effective date and covers one quarter of renewals, the Rate Change Eff Date End would be September 30, 2023.
  - **Average Increase:** Enter the average (premium weighted) annual increase for the market for which the proposed rates are being filed. *Only include plans that currently have enrollees if they will not be terminated prior to or during the projection period in the calculation.* For small group, this average increase estimate should include all renewal periods covered by the filing. The increase calculation should also include the expected change as a result of new Federal requirements related to benefits, rating, taxes and fees, etc. The increase should reflect changes in rating factors, but not reflect changes in enrollee composition underlying the experience. If all current plans in the market will be terminated and all plans that will be offered in the projection period are new, *leave this cell blank.*
- **Minimum Increase:** Enter the minimum annual increase for the market for which the proposed rates are being filed. *Only include plans that currently have enrollees if they will not be terminated prior to or during the projection period in the calculation.* For small group, this minimum increase estimate should include all renewal periods covered by the filing and reflect the minimum increase when calculated at the group level. The increase calculation should also include the expected change as a result of new Federal requirements related to benefits, rating, taxes and fees, etc. If all current plans in the market will be terminated and all plans that will be offered in the projection period are new, *leave this cell blank.*
- **Maximum Increase:** Enter the maximum annual increase for the market for which the proposed rates are being filed. *Only include plans that currently have enrollees if they will not be terminated prior to or during the projection period in the calculation.* For small group, this maximum increase estimate should include all renewal periods

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covered by the filing and reflect the maximum increase when calculated at the group level. The increase calculation should also include the expected change as a result of new Federal requirements related to benefits, rating, taxes and fees, etc. If all current plans in the market will be terminated and all plans that will be offered in the projection period are new, *leave this cell blank*.

▪ **First Date Offering Policies in NC in this Market:** Enter the first effective date that policies were made available by the carrier in North Carolina for the market. This effective date should be specific to the market to which the template applies and could vary between individual and small group for a carrier. In addition, the date should reflect the first effective date for which policies were available for sale, and not the first effective date for which a policy was sold, if later.

- **Section II:** This section contains carrier contact information and identification of prior rate filings.

▪ **Contact Information:** Carriers must identify two contact persons who are knowledgeable of the information included in the rate filing, and able to respond to questions from the NCDOT. In Section II, enter the name, title, e-mail, and phone number information for both contacts. Do not leave any part of this section blank.

▪ **Date:** Enter the date that the data Template was submitted. **A valid date should be entered and the “TODAY()” function should not be used.**

▪ **Past SERFF Tracking Numbers:** Identify SERFF tracking numbers for all rate changes effective during the 12 month period prior to the proposed effective date of the filed rates for this market.

- **Section III:** This section contains the time period and rate basis that the source data for rate development represent.

▪ **Base Experience Start Date:** Enter the starting incurred date for the base period experience in North Carolina.

▪ **Base Experience End Date:** Enter the ending incurred date for the base period experience in North Carolina.

▪ **Rate Basis:** Enter the data basis for the rate development: North Carolina, Blend, or Manual Only

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- **Description (if other):** If the submitting carrier employs experience that is not exclusively from the legal entity’s policies issued in North Carolina for the single risk pool included in the filing, enter a description of the manual rate employed in the rate development.

**Section IV:** This section contains the proposed index rate for the projection period, market level adjustments applied to arrive at the adjusted index rate, and the anticipated loss ratio in the projection period.

This section is not required to be completed if the submitting carrier chooses to support its rates by employing Worksheet 10 – Index Rate Development. If the carrier does not complete Worksheet 10, the carrier will have to provide support for the rate development method in the actuarial memorandum and complete Section IV. (Please see the instructions for the actuarial memorandum for detail as to the type of support that is required).

**Index Rate:** Enter the projected allowed claims for coverage of essential health benefits (EHBs) on a per member per month (PMPM) basis. The projection should reflect the carrier’s market wide average population in terms of morbidity, demographics, benefits, geography and tobacco status anticipated to be covered during the projection period, and should correspond with the projection period that the rate filing supports. The index rate entered in this cell should match the value entered as the ‘Index Rate for Projection Period’ in Worksheet 1 of the Federal Part I Unified Rate Review Template.

- **Risk Adjustment:** Enter the expected charges or payments to or from the carrier as a result of the risk adjustment program in place in North Carolina, including any risk adjustment user fees. The amount should be reflected on a PMPM basis. Carriers that expect to receive payment from the risk adjustment program should enter a negative amount.
- **Reinsurance Adjustment:** Enter the net expected adjustment resulting from assessments and recoveries under the transitional reinsurance program during the projection period. Assessments should be consistent with the amount specified in the HHS Final Annual Notice of Benefit and Payment Parameters. Submissions in support of small group filings should only reflect the program’s assessments. The adjustment should be reflected on a PMPM basis. Carriers that expect to receive a net payment from the transitional reinsurance program should enter a negative

- amount. For 2017 and later effective dates enter zero, unless the program is reinstated in the future.
- **Exchange User Fees:** Enter the expected Exchange user fee. The amount should be consistent with the parameters presented in the HHS Final Annual Notice of Benefit and Payment Parameters, which specify the percent of premium to be used in the calculation of the Exchange user fee. The fee should be reflected on a PMPM basis and entered as a positive amount.
- **Pricing Loss Ratio:** Enter the anticipated pricing loss ratio for the projection period. The pricing loss ratio is defined as the ratio of incurred claims for the dates of service corresponding to the projection period, divided by earned premium for the projection period. Claims should include those which were processed outside of the claim system (e.g. adjustments for provider incentive payments, COB, subrogation). Adjustments to premium and claims that would be made under the Federal MLR calculation should not be made. The estimate for the ‘Current’ column should correspond with the factors in the ‘Proposed’ column from the most recently approved rate filing (as characterized in column d, Section VI of the prior filing).

**Section V:** This section contains the MLR rebate.

- **Calendar Year:** Enter the calendar year for which the reported rebate applies. The most recently completed calendar year should be utilized even if rebates have not yet been finalized.
- **Rebate as a % of Premium:** Enter the amount of any MLR rebates paid for the most recently completed calendar year on a percent of premium basis (this value may be an estimate if the rebates are not finalized at the time the filing is submitted). The premium in this calculation should be the MLR premium after applicable adjustments (i.e., the denominator of the MLR calculation). Enter the percentage that is applicable for the entire market (individual or small group), including any grandfathered business, if applicable.

**Section VI:** This section contains the current index rate, market level adjustments that were applied to arrive at the adjusted index rate, the loss ratio underlying the current rate and the current and proposed rating factors for geography and tobacco use. *For a carrier’s first rate filing submission in the market, all cells in the ‘Current’ column should be left blank.*



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The ‘Current’ rate and factors should reflect those estimates that the carrier employed in its most recently approved rate filing. If, for example, the carrier is filing for a rate increase effective July 1, 2023 and last submitted a small group filing effective April 1, 2023, the carrier should populate Section VI with the index rate and corresponding adjustments for the April 1, 2023 issues. These amounts should not be restated based on more recent information.

- **Effective Date:** For the current rating factors, the effective date should represent the first date the most recently approved rate filing became effective. For the proposed rating factors, the effective date should represent the first date that the proposed rating factors will become effective.
- **Index Rate:** Enter the projected allowed claims for coverage of the essential health benefits (EHBs) for the single risk pool on a per member per month (PMPM) basis. The estimate for the ‘Current’ column should equal the value in the ‘Proposed’ column from the most recently approved rate filing.  
**Risk Adjustment:** Enter the expected charge (or payment) anticipated to be paid (or received) as a result of the risk adjustment program in place in North Carolina. The adjustment should be reflected on a PMPM basis. Carriers that expect to receive payment from the risk adjustment program should enter a negative amount. The estimate for the ‘Current’ column should equal the value in the ‘Proposed’ column from the most recently approved rate filing.
- **Reinsurance Adjustment:** Enter the net expected adjustment resulting from assessments and recoveries under the transitional reinsurance program. Submissions in support of small group filings should only reflect the program’s assessments. The adjustment should be reflected on a PMPM basis. Carriers that expect to receive a net payment from the transitional reinsurance program should enter a negative amount. The estimate for the ‘Current’ column should equal the value in the ‘Proposed’ column from the most recently approved rate filing. For 2017 and later filing effective dates it is expected that the current rates will not reflect an adjustment for the transitional reinsurance program, unless the program is reinstated in the future; therefore, it is expected that zero will be entered for this field for these filings.
- **Exchange User Fees:** Enter the expected Exchange user fee as specified in the corresponding HHS Final Annual Notice of Benefit and Payment Parameters. The

- fee should be reflected on a PMPM basis and should be reflected as a positive amount. The estimate for the ‘Current’ column should equal the value in the ‘Proposed’ column from the most recently approved rate filing.
  - **Pricing Loss Ratio:** Enter the anticipated pricing loss ratio for the corresponding projection period. The pricing loss ratio is defined as the ratio of incurred claims for the dates of service corresponding to the projection period, divided by earned premium for the projection period. Claims should include those which were processed outside of the claim system (e.g., adjustments for provider incentive payments, COB, subrogation). Adjustments to premium and claims that would be made under the Federal MLR calculation should not be made. The estimate for the ‘Current’ column should equal the value in the ‘Proposed’ column from the most recently approved rate filing.
  - **Geographic Adjustments:** The geographic adjustment factors in the ‘Current’ column should equal the factors in the ‘Proposed’ column from the most recently approved rate filing. For the ‘Proposed’ rating factors, the geographic adjustment should represent the proposed factors. If the carrier is not offering coverage in a specific area, 0.0 should be entered for the factor for that area.
- Tobacco Use Adjustment:** The tobacco use adjustment factors in the ‘Current’ column should equal the factors in the ‘Proposed’ column from the most recently approved rate filing. For the ‘Proposed’ rating factors, the tobacco use adjustment should represent the proposed factors.

**Section VII:** 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 rate and the projection period, along with other information for the plan such as metal level, wellness indicator and whether the plan will be sold on the Exchange.

- **Product ID:** Enter the Product ID (assigned in HIOS) for all products associated with the rate filing, including products that were included in the most recently approved rate filing but will be terminated prior to the effective date of this filing and new products that will be first offered on the effective date of this filing. As this table is at the plan-level, a single product may lead to multiple entries with the same value in the Product ID field.

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- **Standard Component 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.
- **Form:** Enter the form filing number associated with the Standard Component Plan ID.
- **Product Name:** Enter the product name associated with the Product ID.
- **Exchange:** Identify whether the plan is or is expected to be sold on the Exchange ('Y'), off the Exchange ('N') or both on and off the Exchange ('B').
- **Product Type:** Enter the Network Description associated with the product. Allowable entries are the following: 'HMO,' 'PPO,' 'POS,' 'IND' (indemnity), and 'OTH' (other).
- **Metal AV:** Enter the actuarial value as calculated by HHS' AV Calculator. If the plan contains unique benefits that required the actuary to make an adjustment to HHS' AV Calculator value as allowed under 45 CFR 156.135(b)(2) or (b)(3), the adjusted value that was certified should be entered.
- **Metal Level:** Enter the metal level that corresponds with the Metal AV. Allowable entries are the following: 'P' (Platinum), 'G' (Gold), 'S' (Silver), 'B' (Bronze), and 'C' (Catastrophic).
  - **Wellness:** 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 until such time when wellness programs may be allowed in the individual market.
- **Pediatric Dental:** 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:** An indicator of whether or not the plan includes non-EHB services. Allowable field entries are 'Y' and 'N.'

**Current Rating Factors:** *(These fields are not required to be populated for a carrier's first rate filing submission in the market.)* For plans that are offered for the first time, enter a zero in the 'Current' rating factors section. The 'Current' factors should reflect

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those factors that the carrier employed in its most recently approved rate filing. If, for example, the carrier is filing for a rate increase effective July 1, 2023 and last submitted a small group filing effective April 1, 2023, the information in columns (q) through (w) should be populated with the value from columns (x) through (ad) from the prior April 1, 2023 filing. These amounts should not be restated based on more recent information.

▪ **Effective Date:** The effective date should represent the first date the most recently approved rate filing became effective.

▪ **Actuarial Value Cost Sharing:** 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 in cell C36. This entry refers to the plan-level adjustment allowed under 45 CFR 156.80 (D)(2)(i) and is not the actuarial value used in determining metal level.

▪ **Network and Management:** 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 in cell C36. This entry refers to the plan-level adjustment allowed under 45 CFR 156.80 (D)(2)(ii).

**Non-EHB Coverage:** Enter the multiplicative factors that are applied in rating to reflect the value of the plan's additional, non-EHB benefits. These factors should reflect the non-EHB cost differences for each plan relative to the adjusted index rate in cell C36. This entry refers to the plan-level adjustment allowed under 45 CFR 156.80 (D)(2)(iii).

▪ **Catastrophic Adjustment:** 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 in cell C36. This entry refers to the plan-level adjustment allowed under 45 CFR 156.80 (D)(2)(v).

▪ **Admin Costs Excl. Exch 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 NCDOJ to assess administrative costs across all carriers regardless of their average benefit design in the marketplace.) 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).

**Proposed Rating Factors:** (These fields are required of all carriers.) For plans that will be terminated prior to the effective date of this filing, enter the effective date on which the plan will no longer be offered in column (x) and a zero in columns (z) through (ad).

- **Effective Date:** For the proposed rating factors, the effective date should represent the first date that rates included in the rate filing will become effective.
- **Actuarial Value Cost Sharing:** 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 liability under different cost sharing provisions for each plan relative to the proposed adjusted index rate in cell D36. This entry refers to the plan-level adjustment allowed under 45 CFR 156.80 (D)(2)(i) and is not the actuarial value used in determining metal level.
- **Network and Management:** 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 proposed adjusted index rate in cell D36. This entry refers to the plan-level adjustment allowed under 45 CFR 156.80 (D)(2)(ii).
- **Non-EHB Coverage:** Enter the multiplicative factors that are applied in rating to reflect the value of the plan’s additional, non-EHB benefits. These factors should reflect the non-EHB cost differences for each plan relative to the proposed adjusted index rate in cell D36. This entry refers to the plan-level adjustment allowed under 45 CFR 156.80 (D)(2)(iii).
- **Catastrophic Adjustment:** 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 proposed

- adjusted index rate in cell D36. This entry refers to the plan-level adjustment allowed under 45 CFR 156.80 (D)(2)(v).
- **Admin Costs Excl. Exch 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. 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).

**Section VIII:** This table contains average pricing actuarial values by metal-plans vs the average paid-to-allowed ratio by metal-plans from claims experience. The issuers must populate for all the policy years they have participated in the NC individual market.

- The average pricing actuarial value represents the actuarial value component of the AV and cost sharing design of plan factor.

**Section IX:** This table contains induced demand factors by metal-plans developed under two different approaches: based on the CMS factors vs carrier specifically developed factors. The issuers must populate for all the policy years they have participated in the NC individual market.

- The induced demand factor represents the utilization component of the AV and cost sharing design of plan factor.

## **Worksheet 2 – Rate & Enrollment Distribution**

This worksheet collects information on the assumed pricing trends, distribution of proposed rate changes, and historical and projected rates and enrollment by rating characteristics. The worksheet captures the following information in five sections:

**Section I:** This section contains carrier and market identification, effective dates, and average increases. The values in this section are imported from Worksheet 1. Carriers are not required to enter anything in this section.

**Section II:** This section contains medical/drug/total assumed trends used to develop proposed rates for the first effective date in the filing, and quarterly pricing trend increases for the next three quarters (applicable to small group only).

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- **Medical From Base:** Enter the medical trend that was employed to project allowed medical claims experience from the base period to the projection period. This estimate should only include adjustments for medical secular trend; it should not reflect changes in plan provisions, changes in demographics, etc. This should reflect the cumulative trend for the number of months from the base period to the projection, and not an annualized amount.
- **Drug From Base:** Enter the prescription drug trend that was employed to project drug claims experience from the base period to the projection period. This estimate should only include adjustments for drug secular trend; it should not reflect changes in plan provisions, changes in demographics, etc. This should reflect the cumulative trend for the number of months from the base period to the projection, and not an annualized amount.
- **Total From Base:** Enter the total trend that has been assumed to project all claims experience from the base period to the projection period. This estimate should only include adjustments for secular trend; it should not reflect changes in plan provisions, changes in demographics, etc. The total trend estimate from the base period should also be consistent with the combined medical and prescription drug trends from the base period. This should reflect the cumulative trend for the number of months from the base period to the projection, and not an annualized amount.
- **Total Second, Third, and Fourth Quarterly Trend Rates:** Enter the proposed trend that will be applied by small group carriers to rates for groups renewing at each quarter. This trend should represent the rate increase over the primary projection period represented by the date in the Rate Change Eff Start Date in cell G6. Individual products and products for small groups where the carrier is not requesting quarterly rate revisions should reflect 0% in these cells. The Second, Third, and Fourth quarters will not necessarily be the second, third, and fourth calendar quarters, but instead should reflect quarters that follow the first effective date in the filing. For example, if the carrier is requesting a July 1, 2023 effective date (as the primary effective date in the filing), the ‘Second Quarter’ in the Template would correspond with October 1, 2023 through December 31, 2023 effective dates.

**Section III:** This section contains measures of the current membership. Current member measures should reflect reasonably recent experience (i.e., as close as possible to the rate submission date). Section III should show the current number of policies, contracts, and members, a distribution of members by level of rate change,

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and the average expected rate change within each rate change range. In completing this section, *only plans that are currently offered that will continue to be offered on the first effective date of the filing need be included. In other words, carriers are not required to map members from a current plan to a new plan if their current plan will be terminated prior to the first effective date of the filing. For small group filings, only include those groups that are scheduled to renew during the period covered by the proposed rates. For example, if the filing is for rates for the first quarter, only include groups scheduled to renew in the first quarter in this section. (These fields are not required to be populated for a carrier's first rate filing submission in the market.)*

- **Policies:** Enter the number of policyholders *currently in force*. For the small group market, only enter the number of employers (count each employer once, even if some employers have multiple plans). The policyholder counts do not need to correspond with the base period used for rate development.
- **Contracts:** Enter the number of contracts *currently in force*. For individual filings, this measure will be the same as the number of policies. For small group filings, this measure will be the number of covered employees. The contract counts do not need to correspond with the base period used for rate development.
- **Members:** Enter the number of members *currently in force*. The membership counts do not need to correspond with the base period used for rate development.
- **Percent of Membership by Rate Change Range:** In each cell in columns (e) through (x), enter the percentage of the total membership from column (d) that will receive a rate change that corresponds with the range specified in the preceding row. For small group, the applicable rate change should be the average increase calculated at the group level. The increase should reflect changes in rating factors, but not reflect changes in enrollee composition underlying the experience.
- **Expected Average Rate Change:** In each cell, enter the average expected rate change for the members reflected in the corresponding rate change range cell. The increase should reflect changes in rating factors, but not reflect changes in enrollee composition underlying the experience.

**Section IV:** This section contains a summary of current membership by age. Covered members over age 64 should be included in the age 64 entries. **A zero should be entered if there is an age without any current membership.**



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**Section V:** This section contains a summary of current membership by rating area. **A zero should be entered if there is a rating area without any current membership.**

**Section VI:** This section contains a summary of current membership by tobacco status. A tobacco status of Y (yes) indicates that the applicable tobacco load was applied to those members entered in the field. **A zero should be entered if there is a status without any current membership.**

**Section VII:** This section contains a summary of projected membership by age. Covered members over age 64 should be included in the age 64 entries. **A zero should be entered if there is an age without any projected membership.**

**Section VIII:** This section contains a summary of projected membership by rating area. **A zero should be entered if there is a rating area without any projected membership.**

**Section IX:** This section contains a summary of projected membership by tobacco status. A tobacco status of Y (yes) indicates that the applicable tobacco load was applied to those members entered in the field. **A zero should be entered if there is a status without any projected membership.**

**Section X:** This section contains the current members and current annual revenue separately by product, plan, and quarterly renewal cohort. *(These fields are not required to be populated for a carrier's first rate filing submission in the market.)*

▪ **Product ID:** Enter all products associated with the rate filing. The product ID (assigned in HIOS) should include all products that are currently offered regardless of whether they will be terminated prior to the effective date of the filing. As this table is a reflection of various characteristic combinations, a single product will have multiple entries with the same value in the Product ID field.

▪ **Standard Component Plan ID:** Enter all plans associated with the rate filing. The Standard Component Plan ID (assigned in HIOS) should include all plans that are currently offered, regardless of whether they will be terminated prior to the effective date of the filing. As this table is a reflection of various characteristic combinations, a

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single plan will have multiple entries with the same value in the Standard Component Plan ID field.

- **Current Membership:** Enter the most up-to-date membership that is expected to renew in the specified quarter of the projection period for each plan and product combination. **For individual products, all current membership should be reported in the First Quarter Renewal section only; all other renewal periods should be populated with zeros for the individual market.** For small group filings, membership should be listed based on the scheduled renewal date of the group.
- **Revenue:** Enter the total annual revenue that is currently in place for the enrollees in the specified quarter for each plan and product combination. **For individual products, all revenue should be reported in the First Quarter Renewals section; all other renewal periods should be populated with zeros.**

**Section XI:** This section contains projected members and associated annual revenue reported separately by product, plan, and quarterly renewal cohort.

- **Product ID:** Enter the Product ID for each product associated with the rate filing. The product ID should include new products that will be offered during the projection period but are not currently offered, as well as those that are currently offered that will continue to be offered. As this table is a reflection of various characteristic combinations, a single product will have multiple entries with the same value in the Product ID field.
- **Standard Component Plan ID:** Enter all plans associated with the rate filing. The Standard Component Plan ID should include new plans that will be offered during the projection period but are not currently offered, as well as those that are currently offered that will continue to be offered. As this table is a reflection of various characteristic combinations, a single plan will have multiple entries with the same value in the Standard Component Plan ID field.
- **Expected Membership:** Enter the membership for each plan and product combination that could be issued or renewed in the specified quarter of the projection period. If membership is not projected for a given combination, enter zero. For individual products, only the First Quarter section should be populated and should

- contain the expected membership of all issues and renewals; all other periods should be populated with zeros for the individual market.
- **Revenue at Current Rates:** Enter the total annual revenue at the current rates for the enrollees in the specified quarter for each plan and product combination. **For individual products, all revenue should be reported in the First Quarter Renewals section; all other renewal periods should be populated with zeros.**

**Revenue at Proposed Rates:** Enter the total annual revenue at the proposed rates for the enrollees in the specified quarter for each plan and product combination. **For individual products, all revenue should be reported in the First Quarter Renewals section; all other renewal periods should be populated with zeros.**

**Section XII:** This table contains projected member months vs the actual member months experienced by metal-plan and by policy year. The issuers must populate for all the policy years they have participated in the NC individual market.

- Populate the table with on exchange enrollees only

**Section XIII:** This table contains projected member months vs the actual member months experienced by CSR variant plans and by policy year. The issuers must populate for all the policy years they have participated in the NC individual market.

- Populate the table with on exchange enrollees only

**Section XIV:** This table contains projected member months vs the actual member months experienced by metal-plan and by policy year. The issuers must populate for all the policy years they have participated in the NC individual market.

- Populate the table with off exchange enrollees only

### **Worksheet 3 – Admin & Profit**

This worksheet captures historical information on administrative expenses (split by various administrative categories), investment income, and profit/contribution to surplus; projected administrative expenses, investment income, and profit/contribution to surplus; and historical risk adjustment transfers, Federal transitional reinsurance recoveries, and risk corridor payments for the market for which rates are being filed. Historical data should be reflected for the market included in the filing for each of the

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three prior years. The worksheet allows separate reporting for different time periods and can be entered on a quarterly basis, but should not be aggregate beyond an annual basis. The worksheet captures the following information in four sections:

**Section I:** This section contains carrier and market identification, effective dates, and average increases. The values in this section are imported from Worksheet 1. Carriers are not required to enter anything in this section.

**Section II:** This section contains experience start and end dates, administrative expenses (general administration, sales and marketing, commissions and broker fees, premium taxes, other taxes, licenses and fees, quality improvement and fraud detection, other expenses, ACA fees), investment income credit, and profit/contribution to surplus. For this section the carrier should enter the requested information for all policies for the applicable market (e.g., individual or small group), including any grandfathered or transitional policies.

Carriers are asked to provide three years of historical administrative cost experience. The three years may correspond to the most recently completed three calendar years; alternatively, carriers may provide more recent experience that is not on a calendar year basis to correspond with reported claims and membership in Worksheets 5 through 7. If more recent experience is reported that does not represent three complete calendar years, the data should be grouped such that the From Date and To Date fields do not span more than one calendar year in a given row. All of the fields in columns (d) through (q) are mutually exclusive. *(These fields are not required to be populated for a carrier's first rate filing submission in the market.)*

**From Date:** Enter the date at which the reported admin and profit experience period shown in the row begin. Note that the period covered in each row should not contain more than one calendar year.

▪ **To Date:** Enter the date at which the reported admin and profit experience period shown in the row end. Note that the period covered in each row should not contain more than one calendar year.

▪ **General Administration:** Enter the total costs related to the general administration of the business. Enter as a total dollar amount for the period. ▪ **Sales and Marketing:** Enter the total costs for activities associated with obtaining new business. These costs should not include expenses associated with enrollment related functions as these would

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- fall into general administrative expenses. Do not include any Exchange user fees in this category. Enter as a total dollar amount for the period.
- **Commissions and Broker Fees:** 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. Enter as a total dollar amount for the period.
- **Premium Taxes:** Enter the total costs related to payments made to a state or municipality based on premiums paid by insured individuals or groups. Enter as a total dollar amount for the period.
- **ACA Insurer Tax:** Enter the total cost for fees paid related to the ACA insurer tax. Enter as a total dollar amount for the period.
- **ACA Exchange User Fees:** Enter the total cost for fees paid to the Exchange for policies sold through the Exchange. Enter as a total dollar amount for the period. ▪ **ACA Transitional Reinsurance Fees:** Enter the total cost for fees paid under the transitional reinsurance program under the ACA. Enter as a total dollar amount for the period. Do not reflect any payments from the reinsurance program to the Individual market in this section. This should not be populated for years other than 2014 through 2016, unless the program is extended or reinstated after 2016.
- **ACA Risk Adj. Fees:** Enter the total cost for fees paid as a user fee for the risk adjustment program under the ACA. Enter as a total dollar amount for the period.
- **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.  
Enter as a total dollar amount for the period.
  - **Licenses and Fees:** Enter the total costs related to licenses and fees that are not implemented as a result of the ACA. Enter as a total dollar amount for the period.
  - **Quality Improvement and Fraud Detection:** Enter the total costs related to quality improvement and fraud detection. Include only those amounts that can be added to the numerator for purposes of calculating the Federal MLR. Enter as a total dollar amount for the period.
- **Other Expenses:** Enter the total non-claim expenses for any items that have not already been included above. Enter as a total dollar amount for the period.

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- **Investment Income Credit:** Enter the total investment income earned during the period on assets backing the policies that are the subject of this filing. The amount would be expected to be consistent with how investment income is allocated to the market in the Supplemental Health Care Exhibit. Enter as a total dollar amount for the period. Investment earnings should be entered as a negative number. Losses should be entered as a positive number.
- **Profit / Contribution to Surplus:** Enter the total gain or loss that was incurred during the period. Enter as a total dollar amount for the period.

**Section III:** This section contains projection period start and end dates, administrative expenses (general administration, sales and marketing, commissions and broker fees, premium taxes, other taxes, licenses and fees, quality improvement and fraud detection, other expenses, ACA fees), investment income credit, and profit/contribution to surplus. For this section the carrier should enter the requested information only for those policies associated with the rate filing.

- **From Date:** The Template calculates the projection period From Date from the general information provided by the carrier on Worksheet 1.
- **To Date:** The Template calculates the projection period To Date such that the projection period is a one-year period.

All remaining fields in this section have the same definitions as they did in Section II. Any explicit risk margin that is included in the rates should be included in the Profit/Contribution to Surplus field in column (q). Enter the load or credit for each of the categories as a percent of projected premium. The percentages entered should be consistent with the projected premium rates and membership included in Worksheet 2, Section V.

If the filing is for the small group market and prospective trend adjustments are being filed, the projected administrative expenses should reflect only what was built into the rates for the first quarter of issues or renewals. Subsequent changes to projected administrative costs will be embedded in the filed premium trend adjustments.

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**Section IV:** This section contains experience start and end dates, risk transfer payments, Federal transitional reinsurance recoveries, and risk corridor payments. Carriers are asked to provide three years of historical risk adjustment, reinsurance, and risk corridor experience. This section contains actual final payments as calculated by HHS. Since the amounts in this section are only determined on a calendar year basis, the three years should correspond to the most recently completed three calendar years for which this information is available at the time the filing is submitted. For this section the carrier should enter the requested information only for those policies associated with the rate filing.

- **From Date:** Enter the date at which the reported experience period shown in the row begins. Note that the period covered in each row should not contain more than one calendar year.
- **To Date:** Enter the date at which the reported experience period shown in the row ends. Note that the period covered in each row should not contain more than one calendar year.
- **Risk Transfer Payments:** Carriers will only need to populate this field for periods during which the final risk transfer payments are known. If experience is reported on a basis other than calendar year, risk transfer payments for a given period for each member should be allocated using risk score weighted enrollment for each period as defined in columns (b) through (c). Carriers that received payment from the risk adjustment program should enter a negative amount.
- **Reinsurance Recoveries:** Enter the total funds that the carrier received under the Federal government’s transitional reinsurance program. For small group filings, this field should reflect \$0. For individual filings, the funds should correspond to the experience period as defined in columns (b) through (c); it should not reflect any assessments under the program as these amounts are reported in Section II. Enter recoveries as negative amounts. *This field must only be populated for experience between 2014 and 2016. For all other periods this field should be populated with \$0 unless the program is extended or reinstated.*
  - **Risk Corridor Payments:** Enter the total funds that the carrier paid or received under the Federal risk corridor program. Enter payments as positive amounts and funds received as negative amounts. The funds should correspond to the experience period as defined in columns (b) through (c). *This field must only be*

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*populated for experience between 2014 and 2016. For all other periods this field should be populated with \$0 unless the program is extended or reinstated.*

**Section V:** This table contains projected vs experienced metrics by policy years. The issuers must populate for all the policy years they have participated in the NC individual market.

- The metrics to populate include member months, claims, earned premium, risk adjustment transfer, overall paid-to-allowed ratio, SWAP PMPM values.

**Section VI:** This table contains the silver loading factors used historically. The issuers must populate for all the policy years they have participated in the NC individual market.

- Populate the silver loading factors in column C if the factors were developed based on experience.
- Populate the silver loading factors in column D if the factors were developed based on plan relativities.
- Enter source of the IDF factors used on the plan relativities(leave this column as blank if you developed the silver loading factors based on experience).

#### **Worksheet 4 – Area Specific Experience**

***Carriers are not required to fill out Worksheet 4 at this time. The worksheet is locked and nothing should be entered into it. The worksheet and instructions have been left intact in case it is decided to collect this information in the future.***

This worksheet collects three years of historical experience including membership, premium, claims, risk scores, risk transfer payments, reinsurance revenue, and Federal subsidies to members. The worksheet allows for separate reporting by product, plan, time periods, Exchange/subsidy status, and geographic region. The experience should be reported based on the geographic rating region. For small group filings, this is the region used to determine each member's rate (member location, employee location or group location), consistent with current Federal guidance. The three years may correspond to the most recently completed three calendar years; alternatively, carriers may provide more recent experience that is not on a calendar year basis to correspond with reported claims and membership in Worksheets 5 through 9. If more recent experience is reported that does not represent three complete calendar years, the data should be grouped such that the From Date and To Date fields do not include more than one calendar year. Data should be reported for all policies in force during the 3 year



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period, including experience in products or plans that were offered during the period but will be terminated prior to the effective date of this filing.

The worksheet collects the following information in two sections:

**Section I:** This section contains carrier and market identification, effective dates, and average increases. The values are imported from Worksheet 1. Carriers are not required to enter anything in this section.

**Section II:** This section contains member months, contract months, policy months, earned premium, allowed claims, incurred claims, risk score, Federal premium subsidies, and Federal cost sharing subsidies reported by product, plan and variance, time period, Exchange indicator (on/off Exchange; premium subsidized/non-subsidized), and geographic region.

- **Product ID:** Enter the Product ID for all products with policies in force between the From Date and the To Date. The Product ID should include all products in force during the reporting month, including those terminated prior to the effective date of this filing. As this table is a reflection of various combinations of Product ID, Standard Component Plan ID, Variance ID, experience period, etc., a single product will have multiple entries with the same value in the Product ID field.
- **Standard Component Plan ID:** Enter the Standard Component Plan ID for all plans with policies in force between the From Date and the To Date. The Standard Component Plan ID should include all products in force during the reporting month, including those terminated prior to the effective date of this filing. As this table is a reflection of various combinations of Product ID, Standard Component Plan ID, Variance ID, experience period, etc., a single plan will have multiple entries with the same value in the Standard Component Plan ID field.
- **Variance ID:** Enter the Variance ID for all plans with policies in force between the From Date and the To Date. The Variance ID should include all products in force during the reporting month, including those terminated prior to the effective date of this filing. As this table is a reflection of various combinations of Product ID, Standard Component Plan ID, Variance ID, experience period, etc., a single plan will have multiple entries with the same value in the Variance ID field.
- **From Date:** Enter the date at which the reported experience period begins.

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- **To Date:** Enter the date at which the reported experience period ends.
- **Exchange Indicator:** Enter an indicator of whether the experience reflects that of policies sold off the Exchange ('N'), on the Exchange for premium subsidy eligible members ('ES') or on the Exchange for non-premium subsidy eligible members ('EN').
- **Geographic Region:** Enter the Geographic Region that corresponds with the experience in the row. For small group filings, the Geographic Region should correspond with the region used to develop each member's rate (member location, employee location or group location), in a manner consistent with Federal guidance.
- **Member Months:** Enter the number of member months with the indicated policy characteristics and time period as defined in columns (b) through (h).
  - **Contract Months:** Enter the number of contract months with the indicated policy characteristics and time period as defined in columns (b) through (h). For small group filings, this measure will be the number of covered employee months.
  - **Policy Months:** Enter the number of policy months with the indicated policy characteristics and time period as defined in columns (b) through (h). For small group filings, this measure will be the number of employer group months in a given plan. Since a given employer may have more than one plan, the sum of policy months across all plans may exceed the number of employer group months. For individual rate filings, the policy months will be the same as the contract months.
- **Earned Premium:** Enter the total premium that was earned from members with the indicated policy characteristics during the period as defined in columns (b) through (h).
- **Allowed Claims:** Enter the total allowed claims that were incurred by members with the indicated policy characteristics during the period as defined in columns (b) through (h). Allowed claims include claims already paid and claims incurred but not yet paid (IBNP).
- **Incurred Claims:** Enter the total claims that were incurred by members with the indicated policy characteristics during the period as defined in columns (b) through (h). Incurred claims include claims already paid, and IBNP.

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- **Risk Score:** Carriers should calculate the risk score that corresponds for members with the indicated policy characteristics and during the experience period as defined in columns (b) through (h).
- **Federal Premium Subsidies:** Enter the total amount of funds that individuals received as credits from the Federal government for individual premium subsidies. For small group filings, this field should reflect \$0. For individual filings, the funds should correspond to members with the indicated policy characteristics during the experience period as defined in columns (b) through (h). This field should reflect amounts greater than \$0 only for rows where the Exchange Indicator is ‘ES.’
- **Federal Cost Sharing Subsidies:** Enter the total amount of funds that the carrier received or expects to receive from the Federal government for individuals eligible for cost sharing subsidies. For small group filings, this field should reflect \$0. For individual filings, the funds should correspond to members with the indicated policy characteristics during the experience period as defined in columns (b) through (h). This field should reflect amounts greater than \$0 only for rows where the Exchange Indicator is ‘ES.’

### **Worksheet 5 – Monthly Experience**

This worksheet captures 36 months of historical membership and premium information on a monthly basis, reported separately by product and plan.

Data should be reported for all policies in force during the 36 month period, including experience in products or plans that were offered during the period but will be terminated prior to the effective date of this filing. The information should reflect reasonably recent experience (i.e., as close as possible to the rate submission date with allowance for at least two months of claims payment runoff).

Worksheets 5 through 7 should only reflect the carrier’s North Carolina experience for the single risk pool, regardless of its credibility. Worksheets 5 through 7 should also reflect the same 36 incurred months. This worksheet requires that premium and membership statistics be reported by Product ID and Standard Component Plan ID, at the monthly level. *These worksheets are not required to be populated if the first effective date for the proposed rates is less than 24 months after the first date policies in the market were offered, as there is likely no data available to populate these worksheets.*

The worksheet collects the following information in two sections:

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**Section I:** This section contains carrier and market identification, effective dates, and average increases. The values are imported from Worksheet 1. Carriers are not required to enter anything in this section.

**Section II:** This section contains members, contracts, policies, EHB earned premium, prescription drug members, reported by product, plan, and month.

▪ **Product ID:** Enter the Product ID for all products in force between the From Date and the To Date. The Product ID should include all products in force during the reporting month, including those products terminated prior to the effective date of this filing. As this table is a reflection of various combinations of Product ID, Standard Component Plan ID, month, etc., a single product will have multiple entries with the same value in the Product ID field.

▪ **Standard Component Plan ID:** Enter the Standard Component Plan ID for all products in force between the From Date and the To Date. The Standard Component Plan ID should include all products in force during the reporting month, including those plans terminated prior to the effective date of this filing. As this table is a reflection of various combinations of Product ID, Standard Component Plan ID, month, etc., a single plan will have multiple entries with the same value in the Standard Component Plan ID field. *Carriers are not required to report these data for experience prior to 2014.* If the carrier does not complete these cells, they should be populated with 0. ▪ **Month:** Enter each month of the 36 month period for every product and plan combination where the carrier had experience.

▪ **Members:** Enter the number of members that had coverage (either medical alone or medical and prescription drug coverage) by the product and plan combination, in the specified month. Carriers are expected to submit their best estimate of the exposure records for every month at the time of the rate filing. That is, carriers should include any restatement of enrollment since the preceding rate filing submission.

▪ **Rx Members:** Enter the number of members that had prescription drug coverage by the product and plan combination in the specified month. Carriers are expected to submit their best estimate of the exposure records for every month at the time of the rate filing. That is, carriers should include any restatement of enrollment since the preceding rate

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filing submission. Since it is possible that members could have had medical-only coverage (i.e., no drug coverage) prior to 2014, and in some cases for policy periods that end at some point after January 1, 2014, each entry in this field should be equal to or less than the Members field for the corresponding month for months prior to 2015. For months in 2015 and later, the membership shown in this field should be equal to that shown in the Members field.

■ **Contracts:** Enter the number of contracts that were covered by the product and plan combination, in the specified month. For small group filings, this measure will be the number of covered employees. Carriers are expected to submit their best estimate of the exposure records for every month at the time of the rate filing.

■ **Policies:** Enter the number of policies that were covered by the product and plan combination, in the specified month. For individual filings, the number of policies should equal the number of contracts. For small group filings, the number of policies will be the number of employer groups. Since a given employer may have more than one plan, the sum of policies across all plans may exceed the number of employers covered. Carriers are expected to submit their best estimate of the exposure records for every month at the time of the rate filing.

■ **EHB Earned Premium:** Enter the premium that was earned for the product and plan combination in the specified month attributable to coverage for EHB s services. Carriers are expected to submit their best estimate of the earned premium for every month at the time of the rate filing. That is, carriers should include any restatement of premium since the preceding rate filing submission. *For periods prior to 2014, this field should be populated with total premium.*

## **Worksheet 6 – Med Claims**

This worksheet collects 36 months of incurred North Carolina-specific historical medical claims cost and utilization information, cost sharing, and average rating factor information, separated by product, plan, and month. Data should be reported for all policies in force during the 36 month period, including those terminated prior to the effective date of this filing. The information should reflect reasonably recent experience (i.e., as close as possible to the rate submission date with allowance for at least two months of claims payment runout). Note that Worksheets 6 – 9 will be used primarily to support trend analysis.

Worksheets 5 through 7 should only reflect the carrier’s North Carolina experience for the single risk pool, regardless of its credibility. Worksheets 5 through 7 should also

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reflect the same 36 incurred months. This worksheet requires that claims be reported at the major service category level. The definitions for these categories should be consistent with what the carrier reports in Worksheet 1 of the Federal Part I Unified Rate Review Template. *These worksheets are not required to be populated if the first effective date for the proposed rates is less than 24 months after the first date policies in the market were offered as there is likely no data available to populate these worksheets.*

It is critical that carriers review this section of the instructions to understand what elements are required. Unless explicitly stated, none of the fields should be left blank. For dollar entries where the carrier is reporting no experience, the carrier should enter zero.

The worksheet collects the following information in five sections:

**Section I:** This section contains carrier and market identification, effective dates, and average increases. The values are imported from Worksheet 1. Carriers are not required to enter anything in this section.

**Section II:** This section contains the starting and ending payment dates for the incurred claims reported in Section V.

- **Claims Paid Date From:** Enter the date at which the medical claim payments for the experience period begin. This should be consistent with the oldest incurred date in column d of Section V.
- **Claims Paid Date To:** Enter the last date through which claim payments are reflected in Section V. This will be at least 38 months after the Claim Paid Date From since the worksheet must include 36 *incurred* months of data and should allow for at least two months of claims payment runoff.

**Section III:** In this section, the carrier is required to report the dollar threshold used for defining large claims that are reported in Section V.

- **Threshold:** Enter the large claim threshold. The carrier must utilize the large claims threshold level in the following table, which is based on the average number of member months per 12 month period contained in the carrier's experience, over the entire three year period, in Section V. Application of the selected large claim threshold is defined later in this section.

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***Large Claims Threshold***

<b>Average Member Months</b>	<b>Threshold</b>
< 5,000	\$75,000
5,001 – 10,000	\$125,000
> 10,000	\$200,000

**Section IV:** This section contains the utilization type (e.g., visits, admits, etc.) by major service category, for the utilization reflected in Section V. The same utilization type definitions must be used for Worksheet 10, if the carrier elects to apply the methodology in Worksheet 10 in the development of the index rate. The utilization type definitions for these categories should be consistent with what the carrier reports in Worksheet 1 of the Federal Part I Unified Rate Review Template. *Until carriers have experience in 2014, this section is optional unless the carrier elects to populate the utilization statistics in Section V prior to having 2014 experience, or the carrier elects to complete Worksheet 10 as a demonstration of the index rate development.*

- **Inpatient Hospital:** Select from the drop-down menu the utilization type that is reported in Section V for Inpatient Hospital services (i.e., admits or days).
- **Outpatient Hospital:** Select from the drop-down menu the utilization type that is reported in Section V for Outpatient Hospital services (i.e., visits or services).
- **Professional:** Select from the drop-down menu the utilization type that is reported in Section V for Professional services (i.e., visits or services).
- **Other Medical:** Select from the drop-down menu the utilization type that is reported in Section V for Other Medical services (i.e., visits, services, or other).
- **Dental:** Select from the drop-down menu the utilization type that is reported in Section V for Dental services (i.e., visits or services).

**Section V:** This section contains utilization, allowed claims, and incurred claims experience by service category, along with cost sharing, HHS’ portion of cost sharing, and average rating factors (geographic region, age, tobacco, risk score/morbidity, network and other), separated by product, plan, and month.

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Carriers should use restated data for each historical incurred month. The metrics specified in Section V should represent the carrier's best estimate at the date the Template is submitted. As a result, estimates for a specific Product ID, Standard Component Plan ID, and month combination may differ from one filing to the next.

- **Product ID:** Enter the Product ID for all products with policies in force for the indicated Month. The product ID should include all products in force during each month, including experience in those products terminated prior to the effective date of this filing. As this table is a reflection of various combinations of product ID, Standard Component Plan ID and incurred month, a single product will have multiple entries with the same value in the Product ID field.
- **Standard Component Plan ID:** Enter the Standard Component Plan ID for all plans with policies in force for the indicated Month. The Standard Component Plan ID should include all plans in force during each month, including experience in those plans terminated prior to the effective date of this filing. As this table is a reflection of various combinations of product ID, Standard Component Plan ID, and incurred month, a single plan will have multiple entries with the same value in the Standard Component Plan ID field. *Carriers are not required to report these data for experience prior to 2014.* If the carrier does not complete these cells, they should be populated with 0.
- **Month:** Enter each month of the 36 month incurred period for every product and plan combination where the carrier had experience.

### **Utilization**

For each type of service category, report the utilization statistics as indicated below. Include estimates for services incurred but not yet paid. *Until carriers have experience in 2014, reporting of utilization statistics is optional. Do not include utilization for large claimants, as defined below. Carriers are not required to report these data for experience prior to 2014.* If the carrier does not complete these cells, they should leave them blank.

- **Inpatient Hospital:** Depending on the utilization type identified in Section IV, enter the total number of inpatient hospital admissions or hospital days that were incurred



- for the specified Product ID, Standard Component Plan ID, and Month combination. This field should exclude utilization for any non-EHB services that were incurred.
- **Outpatient Hospital:** Depending on the utilization type identified in Section IV, enter the total number of outpatient hospital visits or services that were incurred for the specified Product ID, Standard Component Plan ID, and Month combination. This field should exclude utilization for any non-EHB services that were incurred.
- **Professional:** Depending on the utilization type identified in Section IV, enter the total number of professional visits or services that were incurred for the specified Product ID, Standard Component Plan ID, and Month combination. This field should exclude utilization for any non-EHB services that were incurred.
- **Other Medical:** Depending on the utilization type identified in Section IV, enter the total number of other visits, services, or other utilization that were incurred for the specified Product ID, Standard Component Plan ID, and Month combination. Include any services not included in any of the other identified categories. This field should exclude utilization for any non-EHB services that were incurred.
- **Dental:** Depending on the utilization type identified in Section IV, enter the total number of dental visits or services that were incurred for the specified Product ID, Standard Component Plan ID, and Month combination. This field should exclude utilization for any non-EHB services that were incurred.

**Allowed and Incurred Claims**

For each type of service category, report total allowed and incurred claims as indicated below. The service category definitions below apply equally to the allowed and incurred claims sections. Large claimants are defined based on allowed claims for completing both the allowed and incurred claims sections. *Until carriers have 2014 experience, reporting of claims separately for each type of service column is optional. A carrier may instead submit total allowed fee-for-service claims, including EHB and non-EHB services, in the Other Medical column. If this is done, all other columns should have zeros entered.*

- **Inpatient Hospital:** Enter the total allowed and incurred claims for inpatient hospital facility services that were incurred for the specified Product ID, Standard Component Plan ID, and Month combination. Include estimates for services incurred but not yet paid; do *not* include large claims or non-EHB claims.

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- **Outpatient Hospital:** Enter the total allowed and incurred claims for outpatient hospital facility services that were incurred for the specified Product ID, Standard Component Plan ID, and Month combination. Include estimates for services incurred but not yet paid; do *not* include large claims or non-EHB claims.
- **Professional:** Enter the total allowed and incurred claims for professional services that were incurred for the specified Product ID, Standard Component Plan ID, and Month combination. Include estimates for services incurred but not yet paid; do *not* include large claims or non-EHB claims.
- **Other Medical:** Enter the total allowed and incurred claims for other services that were incurred for the specified Product ID, Standard Component Plan ID, and Month combination. Include any services not included in any of the other identified categories. Include estimates for services incurred but not yet paid; do *not* include large claims. Do not include non-EHB claims unless all claims are being reported in this column. For carriers that choose not to populate the entire series of allowed and incurred fields (e.g., Inpatient Hospital, Outpatient Hospital, Professional, etc.), the carrier should enter an aggregate allowed or incurred claim amount, including both EHB and non-EHB services, in the respective Other Medical field.
- **Dental:** Enter the total allowed and incurred claims for dental services that were incurred for the specified Product ID, Standard Component Plan ID, and Month combination. Include estimates for services incurred but not yet paid; do *not* include large claims or non-EHB claims.
  - **Non-EHB FFS:** Enter the total allowed and incurred claims for any non-EHB fee- for-service benefits that were incurred for the specified Product ID, Standard Component Plan ID, and Month combination. Include estimates for services incurred but not yet paid; do *not* include large claims.
- **EHB Capitation:** Enter the total capitation payments to providers for EHB services that were incurred for the specified Product ID, Standard Component Plan ID, and Month combination. For allowed claims, the capitation field should be populated with capitation paid, plus an estimate of member cost sharing. *For experience prior to 2014, both EHB and non-EHB capitation can be entered into this field.*
- **Non-EHB Capitation:** Enter the total capitation payments to providers for non- EHB services that were incurred for the specified Product ID, Standard Component Plan ID,

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and Month combination. *Carriers are not required to report these data for experience prior to 2014.* If the carrier does not wish to complete these cells, they should leave them blank. For allowed claims, the capitation field should be populated with capitation paid, plus an estimate of member cost sharing.

■ **Large Claims:** Enter the monthly allowed or incurred medical claims for members with large claims. Large claimants are identified by first dividing the 36 month reporting period into three consecutive 12 month periods. For each 12 month period, identify all individuals with allowed claims that exceed the threshold specified in Section III during the corresponding 12 month period as a large claimant. For incurred claims, do not re-identify large claimants based on incurred claims. For each Month, enter the total allowed claims or incurred claims incurred in that specific month for those individuals identified as a large claimant. Include *all* claims, not just the excess over the threshold. Include the known claims, those paid through the runout date, plus an estimate of IBNP. It is anticipated that the sum of the amounts entered in columns (i) through (m) plus (o) through (q) would reflect total allowed claims, and the sum of the amounts entered in columns (s) through (w) plus (y) through (aa) would reflect total incurred claims.

■ **IBNP:** Enter the estimated incurred but not paid allowed or incurred claims associated with each Product ID, Standard Component Plan ID, and Month combination. The estimate should include IBNP amounts for EHB and non-EHB services and large claims, but not for capitated services. If the carrier does not develop IBNP estimates for each product and plan combination, the carrier may allocate the total monthly IBNP estimate based on allowed or incurred claims for each product and plan combination in a given incurrence month.

### **Cost Sharing**

■ **Cost Sharing:** Enter the member cost sharing associated with services that were incurred for the specified Product ID, Standard Component Plan ID, and Month combination. 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 services incurred but not yet paid, and cost sharing attributable to both EHB and non-EHB services should be included.

■ **HHS Portion of Cost Sharing:** Enter the HHS portion of cost sharing associated with services that were incurred for the specified Product ID, Standard Component Plan ID, and Month combination. Include estimates for services incurred but not yet paid. *Carriers should report 0 for experience prior to 2014 and for the small group market.*

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### **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. Since these are not necessarily rating factors, they may include impacts outside of the permissible rating factors; for example, age outside of the 3:1 band and gender may be reflected if the carrier chooses. The factors should rely on all covered members, not just those that had incurred claims.

- **Geographic Region:** Enter the average geographic factor (weighted by membership) for the membership that was in force for the specified Product ID, Standard Component Plan ID, and Month combination.
- **Age/Gender:** Enter the average age/gender factor (weighted by membership) for the membership that was in force for the specified Product ID, Standard Component Plan ID, and Month combination. If the Risk Score/Morbidity normalization factor (discussed below) incorporates the portion of risk related to age and gender, this field should be populated with 1.00.
- **Tobacco:** Enter the average tobacco factor (weighted by membership) for the membership that was in force for the specified Product ID, Standard Component Plan ID, and Month combination. If the carrier does not propose utilizing rates based on tobacco use, this field should be populated with a 1.00.
- **Risk Score/Morbidity:** Enter the average risk score or morbidity factor that represents the *estimated* morbidity for the membership that was in force for the specified Product ID, Standard Component Plan ID, and Month combination. This may be the HHS risk score used for risk adjustment, but it is not required to be the HHS risk score. If utilizing the HHS risk score, use the most recent risk adjustment model for the State (weighted by membership).

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- **Cost Sharing:** Enter the average factors related to the underlying cost sharing benefits (weighted by membership) for the membership that was in force for the specified Product ID, Standard Component Plan ID, and Month combination. This should reflect an estimate of the average incurred to allowed ratio, plus induced utilization, across all plans.
- **Other:** Enter the average ‘other’ factor (weighted by membership) for the membership that was in force for the specified Product ID, Standard Component Plan ID, and Month combination. This estimate should facilitate the normalization of the claim costs for any other dynamics that impact cost and are not better reflected in one of the preceding 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 7 – Rx Claims

This worksheet collects 36 months of North Carolina-specific historical drug claims cost and utilization information, pharmacy rebates, rating factor information, separated by product, plan, and month. Data should be reported for all policies in force during the 36 month period, including those terminated prior to the effective date of this filing. The information should reflect reasonably recent experience (i.e., as close as possible to the rate submission date with allowance for at least two months of claims payment runoff).

Worksheets 5 through 7 should only reflect the carrier’s North Carolina experience for the single risk pool, regardless of its credibility. Worksheets 5 through 7 should also reflect the same 36 incurred months. Claims are reported separately by prescription drug type (i.e., generic, brand, and specialty). *These worksheets are not required to be populated if the first effective date for the proposed rates is less than 24 months after the first date policies were offered in the market as there is likely no data available to populate these worksheets.*

It is critical that carriers review this section of the instructions to understand what elements are required. Unless explicitly stated, none of the fields should be left blank. For dollar entries where the carrier is reporting no experience, the carrier should enter zero.

The worksheet collects the following information in three sections:

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**Section I:** This section contains carrier and market identification, effective dates, and average increases. The values are imported from Worksheet 1. Carriers are not required to enter anything in this section.

**Section II:** This section contains the starting and ending payment dates for the incurred claims reported in Section III.

- **Claims Paid Date From:** Enter the date at which the prescription drug claim payments for the experience period begin. This should be consistent with the oldest incurred date in column d of Section III.
- **Claims Paid Date To:** Enter the last date through which claim payments are reflected in Section III. This will be at least 38 months after the Claim Paid Date From since the worksheet must include 36 *incurred* months of data and should allow for at least two months of claims payment runoff.

**Section III:** This section contains the number of prescriptions, allowed claims, and incurred claims experience, by type of drug (brand/generic/specialty), pharmacy rebates, along with cost sharing, HHS' portion of cost sharing, and average factors (geographic region, age, tobacco, risk score/morbidity), separated by product, plan, and month.

Carriers should use restated data for each historical incurred month. The metrics specified in Section III should represent the carrier's best estimate at the date the Template is submitted. As a result, estimates for a specific Product ID, Standard Component Plan ID, and month combination may differ from one filing to the next.

- **Product ID:** Enter the Product ID for all products in force for the indicated Month. The product ID should include all products with experience in force during each month, including those products terminated prior to the effective date of this filing. As this table is a reflection of various combinations of product ID, Standard Component Plan ID and incurred month, a single product will have multiple entries with the same value in the Product ID field.
  - **Standard Component Plan ID:** Enter the Standard Component Plan ID for all plans in force for the indicated Month. The Standard Component Plan ID should

- include all plans with experience in force during each month, including those plans terminated prior to the effective date of this filing. As this table is a reflection of various combinations of product ID, Standard Component Plan ID, and incurred month, a single plan will have multiple entries with the same value in the Standard Component Plan ID field. *Carriers are not required to report these data for experience prior to 2014.* If the carrier does not complete these cells, they should be populated with 0.
- **Month:** Enter each month of the 36 month incurred period for every product and plan combination where the carrier had experience.

### **Utilization**

For each type of prescription, report the utilization statistics as indicated below. Include estimates for prescriptions filled but not yet paid. *Carriers are not required to report these data for experience prior to 2014.* If the carrier does not complete these cells, they should leave them blank.

- **Generic:** Enter the total number of generic drug prescriptions that were filled for the specified Product ID, Standard Component Plan ID, and Month combination. Prescriptions should be converted to a monthly equivalent basis (e.g., a mail order script for 90 days should be counted as three scripts). This field should include utilization for any non-EHB services that were incurred.
- **Brand:** Enter the total number of brand drug prescriptions that were filled for the specified Product ID, Standard Component Plan ID, and Month combination. Prescriptions should be converted to a monthly equivalent basis. This field should include utilization for any non-EHB services that were incurred.
- **Specialty:** Enter the total number of specialty drug prescriptions that were filled for the specified Product ID, Standard Component Plan ID, and Month combination. Prescriptions should be converted to a monthly equivalent basis. This field should include utilization for any non-EHB services that were incurred.
- **Non-EHB Total:** Enter the total number of non-EHB drug prescriptions that were filled for the specified Product ID, Standard Component Plan ID, and Month combination. Prescriptions should be converted to a monthly equivalent basis.

### **Allowed and Incurred Claims**

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For each type of prescription, report total allowed and incurred claims as indicated below. The field definitions below apply equally to the allowed and incurred claims sections. *Until carriers have 2014 experience, reporting of claims separately for each type of prescription is optional. A carrier may instead submit total allowed or incurred claims in the Generic column. If this is done, all other columns should have zeros entered.*

- **Generic:** Enter the total allowed and incurred claims for generic prescriptions that were filled for the specified Product ID, Standard Component Plan ID, and Month combination. Include estimates for drugs filled but not yet paid for, and do not include non-EHB prescriptions (unless the carrier is entering all drugs in the generic category). *For carriers that choose not to populate the entire series of allowed and incurred fields until experience for 2014 is available (i.e., brand, specialty, and non-EHB), the carrier should report the aggregate allowed and incurred claims across all drug tiers in the Generic field. If this is done, all other columns should have zeros entered.*
- **Brand:** Enter the total allowed and incurred claims for brand prescriptions that were filled for the specified Product ID, Standard Component Plan ID, and Month combination. Include estimates for drugs filled but not yet paid, and do not include non-EHB prescriptions.
- **Specialty:** Enter the total allowed and incurred claims for specialty prescriptions that were filled for the specified Product ID, Standard Component Plan ID, and Month combination. Include estimates for drugs filled but not yet paid, and do not include non-EHB prescriptions.
  - **Non-EHB Total:** Enter the total allowed and incurred claims for non-EHB drug prescriptions that were filled for the specified Product ID, Standard Component Plan ID, and Month combination. Include estimates for drugs filled but not yet paid.
  - **IBNP:** Enter the estimated incurred but not paid allowed and incurred claims associated with each Product ID, Standard Component Plan ID, and Month combination. The estimate should include IBNP amounts for EHB and non-EHB services. If the carrier does not develop IBNP estimates for each product and plan combination, the carrier may allocate the total monthly IBNP estimates based on allowed and incurred charges for each product and plan combination in a given incurrence month.



- - **Rebates:** Enter the total manufacturer rebates that are paid directly 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 NCDOI requests it. Estimates of rebates anticipated to be received but have not yet been received should be reflected.

### **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. Since these are not necessarily rating factors, they may include impacts outside of the permissible rating factors; for example, age outside of the 3:1 band and gender may be reflected if the carrier chooses. The factors should rely on all covered members, not just those that had incurred claims.

- **Geographic Region:** Enter the average geographic factor (weighted by membership) for the membership that was in force for the specified Product ID, Standard Component Plan ID, and Month combination.
- **Age/Gender:** Enter the average age/gender factor (weighted by membership) for the membership that was in force for the specified Product ID, Standard Component Plan ID, and Month combination. If the Risk Score/Morbidity normalization factor (discussed below) incorporates the portion of risk related to age and gender, this field should be populated with 1.00.
- **Tobacco:** Enter the average tobacco factor (weighted by membership) for the membership that was in force for the specified Product ID, Standard Component Plan ID, and Month combination. If the carrier does not propose utilizing rates based on tobacco use, this field should be populated with a 1.00.
- **Risk Score/Morbidity:** Enter the average risk score or morbidity factor that represents the *estimated* morbidity for the membership that was in force for the specified Product ID, Standard Component Plan ID, and Month combination. This may be the HHS risk score used for risk adjustment, but it is not required to be the

- HHS risk score. If utilizing the HHS risk score, use the most recent risk adjustment model for the State (weighted by membership).
- **Other:** Enter the average ‘other’ factor (weighted by membership) for the membership that was in force for the specified Product ID, Standard Component Plan ID, and Month combination. This estimate should facilitate the normalization of the claim costs for any other dynamics that impact cost and are not better reflected in one of the preceding categories, and as such, should contain at a minimum benefits covered beyond EHB. *Do not include cost sharing, since cost sharing for both medical and prescription drug benefits is reflected in the Cost Sharing normalization factor on Worksheet 6.*

### **Worksheet 8 – Med Claims (Other Source)**

This worksheet captures the historical medical claims data for the most recent 36 months that was used to support the carrier’s trend assumption. If the North Carolina experience of the single risk pool included in the filing (i.e., the same experience as that shown in Worksheet 6) is considered 100% credible and was used as the basis for developing the trend assumption, this worksheet may be left unpopulated. If other experience was used to support the trend assumption, enter the most recent 36 months of experience for this alternate population.

The input fields in this worksheet are identical to those in Worksheet 6 and have the same definitions and input requirements, with the following exceptions:

- Data is not required to be reported by product or plan, even after the experience includes 2014 or beyond.
- **Members:** Provide the number of members covered in the alternate risk pool for each month of the incurred period. Include all covered members, even those that did not have any claims during the period.

The only difference between the remaining data entered into Worksheets 6 and 8 is the population that underlies the experience. Please see the instructions for Worksheet 6 for additional information on the definitions of each field.

### **Worksheet 9 – Rx Claims (Other Source)**

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This worksheet captures the historical prescription drug claims data for the most recent 36 months that was used to support the carrier's trend assumption. If the North Carolina experience of the single risk pool included in the filing (i.e., the same experience as that shown in Worksheet 7) is considered 100% credible and was used as the basis for developing the trend assumption, this worksheet may be left unpopulated. If other experience was used to support the trend assumption, enter the most recent 36 months of experience for this alternate population.

The input fields in this worksheet are identical to those in Worksheet 7 and have the same definitions and input requirements, with the following exceptions:

- Data is not required to be reported by product or plan, even after the experience includes 2014 or beyond.
- **Members:** Provide the number of members covered in the alternate risk pool for each month of the incurred period. Include all covered members, even those that did not have any claims during the period.

The only difference between the remaining data input into Worksheets 7 and 9 is the population that underlies the experience. Please see the instructions for Worksheet 7 for additional information on the definitions of each field.

### **Worksheet 10– Index Rate Dev**

This entire worksheet is optional, and as such, all input cells have been shaded pink. The intent of this worksheet is to provide a template for carriers to demonstrate the development of their index rate. State and Federal regulations do not prescribe the exact formula that must be used in the development of the index rate; therefore, NCDOI recognizes that other methods may be used in the development of the index rate as long as they meet all regulatory requirements. However, this Template may be completed by the carrier to facilitate NCDOI review and reduce the number of follow-up questions NCDOI requests of the carrier. If this worksheet is not completed, all cells should be left blank and the carrier will be required to provide similar detailed documentation of the development of their index rate.

This worksheet requires that claims and adjustments occur at the major service category levels. The definitions for these categories should be the same as what the carrier employs in reporting claims in Worksheets 6 through 9. As with those worksheets, the

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category definitions should also be consistent with what the carrier reports in Worksheet 1 of the Federal Part I Unified Rate Review Template.

The worksheet collects the following information in six sections:

**Section I:** This section contains carrier and market identification, effective dates, and average increases. The values are imported from Worksheet 1. Carriers are not required to enter anything in this section.

**Section II:** This section contains membership and earned premium for the base period.

▪ **Base Period Member Months:** Enter the total member months that underlie the base period claims reported in Section III of this worksheet. **The Base Period is defined on Worksheet 1.**

▪ **Base Period Earned Premium:** Enter the total earned premium that underlies the base period claims reported in Section III of this worksheet. **The Base Period is defined on Worksheet 1.**

**Section III:** This section contains base period utilization per 1,000, the average allowed cost per service/script, and incurred claims PMPM for the single risk pool. The net impacts of pooling and private reinsurance are separately reported by service category.

▪ **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 on Worksheet 6.

▪ **Avg. Cost per Service/Script:** Enter the average allowed cost per service/script that corresponds with the utilization measures reported in column (d). The average unit costs should be reflective of the both EHB and non-EHB services present in the base period experience.

▪ **Incurred Claims PMPM:** Enter the net plan liability after recognition of cost sharing (paid by the member or HHS).

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- **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 will be expected to demonstrate the basis for the development of these adjustments as well as to demonstrate consistency with historical pooling adjustments in the actuarial memorandum.
- **Net Impact of Private Reinsurance:** Enter the net adjustment to claims as a result of any private reinsurance the carrier has during the base period. As with large claim pooling, carriers will be expected to demonstrate the appropriateness of any adjustments in the actuarial memorandum.

**Section IV:** 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.

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. The actuary should 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. The projection period is the period over which the first filed index rate applies. For example, if the filing is for the small group market for a January 1, 2023 effective start date and quarterly trends are applied such that rates are filed for an entire year of issues or renewals, the first filed index rate is applied to policies issued or renewed from January 1, 2023 through March 31, 2023. The projection period for this group of effective dates would typically be January 1, 2023 through March 30, 2024.

- **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 demographics 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.
  - **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 their 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 column (k). 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 to reflect other expected cost changes that are not reflected elsewhere.
- **Additive Adjustments – 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.
- **Additive Adjustments – 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.

**Section V:** This section contains Manual rate utilization per 1,000 and average cost per service/script for the projection period, as well as credibility weight, reported separately by service category.

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- **Utilization per 1,000:** Enter the annualized utilization per thousand enrollees for each of the benefit service categories for the manual rate data. These projection estimates should be consistent with the projection period and reflective of the expected covered population. Carriers will have to be able to support the manual rate development. If the base experience is fully credible, the manual rate utilization per 1,000 should be entered as zero.
- **Average Cost per Service or Script:** Enter the average cost per service for the manual rate data that corresponds with the utilization measures reported in column (j). These projection estimates should be consistent with the projection period and reflective of the expected covered population. Carriers will have to be able to support the manual rate development. If the base experience is fully credible, the manual rate unit cost should be entered as zero.
- **Credibility Weights:** Enter the expected credibility weight by service category. 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 1.00, and if the base experience is fully credible, the credibility weights should be entered as 1.00.

**Section VI:** This section contains the index rate calculation, index rate adjustments (risk adjustment, Federal reinsurance, Exchange user fees), and the average member cost sharing. Retention loads including administrative expenses, profit and risk, and taxes and fees are also included.

- **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.
  - **Risk Adjustment:** Enter the expected charge to or payment from the risk adjustment program in place in North Carolina, including any risk adjustment user fees. The amount should be reflected on a PMPM basis. Carriers that expect to receive payment from the risk adjustment program should enter a negative amount.
  - **Reinsurance Adjustment:** Enter the net expected adjustment resulting from assessments and recoveries under the transitional reinsurance program during the



- projection period. Submissions in support of small group filings should only reflect the program’s assessments. The payment should be reflected on a PMPM basis. Carriers that expect to receive a net payment from the transitional reinsurance program should enter a negative amount.
- **Exchange User Fees:** Enter the expected Exchange user fees as specified in the HHS Final Annual Notice of Benefit and Payment Parameters. The payment should be reflected on a PMPM basis. The fee should be reflected as a positive amount.
- **Member Cost Sharing:** Enter the expected average member cost sharing for the projection period. The adjustment should be reflected as a positive value, on a PMPM basis. For those members eligible for cost sharing reduction subsidies, reflect both the amount paid by the member and the amount paid by HHS.
- **Administrative Expenses:** Enter the administrative expenses as a percentage of revenue that the carrier anticipates in the projection period for all products considered in the filing. 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, or any assessments under the transitional reinsurance program.

### **Summary Statistics Worksheet**

The carrier is not required to enter any data on this worksheet, but rather this worksheet summarizes various data from Worksheets 1 through 10 to aid the carrier in ensuring the workbook has been completed correctly. For example, the total member months for the applicable rating period from Worksheet 5 are compared to the base period member months in Worksheet 10 (if the carrier elects to use Worksheet 10). These two amounts should match exactly, and if they do not this serves as an indicator to the carrier that there is an error in compiling the data for one of these two worksheets.

### **Diagnostic Check Worksheet**

The carrier should not enter any data on this worksheet, but rather this worksheet summarizes the data issues that are present throughout the workbook. **Once all required information has been populated in the workbook, a review for potential errors should be performed.** To review and correct potential issues, the 'Run Diagnostic Test' button should be pressed, and the results of the review will then be shown. After an issue has been corrected, the button should be pressed again to verify it was done correctly and the error no longer exists. On occasion, the diagnostic test will indicate an error is present where a valid reason for the warning exists. **Any uncorrected issues should be noted in the actuarial memorandum, and the reason they could not be corrected should be provided.**

**This review must be performed prior to sending the Excel workbook to the NCDOT. Not performing the review may cause the NCDOT's analytical tools to not function properly, in which case the carrier may be required to resubmit the file.**