State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE
LIFE & HEALTH
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June 11, 2020

2021 Rate Filing Requirements

SECTION 1: RATE SUBMISSION DUE DATES

1. **2020 Quarterly SEH rate filings are due 105 days prior to the effective date:**
   4Q2020 rate filings effective 10/01/2020 are due by 06/18/2020.

2. **2021 Annual IHC and SEH rate filings are due June 19, 2020** and must be complete with all elements required for submission to CMS by August 7, 2020 (initial deadline).
   a. Risk Adjustment (RA) revisions will be permitted after the final RA Report is released July 16, 2020 and must be submitted by close of business July 24, 2020.

3. **2021 Annual Pediatric Dental ACA-Compliant rate filings are due June 19, 2020** and must be complete with all elements required for submission to CMS by August 7, 2020 (initial deadline).

4. **2021 Quarterly SEH rate filings are due 105 days prior to the effective date:**
   2Q2021 rate filings effective 04/01/2021 are due by 12/18/2020.
   3Q2021 rate filings effective 07/01/2021 are due by 03/18/2021.
   4Q2021 rate filings effective 10/01/2021 are due by 06/18/2021.

5. **2021 Annual SADP EHB-compliant rate filings are due June 19, 2020** and must be complete with all elements required for submission to CMS by August 7, 2020 (initial deadline).

6. **SHP rate filings are due 90-days prior to the effective date** of the rates. The timeline for review and objection response will take into account the effective date.

SECTION 2: 2021 SPECIFIC FILING GUIDANCE

1. SEH TRANSITIONAL PLANS

The Department has determined that transitional plans (plans that were in effect prior to January 1, 2014 that carriers could continue to make available for renewal) may be continued as outlined in the January 31, 2020 memorandum from CMS. Although New Jersey allowed transitional plans for both the individual and small employer markets, carriers elected to make them available for only the small employer market.

2. IHC AND SEH BENEFIT DESIGN CHANGES FOR 2020

As established in the Department's minimum standards requirements, the maximum permissible annual deductible for a Bronze plan is $3,000 per person. High deductible health plans (HDHP) feature deductible and maximum out of pocket amounts consistent with the ranges in Federal law and the ranges are adjusted annually.

Effective with plan years beginning on or after January 1, 2021, the Department will permit health carriers issuing IHC and SEH plans to increase the network deductible from $3,000 to $6,000 for Bronze HDHPs only.

The Department issued a Bulletin No. 20-25 to make this adjustment.

3. IHC REINSURANCE

Rates submitted by carriers shall take into account the NJ reinsurance program. The parameters have been updated for 2021 to be: 50% coinsurance rate; $35,000 attachment point, and $245,000 reinsurance cap. The Department expects the carriers to reduce the rates in the individual market by at least 15.3% on average (prior to the incorporation of any additional morbidity improvements which might be assumed as a result of the reinsurance program) in consideration of the NJ reinsurance program, as compared to what the rates would be without reinsurance.

The rate filing must document the amount of the rate decrease attributable to the NJ reinsurance program implicit in the 2021 annual rates further detail is provided in the Actuarial Memorandum instructions section.

4. IHC COST-SHARING REDUCTION (CSR) LOAD

Must be applied to all Silver plans sold on-Exchange (same rate for the mirror off-exchange plan), and not to Silver plans sold only off-Exchange.

5. IHC OFF-EXCHANGE SILVER PLANS

Carriers are strongly encouraged to offer at least one off-Exchange Silver plan that would be unaffected by the CSR Load.

6. IHC Market Fee (previously called Exchange User Fee)

Effective 1/1/2021, an IHC market fee of 3.5% will be applied to all business (regardless of

whether it is sold On- or Off-Exchange).

7. New Legislation: Prescription Drug Law - P.L.2019, c.472

This law requires health insurers to limit patient cost-sharing and provider appeal process concerning certain prescription drug coverage. DOBI has provided the following additional guidance:

- P.L.2019, c.472 has $150 or $250 caps per month for each prescription drug for up to 30-day supply of any single drug. We interpret this as meaning for each prescription of up to a 30-day supply. Therefore, if a member gets two prescriptions for the drug, the cap would apply separately to each prescription and the member would pay no more than $150 or $250 for each prescription.
- The law applies to outpatient drugs and not to drugs secured in an office or facility. If the plan covers the drug, the law would apply when covered as a pharmacy benefit but not if covered under a medical benefit.

As with any benefit that cannot be directly entered into the AV calculator, the Carrier should document and certify the methodology used to determine the AV. The Carrier should convert the benefit into a single benefit feature and should provide a spreadsheet (with working formulas) that demonstrates the conversion.

8. Risk Adjustment Data Validation (RADV)

While the Department expects that RADV transfer payments will have little to no impact on the rates filed by carriers, RADV estimates can be included in 2021 rate filings. A detailed explanation of how the RADV estimate was derived should be included in the Actuarial Memorandum and should including spreadsheets (with working formulas) as needed.

SECTION 3: RATE FILING STANDARDS FOR ALL RATE FILINGS

1. SERFF RATE FILING SUBMISSIONS

a. All rate filings must be submitted via SERFF, in compliance with the SERFF Filing rules and requirements, which have been updated and include reference documents, instructions, and standardized templates, as appropriate.
b. All documents are to be uploaded within the appropriate Supporting Documentation tab.
c. Do not to create new tabs under Supporting Documentation.

2. File Naming

All Items under the Supporting Documentation tab in SERFF must adhere to this standard naming convention: SERFF#_FormName_V.#. Adherence to a standard naming convention makes it easier to track new versions as they are updated within SERFF. Always start with v.1 (Version 1) and retain the same file name with each subsequent version.

3. Footers

All elements of the rate filing, except federal or state templates, are required to include a three-column footer showing: (1) SERFF# and form name, (2) page #, and (3) date created or revised. The same date must appear on every page of the document.

4. Revisions to Previously Submitted Documents

When revisions are made to a document, the revised text must be highlighted in turquoise and every page shall be dated clearly and distinctively with the revision date.

5. Rate/Rule Schedule Tab

For SEH, the values should be a comparison of the current quarter (that the company is filing for) to the corresponding quarter of the prior year. The values should NOT reflect a weighted average of all remaining quarters.

Premium rate should include age and area (where applicable). Base rate should not include the age or area.

a. Rate/Rule Schedule – Summary (the URRT references do not apply to SADP)

i. Overall % Rate Impact: For IHC, this should be the 2021 base rate increase averaged across all renewing plans. For SEH, this should be the 2021 base rate increase for the quarter (for example Q1 2020 to Q1 2021) averaged across all renewing plans. The average should be calculated using current total premium (i.e. the same calculation that is used in URRT 5.1 worksheet 2, section I, line 1.13).
ii. Number of Policy Holders Affected for this Program: This should be the number of subscribers corresponding to the current enrollment entered into URRT 5.1 worksheet 2, section II, line 2.10.
iii. Written Premium for this Program: This is the total projected premium for the rating period based on the expected age / area distribution and plan distribution (URRT 5.1 worksheet 2, section IV, line 4.8).

iv. Maximum % Change (where required): This should be the maximum plan base rate change between current year and prior year.
v. Minimum % Change (where required): This should be the minimum plan base rate change between current year and prior year.

b. Rate/Rule Schedule – View Rate Review Detail (this section does not apply to SADP)

vi. Number of Covered Lives: This should be the current members from URRT 5.1 worksheet 2, section II, line 2.10.
vii. Trend factor: Listed the annualized Medical and Pharmacy Trend used in the filing separately.
viii. Requested Rate Change Information:
   1) Member months: This should be the total member months for the rating period corresponding to the current enrollment from URRT 5.1 worksheet 2, section II, line 2.10.
   2) Percent Rate Change Requested: These should match to the percentages recorded on the Rate/Rule Schedule Summary tab.
ix. Prior Rate:
   1) Total Earned Premium: This should reflect the latest projection of 2020 premium used to set 2021 pricing.
   2) Total Incurred Claims: This should reflect the latest projection of 2020 claims used to set 2021 pricing.
   3) Annualized PMPM: These should be the prior year plan base rates weighted by the latest estimate of current 2020 enrollment.
x. Requested Rate:
   1) Projected Earned Premium: This should be the total projected premium from URRT 5.1 worksheet 2, section IV, line 4.8.
   2) Projected Incurred Claims: This should be the total projected incurred claims from URRT 5.1, worksheet 2, section IV, line 4.6.
   3) Annualized PMPM: This should be the plan base rates from URRT 5.1 worksheet 2, section III, line 3.14.

6. Correspondence (Objections)

Carriers must respond to Objection Letters created by the Department within the Objection Letter, not within the Supporting Documentation tab.

SECTION 4: IHC AND SEH RATE FILIING REQUIREMENTS

1. STATUTES AND REGULATIONS

IHC N.J.S.A. 17B:27A-2 et seq and N.J.A.C 11:20-6.3
SEH N.J.S.A. 17B:27A-17 et seq and N.J.A.C 11:21-9.3

2. THRESHOLD INCREASES

The 2020 Proposed Notice of Benefit and Payment Parameters, Part II Justification threshold remains at 15%. NJ will continue to review for rate increases at or above 10%.

3. IHC RATING FACTORS

Rates may vary based only on the following factors:

- Age (within a ratio of 3:1)

4. SEH RATING FACTORS

Rates may vary based only on the following factors:

- Age (within a ratio of 1:824:1); and
- Territory (within a ratio of 1.1:1).

The age and rating area factors together must be within a ratio of 2:1.

SEH Territories

Beginning with calendar year 2020, the SEH rating areas are numerically, rather than alphabetically, identified as:

1. Essex, Hudson, Union
2. Bergen, Passaic
3. Monmouth, Morris, Sussex, Warren
4. Hunterdon, Middlesex, Somerset
5. Burlington, Camden, Mercer
6. Atlantic, Cape May, Ocean, Salem, Cumberland, Gloucester

5. SEH INTRODUCTION OF NEW, NON-SHOP PLANS MID-YEAR

New SEH plans may be introduced mid-year only within the following parameters:

a. Plans may only be offered for non-SHOP business;
b. Rate development for these new plans must be based on the single risk pool;
c. Benefit Summary Tables for these new plans must be included in the rate filings;
d. Network(s) for these new plans must have been filed with, and approved by the Department; evidence of the approval must be included in the rate filing; and

e. Plans must be offered as guaranteed issue and participation and contribution requirements cannot be applied to any small employer applying for such new plans for the balance of the calendar year.
f. The Part III AM must include a discussion of any new plans introduced mid-year.

6. DATA ELEMENTS TO BE INCLUDED IN IHC AND SEH RATE FILINGS

a. HIOS Tracking # – must be entered in the Filing Description (General Information tab).

b. Actuarial Value (AV) Calculator "Screen Shots" – **PDF**

Include one for each plan in the rate filing. For IHC carriers, this includes the three CSR variations (73%, 87%, and 94%) for Silver plans offered through the Marketplace.

c. Benefit Summary Tables – **Excel**

Complete one for each plan to facilitate our review of the benefit information. Each Benefit Summary Table must be formatted to print on 8.5" x 11" paper.

i. To capture information associated with out-of-network benefits, use the table specific to plans that have out-of-network benefits. Similarly, plans that feature tiered network benefits should be described on the appropriate table specific to tiered benefits.
ii. The footnotes include direction to submit evidence regarding network approval as well as documentation to support copays applicable to certain services. If the same documentation applies to multiple plans it is not necessary to enclose the documentation for each plan.
iii. Final NJDOBI action, with respect to a rate filing, will be pended until the Benefit Summary Tables along with the documentation specified in the footnotes has been received and found to be complete and satisfactory.
iv. Carriers offering small employer plans through the SHOP that update the quarterly rates must submit an updated Federal Rate Table Template through SERFF using the Plan Management module.

d. Part I Unified Rate Review Template (URRT) (45 CFR 154.215) **– Excel**

i. As per guidance from CMS, Transitional Plans are not to be included in the URRT.

e. Part II Written Description Justification (45 CFR 154.215) – **PDF, template provided**

A consumer-friendly written description justifying, and listing all rate increases at or above the threshold. For 2021, New Jersey continues to apply a 10% threshold for filing rate increase justifications with CMS.

i. For SHOP, the Annual Part II must specifically address, and list, all rate increases for all plans, by quarter, if any rate increase is at or above the 10% threshold for the year.
ii. The calculation of the rate increases for the 10% threshold should reflect the year-over-year rate increase in the base rate for the plan (i.e., 2021 annual vs 2020 annual, 2Q21 vs 2Q20, 3Q21 vs 3Q20, 4Q21 vs 4Q21), and should reflect any change in the age or geographic factors, if applicable. These rates change should be the same as the rate changes included in the "Cumulative Rate % over 12 months prior" included in the URRT, the Part III and SERFF Rate/Rule Schedule Tab.

f. <u>Part III Actuarial Memorandum (AM) and Certification</u> (45 CFR 154.215) **– PDF, template provided for the Certification, AM should follow URR instructions with the following additions**

i. The Part III AM must contain the additional <u>actuarial memorandum data elements required by New Jersey regulation</u> at: N.J.A.C. 11:20-6.3 (IHC) and N.J.A.C. 11:21-9.3 (SEH).

ii. In prior filings, SEH Carriers providing benefits for religious exemption employers who qualify for contraceptive coverage exemptions under federal rules were required to include additional language describing the impact of these benefits on the premium and support for any premium adjustment or lack thereof. This language is no longer required since, pursuant to P.L.2019, c.361, there is no longer a religious exemption to contraceptive coverage in New Jersey.

iii. In addition to the information required by the URR process, Carriers must provide the detailed impact of the following items:

1) Cost Sharing Reductions (CSR) Adjustments – For 2021, carriers offering individual plans through the Federally-Facilitated Marketplace (FFM) are directed to submit rates that account for the lack of CSR funding by loading that cost into the premiums for silver metal level plans offered through the Marketplace only.

2) Impact of recently enacted laws and any other recently enacted state or federal mandates.

3) Impact of P.L. 2018 c.32 (Out-of-Network): The savings that result from a reduction in out-of-network claims payments pursuant to P.L. 2018 c.32 as required by C.26:2SS-14 of the act. This amount should be shown as total annual dollar impact and a percent impact to premium in the Actuarial Memorandum.

4) Reinsurance (IHC Only): An Excel template (Exhibit A-1) has been provided to collect this data.
   A. Metrics with the reinsurance program in place (these values should be consistent with the 2021 filing):
      - Annual Average Premium per Member
      - Estimated Number of Total Members
      - Estimated Aggregate Premium
   B. Metrics without the reinsurance program in place:
      - Annual Average Premium per Member
      - Estimated Number of Total Members
      - Estimated Aggregate Premium
   C. Impact of reinsurance on premiums (this should be provided as a percent reduction similar to what was provided in prior years)
   D. Projected Reinsurance Payment Estimate (this should be provided in total dollars for the calendar year)
   E. Assumption changes due to reinsurance (this amount should be shown in two ways, one as the change in the factor and one as a change in the premium)
      - Change in morbidity
      - Change in margins (or approach to setting margins)

- Change in demographics

5) NJ Fee Estimate: The 2021 Budget and Brief discusses creating a state-level health insurer assessment to reclaim revenue previously sent to the federal government. Please submit a table in the Actuarial Memorandum or a supporting exhibit that lists for 2021: plan name, plan HIOS ID, 2021 base rate requested (assuming no fee, this should match the Rate Chart), 2021 base rate assuming a 2% of premium NJ Fee applied, a 2021 base rate assuming a 2.5% of premium NJ Fee applied, and 2021 base rate assuming a 3% of premium NJ Fee applied. Please assume the application of the fee would be similar to the former Health Insurer Fee that was repealed for 2021, but would be assessed as a flat percentage of premium, with no exceptions or adjustments. In addition to submitting this table, please describe any adjustments made to pricing when applying this fee (i.e. if margins or any other changes were made).

iv. Actuarial Summary Worksheet (Exhibit A) – Excel
1) This worksheet includes the necessary fields to calculate both the federal and NJ specific MLR and to facilitate rate review by DOBI.

v. Plan Relativity Worksheet (Exhibit B) – Excel
The plan relativity worksheet must be updated to reflect the AV and cost sharing of the plan benefit design as defined in the URR instruction worksheet 2, section III, line 3.3 "AV and Cost Sharing Design of Plan". These should not contain network adjustment, nor additional benefits to EHB, nor administrative expense impact, and:
1) For new plans, enter "New" in the prior AV column.
2) Plans must be listed in this order:
   A. Descending Metal Levels; and
   B. Ascending Rates within each Metal Level.

vi. Exhibit C - Sample of the notice(s) that will be sent to policyholders to advise them of a rate change, including any adjustments for limits pursuant to N.J.S.A. 17B:27A-3.

vii. Exhibit D – Anticipated distribution by age (and location for SEH).

viii. Reconciliation of the earned premiums and incurred claims shown in Worksheet 1 of the URRT to the 2019 Supplemental Health Care Exhibit.

g. Carrier Specific Rate Chart – Excel

All rate charts must be updated to reflect carrier rate information as of the current effective date.
i. Rates for affiliated carriers must be included in the separate rate filings for the affiliated carriers.
ii. Carriers must not change the content (format, footnotes or footers) on the standardized Excel spreadsheet created by the Department.

Refer to the current rate charts on the Department web site:

https://www.state.nj.us/dobi/division_insurance/ihcseh/ihcrates.htm
https://www.state.nj.us/dobi/division_insurance/ihcseh/sehrates.htm

iii. Columns for footnotes 7 and 8 have been added and this should be populated as applicable.
    1) A second tab has been added to the rate charts for any plan with footnote 8 (not available in all counties), these plans should be listed on the "County availability" tab.
iv. Metal level colors in the standardized Excel spreadsheet must be used for all plans.
v. Plans must be listed in this order:
    1) Descending Metal Levels; and
    2) Ascending Rates within each Metal Level.

h. <u>Table of Contents and Rate Manual</u> – PDF

i. Table of Contents shall include the date of the filing, a list of documents and page numbers.
ii. A Rate Manual.
iii. Do not include the Benefit Summary Tables

7. RATE REVIEW TIMELINE

For annual filings with an effective date of January 1, the Department strives to complete its no later than 08/19/20 to meet the CMS deadline for all rate filing justifications for single risk pool coverage that include a QHP to be in a final status in the URR system.

For quarterly rate filings, our goal is to finalize the filings 90 days prior to the effective date of the rates. However, the actual timing for the review may vary depending on the completeness and accuracy of the filings.

Note: Until the Department receives confirmation from CMS that the QHP Certification Agreements have been signed by the carriers and countersigned by CMS, the annual rates cannot be used for marketing or renewal letters. As soon as the certification confirmation is received from CMS, the rate filings will be closed in SERFF and carriers will receive an email from the Department advising that the annual rates may be used.

SECTION 5: IHC AND SEH DOCUMENTS REQUIRED FOR THE HIOS SYSTEM MODULES

1. HIOS MODULES USED FOR THE RATE FILING AND RATE REVIEW PROCESSES:

a. **Unified Rate Review (URR)**

The URR Module is the repository for rate review documents related to IHC and SEH ACA-compliant Qualified Health Plans (QHPs).

i. Part I URRT and Part III AM (and all referenced exhibits) are required for all rate filings.
ii. Part II Justification is required for all rate filings that meet, or exceed, the "subject to review" plan level threshold of 10% and above, on an annualized basis.

b. **Rate Review Justification (RRJ)**

The RRJ Module is the repository for rate review documents related to Transitional Policies.

i. Part I Rate Increase Summary Form, Part II Written Explanation of the Rate Increase and Part III Rate Filing Documentation are required for all rate filings that meet, or exceed, the "subject to review" product level threshold increase of 10% and above, on an annualized basis.
ii. Parts I, II and III must be filed in SERFF for all Transitional Policies.

c. **Plan Management (PM)**

The PM Module is the repository for all QHP related information, much of which is displayed on www.healthcare.gov. This includes the annual and quarterly rates reported to HIOS PM, by the carriers, on the Federal Rate Table template. This is subject to change when New Jersey is fully transitioned to a state-based exchange platform.

2. SEH QUARTERLY RATE FILING CORRESPONDING CMS FORMS, VIA HIOS OR SERFF PM

a. HIOS Unified Rate Review (URR) Module – Parts I, II, and III

i. The URR Instructions require that updated rate submissions for 2Q, 3Q and 4Q, if filed, must contain rates for each of the remaining quarters – regardless of whether the rates shown for the subsequent quarters have changed from what was previously reported for those quarters in the prior filing.
ii. If updated quarterly rates are submitted, the Part I URRT must reflect, in worksheet 2, line 27, the 'Cumulative Rate Change % (over 12 months prior)' for each renewing plan, as compared to the rates currently on file for the same period of the previous year.

b. **HIOS Rate Review Justification (RRJ) – Parts I, II, and III**

Carriers offering Transitional Policies must submit a Preliminary Justification for all rate increases that meet or exceed the Federal "subject to review threshold", which is at or above 15%. The Preliminary Justification consists of three parts:

i. Part I: URRT
ii. Part II: Justification
iii. Part III: Actuarial Memorandum

c. SERFF Plan Management (PM) Module – Federal Rate Table template

i. Rates on the Rate Table template must match the rates in the HIOS Parts I, II and III.

ii. The rates that the issuer submits via SERFF must be approved by the Department before being submitted to HIOS.
iii. This is subject to change when New Jersey is fully transitioned to a state-based exchange platform.

3. CONSISTENT RATE FILING INFORMATION IN SERFF AND IN HIOS

CMS requires states to verify that all rate information submitted to HIOS (in URR, RRJ and PM) matches the rate information submitted in SERFF. The Department, in turn, requires the carriers to confirm this information in writing, via email, prior to the CMS deadline for all rate filing justifications for single risk pool coverage that include a QHP to be in a final status in the URR system.

SECTION 6: RATE REVIEW FOR SINGLE RISK POOL COMPLIANCE

The carrier is required to provide support that the single risk pools in the New Jersey IHC and SEH markets are established according to the requirement in 45 CFR 156.80. The Department will review such support with respect to the following:

a. Does the claims experience satisfy the requirements in 45 CFR 156.80 (a) – (b)?
b. Does the index rate effective January 1, 2021 satisfy the requirements in 45 CFR 156.80 (d)(1)?
c. Are all permitted plan-level adjustments to the index rate actuarially justified, as required by 45 CFR 156.80 (d)(2)?

With respect to the third bullet above, induced utilization plan-level adjustments will be reviewed by directly comparing the proposed plan-level adjustments to the induced utilization factors found in Table 8 – Cost Sharing Reductions Adjustments in the Proposed HHS Notice of Benefit and Payment Parameters for 2021.

Note: All single risk pool-related support documents must be included within the Part III Actuarial Memorandum tab in SERFF Supporting Documentation.

SECTION 7: STAND-ALONE DENTAL PLANS (SADP) (ACA-COMPLIANT)

1. STATUTES AND REGULATIONS

Insurance N.J.S.A. 17B:26 and N.J.A.C. 11:4-18

2. CORRESPONDING RATE AND FORM SERFF #S

The General Description section of the General Information tab in SERFF must contain the corresponding SERFF # for the related policy forms.

3. ALL ACA COMPLIANT SADP FILINGS (RATE, FORM/RATE, AND FORM) MUST BE SUBMITTED IN SERFF USING ONE OF THE DENTAL TYPES OF INSURANCE (TOI) and THIS SUB-TOI:

Health – Dental ACA

4. DATA ELEMENTS TO BE INCLUDED IN SAPD RATE FILINGS

a. INSURANCE – N.J.A.C. 11:4-18.4-7 Rate submission requirements

i. An actuarial memorandum
ii. In connection with rate revisions only, the aggregate loss ratio, a statement of the reason for the revision, and an estimate of the expected average increase or decrease in premium both in dollars and percent.
iii. Loss ratio standards
iv. Annual review of calendar year experience data on filed individual health insurance policy forms
v. Rate manual

SECTION 8: STUDENT HEALTH PLANS (SHP)

1. STATUTES AND REGULATIONS

SHP Order A16-106: Student Health Plan Rate Review
IHC N.J.S.A. 17B:27A-9 and N.J.A.C. 11:20-6.3 individual health benefits plans

2. REQUIREMENTS FOR ALL STUDENT HEALTH PLANS (SHP)

Carriers are responsible for submitting related SHP policy form filings for each rate filing, in a separate SERFF submission, and for including the policy form SERFF tracking # in the corresponding rate filing submission.

a. SHP RATE FILING DUE DATES

SHP rate filings must be submitted at least 90 days prior to the effective date of the rates.

b. DATA ELEMENTS TO BE INCLUDED IN SHP RATE FILINGS

i. Corresponding Rate and Form SERFF #s
   1) The General Description section of the General Information tab in SERFF must contain the corresponding SERFF # for the related policy forms.
ii. Actuarial Value (AV) Calculator Screen Shots
iii. Part I Rate Increase Summary Form
iv. Part II Written Explanation of the Rate Increase
v. Part III Rate Filing Documentation
vi. Table of Contents and Rate Manual

SECTION 9: CARRIER RATE FILING RESOURCES

https://www.state.nj.us/dobi/division_insurance/ihcseh/program_ihc.htm
https://www.state.nj.us/dobi/division_insurance/ihcseh/program_seh.htm

1. **2021 Rate Filing Requirements**

2. **IHC – Individual**
   a. IHC Age Rating Factors
   b. IHC Rate Chart Template
   c. Exhibit A1 – Reinsurance IHC

3. **SEH – Small Employer**
   a. SEH Age Rating Factors and Territories
   b. SEH Rate Chart Template
   c. Bulletin 20-10: Extended Transition for Certain Health Insurance Policies

4. **IHC and SEH**
   a. Benefit Summary Table
   b. Exhibit A – Actuarial Analysis Worksheet
   c. Exhibit B – Plan Relativity Worksheet
   d. Part II Justification Template
   e. Part III Actuarial Certification Template
   f. Attachment 1 – OON Law
   g. Bulletin 17-05: Implementation of Substance Use Disorder
   h. Bulletin 18-12: Short-Term, Limited Duration Insurance
   i. Bulletin 18-13: Association Health Plans
   j. Bulletin 20-25: Amendment to Minimum Standards for Health Benefits Plans to Facilitate the Availability of Bronze High Deductible Health Plans Effective for Plan Year 2021

5. **SHP – Student**
   a. Order A16-106: Student Health Plan Rate and Form Filings

SECTION 10: DOBI CONTACT INFORMATION

Any questions regarding these requirements should be emailed to *all of the following*:

Seong-min Eom, Chief Actuary (seong-min.eom@dobi.nj.gov) 609-940-7611

Kerline M. Pierre, Analyst (kerline.pierre@dobi.nj.gov) 973-489-4889

Reviewing Actuaries (njratesactuarial@riskreg.com)