Nebraska Department of Insurance
Guidance Document
IGD - - B5

Title: Filing Guidance for Individual and Small Employer Major Medical Plans and Stand-Alone Dental Plans in Nebraska

Issue Date: May 30, 2025

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This guidance document provides guidance for filers of individual, small group, and stand-alone dental plans (SADP), offered on and off the Federal Facilitated Marketplace, that wish to issue or renew plans in Plan Year 2026.

Under the implementation of the Affordable Care Act (ACA), the federal government mandated rules for the rating and review of health insurance and stand-alone dental policies. The following information outlines the Nebraska Department of Insurance (NDOI) filing process and rating requirements allowed under ACA and subsequent regulations issued by the federal government. As in previous years, the NDOI will engage in "marketplace plan management."

The following dates and corresponding actions relate to Plan Year 2026. All dates may be subject to change, the NDOI will attempt to promptly post any revisions when they occur. The table of key dates from CCIIO is available at https://www.qhpcertification.cms.gov/s/Timeline.

Qualified Health Plan (QHP) certification requires all templates. Please see https://www.qhpcertification.cms.gov/s/QHP for more information. The NDOI encourages all issuers to ensure that key staff receive CMS training and review QHP requirements to avoid delays and resubmissions due to missing or incorrect templates.

Date	Action
April 16, 2025	First day that initial QHP Application submissions will be accepted.
June 4, 2025	Last day that issuers are allowed to submit their plan binder(s), templates and forms to the NDOI. This includes all QHP and Non-QHP Major Medical Plans in the Individual or Small Employer Marketplace, whether ON-Marketplace or OFF-Marketplace. Issuers must have HIOS and Carrier ID numbers.

	This includes SADP plans ON-Marketplace and certified OFF-Marketplace. These SADPs must also submit rate filings by this date. OFF-Marketplace only non-certified SADPs are not subject to the ACA, and not subject to this Bulletin. For Major Medical Plans the Rate Filings, Rate Table Template (RTT) and Unified Rate Review Template (URRT) are NOT required to be included as part of this initial submission. See subsequent dates for when these are required to be provided. Issuers should consider filing off-exchange Silver plans.
June 11, 2025	Final day for NDOI to submit QHP plans to CMS.
June 18, 2025	Deadline for all issuers providing major medical coverage that includes a QHP in the Single Risk Pool Market (ON-Marketplace Individual or Small Group) to submit SERFF rate filings and Rate Table Templates (RTTs). Issuers must include the RTT in their SERFF binder. Issuers should submit the URRT in the SERFF rate filing on the "URRT" tab, and in the binder. The URR Module consists of the Part I URRT, the Part II Rate Filing Justification (RFJ) if applicable, and the Part III Actuarial Memorandum. The initial QHP On-Exchange Individual Rate Filings, and proposed rates, should be based upon an assumption that the 2021 American Rescue Plan Extended APTC subsidies will be sunset on December 31, 2025. Please note: while rates and forms are not made public by NDOI until final approval, federal law and CMS activities can preempt Nebraska's approach. Public exposure of some rate information is expected to occur by August 1, 2025, as part of the ACA notice and comment requirement. Issuers may submit plans with expanded de minimis ranges in addition to plans with current de minimis ranges. Once final de minimis ranges are determined, issuers will remove plans to follow the maximum number of allowable plans. In accordance with the CMS FAQ issued May 27, 2025, issuers must specify actual or estimated CSRs paid to enrollees for PY2024. https://regtap.cms.gov/reg_librarye.php?i=5894
July 2, 2025	**Deadline for all issuers providing Single Risk Pool major medical coverage that does not include a QHP to submit SERFF rate filings and rate table templates. This pertains to Individual and Small Group Issuers offering plans that are all strictly OFF-Marketplace.** Issuers must include the RTT in their SERFF binder. Issuers should submit the URRT in the SERFF rate filing on the "URRT" tab, and in the binder. The URR Module consists of the Part I URRT, the Part II Rate Filing Justification (RFJ) if applicable, and the Part III Actuarial Memorandum.

July 30, 2025	Final day for NDOI to submit all proposed rates to CMS for both QHP and Non-QHP plans, ON and OFF Marketplace. Note that there will be opportunities during the QHP certification process for issuers to update, correct, or change the QHP Rate Table Template (as may be necessary). Issuers have the option to submit an alternative rate filing, including separate RDT rates. Alternative plans must be submitted to the NDOI in SERFF by July 30, 2025. This alternative plan would reserve the option to adjust rates for one or both of the following decisions that have yet to be determined: • American Rescue Plan Act Extended APTC subsidies continue • CSR subsidies are funded by the federal government after December 31, 2025 If either or both decisions are made, CMS will open a correction window in September, ending on September 12, 2025, during which time the alternate rate filing would be made active and replace the original rate filing. RDT rates contained in the alternate rate filing would be loaded into the binder to replace the original RDT rates. If a determination is made after September 12, 2025, CMS will need to determine what carriers would be allowed to do. Issuers are not required to submit the alternate rate filing and RDT rates; however, no alternative filings will be accepted after July 30, 2025. If an alternative rate filing is not submitted, it is assumed that the issuer is not interested in making a rate adjustment for changes to the original rate filing for APTC or CSR subsidies for PY2026.
August 1, 2025	CMS intends to publish proposed rate changes for comment. Nebraska will use the federal website for state publication purposes. Public access will be via a link to the rate information at: https://ratereview.healthcare.gov.
August 13, 2025	Final CMS deadline for issuer changes to QHP application. This includes all Individual and Small Employer Major Medical ON-Marketplace plans. Note that CMS requires all rate filings that contain a QHP be finalized by 3:00 p.m. EDT on August 13, 2025.
August 6 to 20, 2025	Issuers complete final plan confirmation, and submit final Plan ID Crosswalk Templates, in MPMS.
September 9, 2025	CMS sends issuers QHP Certification Agreements.
September 17, 2025	Deadline for Issuers to return signed Certification Agreements and Final Plan Crosswalks to CMS. States send CMS final plan recommendations.

	Machine Readable/URL Deadline – Issuers' machine-readable data must be posted, and marketing URLs must be live and active.
September 26, 2025	Final date for NDOI to close all non-QHP only rate filings. Note that all issuers must finalize all rate filings that only contain non-QHPs by October 15, 2025.
September 30, to October 2, 2025	CMS releases certification notices to issuers and states.
November 1, 2025	The target date for NDOI to release all ACA SERFF rate filings to be publicly viewable. Material within the filing that has been accepted as being "Trade Secret" is kept confidential and not publicly viewable.
November 1, 2025	Open enrollment begins. Final rates are published by CMS.
January 2, 2026	Deadline to submit 2nd Quarter 2026 rate adjustments, with rate filings and binders in SERFF for Small Group On and Off-Exchange plans. Also, URRTs must be submitted in SERFF by this date.
February 15, 2026	Deadline for 2nd Quarter 2026 Small Group rate filings to be completed with final RTTs and URRTs transmitted by the NDOI to CMS.
April 1, 2026	Deadline to submit 3rd Quarter 2026 rate adjustments, with rate filings and binders in SERFF for Small Group On and Off-Exchange plans. Also, URRTs must be submitted in SERFF by this date.
May 15, 2026	Deadline for 3rd Quarter 2026 Small Group rate filings to be completed with final RTTs and URRTs transmitted by the NDOI to CMS.
July 1, 2026	Deadline to submit 4th Quarter 2026 rate adjustments, with rate filings and binders in SERFF for Small Group On and Off-Exchange plans. Also, URRTs must be submitted in SERFF by this date.
August 15, 2026	Deadline for 4th Quarter 2026 Small Group rate filings to be completed with final RTTs and URRTs transmitted by the NDOI to CMS.

IMPORTANT: The following form and rate filing requirements are offered to clarify the process. The sequence in which the information is shown is not indicative of the level of importance.

1. The issuer's plans must be certified to participate in the Marketplace. Nebraska's benchmark plan, as determined by the United States Department of Health and Human Services, is the BlueCross BlueShield of Nebraska BluePridePlus, Option 102 Gold.

2. Both ON-Marketplace and OFF-Marketplace plans must be submitted in SERFF Plan Management. The General Instructions for Nebraska in SERFF provide checklists and trade secret protection guidance.

    - All filings are required to be in Binders (including OFF-Marketplace only Health Plans) when entered in SERFF.

    - Individual and Small Group filings must be submitted under separate SERFF tracking numbers.

    - The Binder(s) will include forms, rates (the RTT) and other templates for Individual plans and a separate binder for Small Employer plans. Nebraska's statutory definition of small employer group size is 2 to 50.

    - For major medical plans the final Rate Table Template ("RTT") and Uniform Rate Review Template ("URRT") must be submitted by June 18, 2025, for QHPs, and by July 2, 2025, for non-QHPs. For SADPs the RTT should be submitted with the binder by the June 4, 2025, deadline.

3. All ACA compliant filings should include the NDOI's PY2026 ACA Review Checklist (available in SERFF and on the NDOI L&H webpage), redline versions showing changes from previously approved forms, the Nebraska Filing Form, URRT, Actuarial Memorandum (unredacted and redacted versions), templates, template SBC with Statement of Variability listing benefit levels specific to each plan ID or an SBC for every plan, Readability Certification, Accreditation Certificate, attestations, any Justifications, Access Plan and network maps, URLs for SBCs and provider networks, Federal tool results (you can find the federal tools at: https://www.qhpcertification.cms.gov/s/Review%20Tools) and cover letter information. Each product submitted can only be filed in one SERFF filing, with its corresponding plan documents in that same SERFF filing.

    - **You must run the Federal tools before submitting each template and upload the tool results in the Supporting Documentation tab in the Binder. Templates must include an .xml and .xlsm or .xlsx version.**

    - When submitting documents in SERFF, Insurers should avoid using commas in the documents name. If documents names contain commas, SERFF will not recognize them. Also make sure that the document is saved with the right file name extension.

4. All SADP filers must complete the ACA Pediatric Dental Checklist (available in SERFF and on the NDOI L&H webpage).

5. All Small Group or Individual Health Plan issuers must make available an off-exchange plan to mirror each on-exchange plan submitted.

6. **A separate Summary of Benefits and Coverage must be submitted for each product, with a Statement of Variability listing benefit levels by plan ID. In the alternative, an SBC must be submitted for each plan. SBCs must be filed in the Binder. Similarly, any applications filed in SERFF must be filed in the same filing as the coverage document for which the**

application will be used. Because the SBCs will be in the binder, they do not need to be included in the form filings. Please see https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-41.pdf for a description of the most recent changes to the SBC coverage examples calculator, the guide and narratives for coverage examples, instructions for completing the SBC template, and the SBC template and associated materials.

7. In general, the ACA requirements for Individual and Small Group cannot be added by endorsement, matrix inserts, variables, or amendment rider.

   - Policy forms must meet state requirements, as well as the 2017 ACA benchmark essential health benefits, metal levels, PPACA, and community rating requirements. State benchmark plans are listed on the CMS website at https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb#ehb.

   - Plans must be guaranteed issue and guaranteed renewable, with no pre-existing condition limitations. NDOI allows only limited form variability.

   - Each metal level of Platinum (90% AV), Gold (80% AV), Silver (70% AV), or Bronze (60% AV) should have a separate non-variable schedule with a unique form number.

   - Please note that each FFM issuer must offer a Silver plan statewide and a Gold plan statewide. The Platinum and Bronze levels are optional.

8. Network Adequacy review requires insurers to submit an Access Plan (template available on the NDOI website, under the Insurers tab, under Life and Health), along with maps showing locations of hospitals, primary care providers, specialists, behavioral health inpatient and outpatient, and a URL to the provider directory.

9. Individual Catastrophic plans are for under age 30 and are optional.

10. Issuers will maintain a single statewide risk pool for each of their non-grandfathered individual and small group markets.

11. Rating territories are limited to no greater than four in the state, determined by three-digit zip codes for the Small Employer market, and determined by Counties for the Individual market.

12. No application may contain health questions, although questions determining tobacco use, age, and gender, may be asked.

13. No Binders will be accepted after June 4, 2025. Except for small group quarterly rate filing adjustment requests, rates and forms may only be filed once per year.

14. MHPAEA compliance review includes Financial Requirements (FR), Quantitative Treatment Limitations (QTL) and a self-evaluation for Non-Quantitative Treatment Limitations (NQTLs). **Issuers must complete the Self-Compliance Tool** found at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf which provides a template for insurer evaluation of

benefits for MHPAEA compliance, and is reflected in the NAIC Market Regulation Handbook Chapter 24B. If parity concerns are flagged during review, a SERFF objection describing the potential violation will be transmitted, and the filer will have an opportunity to re-evaluate the provision and either make a plan correction or explain to the NDOI the reason the provision does not violate MPHAEA.

Issuers must also complete the FR/QTL and NQTL templates provided NDOI L&H webpage, under the Insurers tab, under Life and Health to demonstrate MHPAEA compliance. Filers may find it efficient to complete these tables during pre-filing compliance checks, to avoid delays during review of filed plans. **Please submit the FR/QTL template in excel file format with open formulas. Please also include an actuarial memorandum certifying MHPAEA documentation in the SERFF binder.**

15. Requests for trade secret protection should be submitted using the trade secret request template found in the Attachments list at the bottom of Nebraska's General Instructions in SERFF and on the NDOI L&H webpage. All information is considered Public unless a valid Trade Secret request has been properly submitted within the rate filing.

16. The NDOI will work with carriers and their rate submissions during the period of time allotted under this Guidance Document and CMS guidelines. Insurers are encouraged to submit early and will be served on a first come, first served basis.

Uniform Rate Review Module (URR) Filings:

17. For Individual and Small Employer major medical health plans Issuers are required to submit the following URR components in SERFF under the new "URRT" tab:

    - Part 1 – Uniform Rate Review Template (URRT).
    - Part 2 – Rate Increase Justification. Is only provided if any plan within a product in the filing is receiving a rate increase of 15% or greater.
    - Part 3 – Actuarial Memorandum Un-redacted version, and optional Redacted version.

Submission of RATEE Files by May 1st to Support Early Risk Adjustment Calculations:

18. For Individual and Small Employer major medical health plans Issuers are required to submit their RATEE (Risk Adjustment Transfer Elements Extract) Report final submission files directly to the NE DOI by May 5th, 2025. This should include Nebraska Individual and Small Employer market RATEE Reports. These are the same files as provided to Issuers from the HHS EDGE Data process supporting Risk Adjustment Transfer calculations. The Department will proceed to perform an early Risk Adjustment Transfer calculation to be completed with an expected date between May 8th and May 15th. The Department will subsequently send each Nebraska ACA Carrier their own specific calculated PY2024 Risk Transfer amounts, along with the overall market risk score.

Off-Exchange Silver Plans

19. Due to the uncertainty of CSR funding by the federal government, issuers should consider submitting unloaded plans that are available exclusively outside the Exchange included in submission of all appropriate Binders.

Guidelines for the Development of "Actuarial Value and Cost Sharing Design" of Each Plan:

URRT Wksh 2, Sec. 3, line 3.3: "AV and Cost Sharing Design of the Plan"

- Each specific Plan has an "AV and Cost Sharing Design of the Plan" associated with it, more informally referred to as the plan's "Benefit Factor". This factor is one of the 5 Plan Level Adjustments allowed in CMS 45 CFR 156.80 rating development to adjust an issuer's MAIR (Market Adjusted Index Rate) to reflect the impact of the specific cost sharing of the plan, including Unit Cost and Utilization adjustments.

- The Benefit Factor for each plan must be developed to meet the "Single Risk Pool" rating requirements of the ACA. Benefit Factors must not reflect the differences in morbidity between members expected to enroll in each plan, and each Benefit Factor should be developed assuming that the same standard population of members is enrolled on every Plan design.

- CMS has delegated to each state's effective rate review function the responsibility for determining how the Cost Sharing Reduction (CSR) benefit costs should be applied in ACA Individual rate setting within that state. The following guidelines are being posted to inform issuers as to what would be considered the acceptable standard for developing and filing Benefit Factors in plan year 2024 Nebraska ACA Individual rate filings.

    - Issuers may set their own CSR rating adjustments if they do not deviate from the standards below. The NDOI does not establish a minimum CSR load factor and will not set a uniform CSR load factor for all issuers to use as some states have done. The NDOI has determined that applying such a uniform factor will likely never accurately reflect the correct value for any specific issuer. Issuers should utilize their own experience or other credible data when setting benefit factors, CSR Loads, Induced Demand Factors or other unit cost and utilization adjustments.

    - Issuers may apply formal Induced Demand Factors, or make appropriate utilization adjustments, if they meet the ACA Single Risk Pool rating requirements. Expected utilization differences due to member's health status, income levels, or other member case characteristics may NOT be reflected in Induced Demand Factors or other utilization adjustments used to develop the benefit factors.

    - Issuers may maintain **Actuarial Soundness** of their Index Rate by adjusting for the impacts of morbidity, reduced utilizations due to low-income members, and other causes by using the index rate adjustments listed below. As such, Silver Plan rates should not be adjusted independently to reflect lower utilizations due to more low-income members enrolling on 87% and 94% Silver Plan variants.

        - URRT Wksh 1, Sec. 2: "Morbidity Adjustment".

        - URRT Wksh 1, Sec. 2: “Other” Adjustment.

    - Issuers should assume expected distributions of members among their Silver Plan variants that reflects the most likely distribution that will occur. Simply assuming that all members will be enrolled on the 87% and 94% Silver Plan variants is not accepted as the standard method, though may be accepted if the issuer demonstrates it is the most likely distribution to occur. Utilizing Nebraska PUF enrollment data from the recent plan year’s enrollment among the standard Silver Plan, and the 73%, 87% and 94% variants, may provide a realistic distribution of membership to assume, given that the environment has not changed from the current year to the projected year (ARPA subsidies remain in place, etc.).

Minimum Required Contents of Nebraska ACA Major Medical Rate Filings:

ACA Major Medical rate filings should contain at a minimum the following items:

- A cover letter outlining the rate action being taken, comments on key plan changes.

- An authorization letter if an outside organization will be submitting the rate filing on behalf of the issuer.

- The Federal Uniform Rate Review (URR) Module, which includes the following:

    - Part 1 URRT
    - Part 2 Rate Increase Justification (if applicable)
    - Part 3 Actuarial Memorandum; an un-redacted version must be submitted, and a redacted version may be submitted. Note that Nebraska applies different requirements regarding items allowed to be Trade Secret than what is allowed to be redacted in the Federal Memorandum.

- In the Part 1 URRT spreadsheet the NDOI requests that all issuers complete the “Current Enrollment” line on Worksheet 2, Section 2, using enrollment as of June 1, 2025. If enrollment as of this date is not yet available at time of filing, then indicate the most recent date that you did have available and have used but note that you will be requested to update the URRT during rate filing review when this enrollment data as of June 1, 2025, becomes available.

- Issuers with 2024 ACA experience must also enter this data into the URRT spreadsheet on Worksheet 1, Section 1.

- Issuers may provide an alternate rate development for 2026 using experience other than their own ACA 2024 experience if they deem their 2024 experience to be less than 100% credible. Alternative experience should be provided and documented elsewhere in the Actuarial Memorandum and entered as the projected Manual EHB Allowed Claims PMPM in Section 2.

- A Rate Manual to be provided under the Rate / Rule Schedule tab containing at least the “Base Rates” and all rating factors that are applied to the Base Rates to determine any policyholder’s rates (Age rating factors, Area rating factors, Benefit factors / AV Pricing factors).

- Base Rates are defined to be the calibrated Plan Adjusted Index Rates to which each allowable consumer level rating adjustment is applied to obtain the Consumer Adjusted Premium Rates. Consumer level rating adjustments are Age factors, Geographic Area factors, Tobacco factors, Family Structure rating.

- The Nebraska Rate Table Spreadsheet.

    - Note: this is not the RTT (RDT) which is only expected to be included in the binder and not required to be included in the rate filing. The RTT should NOT be used to replace the Rate Manual under the SERFF Rate / Rule Schedule tab. The one exception is that if an issuer submits the Alternate rate filing by July 16, 2025, to adjust rates if ARP Extended APTC subsidies are continued for PY2026, then the alternate RDT rates should be included in that Alternate rate filing to allow for review.

- Actuarial Value (AV) Calculation sheets for each plan, and an Actuarial Attestation that AVs were calculated using accepted methods.

- A complete Actuarial Memorandum with development of rates including a projection calculation demonstrating how 2026 projected claims, premium and membership were developed and illustrating how all trend and projection factors were applied to base experience.

    - Note that the Federal URRT and its supporting Part III Actuarial Memorandum are not required to be the official rate development used to set rates. If the Un-redacted Part III Actuarial Memorandum completely describes the rate setting method with detailed support for how all base rates and rating adjustments were developed and applied, then this may be used to satisfy this requirement.

- Within the rate filing, carriers must delineate their broker commission schedules for the upcoming calendar year. The schedules must not distinguish between special enrollments or open enrollments or any other factor that could be related to health status such as metal level, age, family size, etc. As commissions are a key component of the rate development, changes to the schedules for individual and small group health benefit plans should largely align with the calendar year rate setting process. Commission schedule changes must be submitted to the NDOI General Counsel and Deputy Director at least 90 days prior to implementation and may not be accepted without clear justification as to why the change cannot be postponed until the next calendar year. If approval is granted, the revised commission schedule must be added to the affected SERFF rate filing.

- A Trade Secret request if the company will be requesting any documents to be kept confidential once the filing is released publicly. The NDOI has posted a Nebraska SERFF Rate Filing Guideline with instructions for requesting Trade Secret protection for any item. The process for requesting trade secret protection through SERFF is available online at: https://doi.nebraska.gov/sites/default/files/doc/Trade%20Secret%20Request%20Template%2C%20Major%20Medical.pdf

    - The Trade Secret Request Template should be followed when submitting requests for Trade Secret handling of filing material. The format indicated in this template must be followed.

- The Standard Rate Filing Form Listing.

- Completed SERFF information tabs as required by NDOI.

Additional Requirement for What Needs to Be Provided as Rate Filing Support:

Transparency of Benefit Factors.

The NDOI is requiring a Public Summary sheet of CSR Loads and Benefit Factors as outlined below. Additionally, the NDOI is requiring CSR Load and Benefit Factor development to be included in issuer's Individual Market rate filings.

(1) Required Individual Market Public Summary Sheet for CSR Loads and Benefit Factors.

This requirement applies to Individual On-Exchange Plans excluding Catastrophic Plans.

Issuers should provide a single Excel sheet in their annual SERFF rate filing containing the following columns of information which will be made Public when NE SERFF rate filings become Public on November 1st, 2025.

- HIOS Plan ID Number
- Metal Level
- AV Factor
- Benefit Factor (The AV Pricing & Cost Sharing Factor)
- Provider Network Adjustment
- CSR Load for Silver Plans, or 1.0 for all Non-Silver Plans
- Induced Demand Factor (plan aggregate for all services)

(2) Required Supporting Development of Benefit Factors and CSR Loads:

This requirement applies to Individual On-Exchange Plans and is not required to be made Public if the issuer submits a valid Trade-Secret Request within the rate filing.

(a) Issuers should provide a high-level summary of the data used for setting Benefit Factors, including:

- Incurred claim dates
- Paid claim dates
- Lines of business, States, other Geographic factors
- Incurred Claims and Member Months by Calendar Year, summarized by each major service category (Similar to those used in URRT Worksheet 1, section 1).

Note this should summarize the data used to set benefit factors, whether it was from the company's own ACA Individual business, a consultant's health cost guidelines, National Group Business, etc.

(b) At the time of submitting the rate filing, Issuers should provide their complete detailed development of Benefit Factors for each of the following:

Plans with the lowest and highest Benefit Factor within each of the following Metal Levels:

- Bronze & Enhanced Bronze Plans
- Silver Plans
- Gold Plans
- Platinum Plans

(c) For each of the Plans indicated in (2b) above, the complete detailed Benefit Factor development should be included, showing the development from the underlying base experience by service category, including all adjustments or modeling applied to arrive at the final benefit factors. The level of service category included in the supporting development should reflect the level at which benefit factors are developed. This may be at a High-Level Service Category (Inpatient, Outpatient, Physician, Pharmacy, etc.) or at more refined levels if utilization and unit cost adjustments are applied at a more granular level.

(d) Identify all utilization and unit cost adjustments that have been applied at any step in the process to obtain the final estimated benefit cost factor in the new benefit period. A description and quantitative support should be provided for each adjustment.

Demonstrate how Induced Demand Factors (IDF) or other specific Utilization adjustments were determined and show how they are applied.

For provider contracting changes in the new plan year that result in adjustments to your unit cost assumptions, those adjustments should be documented and quantified.

(e) For On-Exchange Silver Plans the complete development of the CSR Load should be provided, and should include at least the following:

- Membership distribution assumptions used for enrollment in Base Silver, 73%, 87% and 94% Silver plan variants
- Data source used to determine the distribution (i.e. NE PUF Enrollment Data, Issuer's own experience, or other source)
- Membership adjustments made to the source data
- Utilization adjustments, including a description of any adjustments

(f) Issuers utilizing predictive models, such as GLMs, GAMs or other such predictive models, must provide the required support contained on the NDOI L&H webpage. Any other simulation models, or other models used in the process of setting benefit factors, need to be fully documented.

Please direct any questions regarding this guidance document to the Life and Health Division at 402- 471-2201.