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2026 Rate Filing Requirements

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SECTION 1: RATE AND REPORTING SUBMISSION DUE DATES

Filing Type	Period	Due Date
IHC	2025 Annual	6/4/2025
SEH *(Quarterly filings are due 105 days prior to effective date)*	4Q2024 Quarterly	6/18/2025
	2025 Annual	6/4/2025
	2Q2025 Quarterly	12/17/2025
	3Q2025 Quarterly	3/18/2026
	4Q2025 Quarterly	6/18/2026
SADP EHB-compliant	2025 Annual	6/11/2025
SHP	2024-25 School Year	90 days prior to the earliest effective date
OON Law Report	6/1/2023-5/31/2024	8/31/25

SECTION 2: 2026 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 March 23, 2022 memorandum from CMS. Carriers should check for guidance prior to filing for transitional plans.

2. IHC Reinsurance

2026 IHC Reinsurance parameters are: 50% coinsurance rate; $35,000 attachment point, and $270,000 reinsurance cap. The Department expects each carrier to reduce their rates in the individual market by at least 15.5% 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 2026 annual rates and include "Exhibit A1 – NJ Reinsurance IHC Worksheet" provided on the Department's website. Further detail is provided in the Actuarial Memorandum instructions section.

3. 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.

4. IHC Off-Exchange Silver Plans

Consistent with May 2, 2025 guidance from CMS, carriers are required to offer at least one off-Exchange Silver plan that would be unaffected by the CSR Load.

5. IHC Market Fee

Effective 1/1/2021, an IHC market fee of 3.5% is applied to all business (regardless of whether it is sold On- or Off-Exchange). This fee is unchanged in 2026.

6. Health Insurer Assessment

As provided in Bulletin 21-06, and pursuant to N.J.S.A. 17B:27A-65 to -67, IHC and certain Dental carriers will be assessed 2.5% of net written premiums annually.

7. New Jersey Health Plan Savings

New Jersey state subsidies were added in plan year 2021.

The state subsidies were revised with the introduction of the American Rescue Plan Act (ARPA). The Inflation Reduction Act extended the enhanced subsidies from the ARPA through 2025.

Under current federal law, the enhanced subsidies are due to expire at the end of 2025. Therefore, carrier rate filings should assume that the enhanced subsidies are not extended for 2026. However, at the time of this guidance, it is unclear whether the enhanced federal subsidies will be extended into 2026. To be prepared in the event the federal government acts to extend the enhanced subsidies, carriers should also submit rate filing documentation assuming that the enhanced federal subsidies are continued for 2026. Additional information is noted in Section 4 of this document.

With regard to New Jersey Health Plan Savings, carriers are to assume that, if the enhanced federal subsidies expire at the end of 2025, the state subsidy amounts would revert to the subsidy amounts that were in place pre-ARPA, as shown in the table below. In the event that the enhanced subsidies are extended for 2026, carriers are to assume the state subsidy will be unchanged from the 2025 state subsidy amounts. The assumptions for 2026 state subsidy amounts, are as follows:

State Subsidies		
Federal Poverty Level Range	**2026 State Subsidy Amounts (Enhanced federal subsidies not extended)**	**2026 State Subsidy Amounts (Enhanced federal subsidies extended)**
Less than 150% FPL	$0	$20
At least 150% FPL but less than 200% FPL	$30	$40
At least 200% FPL but less than 250% FPL	$40	$50
At least 250% FPL but less than 400% FPL	$95	$100
At least 400% FPL but less than 450% FPL	$0	$50
At least 450% FPL but less than 500% FPL	$0	$50
At least 500% FPL but less than 550% FPL	$0	$50
At least 550% FPL but less than or equal to 600% FPL	$0	$50
Above 600% FPL	$0	$0

8. Compliance with the Small Business Health Insurance Affordability Act

In 2023, the state enacted legislation affecting the IHC and SEH, P.L. 2023, c. 194 (S3480): The Small Business Health Insurance Affordability Act. NJDOBI expects each carrier to review the law and ensure that its PY 2026 filing is compliant with the law. The law includes requirements related to standard plan offerings, benefit cost sharing, pharmacy formularies, and other items that impact benefit design and premium rates. See also Department Bulletin No. 24-08.

9. IHC and SEH Statewide Availability

Note that it is expected that any carrier that is not currently writing in all counties in New Jersey will work toward, and take such steps as are necessary to, expand Statewide as soon as practicable. To the extent a carrier is not offering plans in a specific county, a justification shall be provided that contains a reasonable basis for not offering plans in that county and a plan to offer plans in the county as soon as practicable.

10. Quality Improvement and Cost Containment Strategies

Note that it is expected that carriers will incorporate into their PY 2026 plan designs strategies and elements to promote the use of primary and preventative care, implement quality improvement initiatives, and promote quality of care and improved outcomes, with any resulting cost savings being used to reduce premium rates. It is expected that all such strategies and elements will be designed in a manner that maintains or improves quality while preserving or improving upon patient safety and outcomes. Carriers shall include an overview of all such plan design elements and strategies, along with the projected impact of those elements and strategies on costs and premium rates both in PY 2026 and in successive plan years.

SECTION 3: RATE FILING STANDARDS FOR ALL RATE FILINGS

1. SERFF Rate Filing Submissions

a. Carriers should continue to use the URRT tab which feeds directly to HIOS. Questions related to the SERFF submission process should be submitted to the SERFF help desk.
b. 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.
c. All documents are to be uploaded within the appropriate Supporting Documentation tab.
d. Do not 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 yellow and every page shall be dated 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 2026 base rate increase averaged across all renewing plans. For SEH, this should be the 2026 base rate increase for the quarter (for example Q1 2025 to Q1 2026) averaged across all renewing plans. The average should be calculated using current total premium (i.e. the same calculation that is used in URRT 6.0 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 6.0 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 6.0 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)

i. Number of Covered Lives: This should be the current members from URRT 6.0 worksheet 2, section II, line 2.10.

ii. Trend factor: Listed the annualized trend used in the filing separately for Medical and Pharmacy.

iii. 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 6.0 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.

iv. Prior Rate:

1) Total Earned Premium: This should reflect the latest projection of 2025 premium used to set 2026 pricing.

2) Total Incurred Claims: This should reflect the latest projection of 2025 claims used to set 2026 pricing.

3) Annualized PMPM: These should be the 2025 plan base rates weighted by the latest estimate of current 2025 enrollment.

v. Requested Rate:

1) Projected Earned Premium: This should be the total projected premium from URRT 6.0 worksheet 2, section IV, line 4.8.

2) Projected Incurred Claims: This should be the total projected incurred claims from URRT 6.0, worksheet 2, section IV, line 4.6.

3) Annualized PMPM: This should be the plan base rates from URRT 6.0 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: INDIVIDUAL (IHC) AND SMALL GROUP (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

NJ will continue to review for rate increases at or above 10%. A Part II Justification must be submitted if any plan's renewal increase is 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.

5. SEH Territories

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

6. SEH Introductions 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.

7. Data Elements to Be Included in IHC and SEH Rate Filings

a. 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.

b. 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. The documentation submitted with the rate filing must be consistent with the documentation submitted in Plan Management.

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 using the template provided by DOBI, see section 6.e.vii., 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.

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

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

d. 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 2026, 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., 2026 annual vs 2025 annual, 2Q26 vs 2Q25, 3Q26 vs 3Q25, 4Q26 vs 4Q25), 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.

e. Part III Actuarial Memorandum (AM) and Certification (45 CFR 154.215) – PDF, template provided for the Certification, AM should follow URR instructions with the following additions:

For the 2026 plan year IHC filings, two set of filing documentation should be submitted. The first set should reflect that the enhanced federal subsidies are not continued and that the state subsidies are as outlined in the table in Section 2.7. The first set of documentation is the primary filing documents and should be loaded into the SERFF URR tab. The second set of filing documentation should be submitted under supporting documentation and reflect that the expanded federal subsidies are continued in addition to the existing state subsidies. Please submit both a clean version and a redlined version (marking changes from the first set) of the second set of filing documents. Because of uncertainty in federal policies regarding subsidies, carriers should be prepared for the Department to use either set of rates, with expanded subsidies and without, at any time before the open enrollment period. Carriers should also be aware that these rate instructions may be updated at any time in response to federal law and/or policy changes or other developments occurring after the date these Requirements are issued.

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

ii. 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 2026, carriers offering individual plans through the State-Based Exchange (SBE) are directed to submit rates that account for the lack of CSR funding by loading that cost into the premiums both for silver metal level plans offered through the Marketplace and for the same silver metal level plans when offered outside of the marketplace.

2) Impact of P.L. 2018 c. 32 (Out-of-Network): The savings that result from a reduction in out-of-network claims payments, as required pursuant to section 14 of P.L. 2018 c. 32 (C.26:2SS-14). This amount should be shown as total annual dollar impact and a percent impact to premium in the Actuarial Memorandum. The savings should reflect the difference between the actual premium and the expected premium without P.L. 2018, c. 32.

3) Reinsurance (IHC Only): An Excel template (Exhibit A-1) has been provided to collect this data.
   A. Metrics with the reinsurance program in place:
      - 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

4) Formularies (SEH filings only): If the carrier uses a formulary to limit or exclude coverage for prescription drugs, the carrier should provide the number of closed and open formularies included in the carrier's plan offerings and state the expected effect of the formulary on cost, utilization, and pricing as compared with the plan offering that uses an open formulary.

5) Broker Commissions: Carriers should specify the projected commissions with commission amount and commission structure in the actuarial memorandum or supporting exhibits. Carriers should comment on any changes in the commissions amount or structure compared with the prior filing and from the experience period, if applicable.

6) Child(ren)-Only Rating Methodology (for IHC filings only): Include a description of the methodology used to calculate child(ren)-only rates (i.e., when there is no adult subscriber). The methodology should document that the premium is capped at the sum of the premiums for three children. The underlying rates should match the base rates in the rate chart.

7) The filing should confirm that all plans cover all mandated benefits.

8) Risk Adjustment Data Validation (RADV): RADV estimates can be included in 2026 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.

9) Impact of the Change in MLR Formula: P.L.2024, c.62 revised how loss ratios are calculated under N.J.S.A.17B:27A-9 and 17B:27A-25 to provide that the prior year's MLR be calculated using a rolling three-year average, including a three-month runout through the first quarter of the subsequent year, and the data for the two years immediately preceding, the reporting year. Carriers must include the prospective MLR under the new formula and the old formula. Carriers must also include the pricing impact of the MLR change as an item in the AM or supporting exhibit.

10) P.L.2023, c.107 establishes greater oversight of pharmacy benefit managers (PBMs). Specifically, section 9 of P.L.2023, c.107 (C.17B:27F-3.4) requires carriers to submit, with any rate filing that provides coverage for prescription drugs or pharmacy services that is administered by a PBM, a memorandum prepared by a qualified actuary describing the calculation of the PBM's compensation. "Pharmacy benefits manager compensation" is defined to mean "the difference between: (1) the amount of payments made by a carrier of a health benefits plan to its pharmacy benefits manager; and (2) the value of payments made by the pharmacy benefits manager to dispensing pharmacists for the provision of prescription drugs or pharmacy services with regard to pharmacy benefits covered by the health benefits plan." The PBM compensation is required to be reflected in the projected medical loss ratio for the carrier as an administrative cost and not as a benefit provided under the health

benefits plan. The carrier may only claim amounts paid by the PBM to pharmacies or pharmacists as incurred claims. DOBI may request supplementary data submissions to support the review and validation of the submitted memoranda.

11) Additionally, section 6 of P.L.2023, c.107 (C.17B:27F-3.2) requires that certain rebates be used to lower premiums and out-of-pocket costs for consumers. Provide the estimated premium impact and support for the premium impact associated with C.17B:27F-3.2.

12) Impact of plan design elements that promote the use of primary and preventative care, quality improvement initiatives, and cost containment strategies, including projected effect of cost savings on premium rates in current, succeeding, and subsequent plan years. Specifically, provide details as to how the elements outlined in Exhibit F contribute to primary care utilization and quality improvements, as well as their effect on overall spend and how they contribute to cost containment.

iii. Actuarial Summary Worksheet (Exhibit A) – Excel

This worksheet includes the necessary fields to calculate both the federal and NJ specific MLR and to facilitate rate review by DOBI.

iv. 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. For new plans, enter "New" in the prior AV column. Plans must be listed in this order:

A. Descending Metal Levels; and
B. Ascending Rates within each Metal Level.

v. 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.

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

vii. Exhibit E – Demonstration of Copay Compliance for copay limits pursuant to N.J.A.C. 11:22-5.5(a)11.

viii. Exhibit F - Carriers must report in detail the cost drivers underlying medical trend, including the aggregate amount of spending on primary care services, behavioral health, and retail pharmacy.

ix. Reconciliation of the earned premiums and incurred claims shown in Worksheet 1 of the URRT to the 2023 Supplemental Health Care Exhibit.

f. 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 each affiliated carrier.

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 these should be populated as applicable. 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.

g. Table of Contents and Rate Manual – PDF

Table of Contents shall include the date of the filing, a list of documents and page numbers.

i. A Rate Manual.
ii. Do not include the Benefit Summary Tables.

8. Rate Review Timeline

For annual filings with an effective date of January 1, the Department strives to complete its review no later than 8/13/2025 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.

The Department may request additional information in connection with the Plan Year 2026 rate filings, and may supplement these Rate Filing Requirements, in response to changes in federal law or other developments occurring after the date these Requirements are issued.

Note: Until the QHP Certification Agreements have been signed by the carriers and countersigned by Get Covered New Jersey (GetCoveredNJ), the annual rates cannot be used for marketing or renewal letters. As soon as the certification confirmation is received from GetCoveredNJ, 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). This data is transferred directly from the SERFF URR tab.

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 GetCoveredNJ.

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 10%. The Preliminary Justification consists of three parts:

i. Part I: Rate Increase Summary Form
ii. Part II: Written Explanation of the Rate Increase
iii. Part III: Rate Filing Documentation (not required in NJ – only required when CMS is conducting the rate review)

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

i. Rates on the Rate Table template must match the rates in the Rate review.
ii. If the rates are revised during the review process, the Rate Table Template must be consistently revised in the Plan Management.

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, including review of plans offered both on and off the GetCovered New Jersey exchange. The Department will review such support with respect to the following:

- Does the claims experience satisfy the requirements in 45 CFR 156.80 (a) – (b)?
- Does the index rate effective January 1, 2026 satisfy the requirements in 45 CFR 156.80 (d)(1)?
- Are all permitted plan-level adjustments to the index rate actuarially justified, as required by 45CFR 156.80 (d)(2)?

With respect to the third bullet above, cost sharing reduction loads will be compared to those in *TABLE 7 – CSR ADJUSTMENT FACTORS FOR THE 2025 BENEFIT YEAR AND BEYOND* in the Final HHS Notice of Benefit and Payment Parameters for 2025.

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

The 2026 Final Letter to Issuers in the Federally-facilitated Exchanges states that the maximum annual limitation on cost sharing (Maximum Out of Pocket or MOOP) for SADP is $450 for one child and $900 for two or more children.

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 SADP Rate Filings

a. INSURANCE – N.J.A.C. 11:4-18.4 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. 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.

3. 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. **2026 Rate Filing Requirements**

2. **IHC - Individual**
   a. IHC Age Rating Factors
   b. IHC Rate Chart Template
   c. Exhibit A1 – Reinsurance IHC
   d. Bulletin 21-06: Health Insurance Affordability Fund Assessment Collection Pursuant to N.J.S.A. 17B:27A-65 to -67
   e. Bulletin 23-07: Amendments to HINT Non-Group Enrollment/Change Request Form
   f. Bulletin 24-02: New Jersey Easy Enrollment Health Insurance Program Special Enrollment Period
   g. Bulletin 24-12: Extension of Easy Enroll Program Special Enrollment Period
   h. Bulletin 24-15: Amendments to HINT Non-Group Enrollment/Change Request Form

3. **SEH – Small Employer**
   a. SEH Age Rating Factors and Territories
   b. SEH Rate Chart Template
   c. Bulletin 24-08: Rate Filing and Small Business Health Insurance Affordability Act

4. **IHC and SEH**
   a. Benefit Summary Table
   b. Exhibit A – Actuarial Analysis Worksheet
   c. Exhibit B – Plan Relativity Worksheet
   d. Exhibit E – Demonstration of Copay Compliance
   e. Part II Justification Template
   f. Part III Actuarial Certification Template
   g. Attachment 1 – OON Law
   h. Bulletin 17-05: Implementation of Substance Use Disorder
   i. Bulletin 18-12: Short-Term, Limited Duration Insurance
   j. Bulletin 18-13: Association Health Plans
   k. 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
   l. Bulletin 21-14 Implementation of the Federal No Surprises Act
   m. P.L. 2008, c. 126 Coverage of Hearing Aids. As required by §156.125(a), the age limit for this benefit was removed beginning with plan year 2023. P.L.2008, c.126 was later amended by P.L. 2023, c. 275 to remove age and dollar limits from the coverage requirement.
   n. Bulletin 23-02: Special Enrollment Period for Medicaid Unwinding
   o. P.L. 2023, c. 105: Requires health insurance carriers to provide coverage for epinephrine auto-injector devices and asthma inhalers; limits cost sharing for health insurance coverage of insulin
   p. P.L. 2023, c. 194: The Small Business Health Insurance Affordability Act
   q. Bulletin 23-05: Nondiscriminatory Coverage for Health Services Provided to Transgender Individuals
   r. Bulletin 24-04: Cyber Incident – Change Healthcare

s. Bulletin 24-14: Coverage for Mental Health Conditions and Substance Use Disorders, Implementation of P.L. 2019, c. 58 and P.L. 2022, c. 33
t. Bulletin 24-16: Coverage for Hearing Aids and Cochlear Implants (P.L. 2023, c. 275) and Maximum Cost Sharing for Treatment of Diabetes, Epinephrine Auto-Injector Devices, and Asthma Inhalers
u. Bulletin 24-17: Ensuring Transparency in Prior Authorization Act (P.L. 2023, C.296)
v. Bulletin 24-18: Carrier, Pharmacy Benefit Manager, and Pharmacy Services Administrative Organization Compliance with P.L. 2023, c.107, Pharmacy Benefits Managers
w. Bulletin 25-01: Coverage for HIV Pre-Exposure Prophylaxis
x. Bulletin 25-03: The Use of Artificial Intelligence Systems in Insurance

5. SHP – Student

a. Order A16-106: Student Health Plan Rate and Form Filings

SECTION 10: OUT-OF-NETWORK (OON) LAW REPORTING REQUIREMENTS

In addition to requiring that savings reductions be submitted with each rate filing, the "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act," P.L. 2018 c. 32, requires, under N.J.S.A. 26:2SS-12(e), that the following information be compiled and made available on the NJDOBI website: "Annual trends on health benefits plan premium rates, total annual amount of spending on inadvertent and emergency out-of-network costs by carriers, and medical loss ratios in the State to the extent that the information is available."

NJDOBI has created a template to collect the required information.

This template should be populated and submitted in SERFF as a ML02 Multi-Line – Other TOI and OON Experience Report Sub-TOI.

This template is required for all IHC, SEH, and Large Group carriers, MEWAs, and most dental carriers. The completed template is due 8/31/2025.

SECTION 11: 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)
- Reviewing Actuaries (njratesactuarial@riskreg.com)

APPENDIX A: Rate Filing Checklist SADP

Status	Item	Comments
☐	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.	
☐	All documents are to be uploaded within the appropriate Supporting Documentation tab in SERFF.	
☐	Do not create new tabs under Supporting Documentation in SERFF	
☐	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.	
☐	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.	
☐	When revisions are made to a document, the revised text must be highlighted in yellow and every page shall be dated with the revision date.	
☐	Carriers must respond to Objection Letters created by the Department within the Objection Letter, not within the Supporting Documentation tab.	
☐	The General Description section of the General Information tab in SERFF must contain the corresponding SERFF # for the related policy forms.	
☐	An actuarial memorandum including	
☐	• 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.	

☐	• Loss ratio projections.	
☐	• Support for key pricing assumptions including morbidity and trend.	
☐	Complete rate manual.	

APPENDIX B: Rate Filing Checklist SHP

Status	Item	Comments
☐	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.	
☐	All documents are to be uploaded within the appropriate Supporting Documentation tab in SERFF.	
☐	Do not create new tabs under Supporting Documentation in SERFF	
☐	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.	
☐	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.	
☐	When revisions are made to a document, the revised text must be highlighted in yellow and every page shall be dated with the revision date.	
☐	Carriers must respond to Objection Letters created by the Department within the Objection Letter, not within the Supporting Documentation tab.	
☐	The General Description section of the General Information tab in SERFF must contain the corresponding SERFF # for the related policy forms.	
☐	Actuarial Value (AV) Calculator Screen Shots.	
☐	Part I Rate Increase Summary Form.	
☐	Part II Written Explanation of the Rate Increase.	
☐	Part III Rate Filing Documentation including detailed support for:	
	• Claim experience	
	• Benefit relativities	

☐	• Enrollment assumptions	
☐	• Morbidity assumptions	
☐	• Administrative expense assumptions	
☐	• Profit and risk margin assumptions	
☐	• Taxes and fees assumptions	
☐	Table of Contents and Rate Manual.	

APPENDIX C: Rate Filing Checklist IHC

Status	Item	Comments
☐	Carriers should continue to use the URRT tab which feeds directly to HIOS. Questions related to the SERFF submission process should be submitted to the SERFF help desk.	
☐	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.	
☐	All documents are to be uploaded within the appropriate Supporting Documentation tab in SERFF.	
☐	Do not create new tabs under Supporting Documentation in SERFF	
☐	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.	
☐	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.	
☐	When revisions are made to a document, the revised text must be highlighted in yellow and every page shall be dated with the revision date.	
☐	Carriers must respond to Objection Letters created by the Department within the Objection Letter, not within the Supporting Documentation tab.	
☐	Actuarial Value (AV) Calculator “Screen Shots” – PDF	
☐	Benefit Summary Tables – Excel	
☐	Part I Unified Rate Review Template (URRT) (45 CFR 154.215) – Excel	
☐	Part II Written Description Justification (45 CFR 154.215) – PDF, template provided	

☐	Part III Actuarial Memorandum (AM) and Certification (45 CFR 154.215) – PDF, template provided for the Certification, AM should follow URR instructions with the following additions	
☐	• The Part III AM must contain the additional actuarial memorandum data elements required by New Jersey regulation at: N.J.A.C. 11:20-6.3.	
☐	• Cost Sharing Reductions (CSR) Adjustments	
☐	• Impact of P.L. 2018 c. 32 (Out-of-Network)	
☐	• Reinsurance: An Excel template (Exhibit A-1) has been provided to collect this data.	
☐	• Broker Commissions	
☐	• Child(ren)-Only Rating Methodology	
☐	• The filing should confirm that all plans cover all mandated benefits.	
☐	• Risk Adjustment Data Validation (RADV)	
☐	• MLR Impact	
☐	• PBM Actuarial Memorandum	
☐	• Pricing impact of P.L.2023, c.107	
	The AM or supporting documents must fully support the following data and assumptions:	
☐	• Claim experience	
☐	• Trend	
☐	• Morbidity	
☐	• Demographic factors	
☐	• Plan Design factors	
☐	• Credibility	
☐	• Manual rate (if applicable)	
☐	• Risk adjustment	
☐	• Reinsurance	
☐	• Actuarial value and cost-sharing factor	
☐	• Provider network adjustments	
☐	• Benefits in addition to the Essential Health Benefits	
☐	• Administrative expenses	
☐	• Taxes and fees	
☐	• Profit	
☐	• Calibration factors	
☐	Actuarial Summary Worksheet (Exhibit A) – Excel	

☐	Plan Relativity Worksheet (Exhibit B) – Excel	
☐	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.	
☐	Exhibit D – Anticipated distribution by age.	
☐	Exhibit E – Demonstration of Copay Compliance for copay limits pursuant to N.J.A.C. 11:22-5.5(a)11.	
☐	Exhibit F - Carriers must report in detail the cost drivers underlying medical trend, including the aggregate amount of spending on primary care services, behavioral health, and retail pharmacy.	
☐	Reconciliation of the earned premiums and incurred claims shown in Worksheet 1 of the URRT to the 2023 Supplemental Health Care Exhibit.	
☐	Carrier Specific Rate Chart – Excel	
☐	Table of Contents and Rate Manual – PDF	

APPENDIX D: Rate Filing Checklist SEH

Status	Item	Comments
☐	Carriers should continue to use the URRT tab which feeds directly to HIOS. Questions related to the SERFF submission process should be submitted to the SERFF help desk.	
☐	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.	
☐	All documents are to be uploaded within the appropriate Supporting Documentation tab in SERFF.	
☐	Do not create new tabs under Supporting Documentation in SERFF	
☐	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.	
☐	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.	
☐	When revisions are made to a document, the revised text must be highlighted in yellow and every page shall be dated with the revision date.	
☐	Carriers must respond to Objection Letters created by the Department within the Objection Letter, not within the Supporting Documentation tab.	
☐	Actuarial Value (AV) Calculator “Screen Shots” – PDF	
☐	Benefit Summary Tables – Excel	
☐	Part I Unified Rate Review Template (URRT) (45 CFR 154.215) – Excel	
☐	Part II Written Description Justification (45 CFR 154.215) – PDF, template provided	

☐	Part III Actuarial Memorandum (AM) and Certification (45 CFR 154.215) – PDF, template provided for the Certification, AM should follow URR instructions with the following additions	
☐	• The Part III AM must contain the additional actuarial memorandum data elements required by New Jersey regulation at: N.J.A.C. 11:21-9.3.	
☐	• Cost Sharing Reductions (CSR) Adjustments	
☐	• Impact of P.L. 2018 c. 32 (Out-of-Network)	
☐	• Open/closed formulary count and pricing impact	
☐	• Broker Commissions	
☐	• The filing should confirm that all plans cover all mandated benefits.	
☐	• Risk Adjustment Data Validation (RADV)	
☐	• MLR Impact	
☐	• PBM Actuarial Memorandum	
☐	• Pricing impact of P.L.2023, c.107	
	The AM or supporting documents must fully support the following data and assumptions:	
☐	• Claim experience	
☐	• Trend	
☐	• Morbidity	
☐	• Demographic factors	
☐	• Plan Design factors	
☐	• Credibility	
☐	• Manual rate (if applicable)	
☐	• Risk adjustment	
☐	• Actuarial value and cost-sharing factor	
☐	• Provider network adjustments	
☐	• Benefits in addition to the Essential Health Benefits	
☐	• Administrative expenses	
☐	• Taxes and fees	
☐	• Profit	
☐	• Calibration factors	
☐	Actuarial Summary Worksheet (Exhibit A) – Excel	
☐	Plan Relativity Worksheet (Exhibit B) – Excel	
☐	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.	
☐	Exhibit D – Anticipated distribution by age and location for SEH.	
☐	Exhibit E – Demonstration of Copay Compliance for copay limits pursuant to N.J.A.C. 11:22-5.5(a)11.	
☐	Exhibit F - Carriers must report in detail the cost drivers underlying medical trend, including the aggregate amount of spending on primary care services, behavioral health, and retail pharmacy.	
☐	Reconciliation of the earned premiums and incurred claims shown in Worksheet 1 of the URRT to the 2023 Supplemental Health Care Exhibit.	
☐	Carrier Specific Rate Chart – Excel	
☐	Table of Contents and Rate Manual – PDF	