Ohio Health Insurance Rate Filing Checklist

These guidelines apply to all contractual periodic prepayment (CPP) / premium rate filings for Group, Non-Group and Medicare / Medicaid / Federal Employee Coverage. The CPP / premium rate portions of Certificates of Authority (COAs) and Major Modifications (such as service area expansions) for the appropriate type of filing (Group, Non-Group and Medicare / Medicaid / Federal Employee Coverage) are also subject to these guidelines (ORC 3923.02, 3923.021, 3924.04, 1751.12).

Pages 4 – 8 do not apply to Large Employer Group rate filings.

All CPP / premium rate filings are required to be filed on an as needed basis. Any time there is a change in benefits, experience, methodology, or factors, which necessitates a change in rates, a CPP/premium rate filing is required. Note: All filings received by the Department are placed in the public record files. No proprietary filings will be accepted.

Filings of CPPs / premium rates for Group, Non-Group and Medicare / Medicaid / Federal Employee Coverage must be submitted separately. Filings received with more than one type of product or the incorrect TOI will be returned to the corporation.

I. GROUP FILINGS

Group CPP / premium filings are considered file and use. (ORC 3923.02, 3924.04, 3924.06) The CPPs / premiums may be used upon receipt by the Department of a complete filing, however this type of filing may be rejected at any time after review by the Department. Any incomplete filing, including a filing that does not have an Actuarial Certification will be returned and treated as not received, and consequently, not filed. For complete filings, the corporation will receive either a notification indicating that all necessary information has been provided and that the filing has been filed as a public record, or a response indicating those parts of the filing which require more information.

Amendment / Rider filings will no longer be accepted. Any time there is a change in experience, methodology, or factors which necessitates a change in rate(s), a complete CPP / Premium rate filing is required.

The following items must be included in all group CPP/Premium filings:

A. An Actuarial Certification by an actuary who is a member of the American Academy of Actuaries and qualified to provide such certifications as described in the U.S. Qualifications Standards promulgated by the American Academy of Actuaries pursuant to the Code of Professional Conduct. (See attached sample).
B. A rate filing checklist in the same format as shown in the attached sample and an Actuarial Memorandum which includes the requirements of the checklist. The checklist must be completed and an explanation provided in the comment section for any components that are not applicable.
C. A statement describing the purpose of the filing.
D. A statement giving the effective date of the contractual periodic prepayments. The effective date must be within 6 months of the filing's receipt by the Department, unless otherwise required. If the CPPs have not been rejected, they must be used starting on the effective date.
E. Provide the base CPPs for all products and / or benefit plans. Include the base CPPs for prescription drug riders and any other supplemental riders separately. The following items must be included:
    1. The formula used.
    2. The trend used to project beyond the first month / quarter. Trend is only approved for a maximum twelve month period from the effective date of the filing.
    3. All factors / variables (age, geographic area, etc. for all tiering structures, credibility factors,) used to calculate the CPPs.
    4. An example of how the CPPs will be calculated for all new groups, first year renewals, and subsequent year renewals.
    5. A comparison of current CPPs with proposed CPPs to indicate the average, minimum, and maximum percent and dollar changes.
F Rates for small groups (up to and including 50 participants) must conform to the premium rate limitations specified in ORC 3924.04.
G. A copy of the latest retrospective certification of compliance with ORC 3924.06.

Additional information needed to adequately review filings may be requested by the Superintendent.

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II. NON-GROUP FILINGS / NON_EMPLOYER GROUP

All premium rates for Non-Group policies must be filed with the Department. (ORC 3923.02, 3923.021, 1751.12) These filings must be approved by the Department prior to use. The review period after receipt of a complete filing is 60 days for HICs and 30 days for Insurance companies, after which the filing is deemed approved if the filer has not received a disposition from the superintendent. Approval or disapproval notifications will be sent upon review.

Amendment / Rider filings will no longer be accepted. Any time there is a change in experience, methodology, or factors which necessitates a change in rate(s), a complete CPP / Premium rate filing is required.

The following items must be included in all nongroup / non-emplover group CPP / Premium rate filings:

A. An Actuarial Certification by an actuary who is a member of the American Academy of Actuaries and qualified to provide such certifications as described in the U.S. Qualification Standards promulgated by the American Academy of Actuaries pursuant to the Code of Professional Conduct. (See attached sample.)
B. A rate filing checklist in the same format as shown in the attached sample and an Actuarial Memorandum which includes the requirements of the checklist. The checklist must be completed and an explanation provided in the comment section for any components that are not applicable.
C. A statement describing the purpose of the filing.
D. A statement giving the effective date of the contractual periodic prepayments/premiums. The effective date must be within 6 months of the filing's receipt by the Department. If the CPPs/premiums have not been rejected, they must be used starting on the effective date.
E. Provide the base CPPs/premiums for all products and/or benefit plans. Include the base CPPs for prescription drug riders and any other riders separately. The following items must be included:
    1. The formula used
    2. The trend used to project beyond the first month/quarter. Trend is only approved for a maximum twelve month period from the effective date of the filing.
    3. All factors / variables (age, geographic area, etc. for all tiering structures, credibility factors) used to calculate the CPPs.
    4. An example of how the CPPs will be calculated for all new groups, first year renewals, and subsequent year renewals.
    5. A comparison of current CPPs with proposed CPPs to indicate the average, minimum, and maximum percent and dollar changes.

Additional information needed to adequately review filings may be requested by the Superintendent.

III. MEDICARE / MEDICAID / FEDERAL EMPLOYEE COVERAGE

Medicare / Medicaid / Federal Employee Coverage CPPs / premium rates must be filed with the Department prior to use and may be used upon receipt by the Department. A filing will be considered complete if it includes the amount to be charged to the member and the appropriate government approval letter. These filings will be considered informational filings only. The Department will provide verification of receipt, not an approval. The informational filing will be placed in the public record files.

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ACTUARIAL CERTIFICATION

I, [Name], [Title] of [Company Name,] OR a consulting actuary with [Name of Firm] working for [Company Name,] am a Member of the American Academy of Actuaries and meet its qualification standards for preparing {contractual periodic prepayments for Health Insuring Corporations (HIC's)} OR {premium rate filings for Insurers}. This Actuarial Certification applies to:

(List All Product Names)

1. The contractual periodic prepayments OR premium rates filed are in compliance with the applicable laws, rules and guidelines of the State of Ohio.

2. The contractual periodic prepayments OR premium rates filed are reasonable in relation to the benefits provided and are not excessive, inadequate, or unfairly discriminatory.

3. The contractual periodic prepayments OR premium rates are calculated on the basis of sound actuarial principles.

4. The contractual periodic prepayments OR premium rates are reasonable when related to the applicable coverage and characteristics of the applicable class of enrollees.

5. The contractual periodic prepayments OR premium rates filed are prepared in conformity with the Actuarial Standards of Practice (ASOPs) promulgated by the Actuarial Standards Board that are checked below [*check the ASOPs used below and provide a separate page with an explanation of why the others were not used*].

CHECK LIST OF ACTUARIAL STANDARDS OF PRACTICE (ASOPs) FOR STATEMENT 5 ABOVE

ASOP No. 5 - Incurred Health Claim Liabilities
ASOP No. 8 - Regulatory Filings for Health Plan Entities
ASOP No. 12 - Risk Classification (for All Practice Areas)
ASOP No. 23 - Data Quality
ASOP No. 25 - Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property / Casualty Coverages
ASOP No. 26 - Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
ASOP No. 41 - Actuarial Communications
ASOP No. 42 - Determining health and disability liabilities other than liabilities for incurred claims
ASOP No. __ - Other Appropriate Standards of Practice as adopted by the Actuarial Standards Board.

_____ _____
Name of Actuary & Professional Designations Telephone Number of Actuary

_____
Signature of Actuary

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RATE FILING CHECKLIST

Required Item	Description of Review Requirement	Location in the Filing	DOI Use
Cover Letter	Include the legal name and address of the submitting company, toll-free number and valid email address of the filer, unique identifying form number of each form submitted and its descriptive title, whether the form is new or a form revision, and identify for any revised forms, the form being replaced by its form number, assigned tracking number and approval date.		
SERFF Rate Review Detail	Complete the Rate Review Detail screen within SERFF. Include supporting documentation of the calculation within the Supporting Documentation tab of SERFF. For initial rate submission of new products, these fields should be zero.		
Rate Schedule	A schedule of rates for the filed effective date for all products and plans which are part of the single risk pool must be submitted. Include all products and plans regardless of whether or not a rate increase is being requested.		
Ohio Actuarial Memorandum	An actuarial memorandum signed by a current member of the American Academy of Actuaries.		
Scope and Purpose	The scope and purpose of the filing, including all laws the filing is intended to comply with.		
Description of Benefits	A narrative description of the benefits that will be provided by the policy forms included in the filing.		
Marketing Method	A description of the marketing methods used to inform consumers of the availability of the policies and whether policies are to be offered on the government exchange.		
History of Rate Adjustments	The month, year and percentage amount of all previous rate revisions.		
Effective Date and Implementation Date of Proposed Rate Adjustment	The month and year that the rate revision is scheduled to be implemented, and the implementation method, such as the next policy anniversary date, etc.		
Months of Rate Guarantee	The number of months that the rate will be guaranteed to an individual policyholder.		
Proposed Percentage Rate Adjustment	The requested rate adjustments for each product and plan, including an explanation and actuarial justification of the apportionment of the aggregate rate revision within each policy form or between policy forms.		

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Required Item	Description of Review Requirement	Location in the Filing	DOI Use
Description of How Rates Were Determined	The type of rating methodology used and a description of how rates were determined and how they meet the requirements of ORC 3923.02 to be reasonable relative to the level of benefits provided, and not excessive, inadequate, or unfairly discriminatory.		
Reason for Rate Adjustment	A narrative description of the significant factors driving the change in rates.		
Premium and Benefits Experience for Forms Included in Filing	Earned premium and incurred benefits since inception shall be provided. If available, the experience for the most recent three calendar years shall be provided for each calendar year. Experience since inception may be combined for years prior to the most recent three calendar years.		
Percentage of Rate Adjustment Not Attributable to Experience	The portion of the rate adjustment for each plan that is not attributable to experience.		
Average Annual Premium	The average annual premium for Ohio, before and after the proposed rate adjustment.		
Number of Policyholders and Covered Lives	The number of Ohio policyholders and covered lives affected by the proposed rate increase.		
Dates of Service for the Experience Period Used to Develop Rates	The dates or service of claims representing the base period experience used to develop the index rate for the single risk pool.		
Date Through Which Claims Were Paid	The date through which claim payments were made on claims incurred during the experience period.		
Estimated Allowed Claims During the Experience Period Used to Develop Rates	The actuary's best estimate of allowed claims for the single risk pool during the experience period that were used as a basis for developing the projected index rate.		
Premium in Experience Period (Net of MLR Rebate)	The best estimate of premium earned during the experience period, both before and after MLR rebates.		
Adjustments to Allowed Claims During the Experience Period	Description and numerical support for adjustments made to the experience period allowed claims for the single risk pool that were used as a basis for developing the projected index rate.		
Changes in Benefits	A description of average benefit changes (i.e. changes to covered services) between the experience period and the projection period, and a description of and support for the impact of each change on rates.		
Trend Factors (Cost and Utilization)	A description and numerical support of how trend is developed and a detailed trend analysis supporting the factor used.		

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Required Item	Description of Review Requirement	Location in the Filing	DOI Use
Projected Changes in the Demographics of the Population Insured	A description and quantitative support for the development of factors used to reflect differences in the average demographics of the population covered in the experience period and the population anticipated to be covered in the projection period.		
Projected Changes in the Morbidity of the Population Insured	A description and quantitative support for the development of factors used to adjust the experience period claims to reflect differences in the average morbidity of the population covered in the experience period and the population anticipated to be covered in the projection period.		
Other Projected Changes	A description and quantitative support for the development of any other factors used to adjust the experience period claims to reflect differences between the experience period and the population anticipated to be covered in the projection period.		
Methodology Used to Develop the Credibility Manual Rate	A description of the methodology used to develop the credibility manual index rate, if applicable.		
Source and Appropriateness of Experience Used to Develop the Credibility Manual Rate	A description of the source data used to develop the credibility manual index rate and support that the data is appropriate, if applicable.		
Adjustments Made to Data Used to Develop the Credibility Manual Rate	A description and support for each adjustment made to the experience used to develop the credibility manual index rate, if applicable.		
Inclusion of Capitation Payments in Developing the Credibility Manual	A description of how capitated services were accounted for in developing the credibility manual index rate, if applicable.		
Credibility Methodology	Description of the methodology used to determine the credibility of the base period experience.		
Credibility Level(s)	The credibility level assigned to the base period experience.		
Covered Services – Essential Health Benefits	Description and percent of claims represented by newly added benefits which are Essential Health Benefits.		
Covered Services – State Mandated Benefits Which are Not Essential Health Benefits	Description and percent of claims represented by benefits which are Ohio state mandated benefits but are Not Essential Health Benefits.		
Covered Services – Eliminated Benefits	Description and percent of claims represented by benefits which are currently covered but will not be covered in the projection period.		
Covered Services – Additional Mandatory Supplemental Benefits	Listing of benefits that will be covered on a mandatory basis in the projection period but are Not an Essential Health Benefit.		

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Required Item	Description of Review Requirement	Location in the Filing	DOI Use
Covered Services – Changes in the Level of Covered Services	Description of benefits which are currently covered but will be covered at a different level in the projection period (e.g. change in the number of visits covered).		
Covered Services – EHB Substitutions	Description and quantitative support for any benefits substituted for Essential Health Benefits.		
Credibility Adjusted Projected Claims	Quantitative demonstration of the estimated claims for the projection period, after adjusting for credibility, including appropriate support.		
Projected Index Rate	Quantitative demonstration of the estimated index rate for the projection period, representing the EHB portion of the credibility adjusted projected claims.		
Risk Adjustment Payments	Demonstration of the calculation of the estimate of the risk adjustment payments during the projection period.		
Transitional Reinsurance	Demonstration of the calculation of the estimate of the transitional reinsurance payments during the projection period to include the following: • The proportion of currently insured members who fall within the payout parameters. • The proportion of newly insured members expected to fall within the payout parameters. • The proportion of total claims expected to qualify for reimbursement. Any assumption regarding the proportion of recoverables that will actually be paid.		
Base Rate Development	Demonstrate the relationship between the index rate and the base rate used in rate development.		
AV Metal Values	Description of how the AV Metal Values for each of the plans was calculated, and support for use of alternate methodologies other than the AV calculator.		
AV Pricing Values	Demonstrate how the index rate was adjusted to develop plan level rates, including the plan factors/AV Pricing Values for each plan and an explanation of differences across plans using the format of the allowable plan level adjustments as defined in Section 156.80(d)(2) of the Federal Market Rule.		
Age Factors	Confirm the prescribed standardized factors were used.		
Geographic Factors	Proposed factors for use with the State defined geographic rating regions and support any changes		
Tobacco Factors	Proposed tobacco status categories and corresponding factors and support any changes.		

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Expense Assumptions	Full expansion of the product expense assumptions. Include fixed and variable expenses, profit/contribution to surplus, risk margins, commissions, applicable taxes and fees, and administrative expenses. Administrative expenses include compensation, interest expense, (Occupancy, Depreciation, and Amortization), and marketing, as they may apply.		
Taxes and fees	Full expansion of the expense assumptions related to those taxes and fees considered in rate development.		
Development of Rate Tables	Description of how the plan level adjusted index rate was normalized for use in developing age, geographic and tobacco status specific rates.		
Loss Ratio Requirements	List the appropriate standard from NAIC Model # 134 "Guidelines for Filing of Rates for Individual Health Insurance Forms".		
Ohio Loss Ratio Requirements	Demonstration of compliance with loss ratio requirements. Note that the Ohio loss ratio is the traditional ratio of incurred claims to earned premium without any reference to MLR rebates or payments, risk adjustments, risk corridor payments, or transitional reinsurance payments.		
Reliance	Disclosure of any information developed by other individuals that the actuary relied on in the development of rates.		
Identification of Certifying Actuary	The certifying actuary must identify himself/herself and indicate they are a member of the American Academy of Actuaries		
Certification of Metal AV	Certification that the standard AV Calculator was used to determine the metal AV for each plan or if an alternate methodology is consistent with the AV Calculator.		
Certification of EHB Substitutions	Certification that EHB substitutions meet the requirements of 45 CFR 156.115(b)		
Format of Attachments	Please provide all filing attachments in portable document format (.pdf); if a URRT is provided, please also include Microsoft Excel format (.xls).		
Compliance with Applicable Ohio and Federal Laws and Regulations and Actuarial Standards of Practice.	Certification that the proposed rates are in compliance with applicable Ohio and Federal laws and regulations and applicable Actuarial Standards of Practice.		
For Small Group Only: Certification of compliance with ORC 3924.04	Retrospective certification that rates for small groups (2 to 50 Participants) conform to the premium rate limitations specified in ORC 3924.04.		