



Company Name:		SERFF Tracking # - Rates	
NAIC #:		SERFF Tracking # - Forms	
Form #(s):			
Select the Type of Market:		Plan Intended for Issuance:	
Individual Small Employer Group Non-employer (Association Type) Group Student Health Plan		Both on and off the Exchange Off the Exchange Only Institutions of Higher Learning	

Applicability:

- Applicable to all contractual periodic prepayment (CPP) / premium rate filings for Group, Non-Group, Student Health Plans 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, Student Health Plans and Medicare / Medicaid / Federal Employee Coverage) are also subject to these guidelines (ORC 3923.02, 3923.021, 3924.04, 1751.12).
- The checklist in Section V does not apply to Large Employer Group rate filings.**
- Any time there is a change in benefits, experience, methodology, factors, or a continuation of trend, which necessitates a change in CPP / premium rates, a CPP / premium rate filing is required. Note: Everything submitted in a filing is subject to Public Record laws. Except for pages or parts of documents appropriately marked as trade secret pursuant to Ohio law and the Department’s “Trade Secrets Policy,” the contents will become public record in accordance with R.C. 149.43, R.C. 1751.52, R.C. 3935.04, and/or R.C. 3937.03. Refer to the Trade Secrets Policy in the Attachments section of the SERFF General Instructions. Health Insuring Corporation (HMO) filings submitted in accordance with Chapter 1751 of the Ohio Revised Code (O.R.C) are public record on the applicable date of approval by the Ohio Department of Insurance, pursuant to Ohio Revised Code Section 1751.52(A).
- Filings of CPPs / premium rates for Group, Non-Group, Student Health Plans 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 company.

Instructions:

Important instructions for ACA Compliant major medical plans that are subject to Uniform Rate Review (URR) submission requirements:

SERFF established a new process starting with PY 2023 for submission of all URR documents to CMS and for state rate review. URR documents are no longer submitted in the CMS HIOS system. These items will be submitted on a separate new “URRT” schedule tab of the state rate filing in SERFF and will automatically be transferred to CMS.

To submit a rate filing in SERFF for plans that are subject to URR requirements, the Unified Rate Review Template (URRT), Actuarial Memorandum, Redacted Actuarial Memorandum, and Consumer Justification Narrative (if the URRT is above threshold) must be uploaded on the “URRT” schedule tab of the rate filing.

I. EMPLOYER 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 rate 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 company 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. Anytime 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 certification below).
- B. A rate filing checklist in the same format as shown in the attached sample and an Actuarial Memorandum which includes the requirements provided in 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. Provide the base CPP / premium rates for all products and/or benefit plans. Include the base CPP / premium rates 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 tier structures, credibility factors, etc.) used to calculate the CPP / premium rates.
 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 CPP / premium rates with proposed CPP / premium rates to indicate the average, minimum, and maximum percent, and dollar changes.
- E. Rates for small groups (up to and including 50 participants) must conform to the premium rate limitations specified in ORC 3924.04.
- F. A copy of the latest retrospective certification of compliance with ORC 3924.06.

Additional information needed to adequately review filings may be requested.

Major Medical Products and Student Health Plans

II. NON-GROUP FILINGS / NON-EMPLOYER GROUP / STUDENT HEALTH PLANS

All CPP / premium rates for Non-Group / Non-Employer Group / Student Health Plan 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. Approval or disapproval notifications will be sent upon review.

Amendment / Rider filings will no longer be accepted. Anytime 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 Non-Group / Non-Employer group / Student Health Plans 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 certification below.)
- B. A rate filing checklist in the same format as shown in the attached sample and an Actuarial Memorandum which includes the requirements provided in 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. Provide the base CPP / premium rates for all products and/or benefit plans. Include the base CPP / premium rates 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 tier structures, credibility factors, etc.) used to calculate the CPP / premium rates.
 4. An example of how the CPP / premium rates will be calculated for all new Non-Employer Groups / Student Health Plans, first year renewals, and subsequent year renewals.
 5. A comparison of current CPP / premium rates with proposed CPP / premium rates to indicate the average, minimum, and maximum percent and dollar changes.

Additional information needed to adequately review filings may be requested.

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.

IV. SAMPLE 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 based on 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 Benefits, Accident and Health Insurance, and Entities Providing Health Benefits
- 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. 50: Determining Minimum Value and Actuarial Value under the Affordable Care
- 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

V. RATE FILING CHECKLIST

- Guidance applies to all products unless specifically noted otherwise.
- Only complete the column pertaining to the product being filed.

Required Item	Description of Review Requirement	Location in the Rate Filing
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	<ul style="list-style-type: none"> • For Major Medical Products, 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 a rate increase is being requested. • For Student Health Plans, a schedule of rates / rating methodologies / formulas must be filed, as applicable to the Plan. Include all products and plans regardless of whether 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	<ul style="list-style-type: none"> • For Major Medical Products, a description of the marketing methods used to inform consumers of the availability of the policies. State if policies are to be offered on the government exchange. • For Student Health Plans, a description of the marketing methods used to inform policyholders and students of the availability of the policies. 	
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.	

Required Item	Description of Review Requirement	Location in the Rate Filing
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.	
Description of How Rates Were Determined	The type of rating methodology used and a description of how rates were determined and how they are 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	<ul style="list-style-type: none"> • For Major Medical Products, 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. • For Student Health Plans, earned premium and incurred benefits since inception shall be provided for the block and for the school, if school specific rates developed. If available, the experience for the most recent three calendar/policy years shall be provided for each calendar/policy year. Experience since inception may be combined for years prior to the most recent three calendar/policy years. 	
Percentage of Rate Adjustment Not Attributable to Experience	<ul style="list-style-type: none"> • The portion of the rate adjustment for each plan that is not attributable to experience. 	
Average Annual Premium	<ul style="list-style-type: none"> • The average annual premium for Ohio, before and after the proposed rate adjustment. 	
Number of Policyholders and Covered Lives	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • For Major Medical Products, the dates of service of claims representing the base period experience used to develop the index rate for the single risk pool. • For Student Health Plans, the dates of service of claims representing the base period experience used to develop the manual or school specific rate(s). 	
Date Through Which Claims Were Paid	<ul style="list-style-type: none"> • The date through which claim payments were made on claims incurred during the experience period. 	

Required Item	Description of Review Requirement	Location in the Rate Filing
Estimated Allowed Claims During the Experience Period Used to Develop Rates	<ul style="list-style-type: none"> • For Major Medical Products, the actuary’s best estimate of allowed claims for the single risk pool during the experience period used as a basis for developing the projected index rate. • For Student Health Plans, if applicable to the Plan offered, the actuary’s best estimate of the allowed claims during the experience period for developing the manual base rate(s) or the school specific rate(s). 	
Premium in Experience Period (Net of MLR Rebate)	<ul style="list-style-type: none"> • For Major Medical Products, the best estimate of premium earned during the experience period, both before and after MLR rebates. • For Student Health Plans, the best estimate of premium earned during the experience period, both before and after MLR rebates or any other earned premium adjustment programs that may exist between the issuer and the school. 	
Adjustments to Allowed Claims During the Experience Period	<ul style="list-style-type: none"> • For Major Medical Plans, 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. • For Student Health Plans, if applicable to the Plan offered, description and numerical support for adjustments made to the experience period allowed claims that were used as a basis for developing manual rate(s) or school specific rate(s). 	
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.	
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.	

Required Item	Description of Review Requirement	Location in the Rate Filing
Methodology Used to Develop the Credibility Manual Rate	<ul style="list-style-type: none"> • For Major Medical Products, a description of the methodology used to develop the credibility manual index rate, if applicable. • For Student Health Plans, a description of the methodology used to develop the credibility rate for each school. 	
Source and Appropriateness of Experience Used to Develop the Credibility Manual Rate	<ul style="list-style-type: none"> • For Major Medical Products, a description of the source data used to develop the credibility manual index rate and support that the data is appropriate, if applicable. • For Student Health Plans, a description of the source data used to develop the credibility rate per school, and support that the data is appropriate. 	
Adjustments Made to Data Used to Develop the Credibility Manual Rate	<ul style="list-style-type: none"> • For Major Medical Products, a description and support for each adjustment made to the experience used to develop the credibility manual index rate, if applicable. • For Student Health Plans, a description and support for each adjustment made to the experience used to develop the credibility rate(s) for each school. 	
Inclusion of Capitation Payments in Developing the Credibility Manual Rate	<ul style="list-style-type: none"> • For Major Medical Products, a description of how capitated services were accounted for in developing the credibility manual index rate, if applicable. • For Student Health Plans, if applicable to the Plan offered, a description of how capitated services were accounted for in developing the credibility rate(s) for each school. 	
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.	
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.	

Required Item	Description of Review Requirement	Location in the Rate Filing
Credibility Adjusted Projected Claims	Quantitative demonstration of the estimated claims for the projection period, after adjusting for credibility, including appropriate support.	
Projected Index Rate	<ul style="list-style-type: none"> • For Major Medical Products, quantitative demonstration of the estimated index rate for the projection period, representing the EHB portion of the credibility adjusted projected claims. • For Student Health Plans, quantitative demonstration of the estimated manual rate(s) or school specific rate(s), for the projection period, representing the EHB portion of the credibility adjusted projected claims. 	
Risk Adjustment Transfer Amount	<ul style="list-style-type: none"> • For Major Medical Products only, quantitative demonstration of the estimate of the risk adjustment payment/receivable for the projection period. 	
Base Rate Development	<ul style="list-style-type: none"> • For Major Medical Products only, 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	<ul style="list-style-type: none"> • For Major Medical Products only, demonstrate how the index rate was adjusted to develop plan-adjusted index rates, including the plan factors/AV Pricing Values for each plan and 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	<ul style="list-style-type: none"> • For Major Medical Products, confirm the prescribed standardized factors were used. • For Student Health Plans, proposed factors for use with support, including any changes. 	
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.	
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.	

Required Item	Description of Review Requirement	Location in the Rate Filing
Development of Rate Tables	<ul style="list-style-type: none"> • For Major Medical Products, description of how the plan level adjusted index rate was normalized for use in developing age, geographic and tobacco status specific rates. • For Student Health Plans, if applicable to the Plan offered, description of how the school specific base rate(s) was developed considering the use of age, geographic area and tobacco in rating, demonstrating the impact of these rating factors will not be double counted. 	
Loss Ratio Requirements	List the appropriate standard from NAIC Model # 134 “Guidelines for Filing of Rates for Individual Health Insurance Forms” for minimum loss ratio.	
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, or risk adjustments.	
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).	
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	<ul style="list-style-type: none"> • For Small Group Major Medical Products only, retrospective certification that rates for small groups (2 to 50 Participants) conform to the premium rate limitations specified in ORC 3924.04. 	

Required Item	Description of Review Requirement	Location in the Rate Filing
For Stand-Alone Dental Plans (SADPs) - On- Exchange and Off- Exchange Certified plans only	<ul style="list-style-type: none"> • For Stand-Alone Dental Plans only, Actuarial Value Supporting Documentation and Justification (see form provided as Supporting Document requirement in SERFF) 	
For Stand-Alone Dental Plans (SADPs) - On- Exchange and Off-Exchange Certified plans only	<p>For Stand-Alone Dental Plans only, description of EHB Apportionment for Pediatric Dental (see form provided as Supporting Document requirement in SERFF).</p>	