OH 10

This Project Abstract satisfies the Requirement as noted on page 10 (section IV.B.4 Project Abstract) of the Department of Health and Human Services <u>Grants to States for Health Insurance Premium Review – Cycle 1</u> Grant Announcement CFDA: 93.511 dated June 7, 2010.

Project Abstract

The Ohio Department of Insurance is requesting $1 million in Cycle 1 funding to enhance and expand the current rate review process for individual and group health rate filings. Ohio's objective is to integrate the rate review process using a three-pronged approach involving actuarial rate review, coordinated policy form review, and expanded data analysis. Specific goals include: 1) Using an approach that begins with the assessment of the actuarial elements of every filing; 2) Making sure that the rates and assumptions used in those filings are consistent with the benefits described in the policy forms; and 3) Ensuring that the data can be extracted from all filings to a data base that will enable us to analyze and report effectively. The overall method will include the enhancement and expansion of our current rate review process that involves the hiring of experienced, full-time and contractual actuaries. We also will purchase software for trend analysis.

The Department's current rate review process will need to be enhanced. The Department has the authority to review and accept, approve, or disapprove rates. In our current process, we review more than 500 filings annually that contain rates that need to be analyzed. To meet the requirements of the Patient Protection and Affordable Care Act (PPACA), all rates will need to be refiled. Filings will become more complex and take longer to review because of the PPACA changes. As filings are not now identified using product definitions such as PPO, EPO, etc. that will be required going forward, many of the current filings will actually need to be refiled into two or more separate filings. In addition, filings will need to be categorized as applying to grandfathered or non-grandfathered plans. This will require enhanced coordination and communication with the contract analysts who are reviewing the forms for compliance. Actuarial analysts and contract analysts will need to work in tandem to determine the type of product, its grandfathered status, and which set of rules it must comply with by market type. Significant data analysis will be required to analyze the markets and trends so that the actuarial analysts can evaluate rate requests for reasonableness and actuarial soundness as well as their grandfathered status.

Expansion of our staff is critical to the success of this project. As shown in our budget proposal, we intend to hire a qualified health actuary and an additional actuarial analyst, two additional contract analysts to assist the actuaries in determining if the coverage in contract meets the PPACA requirements and is consistent with the rates the filings propose to implement, and three data analysts to assist in analyzing data and trends, creating an internal database, and to go into the companies to verify that the rates are being applied the way they have been filed so they are able to assist the actuaries in understanding if rates are being calculated as would be expected from the filing. In addition, the Department will need to hire consulting actuaries to assist with the filing review load during peak filing times and assist with training needs. The Department also intends to purchase a subscription to medical trend data updates to verify the consistency of the company's trend analysis with industry-wide data.

GRANTS.GOV

Grant Application Package

Opportunity Title:	"Grants to States for Health Insurance Premium Review-C
Offering Agency:	Ofc of Consumer Information & Insurance Oversight
CFDA Number:	93.511
CFDA Description:	Affordable Care Act (ACA) Grants to States for Health I
Opportunity Number:	RFA-FD-10-999
Competition ID:	ADOBE-FORMS-B
Opportunity Open Date:	06/07/2010
Opportunity Close Date:	07/07/2010
Agency Contact:	Gladys Melendez-Bohler Grant Specialist E-mail: Gladys.Melendez-Bohler@fda.hhs.gov Phone: 301-827-7168

This electronic grants application is intended to be used to apply for the specific Federal funding opportunity referenced here.

If the Federal funding opportunity listed is not the opportunity for which you want to apply, close this application package by clicking on the "Cancel" button at the top of this screen. You will then need to locate the correct Federal funding opportunity, download its application and then apply.

☐ **I will be submitting applications on my behalf, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.**

*** Application Filing Name:** Ohio Department of Insurance

Mandatory Documents

Move Form to Complete

Move Form to Delete

Mandatory Documents for Submission

Optional Documents

Move Form to Submission List

Move Form to Delete

Optional Documents for Submission

Instructions

1 Enter a name for the application in the Application Filing Name field.

- This application can be completed in its entirety offline; however, you will need to login to the Grants.gov website during the submission process.
- You can save your application at any time by clicking the "Save" button at the top of your screen.
- The "Save & Submit" button will not be functional until all required data fields in the application are completed and you clicked on the "Check Package for Errors" button and confirmed all data required data fields are completed.

2 Open and complete all of the documents listed in the "Mandatory Documents" box. Complete the SF-424 form first.

- It is recommended that the SF-424 form be the first form completed for the application package. Data entered on the SF-424 will populate data fields in other mandatory and optional forms and the user cannot enter data in these fields.

- The forms listed in the "Mandatory Documents" box and "Optional Documents" may be predefined forms, such as SF-424, forms where a document needs to be attached, such as the Project Narrative or a combination of both. "Mandatory Documents" are required for this application. "Optional Documents" can be used to provide additional support for this application or may be required for specific types of grant activity. Reference the application package instructions for more information regarding "Optional Documents".

- To open and complete a form, simply click on the form's name to select the item and then click on the => button. This will move the document to the appropriate "Documents for Submission" box and the form will be automatically added to your application package. To view the form, scroll down the screen or select the form name and click on the "Open Form" button to begin completing the required data fields. To remove a form/document from the "Documents for Submission" box, click the document name to select it, and then click the <= button. This will return the form/document to the "Mandatory Documents" or "Optional Documents" box.

- All documents listed in the "Mandatory Documents" box must be moved to the "Mandatory Documents for Submission" box. When you open a required form, the fields which must be completed are highlighted in yellow with a red border. Optional fields and completed fields are displayed in white. If you enter invalid or incomplete information in a field, you will receive an error message.

3 Click the "Save & Submit" button to submit your application to Grants.gov.

- Once you have properly completed all required documents and attached any required or optional documentation, save the completed application by clicking on the "Save" button.
- Click on the "Check Package for Errors" button to ensure that you have completed all required data fields. Correct any errors or if none are found, save the application package.
- The "Save & Submit" button will become active; click on the "Save & Submit" button to begin the application submission process.
- You will be taken to the applicant login page to enter your Grants.gov username and password. Follow all onscreen instructions for submission.

OMB Number: 4040-0004
Expiration Date: 03/31/2012

Application for Federal Assistance SF-424

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
☐ Preapplication	☒ New	
☒ Application	☐ Continuation	* Other (Specify):
☐ Changed/Corrected Application	☐ Revision	

* 3. Date Received:	4. Applicant Identifier:
Completed by Grants.gov upon submission.	

5a. Federal Entity Identifier:	5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:		7. State Application Identifier:	

8. APPLICANT INFORMATION:

* a. Legal Name: Ohio Department of Insurance

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
1311334820A4	8091719450000

d. Address:

* Street1:	50 West Town Street Suite 300
Street2:	
* City:	Columbus
County/Parish:	
* State:	OH: Ohio
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	43215-4186

e. Organizational Unit:

Department Name:	Division Name:
Ohio Department of Insurance	Product Regulation & Actuarial

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:		* First Name:	Mary
Middle Name:			
* Last Name:	Miller		
Suffix:			

Title: Asst. Dir, Product Regulation & Actuarial

Organizational Affiliation:

* Telephone Number:	614-644-3331	Fax Number:	

* Email: Mary.Miller@insurance.ohio.gov

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Ofc of Consumer Information & Insurance Oversight

11. Catalog of Federal Domestic Assistance Number:

93.511

CFDA Title:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

*** 12. Funding Opportunity Number:**

RFA-FD-10-999

* Title:

"Grants to States for Health Insurance Premium Review-Cycle I" Office of Consumer Information and Insurance Oversight (OCIIO)

13. Competition Identification Number:

ADOBE-FORMS-B

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Grants to States for Health Insurance Premium Review-Cycle 1: The Ohio Department of Insurance requests $1 million in Cycle 1 funding to enhance and expand the current rate review process.

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant	OH-015	b. Program/Project	ALL

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date:	08/09/2010	* b. End Date:	09/30/2011

18. Estimated Funding ($):

* a. Federal	1,000,000.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,000,000.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:		* First Name:	Jianming
Middle Name:			
* Last Name:	Xia		
Suffix:			

* Title: Assistant Director, Fiscal Division

* Telephone Number:	614-644-3263	Fax Number:	

* Email: Jianming.Xia@insurance.ohio.gov

* Signature of Authorized Representative:	Completed by Grants.gov upon submission.	* Date Signed:	Completed by Grants.gov upon submission.

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:** Ohio Department of Insurance

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:** Project Director

Prefix:

* First Name: Mary

Middle Name:

* Last Name: Miller

Suffix:

Title:

Organizational Affiliation:

* Street1: 50 West Town Street Suite 300

Street2:

* City: Columbus

County:

* State: OH: Ohio

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 43215-4186

* Telephone Number: 614-644-3331

Fax:

* Email: Mary.Miller@insurance.ohio.gov

Delete Entry | Previous Person | Next Person

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:**

Ohio Department of Insurance

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:** Financial Officer

Prefix:

* First Name: Jianming

Middle Name:

* Last Name: Xia

Suffix:

Title:

Organizational Affiliation:

* Street1: 50 West Town Street Suite 300

Street2:

* City: Columbus

County:

* State: OH: Ohio

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 43215-4186

* Telephone Number: 614-644-3263

Fax:

* Email: Jianming.Xia@insurance.ohio.gov

Delete Entry | Previous Person | Next Person

OMB Number: 4040-0010
Expiration Date: 08/31/2011

Project/Performance Site Location(s)

Project/Performance Site Primary Location

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Ohio Department of Insurance

DUNS Number: 8091719450000

* Street1: 50 West Town Street Suite 300

Street2:

* City: Columbus

County: Franklin

* State: OH: Ohio

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 43215-4186

* Project/ Performance Site Congressional District: OH-015

Project/Performance Site Location a

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City:

County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code:

* Project/ Performance Site Congressional District:

Additional Location(s)

Add Attachment | Delete Attachment | View Attachment

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1		Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2		Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3		Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4		Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5		Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6		Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7		Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

Project:

Grants to States for Health Insurance Premium Review-Cycle 1: The Ohio Department of Insurance requests $1 million in Cycle 1 funding to enhance and expand the current rate review process.

*** Year:** 1

*** Funding Agency Goal:**

Ohio's objective is to integrate the rate review process using a three-pronged approach involving actuarial rate review, coordinated policy form review, and expanded data analysis.

*** Objective:**

Project/Objective 1: Increase staffing to enable integrated rate and policy form reviews, data analysis and reporting, and assistance during high volume filing periods.(Includes hiring of two actuarial analysts, 2 contract analysts, 3 data analysts, and procurement of outside consulting contracts.)

*** Results or Benefits Expected:**

Integration of the rate review process with the policy form review process; consistent rate/pricing assumptions and policy benefits; and data and resources to support complex analysis of actuarial pricing elements.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Activities necessary to post positions and recruit qualified applicants.	Tynesia Dorsey, Assistant Director, Human Resources	08/09/2010	08/30/2010	25
Interview and hiring process.	Mary Miller, Assistant Director, Product Regulation & Actuarial Services	08/30/2010	09/30/2010	80
Orientation and training of new staff as hired	Mary Miller, Assistant Director, Product Regulation & Actuarial Services	09/30/2010	12/24/2010	240
Procurement Process for contracting with Actuarial Consulting Firm(s)	Mary Miller, Assistant Director, Product Regulation & Actuarial Services	09/30/2010	10/30/2010	40

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours

* Criteria for Evaluating Results or Benefits Expected:

Analysis and reporting will demonstrate that rates and pricing assumptions are consistent with policy benefits. Tools and methodology for more complex analysis of actuarial pricing elements will be incorporated into the rate review process.

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

You may attach up to 17 additional Objective Work Plan forms here. To extract, fill and attach each additional form, follow these steps:

- Select the "Select to Extract the Objective Work Plan Attachment" button below.

- Save the file using a descriptive name to help you remember the content of the supplemental form that you are creating. When assigning a name to the file, please remember to give it the extension ".pdf" (for example, "Objective_1.pdf"). If you do not name your file with the ".pdf" extension you will be unable to open it later, using Adobe Reader.

- Use the "Open Form" tool on Adobe Reader to open the new form you just saved.

- Enter your additional Objective information in this supplemental form, similar to the Objective Work Plan form that you see in the main body of your application.

- When you have completed entering information in the supplemental form, save and close it.

- Return to this page and attach the saved supplemental form you just filled in, to one of the blocks provided on this "attachments" form.

Important: Attach additional Objective Work Plan forms, using the blocks below. Please remember that the files you attach must be Objective Work Plan PDF forms that were previously extracted using the process outlined above. Attaching any other type of file may result in the inability to submit your application to Grants.gov. Note: It is important to attach completed forms only. Attach ONLY PDF (.pdf) forms where ALL required fields are filled out. Incomplete or missing data will cause your application to be rejected.

Select to extract the Objective Work Plan Attachment

1) Please attach Attachment 1		Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2		Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3		Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4		Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5		Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6		Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7		Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment
16) Please attach Attachment 16		Add Attachment	Delete Attachment	View Attachment
17) Please attach Attachment 17		Add Attachment	Delete Attachment	View Attachment

OMB Number: 4040-0003
Expiration Date: 09/30/2011

Project Abstract

The Project Abstract must not exceed one page and must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This Abstract must not include any proprietary/confidential information.

* Please click the add attachment button to complete this entry.

Add Attachment | Delete Attachment | View Attachment

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:**

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:**

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 4040-0006
Expiration Date 07/30/2010

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Grants to States for Health Insurance Premium Review - Cycle 1	93.511	$	$	$ 1,000,000.00	$	$ 1,000,000.00
2.						
3.						
4.						
5. **Totals**		$	$	$ 1,000,000.00	$	$ 1,000,000.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1)	(2)	(3)	(4)	(5)
	Grants to States for Health Insurance Premium Review - Cycle 1				
a. Personnel	$ 618,087.00	$	$	$	$ 618,087.00
b. Fringe Benefits	185,849.00				185,849.00
c. Travel	0.00				
d. Equipment	0.00				
e. Supplies	0.00				
f. Contractual	126,064.00				126,064.00
g. Construction					
h. Other	70,000.00				70,000.00
i. Total Direct Charges (sum of 6a-6h)	1,000,000.00				$ 1,000,000.00
j. Indirect Charges					$
k. TOTALS (sum of 6i and 6j)	$ 1,000,000.00	$	$	$	$ 1,000,000.00
7. Program Income	$	$	$	$	$

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SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8.	$	$	$	$
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 1,000,000.00	$ 250,000.00	$ 250,000.00	$ 250,000.00	$ 250,000.00
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$ 1,000,000.00	$ 250,000.00	$ 250,000.00	$ 250,000.00	$ 250,000.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
	(b)First	(c) Second	(d) Third	(e) Fourth
16.	$	$	$	$
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: 0	22. Indirect Charges: 0
23. Remarks: N/A	

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OMB Approval No.: 4040-0007
Expiration Date: 07/30/2010

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Completed on submission to Grants.gov	Assistant Director, Fiscal Division
* APPLICANT ORGANIZATION	* DATE SUBMITTED
Ohio Department of Insurance	Completed on submission to Grants.gov

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
0348-0046

1. * Type of Federal Action:
- [ ] a. contract
- [X] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [X] b. initial award
- [ ] c. post-award

3. * Report Type:
- [X] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[X] Prime [ ] SubAwardee

** Name* Ohio Department of Insurance

** Street 1* 50 West Town Street Suite 300 *Street 2*

** City* Columbus *State* OH: Ohio *Zip* 43215-4186

Congressional District, if known: 15th

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:

Health and Human Services

7. * Federal Program Name/Description:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

CFDA Number, *if applicable:* 93.511

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix ** First Name* Melissa *Middle Name*

** Last Name* Wheeler *Suffix*

** Street 1* 50 West Town Street Suite 300 *Street 2*

** City* Columbus *State* OH: Ohio *Zip* 43215-4186

b. Individual Performing Services (including address if different from No. 10a)

Prefix ** First Name* Melissa *Middle Name*

** Last Name* Wheeler *Suffix*

** Street 1* 50 West Town Street Suite 300 *Street 2*

** City* Columbus *State* OH: Ohio *Zip* 43215-4186

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Completed on submission to Grants.gov

***Name:** *Prefix* ** First Name* Mary Jo *Middle Name*

** Last Name* Hudson *Suffix*

Title: Director **Telephone No.:** 614-728-1003 **Date:** Completed on submission to Grants.gov

OMB Number: 2125-0611
Expiration Date: 03/31/2010

Basic Work Plan

1. Estimated date of established funding agreement with State:

Note: Tasks starting before this date are not eligible for funding, and cannot be counted toward matching funds.

Describe the tasks in the work plan:

2 a. Describe this task or milestone:

b. Name of person or organization responsible for carrying out task:

c. How long will this task take to complete? months

d. Justify how this project task contributes to project completion: (800 character limit - about 133 words)

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Project Abstract Summary

Program Announcement (CFDA)

93.511

*** Program Announcement (Funding Opportunity Number)**

RFA-FD-10-999

*** Closing Date**

07/07/2010

*** Applicant Name**

Ohio Department of Insurance

*** Length of Proposed Project**

Application Control No.

Federal Share Requested (for each year)

* Federal Share 1st Year	* Federal Share 2nd Year	* Federal Share 3rd Year
$	$	$
*** Federal Share 4th Year**	*** Federal Share 5th Year**	
$	$	

Non-Federal Share Requested (for each year)

* Non-Federal Share 1st Year	* Non-Federal Share 2nd Year	* Non-Federal Share 3rd Year
$	$	$
*** Non-Federal Share 4th Year**	*** Non-Federal Share 5th Year**	
$	$	

*** Project Title**

Grants to States for Health Insurance Premium Review-Cycle 1: The Ohio Department of Insurance requests $1 million in Cycle 1 funding to enhance and expand the current rate review process.

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Project Abstract Summary

*** Project Summary**

*** Estimated number of people to be served as a result of the award of this grant.**

Other Attachment File(s)

*** Mandatory Other Attachment Filename:**

Add Mandatory Other Attachment | Delete Mandatory Other Attachment | View Mandatory Other Attachment

To add more "Other Attachment" attachments, please use the attachment buttons below.

Add Optional Other Attachment | Delete Optional Other Attachment | View Optional Other Attachment

APPENDIX A – RATE REVIEW CODE SECTIONS

149.43 Availability of public records for inspection and copying.

(A) As used in this section:

(1) "Public record" means records kept by any public office, including, but not limited to, state, county, city, village, township, and school district units, and records pertaining to the delivery of educational services by an alternative school in this state kept by the nonprofit or for-profit entity operating the alternative school pursuant to section 3313.533 of the Revised Code. "Public record" does not mean any of the following:

(a) Medical records;

(b) Records pertaining to probation and parole proceedings or to proceedings related to the imposition of community control sanctions and post-release control sanctions;

(c) Records pertaining to actions under section 2151.85 and division (C) of section 2919.121 of the Revised Code and to appeals of actions arising under those sections;

(d) Records pertaining to adoption proceedings, including the contents of an adoption file maintained by the department of health under section 3705.12 of the Revised Code;

(e) Information in a record contained in the putative father registry established by section 3107.062 of the Revised Code, regardless of whether the information is held by the department of job and family services or, pursuant to section 3111.69 of the Revised Code, the office of child support in the department or a child support enforcement agency;

(f) Records listed in division (A) of section 3107.42 of the Revised Code or specified in division (A) of section 3107.52 of the Revised Code;

(g) Trial preparation records;

(h) Confidential law enforcement investigatory records;

(i) Records containing information that is confidential under section

2710.03or 4112.05 of the Revised Code;

(j) DNA records stored in the DNA database pursuant to section 109.573 of the Revised Code;

(k) Inmate records released by the department of rehabilitation and correction to the department of youth services or a court of record pursuant to division (E) of section 5120.21 of the Revised Code;

(l) Records maintained by the department of youth services pertaining to children in its custody released by the department of youth services to the department of rehabilitation and correction pursuant to section 5139.05 of the Revised Code;

(m) Intellectual property records;

(n) Donor profile records;

(o) Records maintained by the department of job and family services pursuant to section 3121.894 of the Revised Code;

(p) Peace officer, parole officer, prosecuting attorney, assistant prosecuting attorney, correctional employee, youth services employee, firefighter, EMT , or investigator of the bureau of criminal identification and investigation residential and familial information;

(q) In the case of a county hospital operated pursuant to Chapter 339. of the Revised Code or a municipal hospital operated pursuant to Chapter 749. of the Revised Code, information that constitutes a trade secret, as defined in section 1333.61 of the Revised Code;

(r) Information pertaining to the recreational activities of a person under the age of eighteen;

(s) Records provided to, statements made by review board members during meetings of, and all work products of a child fatality review board acting under sections 307.621 to 307.629 of the Revised Code, and child fatality review data submitted by the child fatality review board to the department of health or a national child death

review database, other than the report prepared pursuant to division (A) of section 307.626 of the Revised Code;

(t) Records provided to and statements made by the executive director of a public children services agency or a prosecuting attorney acting pursuant to section 5153.171 of the Revised Code other than the information released under that section;

(u) Test materials, examinations, or evaluation tools used in an examination for licensure as a nursing home administrator that the board of examiners of nursing home administrators administers under section 4751.04 of the Revised Code or contracts under that section with a private or government entity to administer;

(v) Records the release of which is prohibited by state or federal law;

(w) Proprietary information of or relating to any person that is submitted to or compiled by the Ohio venture capital authority created under section 150.01 of the Revised Code;

(x) Information reported and evaluations conducted pursuant to section 3701.072 of the Revised Code;

(y) Financial statements and data any person submits for any purpose to the Ohio housing finance agency or the controlling board in connection with applying for, receiving, or accounting for financial assistance from the agency, and information that identifies any individual who benefits directly or indirectly from financial assistance from the agency;

(z) Records listed in section 5101.29 of the Revised Code.

(aa) Discharges recorded with a county recorder under section 317.24 of the Revised Code, as specified in division (B)(2) of that section.

(2) "Confidential law enforcement investigatory record" means any record that pertains to a law enforcement matter of a criminal, quasi-criminal, civil, or administrative nature, but only to the extent that the release of the record would create a high probability of disclosure of any of the following:

(a) The identity of a suspect who has not been charged with the offense to which the record pertains, or of an information source or witness to whom confidentiality has been reasonably promised;

(b) Information provided by an information source or witness to whom confidentiality has been reasonably promised, which information would reasonably tend to disclose the source's or witness's identity;

(c) Specific confidential investigatory techniques or procedures or specific investigatory work product;

(d) Information that would endanger the life or physical safety of law enforcement personnel, a crime victim, a witness, or a confidential information source.

(3) "Medical record" means any document or combination of documents, except births, deaths, and the fact of admission to or discharge from a hospital, that pertains to the medical history, diagnosis, prognosis, or medical condition of a patient and that is generated and maintained in the process of medical treatment.

(4) "Trial preparation record" means any record that contains information that is specifically compiled in reasonable anticipation of, or in defense of, a civil or criminal action or proceeding, including the independent thought processes and personal trial preparation of an attorney.

(5)"Intellectual property record" means a record, other than a financial or administrative record, that is produced or collected by or for faculty or staff of a state institution of higher learning in the conduct of or as a result of study or research on an educational, commercial, scientific, artistic, technical, or scholarly issue, regardless of whether the study or research was sponsored by the institution alone or in conjunction with a governmental body or private concern, and that has not been publicly released, published, or patented.

(6)"Donor profile record" means all records about donors or potential donors to a public institution of higher education except the names and reported addresses of the actual donors and the date, amount, and conditions of the actual donation.

(7) "Peace officer, parole officer, prosecuting attorney, assistant prosecuting attorney, correctional employee, youth services employee, firefighter, EMT, or investigator of the bureau of criminal identification and investigation residential and familial information" means any information that discloses any of the following

about a peace officer, parole officer, prosecuting attorney, assistant prosecuting attorney, correctional employee, youth services employee, firefighter, EMT, or investigator of the bureau of criminal identification and investigation:

(a) The address of the actual personal residence of a peace officer, parole officer, assistant prosecuting attorney, correctional employee, youth services employee, firefighter, EMT, or an investigator of the bureau of criminal identification and investigation, except for the state or political subdivision in which the peace officer, parole officer, assistant prosecuting attorney, correctional employee, youth services employee, firefighter, EMT, or investigator of the bureau of criminal identification and investigation resides;

(b) Information compiled from referral to or participation in an employee assistance program;

(c) The social security number, the residential telephone number, any bank account, debit card, charge card, or credit card number, or the emergency telephone number of, or any medical information pertaining to, a peace officer, parole officer, prosecuting attorney, assistant prosecuting attorney, correctional employee, youth services employee, firefighter, EMT, or investigator of the bureau of criminal identification and investigation;

(d) The name of any beneficiary of employment benefits, including, but not limited to, life insurance benefits, provided to a peace officer, parole officer, prosecuting attorney, assistant prosecuting attorney, correctional employee , youth services employee, firefighter, EMT, or investigator of the bureau of criminal identification and investigation by the peace officer's, parole officer's, prosecuting attorney's, assistant prosecuting attorney's, correctional employee's, youth services employee's, firefighter's, EMT's, or investigator of the bureau of criminal identification and investigation's employer;

(e) The identity and amount of any charitable or employment benefit deduction made by the peace officer's, parole officer's, prosecuting attorney's, assistant prosecuting attorney's, correctional employee's, youth services employee's, firefighter's, EMT's, or investigator of the bureau of criminal identification and investigation's employer from the peace officer's, parole officer's, prosecuting attorney's, assistant prosecuting attorney's, correctional employee's, youth services employee's, firefighter's, EMT's, or investigator of the bureau of criminal identification and investigation's compensation unless the amount of the deduction is required by state or federal law;

(f) The name, the residential address, the name of the employer, the address of the employer, the social security number, the residential telephone number, any bank account, debit card, charge card, or credit card number, or the emergency telephone number of the spouse, a former spouse, or any child of a peace officer, parole officer, prosecuting attorney, assistant prosecuting attorney, correctional employee, youth services employee, firefighter, EMT, or investigator of the bureau of criminal identification and investigation;

(g) A photograph of a peace officer who holds a position or has an assignment that may include undercover or plain clothes positions or assignments as determined by the peace officer's appointing authority.

As used in divisions (A)(7) and (B)(9) of this section, "peace officer" has the same meaning as in section 109.71 of the Revised Code and also includes the superintendent and troopers of the state highway patrol; it does not include the sheriff of a county or a supervisory employee who, in the absence of the sheriff, is authorized to stand in for, exercise the authority of, and perform the duties of the sheriff.

As used in divisions (A)(7) and (B)(5) of this section, "correctional employee" means any employee of the department of rehabilitation and correction who in the course of performing the employee's job duties has or has had contact with inmates and persons under supervision.

As used in divisions (A)(7) and (B)(5) of this section, "youth services employee" means any employee of the department of youth services who in the course of performing the employee's job duties has or has had contact with children committed to the custody of the department of youth services.

As used in divisions (A)(7) and (B)(9) of this section, "firefighter" means any regular, paid or volunteer, member of a lawfully constituted fire department of a municipal corporation, township, fire district, or village.

As used in divisions (A)(7) and (B)(9) of this section, "EMT" means EMTs-basic, EMTs-I, and paramedics that provide emergency medical services for a public emergency medical service organization. "Emergency medical service organization," "EMT-basic," "EMT-I," and "paramedic" have the same meanings as in section 4765.01 of the Revised Code.

As used in divisions (A)(7) and (B)(9) of this section, "investigator of the bureau of criminal identification and investigation" has the meaning defined in section 2903.11 of the Revised Code.

(8) "Information pertaining to the recreational activities of a person under the age of eighteen" means information that is kept in the ordinary course of business by a public office, that pertains to the recreational activities of a person under the age of eighteen years, and that discloses any of the following:

(a) The address or telephone number of a person under the age of eighteen or the address or telephone number of that person's parent, guardian, custodian, or emergency contact person;

(b) The social security number, birth date, or photographic image of a person under the age of eighteen;

(c) Any medical record, history, or information pertaining to a person under the age of eighteen;

(d) Any additional information sought or required about a person under the age of eighteen for the purpose of allowing that person to participate in any recreational activity conducted or sponsored by a public office or to use or obtain admission privileges to any recreational facility owned or operated by a public office.

(9) "Community control sanction" has the same meaning as in section 2929.01 of the Revised Code.

(10)"Post-release control sanction" has the same meaning as in section 2967.01 of the Revised Code.

(11) "Redaction" means obscuring or deleting any information that is exempt from the duty to permit public inspection or copying from an item that otherwise meets the definition of a "record" in section 149.011 of the Revised Code.

(12) "Designee" and "elected official" have the same meanings as in section 109.43 of the Revised Code.

(B)(1) Upon request and subject to division (B)(8) of this section, all public records responsive to the request shall be promptly prepared and made available for inspection to any person at all reasonable times during regular business hours. Subject to division (B)(8) of this section, upon request, a public office or person responsible for public records shall make copies of the requested public record available at cost and within a reasonable period of time. If a public record contains information that is exempt from the duty to permit public inspection or to copy the public record, the public office or the person responsible for the public record shall make available all of the information within the public record that is not exempt. When making that public

record available for public inspection or copying that public record, the public office or the person responsible for the public record shall notify the requester of any redaction or make the redaction plainly visible. A redaction shall be deemed a denial of a request to inspect or copy the redacted information, except if federal or state law authorizes or requires a public office to make the redaction.

(2) To facilitate broader access to public records, a public office or the person responsible for public records shall organize and maintain public records in a manner that they can be made available for inspection or copying in accordance with division (B) of this section. A public office also shall have available a copy of its current records retention schedule at a location readily available to the public. If a requester makes an ambiguous or overly broad request or has difficulty in making a request for copies or inspection of public records under this section such that the public office or the person responsible for the requested public record cannot reasonably identify what public records are being requested, the public office or the person responsible for the requested public record may deny the request but shall provide the requester with an opportunity to revise the request by informing the requester of the manner in which records are maintained by the public office and accessed in the ordinary course of the public office's or person's duties.

(3) If a request is ultimately denied, in part or in whole, the public office or the person responsible for the requested public record shall provide the requester with an explanation, including legal authority, setting forth why the request was denied. If the initial request was provided in writing, the explanation also shall be provided to the requester in writing. The explanation shall not preclude the public office or the person responsible for the requested public record from relying upon additional reasons or legal authority in defending an action commenced under division (C) of this section.

(4) Unless specifically required or authorized by state or federal law or in accordance with division (B) of this section, no public office or person responsible for public records may limit or condition the availability of public records by requiring disclosure of the requester's identity or the intended use of the requested public record. Any requirement that the requester disclose the requestor's identity or the intended use of the requested public record constitutes a denial of the request.

(5) A public office or person responsible for public records may ask a requester to make the request in writing, may ask for the requester's identity, and may inquire about the intended use of the information requested, but may do so only after disclosing to the requester that a written request is not mandatory and that the requester may decline to reveal the requester's identity or the intended use and when a written request or disclosure of the identity or intended use would benefit the requester by enhancing the ability of the public office or person responsible for public records to identify, locate, or deliver the public records sought by the requester.

(6) If any person chooses to obtain a copy of a public record in accordance with division (B) of this section, the public office or person responsible for the public record may require that person to pay in advance the cost involved in providing the copy of the public record in accordance with the choice made by the person seeking the copy under this division. The public office or the person responsible for the public record shall permit that person to choose to have the public record duplicated upon paper, upon the same medium upon which the public office or person responsible for the public record keeps it, or upon any other medium upon which the public office or person responsible for the public record determines that it reasonably can be duplicated as an integral part of the normal operations of the public office or person responsible for the public record. When the person seeking the copy makes a choice under this division, the public office or person responsible for the public record shall provide a copy of it in accordance with the choice made by the person seeking the copy. Nothing in this section requires a public office or person responsible for the public record to allow the person seeking a copy of the public record to make the copies of the public record.

(7) Upon a request made in accordance with division (B) of this section and subject to division (B)(6) of this section, a public office or person responsible for public records shall transmit a copy of a public record to any person by United States mail or by any other means of delivery or transmission within a reasonable period of time after receiving the request for the copy. The public office or person responsible for the public record may require the person making the request to pay in advance the cost of postage if the copy is transmitted by United States mail or the cost of delivery if the copy is transmitted other than by United States mail, and to pay in advance the costs incurred for other supplies used in the mailing, delivery, or transmission.

Any public office may adopt a policy and procedures that it will follow in transmitting, within a reasonable period of time after receiving a request, copies of public records by United States mail or by any other means of

delivery or transmission pursuant to this division. A public office that adopts a policy and procedures under this division shall comply with them in performing its duties under this division.

In any policy and procedures adopted under this division, a public office may limit the number of records requested by a person that the office will transmit by United States mail to ten per month, unless the person certifies to the office in writing that the person does not intend to use or forward the requested records, or the information contained in them, for commercial purposes. For purposes of this division, "commercial" shall be narrowly construed and does not include reporting or gathering news, reporting or gathering information to assist citizen oversight or understanding of the operation or activities of government, or nonprofit educational research.

(8) A public office or person responsible for public records is not required to permit a person who is incarcerated pursuant to a criminal conviction or a juvenile adjudication to inspect or to obtain a copy of any public record concerning a criminal investigation or prosecution or concerning what would be a criminal investigation or prosecution if the subject of the investigation or prosecution were an adult, unless the request to inspect or to obtain a copy of the record is for the purpose of acquiring information that is subject to release as a public record under this section and the judge who imposed the sentence or made the adjudication with respect to the person, or the judge's successor in office, finds that the information sought in the public record is necessary to support what appears to be a justiciable claim of the person.

(9) Upon written request made and signed by a journalist on or after December 16, 1999, a public office, or person responsible for public records, having custody of the records of the agency employing a specified peace officer, parole officer, prosecuting attorney, assistant prosecuting attorney, correctional employee, youth services employee, firefighter, EMT, or investigator of the bureau of criminal identification and investigation shall disclose to the journalist the address of the actual personal residence of the peace officer, parole officer, prosecuting attorney, assistant prosecuting attorney, correctional employee, youth services employee , firefighter, EMT, or investigator of the bureau of criminal identification and investigation and, if the peace officer's, parole officer's, prosecuting attorney's, assistant prosecuting attorney's, correctional employee's, youth services employee's, firefighter's, EMT's, or investigator of the bureau of criminal identification and investigation's spouse, former spouse, or child is employed by a public office, the name and address of the

employer of the peace officer's, parole officer's, prosecuting attorney's, assistant prosecuting attorney's, correctional employee's, youth services employee's, firefighter's, EMT's, or investigator of the bureau of criminal identification and investigation's spouse, former spouse, or child. The request shall include the journalist's name and title and the name and address of the journalist's employer and shall state that disclosure of the information sought would be in the public interest.

As used in this division, "journalist" means a person engaged in, connected with, or employed by any news medium, including a newspaper, magazine, press association, news agency, or wire service, a radio or television station, or a similar medium, for the purpose of gathering, processing, transmitting, compiling, editing, or disseminating information for the general public.

(C)(1) If a person allegedly is aggrieved by the failure of a public office or the person responsible for public records to promptly prepare a public record and to make it available to the person for inspection in accordance with division (B) of this section or by any other failure of a public office or the person responsible for public records to comply with an obligation in accordance with division (B) of this section, the person allegedly aggrieved may commence a mandamus action to obtain a judgment that orders the public office or the person responsible for the public record to comply with division (B) of this section, that awards court costs and reasonable attorney's fees to the person that instituted the mandamus action, and, if applicable, that includes an order fixing statutory damages under division (C)(1) of this section. The mandamus action may be commenced in the court of common pleas of the county in which division (B) of this section allegedly was not complied with, in the supreme court pursuant to its original jurisdiction under Section 2 of Article IV, Ohio Constitution, or in the court of appeals for the appellate district in which division (B) of this section allegedly was not complied with pursuant to its original jurisdiction under Section 3 of Article IV, Ohio Constitution.

If a requestor transmits a written request by hand delivery or certified mail to inspect or receive copies of any public record in a manner that fairly describes the public record or class of public records to the public office or person responsible for the requested public records, except as otherwise provided in this section, the requestor shall be entitled to recover the amount of statutory damages set forth in this division if a court determines that the public office or the person responsible for public records failed to comply with an obligation in accordance with division (B) of this section.

The amount of statutory damages shall be fixed at one hundred dollars for each business day during which the public office or person responsible for the requested public records failed to comply with an obligation in accordance with division (B) of this section, beginning with the day on which the requester files a mandamus action to recover statutory damages, up to a maximum of one thousand dollars. The award of statutory damages shall not be construed as a penalty, but as compensation for injury arising from lost use of the requested information. The existence of this injury shall be conclusively presumed. The award of statutory damages shall be in addition to all other remedies authorized by this section.

The court may reduce an award of statutory damages or not award statutory damages if the court determines both of the following:

(a) That, based on the ordinary application of statutory law and case law as it existed at the time of the conduct or threatened conduct of the public office or person responsible for the requested public records that allegedly constitutes a failure to comply with an obligation in accordance with division (B) of this section and that was the basis of the mandamus action, a well-informed public office or person responsible for the requested public records reasonably would believe that the conduct or threatened conduct of the public office or person responsible for the requested public records did not constitute a failure to comply with an obligation in accordance with division (B) of this section;

(b) That a well-informed public office or person responsible for the requested public records reasonably would believe that the conduct or threatened conduct of the public office or person responsible for the requested public records would serve the public policy that underlies the authority that is asserted as permitting that conduct or threatened conduct.

(2)(a) If the court issues a writ of mandamus that orders the public office or the person responsible for the public record to comply with division (B) of this section and determines that the circumstances described in division (C)(1) of this section exist, the court shall determine and award to the relator all court costs.

(b) If the court renders a judgment that orders the public office or the person responsible for the public record to comply with division (B) of this section, the court may award reasonable attorney's fees subject to reduction

as described in division (C)(2)(c) of this section. The court shall award reasonable attorney's fees, subject to reduction as described in division (C)(2)(c) of this section when either of the following applies:

(i) The public office or the person responsible for the public records failed to respond affirmatively or negatively to the public records request in accordance with the time allowed under division (B) of this section.

(ii) The public office or the person responsible for the public records promised to permit the relator to inspect or receive copies of the public records requested within a specified period of time but failed to fulfill that promise within that specified period of time.

(c) Court costs and reasonable attorney's fees awarded under this section shall be construed as remedial and not punitive. Reasonable attorney's fees shall include reasonable fees incurred to produce proof of the reasonableness and amount of the fees and to otherwise litigate entitlement to the fees. The court may reduce an award of attorney's fees to the relator or not award attorney's fees to the relator if the court determines both of the following:

(i) That, based on the ordinary application of statutory law and case law as it existed at the time of the conduct or threatened conduct of the public office or person responsible for the requested public records that allegedly constitutes a failure to comply with an obligation in accordance with division (B) of this section and that was the basis of the mandamus action, a well-informed public office or person responsible for the requested public records reasonably would believe that the conduct or threatened conduct of the public office or person responsible for the requested public records did not constitute a failure to comply with an obligation in accordance with division (B) of this section;

(ii) That a well-informed public office or person responsible for the requested public records reasonably would believe that the conduct or threatened conduct of the public office or person responsible for the requested public records as described in division (C)(2)(c)(i) of this section would serve the public policy that underlies the authority that is asserted as permitting that conduct or threatened conduct.

(D) Chapter 1347. of the Revised Code does not limit the provisions of this section.

(E)(1) To ensure that all employees of public offices are appropriately educated about a public office's obligations under division (B) of this section, all elected officials or their appropriate designees shall attend training approved by the attorney general as provided in section 109.43 of the Revised Code. In addition, all public offices shall adopt a public records policy in compliance with this section for responding to public records requests. In adopting a public records policy under this division, a public office may obtain guidance from the model public records policy developed and provided to the public office by the attorney general under section 109.43 of the Revised Code. Except as otherwise provided in this section, the policy may not limit the number of public records that the public office will make available to a single person, may not limit the number of public records that it will make available during a fixed period of time, and may not establish a fixed period of time before it will respond to a request for inspection or copying of public records, unless that period is less than eight hours.

(2) The public office shall distribute the public records policy adopted by the public office under division (E)(1) of this section to the employee of the public office who is the records custodian or records manager or otherwise has custody of the records of that office. The public office shall require that employee to acknowledge receipt of the copy of the public records policy. The public office shall create a poster that describes its public records policy and shall post the poster in a conspicuous place in the public office and in all locations where the public office has branch offices. The public office may post its public records policy on the internet web site of the public office if the public office maintains an internet web site. A public office that has established a manual or handbook of its general policies and procedures for all employees of the public office shall include the public records policy of the public office in the manual or handbook.

(F)(1) The bureau of motor vehicles may adopt rules pursuant to Chapter 119. of the Revised Code to reasonably limit the number of bulk commercial special extraction requests made by a person for the same records or for updated records during a calendar year. The rules may include provisions for charges to be made for bulk commercial special extraction requests for the actual cost of the bureau, plus special extraction costs, plus ten per cent. The bureau may charge for expenses for redacting information, the release of which is prohibited by law.

(2) As used in division (F)(1) of this section:

(a) "Actual cost" means the cost of depleted supplies, records storage media costs, actual mailing and alternative delivery costs, or other transmitting costs, and any direct equipment operating and maintenance costs, including actual costs paid to private contractors for copying services.

(b) "Bulk commercial special extraction request" means a request for copies of a record for information in a format other than the format already available, or information that cannot be extracted without examination of all items in a records series, class of records, or data base by a person who intends to use or forward the copies for surveys, marketing, solicitation, or resale for commercial purposes. "Bulk commercial special extraction request" does not include a request by a person who gives assurance to the bureau that the person making the request does not intend to use or forward the requested copies for surveys, marketing, solicitation, or resale for commercial purposes.

(c)"Commercial" means profit-seeking production, buying, or selling of any good, service, or other product.

(d) "Special extraction costs" means the cost of the time spent by the lowest paid employee competent to perform the task, the actual amount paid to outside private contractors employed by the bureau, or the actual cost incurred to create computer programs to make the special extraction. "Special extraction costs" include any charges paid to a public agency for computer or records services.

(3) For purposes of divisions (F)(1) and (2) of this section, "surveys, marketing, solicitation, or resale for commercial purposes" shall be narrowly construed and does not include reporting or gathering news, reporting or gathering information to assist citizen oversight or understanding of the operation or activities of government, or nonprofit educational research.

Amended by 128th General Assembly File No. 9, HB 1, § 101.01, eff. 10/16/2009.

Effective Date: 02-12-2004; 04-27-2005; 07-01-2005; 10-29-2005; 03-30-2007; 2006 HB9 09-29-2007; 2008 HB214 05-14-2008; 2008 SB248 04-07-2009

1751.12 Contractual periodic prepayment or premium rate.

(A)(1) No contractual periodic prepayment and no premium rate for nongroup and conversion policies for health care services, or any amendment to them, may be used by any health insuring corporation at any time until the contractual periodic prepayment and premium rate, or amendment, have been filed with the superintendent of insurance, and shall not be effective until the expiration of sixty days after their filing unless the superintendent sooner gives approval. The filing shall be accompanied by an actuarial certification in the form prescribed by the superintendent. The superintendent shall disapprove the filing, if the superintendent determines within the sixty-day period that the contractual periodic prepayment or premium rate, or amendment, is not in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees. The superintendent shall notify the health insuring corporation of the disapproval, and it shall thereafter be unlawful for the health insuring corporation to use the contractual periodic prepayment or premium rate, or amendment.

(2) No contractual periodic prepayment for group policies for health care services shall be used until the contractual periodic prepayment has been filed with the superintendent. The filing shall be accompanied by an actuarial certification in the form prescribed by the superintendent. The superintendent may reject a filing made under division (A)(2) of this section at any time, with at least thirty days' written notice to a health insuring corporation, if the contractual periodic prepayment is not in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees.

(3) At any time, the superintendent, upon at least thirty days' written notice to a health insuring corporation, may withdraw the approval given under division (A)(1) of this section, deemed or actual, of any contractual periodic prepayment or premium rate, or amendment, based on information that either of the following applies:

(a) The contractual periodic prepayment or premium rate, or amendment, is not in accordance with sound actuarial principles.

(b) The contractual periodic prepayment or premium rate, or amendment, is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees.

(4) Any disapproval under division (A)(1) of this section, any rejection of a filing made under division (A)(2) of this section, or any withdrawal of approval under division (A)(3) of this section, shall be effected by a written notice, which shall state the specific basis for the disapproval, rejection, or withdrawal and shall be issued in accordance with Chapter 119. of the Revised Code.

(B) Notwithstanding division (A) of this section, a health insuring corporation may use a contractual periodic prepayment or premium rate for policies used for the coverage of beneficiaries enrolled in medicare pursuant to a medicare risk contract or medicare cost contract, or for policies used for the coverage of beneficiaries enrolled in the federal employees health benefits program pursuant to 8905, or for policies used for the coverage of medicaid recipients, or for policies used for coverage of participants of the children's buy-in program, or for policies used for the coverage of beneficiaries under any other federal health care program regulated by a federal regulatory body, or for policies used for the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services, if both of the following apply:

(1) The contractual periodic prepayment or premium rate has been approved by the United States department of health and human services, the United States office of personnel management, the department of job and family services, or the department of administrative services.

(2) The contractual periodic prepayment or premium rate is filed with the superintendent prior to use and is accompanied by documentation of approval from the United States department of health and human services, the United States office of personnel management, the department of job and family services, or the department of administrative services.

(C) The administrative expense portion of all contractual periodic prepayment or premium rate filings submitted to the superintendent for review must reflect the actual cost of administering the product. The superintendent may require that the administrative expense portion of the filings be itemized and supported.

(D)(1) Copayments must be reasonable and must not be a barrier to the necessary utilization of services by enrollees.

(2) A health insuring corporation, in order to ensure that copayments are reasonable and not a barrier to the necessary utilization of basic health care services by enrollees, may do one of the following:

(a) Impose copayment charges on any single covered basic health care service that does not exceed forty per cent of the average cost to the health insuring corporation of providing the service;

(b) Impose copayment charges that annually do not exceed twenty per cent of the total annual cost to the health insuring corporation of providing all covered basic health care services, including physician office visits, urgent care services, and emergency health services, when aggregated as to all persons covered under the filed product in question. In addition, annual copayment charges as to each enrollee shall not exceed twenty per cent of the total annual cost to the health insuring corporation of providing all covered basic health care services, including physician office visits, urgent care services, and emergency health services, as to such enrollee. The total annual cost of providing a health care service is the cost to the health insuring corporation of providing the health care service to its enrollees as reduced by any applicable provider discount.

(3) To ensure that copayments are reasonable and not a barrier to the utilization of basic health care services, a health insuring corporation may not impose, in any contract year, on any subscriber or enrollee, copayments that exceed two hundred per cent of the average annual premium rate to subscribers or enrollees.

(4) For purposes of division (D) of this section, both of the following apply:

(a) Copayments imposed by health insuring corporations in connection with a high deductible health plan that is linked to a health savings account are reasonable and are not a barrier to the necessary utilization of services by enrollees.

(b) Divisions (D)(2) and (3) of this section do not apply to a high deductible health plan that is linked to a health savings account.

(E) A health insuring corporation shall not impose lifetime maximums on basic health care services. However, a health insuring corporation may establish a benefit limit for inpatient hospital services that are provided pursuant to a policy, contract, certificate, or agreement for supplemental health care services.

(F) A health insuring corporation may require that an enrollee pay an annual deductible that does not exceed one thousand dollars per enrollee or two thousand dollars per family, except that:

(1) A health insuring corporation may impose higher deductibles for high deductible health plans that are linked to health savings accounts;

(2) The superintendent may adopt rules allowing different annual deductible amounts for plans with a medical savings account, health reimbursement arrangement, flexible spending account, or similar account;

(3) A health insuring corporation may impose higher deductibles under health plans if requested by the group contract, policy, certificate, or agreement holder, or an individual seeking coverage under an individual health plan. This shall not be construed as requiring the health insuring corporation to create customized health plans for group contract holders or individuals.

(G) As used in this section, "health savings account" and "high deductible health plan" have the same meanings as in the "Internal Revenue Code of 1986," 100 Stat. 2085, 223, as amended.

Effective Date: 09-26-2003; 11-16-2005; 03-29-2007; 2008 HB562 09-22-2008

1751.52 Confidentiality of information.

(A) All applications, filings, and reports required under this chapter shall be treated as public documents after the date the application, filing, or report becomes effective, regardless of the application of the Uniform Trade Secrets Act set forth in sections 1333.61 to 1333.69 of the Revised Code.

(B) Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant for enrollment that is obtained by the health insuring corporation from the enrollee or applicant, or from any health

care facility or provider, shall be held in confidence and shall not be disclosed to any person except under one of the following circumstances:

(1) To the extent that it may be necessary to carry out the purposes of this chapter;

(2) Upon the express consent of the enrollee or applicant;

(3) Pursuant to statute or court order for the production of evidence;

(4) In the event of claim litigation between such person and the health insuring corporation wherein such data or information is pertinent.

(C) A health insuring corporation shall be entitled to claim any statutory privileges against disclosure under division (B) of this section that the facility or provider who furnished the data or information to the health insuring corporation is entitled to claim.

Effective Date: 06-04-1997

3923.02 Form of policy filed with superintendent.

No certificate shall be furnished by any insurer in connection with, or pursuant to any provision of, any group sickness and accident insurance policy delivered, issued for delivery, or used in this state, and no policy of sickness and accident insurance shall be delivered, issued for delivery, or used in this state, nor shall any indorsement, rider, or application which becomes or which is designed to become a part of any such policy or certificate be delivered, issued for delivery, or used in this state, until a copy of the form of such policy, certificate, indorsement, rider, or application and of the premium rates and of the classification of risks pertaining thereto has been filed with the superintendent of insurance. No such policy, certificate, indorsement, rider or application shall be delivered, issued for delivery, or used until the expiration of thirty days after the form of such policy, certificate, indorsement, rider, or application has been filed with the superintendent, unless he has previously given to the insurer his written approval thereto. If the superintendent finds that any such form of policy, certificate, indorsement, rider, or application which has been filed with him by an insurer contains any provision which is contrary to the law of this state, or contains inconsistent provisions, or contains

any question, provision, title, heading, backing, or other indication of its contents, which is ambiguous, misleading, or deceptive, or likely to mislead or deceive the policyholder, certificate holder or applicant, he shall give written notice of his finding to the insurer which has filed such form, and thereafter no insurer which has filed such form shall deliver, issue for delivery, or use such form in this state.

After the expiration of thirty days from the filing of any such form, or at any time after the superintendent has given written approval thereof, the superintendent may, after a hearing of which at least twenty days' written notice has been given to the insurer issuing such form, withdraw approval on any ground stated in this section. Such disapproval shall be effected by written order of the superintendent which shall state the ground for disapproval and the date, not less than thirty days after such hearing, when the withdrawal of approval shall become effective. After the date when the withdrawal of approval of any such form becomes effective, such form shall not be delivered, issued for delivery, or used in this state. The form of any certificate furnished by any insurer to a resident of this state in connection with, or pursuant to any provisions of, any group sickness and accident insurance policy which policy is not delivered, issued for delivery, or used in this state but which insures residents of this state shall, upon request of the superintendent, be filed with the superintendent.

Effective Date: 07-01-1956

3923.15 Unfair discrimination prohibited.

No insurer doing the business of sickness and accident insurance in this state shall make or permit any unfair discrimination between individuals of substantially the same hazard in the amount of premium rates charged for any policy or contract of such insurance or in the benefits payable thereunder. This section does not prohibit different premium rates, different benefits, or different underwriting procedure for individuals insured under group, franchise, or blanket plans of insurance, or for individuals insured under a policy issued to the head of a family as provided in section 3923.03 of the Revised Code.

Effective Date: 10-01-1953

3923.021 Approval or disapproval of premium rates.

(A) As used in this section:

(1)"Benefits provided are not unreasonable in relation to the premium charged" means the rates were calculated in accordance with sound actuarial principles.

(2) "Individual policy of sickness and accident insurance" includes sickness and accident insurance made available by insurers in the individual market to individuals, with or without family members or dependents, through group policies issued to one or more associations or entities.

(B) With respect to any filing, made pursuant to section 3923.02 of the Revised Code, of any premium rates for any individual policy of sickness and accident insurance or certificates made available by an insurer to individuals in the individual market through a group policy or for any indorsement or rider pertaining thereto, the superintendent of insurance may, within thirty days after filing:

(1) Disapprove such filing after finding that the benefits provided are unreasonable in relation to the premium charged. Such disapproval shall be effected by written order of the superintendent, a copy of which shall be mailed to the insurer that has made the filing. In the order, the superintendent shall specify the reasons for the disapproval and state that a hearing will be held within fifteen days after requested in writing by the insurer. If a hearing is so requested, the superintendent shall also give such public notice as the superintendent considers appropriate. The superintendent, within fifteen days after the commencement of any hearing, shall issue a written order, a copy of which shall be mailed to the insurer that has made the filing, either affirming the prior disapproval or approving such filing after finding that the benefits provided are not unreasonable in relation to the premium charged.

(2) Set a date for a public hearing to commence no later than forty days after the filing. The superintendent shall give the insurer making the filing twenty days' written notice of the hearing and shall give such public notice as the superintendent considers appropriate. The superintendent, within twenty days after the commencement of a hearing, shall issue a written order, a copy of which shall be mailed to the insurer that has made the filing, either approving such filing if the superintendent finds that the benefits provided are not unreasonable in relation to the premium charged, or disapproving such filing if the superintendent finds that the benefits provided are unreasonable in relation to the premium charged. This division does not apply to any insurer organized or transacting the business of insurance under Chapter 3907. or 3909. of the Revised Code.

(3) Take no action, in which case such filing shall be deemed to be approved and shall become effective upon the thirty-first day after such filing, unless the superintendent has previously given to the insurer a written approval.

(C) At any time after any filing has been approved pursuant to this section, the superintendent may, after a hearing of which at least twenty days' written notice has been given to the insurer that has made such filing and for which such public notice as the superintendent considers appropriate has been given, withdraw approval of such filing after finding that the benefits provided are unreasonable in relation to the premium charged. Such withdrawal of approval shall be effected by written order of the superintendent, a copy of which shall be mailed to the insurer that has made the filing, which shall state the ground for such withdrawal and the date, not less than forty days after the date of such order, when the withdrawal or approval shall become effective.

(D) The superintendent may retain at the insurer's expense such attorneys, actuaries, accountants, and other experts not otherwise a part of the superintendent's staff as shall be reasonably necessary to assist in the preparation for and conduct of any public hearing under this section. The expense for retaining such experts and the expenses of the department of insurance incurred in connection with such public hearing shall be assessed against the insurer in an amount not to exceed one one-hundredth of one per cent of the sum of premiums earned plus net realized investment gain or loss of such insurer as reflected in the most current annual statement on file with the superintendent. Any person retained shall be under the direction and control of the superintendent and shall act in a purely advisory capacity.

Amended by 128th General Assembly File No. 9, HB 1, § 101.01, eff. 10/16/2009.

Effective Date: 03-22-1999

3923.58 Open enrollment coverage - insurers in the business of issuing individual policies of sickness and accident insurance.

(A) As used in sections 3923.58 and 3923.59 of the Revised Code:

(1) "Base rate" means, as to any health benefit plan that is issued by a carrier in the individual market, the lowest premium rate for new or existing business prescribed by the carrier for the same or similar coverage under a plan or arrangement covering any individual with similar case characteristics.

(2) "Carrier," "health benefit plan," and "MEWA" have the same meanings as in section 3924.01 of the Revised Code.

(3)"Network plan" means a health benefit plan of a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

(4) "Ohio health care basic and standard plans" means those plans established under section 3924.10 of the Revised Code.

(5) "Pre-existing conditions provision" means a policy provision that excludes or limits coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage as to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received, or a pregnancy existing on the effective date of coverage.

(B) Beginning in January of each year, carriers in the business of issuing health benefit plans to individuals and nonemployer groups, except individual health benefit plans issued pursuant to sections 1751.16 and 3923.122

of the Revised Code, shall accept applicants for open enrollment coverage, as set forth in this division, in the order in which they apply for coverage and subject to the limitation set forth in division (G) of this section. Carriers shall accept for coverage pursuant to this section individuals to whom both of the following conditions apply:

(1) The individual is not applying for coverage as an employee of an employer, as a member of an association, or as a member of any other group.

(2) The individual is not covered, and is not eligible for coverage, under any other private or public health benefits arrangement, including the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 301, as amended, or any other act of congress or law of this or any other state of the United States that provides benefits comparable to the benefits provided under this section, any medicare supplement policy, or any continuation of coverage policy under state or federal law.

(C) A carrier shall offer to any individual accepted under this section the Ohio health care basic and standard plans or health benefit plans that are substantially similar to the Ohio health care basic and standard plans in benefit plan design and scope of covered services.

A carrier may offer other health benefit plans in addition to, but not in lieu of, the plans required to be offered under this division. A basic health benefit plan shall provide, at a minimum, the coverage provided by the Ohio health care basic plan or any health benefit plan that is substantially similar to the Ohio health care basic plan in benefit plan design and scope of covered services. A standard health benefit plan shall provide, at a minimum, the coverage provided by the Ohio health care standard plan or any health benefit plan that is substantially similar to the Ohio health care standard plan in benefit plan design and scope of covered services.

For purposes of this division, the superintendent of insurance shall determine whether a health benefit plan is substantially similar to the Ohio health care basic and standard plans in benefit plan design and scope of covered services.

(D)(1) Health benefit plans issued under this section may establish pre-existing conditions provisions that exclude or limit coverage for a period of up to twelve months following the individual's effective date of coverage and that may relate only to conditions during the six months immediately preceding the effective date of coverage. A health insuring corporation may apply a pre-existing condition provision for any basic health care service related to a transplant of a body organ if the transplant occurs within one year after the effective date of an enrollee's coverage under this section except with respect to a newly born child who meets the requirements for coverage under section 1751.61 of the Revised Code.

(2) In determining whether a pre-existing conditions provision applies to an insured or dependent, each policy shall credit the time the insured or dependent was covered under a previous policy, contract, or plan if the previous coverage was continuous to a date not more than sixty-three days prior to the effective date of the new coverage, exclusive of any applicable service waiting period under the policy.

(E) Premiums charged to individuals under this section may not exceed the amounts specified below:

(1)For calendar years 2010 and 2011, an amount that is two times the base rate for coverage offered to any other individual to which the carrier is currently accepting new business, and for which similar copayments and deductibles are applied;

(2)For calendar year 2012 and every year thereafter, an amount that is one and one-half times the base rate for coverage offered to any other individual to which the carrier is currently accepting new business and for which similar copayments and deductibles are applied, unless the superintendent of insurance determines that the amendments by this act to this section and section 3923.581 of the Revised Code, have resulted in the market-wide average medical loss ratio for coverage sold to individual insureds and nonemployer group insureds in this state, including open enrollment insureds, to increase by more than five and one quarter percentage points during calendar year 2010. If the superintendent makes that determination, the premium limit established by division (E)(1) of this section shall remain in effect. The superintendent's determination shall be supported by a signed letter from a member of the American academy of actuaries.

(F) In offering health benefit plans under this section, a carrier may require the purchase of health benefit plans that condition the reimbursement of health services upon the use of a specific network of providers.

(G)(1) A carrier shall not be required to accept new applicants under this section if the total number of the carrier's current insureds with open enrollment coverage issued under this section calculated as of the immediately preceding thirty-first day of December and excluding the carrier's medicare supplement policies and conversion or continuation of coverage policies under state or federal law and any policies described in division (L) of this section meets the following limits:

(a)For calendar years 2010 and 2011, four per cent of the carrier's total number of individual or nonemployer group insureds in this state;

(b)For calendar year 2012 and every year thereafter, eight per cent of the carrier's total number of insured individuals and nonemployer group insureds in this state, unless the superintendent of insurance determines that the amendments by this act to this section and section 3923.581 of the Revised Code, have resulted in the market-wide average medical loss ratio for coverage sold to individual insureds and nonemployer group insureds in this state, including open enrollment insureds, to increase by more than five and one quarter percentage points during calendar year 2010. If the superintendent makes that determination, the enrollment limit established by division (G)(1)(a) of this section shall remain in effect. The superintendent's determination shall be supported by a signed letter from a member of the American academy of actuaries.

(2) An officer of the carrier shall certify to the department of insurance when it has met the enrollment limit set forth in division (G)(1) of this section. Upon providing such certification, the carrier shall be relieved of its open enrollment requirement under this section as long as the carrier continues to meet the open enrollment limit. If the total number of the carrier's current insureds with open enrollment coverage issued under this section falls below the enrollment limit, the carrier shall accept new applicants. A carrier may establish a waiting list if the carrier has met the open enrollment limit and shall notify the superintendent if the carrier has a waiting list in effect.

(H) A carrier shall not be required to accept under this section applicants who, at the time of enrollment, are confined to a health care facility because of chronic illness, permanent injury, or other infirmity that would cause economic impairment to the carrier if the applicants were accepted. A carrier shall not be required to make the effective date of benefits for individuals accepted under this section earlier than ninety days after the

date of acceptance, except that when the individual had prior coverage with a health benefit plan that was terminated by a carrier because the carrier exited the market and the individual was accepted for open enrollment under this section within sixty-three days of that termination, the effective date of benefits shall be the date of enrollment.

(I) The requirements of this section do not apply to any carrier that is currently in a state of supervision, insolvency, or liquidation. If a carrier demonstrates to the satisfaction of the superintendent that the requirements of this section would place the carrier in a state of supervision, insolvency, or liquidation, or would otherwise jeopardize the carrier's economic viability overall or in the individual market, the superintendent may waive or modify the requirements of division (B) or (G) of this section. The actions of the superintendent under this division shall be effective for a period of not more than one year. At the expiration of such time, a new showing of need for a waiver or modification by the carrier shall be made before a new waiver or modification is issued or imposed.

(J) No hospital, health care facility, or health care practitioner, and no person who employs any health care practitioner, shall balance bill any individual or dependent of an individual for any health care supplies or services provided to the individual or dependent who is insured under a policy issued under this section. The hospital, health care facility, or health care practitioner, or any person that employs the health care practitioner, shall accept payments made to it by the carrier under the terms of the policy or contract insuring or covering such individual as payment in full for such health care supplies or services.

As used in this division, "hospital" has the same meaning as in section 3727.01 of the Revised Code; "health care practitioner" has the same meaning as in section 4769.01 of the Revised Code; and "balance bill" means charging or collecting an amount in excess of the amount reimbursable or payable under the policy or health care service contract issued to an individual under this section for such health care supply or service. "Balance bill" does not include charging for or collecting copayments or deductibles required by the policy or contract.

(K) A carrier may pay an agent a commission in the amount of not more than five per cent of the premium charged for initial placement or for otherwise securing the issuance of a policy or contract issued to an individual under this section, and not more than four per cent of the premium charged for the renewal of such a

policy or contract. The superintendent may adopt, in accordance with Chapter 119. of the Revised Code, such rules as are necessary to enforce this division.

(L) This section does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited-duration policy of no longer than six months, or other policy that offers only supplemental benefits.

(M) If a carrier offers a health benefit plan in the individual market through a network plan, the carrier may do both of the following:

(1)Limit the individuals that may apply for such coverage to those who live, work, or reside in the service area of the network plan;

(2) Within the service area of the network plan, deny the coverage to individuals if the carrier has demonstrated both of the following to the superintendent:

(a)The carrier will not have the capacity to deliver services adequately to any additional individuals because of the carrier's obligations to existing group contract holders and individuals.

(b)The carrier is applying division (M)(2) of this section uniformly to all individuals without regard to any health status-related factors of those individuals.

(N) A carrier that, pursuant to division (M)(2) of this section, denies coverage to an individual in the service area of a network plan, shall not offer coverage in the individual market within that service area for at least one hundred eighty days after the date the carrier denies the coverage.

Amended by 128th General Assembly File No. 9, HB 1, § 101.01, eff. 10/16/2009.

Effective Date: 03-22-1999

3923.581 Open enrollment coverage - carriers in the business of issuing health benefit plans to individuals or nonemployer groups.

(A) As used in this section:

(1)"Base rate" means, as to any health benefit plan that is issued by a carrier in the individual market, the lowest premium rate for new or existing business prescribed by the carrier for the same or similar coverage under a plan or arrangement covering any individual with similar case characteristics.

(2) "Carrier," "health benefit plan," "MEWA," and "pre-existing conditions provision" have the same meanings as in section 3924.01 of the Revised Code.

(3) "Federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103.

(4) "Health status-related factor" means any of the following:

(a) Health status;

(b) Medical condition, including both physical and mental illnesses;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including conditions arising out of acts of domestic violence;

(h) Disability.

(5)"Network plan" means a health benefit plan of a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

(6) "Ohio health care basic and standard plans" means those plans established under section 3924.10 of the Revised Code.

(B) Beginning in January of each year, carriers in the business of issuing health benefit plans to individuals or nonemployer groups shall accept federally eligible individuals for open enrollment coverage, as provided in this section, in the order in which they apply for coverage and subject to the limitation set forth in division (J) of this section.

(C) No carrier shall do either of the following:

(1) Decline to offer such coverage to, or deny enrollment of, such individuals;

(2) Apply any pre-existing conditions provision to such coverage.

(D) A carrier shall offer to federally eligible individuals the Ohio health care basic and standard plans or plans substantially similar to the basic and standard plans in benefit design and scope of covered services. For purposes of this division, the superintendent of insurance shall determine whether a plan is substantially similar to the basic or standard plan in benefit design and scope of covered services.

(E) Premiums charged to individuals under this section may not exceed the amounts specified below:

(1) For calendar years 2010 and 2011, an amount that is two times the base rate for coverage offered to any other individual to which the carrier is currently accepting new business, and for which similar copayments and deductibles are applied;

(2) For calendar year 2012 and every calendar year thereafter, an amount that is one and one-half times the base rate for coverage offered to any other individual to which the carrier is currently accepting new business and for which similar copayments and deductibles are applied, unless the superintendent of insurance determines that the amendments by this act to this section and section 3923.58 of the Revised Code, have resulted in a market-wide average medical loss ratio for coverage sold to individual insureds and nonemployer group insureds in this state, including open enrollment insureds, to increase by more than five and one quarter percentage points during calendar year 2010. If the superintendent makes that determination, the premium

limit established by division (E)(1) of this section shall remain in effect. The superintendent's determination shall be supported by a signed letter from a member of the American academy of actuaries.

(F) If a carrier offers a health benefit plan in the individual market through a network plan, the carrier may do both of the following:

(1) Limit the federally eligible individuals that may apply for such coverage to those who live, work, or reside in the service area of the network plan;

(2) Within the service area of the network plan, deny the coverage to federally eligible individuals if the carrier has demonstrated both of the following to the superintendent:

(a) The carrier will not have the capacity to deliver services adequately to any additional individuals because of the carrier's obligations to existing group contract holders and individuals.

(b) The carrier is applying division (F)(2) of this section uniformly to all federally eligible individuals without regard to any health status-related factor of those individuals.

(G) A carrier that, pursuant to division (F)(2) of this section, denies coverage to an individual in the service area of a network plan, shall not offer coverage in the individual market within that service area for at least one hundred eighty days after the date the coverage is denied.

(H) A carrier may refuse to issue health benefit plans to federally eligible individuals if the carrier has demonstrated both of the following to the superintendent:

(1) The carrier does not have the financial reserves necessary to underwrite additional coverage.

(2) The carrier is applying division (H) of this section uniformly to all federally eligible individuals in this state consistent with the applicable laws and rules of this state and without regard to any health status-related factor relating to those individuals.

(1) A carrier that, pursuant to division (H) of this section, refuses to issue health benefit plans to federally eligible individuals, shall not offer health benefit plans in the individual market in this state for at least one

hundred eighty days after the date the coverage is denied or until the carrier has demonstrated to the superintendent that the carrier has sufficient financial reserves to underwrite additional coverage, whichever is later.

(J)(1) Except as provided in division (J)(2) of this section, a carrier shall not be required to accept new applicants under this section if the total number of the carrier's current insureds with open enrollment coverage issued under this section calculated as of the immediately preceding thirty-first day of December and excluding the carrier's medicare supplement policies and conversion or continuation of coverage policies under state or federal law and any policies described in division (L) of section 3923.58 of the Revised Code meets the following limits:

(a)For calendar years 2010 and 2011, four per cent of the carrier's total number of individual or nonemployer group insureds in this state;

(b)For calendar year 2012 and every year thereafter, eight per cent of the carrier's total number of insured individuals and nonemployer group insureds in this state, unless the superintendent of insurance determines that the amendments by this act to this section and section 3923.58 of the Revised Code, have resulted in the market-wide average medical loss ratio for coverage sold to individual insureds and nonemployer group insureds in this state, including open enrollment insureds, to increase by more than five and one quarter percentage points during calendar year 2010. If the superintendent makes that determination, the enrollment limit established by division (J)(1)(a) shall remain in effect. The superintendent's determination shall be supported by a signed letter from a member of the American academy of actuaries.

(2) An officer of the carrier shall certify to the department of insurance when it has met the enrollment limit set forth in division (J)(1) of this section. Upon providing such certification, the carrier shall be relieved of its open enrollment requirement under this section for as long as the carrier continues to meet the open enrollment limit. If the total number of the carrier's current insureds with open enrollment coverage issued under this section falls below the enrollment limit, the carrier shall accept new applicants. A carrier may establish a waiting list if the carrier has met the open enrollment limit and shall notify the superintendent if the carrier has a waiting list in effect. In the event that all the carriers subject to this section have individually met the enrollment limit set

forth in division (J)(1) of this section in a calendar year, carriers shall again accept applicants for open enrollment coverage pursuant to this section, subject to an additional enrollment limit equal to one-half of the limitation set forth in division (J)(1) of this section.

(K) The superintendent may provide for the application of this section on a service-area-specific basis.

(L) The requirements of this section do not apply to any health benefit plan described in division (L) of section 3923.58 of the Revised Code.

(M) A carrier may pay an agent a commission in the amount of not more than five per cent of the premium charged for initial placement or for otherwise securing the issuance of a policy or contract issued to an individual under this section, and not more than four per cent of the premium charged for the renewal of such a policy or contract. The superintendent may adopt, in accordance with Chapter 119. of the Revised Code, such rules as are necessary to enforce this division.

Amended by 128th General Assembly File No. 9, HB 1, § 101.01, eff. 10/16/2009.

Effective Date: 06-30-1997

3924.04 Limits on premium rates - low claim rates.

(A)(1) With respect to any health benefit plan of a carrier and except as otherwise provided in divisions (A)(2) and (3) of this section, the premium rates charged or offered for a rating period for the same or similar coverage under a health benefit plan covering any small employer with similar case characteristics shall not vary from the applicable midpoint rate by more than forty per cent of the midpoint rate, as to all health benefit plans issued on or after the effective date of this section.

(2) A carrier may apply a low claims discount not to exceed five per cent of the midpoint rate to small employers with favorable claims experience. A premium rate for a rating period may fall outside the range set forth in division (A) of this section as the result of a low claims discount.

(3) If the premium rates charged or offered for the same or similar coverage under a health benefit plan covering any small employer with similar case characteristics, as determined by the carrier, exceeds the premium rate limitations described in divisions (A)(1) and (2) of this section, any increase in premium rates for a new rating period shall not exceed the sum of both of the following:

(a) Any percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(b) Any adjustment due to change in case characteristics or plan design of the small employer, as determined by the carrier.

(4) For purposes of this section, a small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(B) If a carrier utilizes industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification shall not vary by more than fifteen per cent from the arithmetic average of the rate factors associated with all industry classifications.

(C) Subject to divisions (A) and (B) of this section, any increase in premium rates for a new rating period shall not exceed any percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period plus fifteen per cent, adjusted on a pro rata basis for rating periods greater or less than one year, of the base premium rate for the new rating period and any adjustments due to a change in case characteristics or plan design of the small employer, as determined by the carrier.

(D) The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code that set forth alternative methods of calculating the premium rates required under this section, which methods result in premium rates that are consistent with, and meet the applicable requirements of, this section. A carrier that utilizes any such method of calculation is deemed to be in compliance with this section.

(E) If a carrier has established a separate class of business for one or more small employer health care alliances in accordance with section 1731.09 of the Revised Code, this section shall apply in accordance with section 1731.09 of the Revised Code.

Effective Date: 04-14-1993; 03-23-2007

APPENDIX B: OHIO STANDARD RATE FILING REQUIREMENTS

	Requirement	Description
1	**Scope and Reason**	Provide the scope and reason for rate revision, including a statement of whether the revision applies only to new business, only to in force business, or to both.
2	**In Force Business**	For in force business, state the policy or certificate count and annualized premium of Ohio policyholders or certificate holders who will be affected by the proposed rate revision. List the average annual premium for Ohio and nationally.
3	**Proposed Effective Date**	State the proposed effective date and method of the proposed rate revision implementation (e.g. next anniversary or next premium due date).
4	**Description of Benefits**	A brief description of the benefits provided by each policy form and any attached riders or endorsements.
5	**History of Rates Adjustments**	List the approval dates and average percentage rate adjustments for the policy form(s), both nationwide and in Ohio since inception of the form(s).
6	**Actuarial Certification**	There must be a certification by a qualified actuary that, to the best of the actuary's knowledge and judgment, the entire rate filing is in compliance with the applicable laws of the State of Ohio and with the rules of the Ohio Department of Insurance, as well as relevant Actuarial Standards of Practice. "Qualified Actuary," as used herein, means a member of the American Academy of Actuaries who meets the Academy's qualification standards for rendering the certification.
7	**Actuarial Memorandum**	Must follow the general outline and requirements described in NAIC Guidelines, including relevant Actuarial Standards of Practice.
8	**Dates of Issue**	State the period during which the policy form was issued in Ohio.
9	**Ohio and National Experience (Past and Future Anticipated)**	Provide Ohio and national experience on the form(s), past and future anticipated, as follows: -Experience from inception for each calendar year and, where appropriate, each policy year must be displayed. -If there have been prior rate adjustments, past experience must be presented on both an actual basis and a current premium rate basis. - Show experience separately for Ohio and for all states in which the form is or was sold. -State whether the proposed rates are based on Ohio experience, national experience, or a combination and explain the reasons this basis was used.
10	**Supporting Information**	Include sufficient supporting information to demonstrate that the rates are not excessive, inadequate, or unfairly discriminatory. At a minimum, include an analysis of actual and projected experience with respect to morbidity, mortality, lapsation, and any other relevant factors. Include a comparison to original pricing assumptions and to the assumptions at the time of any previous rate adjustment.

Please note: This list of filing requirements is a high level summary. Additional information may be required on a case by case basis for adequate review.

APPENDIX C - SUMMARY OF PRODUCTS AND ASSOCIATED GOVERNING LAWS

As of 10/1/2009 Insurance Type	Indemnity Department Action	Ind. Medical Underwriting (Y/N)	Underwriting At Renewal (Y/N)	Health Insuring Corp. Department Action
Individual				
Individual	Prior Approval Required 30 Day Deemer	Y	N (ORC 3923.15)	Prior Approval Required 60 Day Deemer
Short Term	Prior Approval Required 30 Day Deemer	Y	Y	N/A
Non-Employer Based				
Association Group Trust (Individual Market) ERISA	Prior Approval Required 30 Day Deemer	Y	Y	N/A
Conversion to Individual Coverage (Basic and Standard)				
Non-FEI :Any Individual Contract Available	Prior Approval Required 30 Day Deemer (Must have Small or Large Group)	Y	N	Prior Approval Required 60 Day Deemer (Must have Small or Large Group)
Basic & Standard: FEI	Prior Approval Required 30 Day Deemer (Must have Small or Large Group)	Y	N	Prior Approval Required 60 Day Deemer (Must have Small or Large Group)
Open Enrollment (Basic and Standard)				
Pre-HIPPA: non-FEI	Prior Approval Required 30 Day Deemer (Must have Individual or Non-Employer Business)	Y	N	Prior Approval Required 60 Day Deemer (no new business on state held OE)
HIPPA: FEI	Prior Approval Required 30 Day Deemer (Must have Individual or Non-Employer Business)	Y	N	Prior Approval Required 60 Day Deemer (Must have Individual or Non-Employer Business)
Group				
Employer Based				
Fully Insured Group:				
Small Employer (Group Policy) (2-50 as defined in ORC 3924.01N)	File and Use (Rates Maintained On File) Small Group Cert Required	Y	+/- 15% Limit	File and Use (Accept or Reject- 30 Day Process Deemer) Small Group Cert Required
Large Employer (51 and greater)	File and Use (Rates Maintained On File)	Y	Y	File and Use (Accept or Reject- 30 Day Process Deemer)
Self Insured HBP: Health Benefit Plan				
MEWA	No Rate Review Regulation Cert Required	N/A	N/A	N/A
Supplemental HIC	N/A	Y	N	Prior Approval Required 60 Day Deemer
Long Term Care (Individual)	Prior Approval Required 30 Day Deemer	Y	N	N/A
Group	File and Use (Rates Maintained On File)	Y	N	
Medicare Supplemental (Group & Individual)	Prior Approval Required 30 Day Deemer	Y N- open enrollment	N	Admin must be actual. And rate and doc must be on file.
Medicaid	N/A	N/A	N/A	Admin must be actual. And rate and doc must be on file.

Appendix D

DATE: June 25, 2010

TO: All Commissioners

FROM: Julienne L. Fritz, Director of Insurance Products and Services

RE: Department of Health and Human Services (HHS) Grants to States for Health Insurance Premium Review-Cycle I – Estimate for leveraging SERFF

Given the NAIC's Speed to Market initiatives and the role SERFF plays in the rate and form filing and review process, it has been considered logical and cost effective to utilize SERFF in meeting many IT requirements as outlined in the grant. Based on the provisions of the grant and at the request of states, the NAIC has estimated the cost of leveraging SERFF. To that end, the NAIC has provided a description of deliverables, timeline and estimated cost, which are outlined below, and may be incorporated into a grant application. It should be noted that the information provided by the NAIC is based on limited knowledge of the HHS reporting requirements and will be refined once the uniform template and definitions for data reporting are provided, which are tentatively scheduled for availability in early August.

The NAIC is comfortable with our ability to meet HHS requirements and has received information that suggests HHS would accept the proposed delivery timelines. It may be valuable to know that, while not required, HHS has indicated interest in being able to collect data/reports through a uniform system implementation, which the NAIC is willing to facilitate and is contemplated below. HHS has also indicated that there is no intention to build any restrictions into a grant acceptance agreement which would limit the states ability to use grant funds for this purpose.

<u>*Grant Application Information:*</u>

Cost: $18,808

Description of Deliverables:

1) Requirements defined in Section A.1(c)(1) and A.1(c)(2) on pages 15, 16 and 17. Specifically, the estimate covers the expenses associated with modifying SERFF to address data collection and reporting requirements, such as:
    a. State options to indicate premium review grant participation
    b. Company profile changes to incorporate company type
    c. State-maintained indicator for rate filing requests meeting the HHS threshold for 'unreasonable'.
    d. Addition of field to indicate product types

EXECUTIVE OFFICE 444 N. Capitol Street, NW, Suite 701 Washington, DC 20001-1509 p | 202 471 3990 f | 816 460 7493
CENTRAL OFFICE 2301 McGee Street, Suite 800 Kansas City, MO 64108-2662 p | 816 842 3600 f | 816 783 8175
SECURITIES VALUATION OFFICE 48 Wall Street, 6th Floor New York, NY 10005-2906 p | 212 398 9000 f | 212 382 4207
www.naic.org

e. Company-maintained product information including product name, HHS id, and product status that will allow the companies to track products and apply them to filings.
f. A new set of fields added to the Rate/Rule schedule items to provide HIPR data on a policy form basis.
g. Changes to the State API to accommodate retrieval of the data elements added above and to allow for updates of appropriate data elements via the State API.

2) Incorporating the submission of a federally mandated Rate Filing Disclosure Form and Justification (currently being reviewed by the B Committee) that is required to be filed under provisions of the Affordable Care Act if a rate request falls under the definition of 'unreasonable'. The estimate provided by the NAIC would also allow the Rate Filing Disclosure Form, or similar document, to be filed regardless of whether the rate request falls under the definition of 'unreasonable' in the event the states wanted to include this in their submission requirements to facilitate meeting the requirement that consumer friendly descriptions of rate filings be made available publicly.
3) Additional SERFF state training that will support the grant requirements.
4) Support for making non-confidential consumer friendly rate disclosures and/or rate filing information available publicly, as required and permitted.
5) Support the ability to satisfy reporting requirements of the uniform template for data reporting within the SERFF system, if HHS will accept reports directly from SERFF, including basic trending reports.

The workflow on a Health filing that requires the enhanced data reporting fields will vary from the existing SERFF workflow. States will set preferences that will indicate the level of data they would like to require. Fields exposed to the industry during the filing creation process are determined by these state preferences. The overall workflow will be changed in that the filer will now be required to tie schedule items (such as rates and policy forms) to a specific product. This will allow for the reporting of data based on the product the consumer will ultimately be offered. A significant portion of the project hours will be devoted to aggregating the collected data into the reports required by HHS. An interface to allow HHS to get reports from SERFF is included within the estimate should that prove a requirement.

Delivery Timeline:

The SERFF enhancements incorporating HHS reporting requirements will be implemented in a phased approach with the first release to occur within 3 months of the receipt of HHS requirements for the uniform template for reporting. The initial release will focus on implementing the means for data collection; subsequent releases will incorporate reporting needs. Releasing functionality in this manner will allow a period of time during which data can then be submitted by insurers prior to any required reporting to HHS, thus avoiding manual data collection processes. Based on the requirements known at this time, the development will occur over an 8 month period beginning when the NAIC receives the reporting template and supporting documentation.

APPENDIX E - IT PROJECT PLAN

ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1	Grant Award Notification	0 days	Mon 8/9/10	Mon 8/9/10		
2	**Technical Consultants Procurement Process**	**19 days**	**Mon 8/9/10**	**Thu 9/2/10**		
3	RFQ Issued	1 day	Mon 8/9/10	Mon 8/9/10	1	ODI IT Staff
4	RFQ on the street	5 days	Tue 8/10/10	Mon 8/16/10	3	ODI IT Staff
5	Proposal Due Date	0 days	Mon 8/16/10	Mon 8/16/10	4	ODI IT Staff
6	Review Proposals	2 days	Tue 8/17/10	Wed 8/18/10	5	ODI IT Staff
7	Candidate Interviews	5 days	Thu 8/19/10	Wed 8/25/10	6	ODI IT Staff
8	Vendor Selection	0 days	Wed 8/25/10	Wed 8/25/10	7	ODI IT Staff
9	State Release and Permit	5 days	Thu 8/26/10	Wed 9/1/10	8	ODI IT Staff
10	Purchase Order	1 day	Thu 9/2/10	Thu 9/2/10	9	ODI IT Staff
11	Technical Consultants Procurement Process Complete	0 days	Thu 9/2/10	Thu 9/2/10	10	
12	**Initial SERFF API Integration**	**20 days**	**Fri 9/3/10**	**Thu 9/30/10**		
13	Requirements Gathering	3 days	Fri 9/3/10	Tue 9/7/10	11	Business Analyst
14	Data modeling	5 days	Wed 9/8/10	Tue 9/14/10	13	DBA
15	Database design	5 days	Wed 9/15/10	Tue 9/21/10	14	DBA
16	Web Services Development	6 days	Wed 9/22/10	Wed 9/29/10	15	Application Developer
17	Initial data transfer	0 days	Wed 9/29/10	Wed 9/29/10	16	
18	Data Validation	1 day	Thu 9/30/10	Thu 9/30/10	17	ODI IT Staff
19	Initial SERFF API Integration Complete	0 days	Thu 9/30/10	Thu 9/30/10	18	
20	**Federal Reporting Framework**	**15 days**	**Fri 10/1/10**	**Thu 10/21/10**		
21	Requirements Gathering	3 days	Fri 10/1/10	Tue 10/5/10	19	Business Analyst
22	Data Mart modeling	5 days	Wed 10/6/10	Tue 10/12/10	21	DBA
23	Report Development	6 days	Wed 10/13/10	Wed 10/20/10	22	DBA
24	Initial Report Generated	0 days	Wed 10/20/10	Wed 10/20/10	23	
25	Report Validation	1 day	Thu 10/21/10	Thu 10/21/10	24	ODI IT Staff
26	Federal Reporting Framework Complete	0 days	Thu 10/21/10	Thu 10/21/10	25	
27	**Web Application/Consumer Portal**	**118 days**	**Fri 10/22/10**	**Tue 4/5/11**		
28	**Sprint #1**	**34 days**	**Fri 10/22/10**	**Wed 12/8/10**		
29	Requirements	10 days	Fri 10/22/10	Thu 11/4/10	26	Business Analyst
30	Design	5 days	Fri 11/5/10	Thu 11/11/10	29	Application Architect
31	Development	15 days	Fri 11/12/10	Thu 12/2/10	30	Application Developer
32	Integration Testing	2 days	Fri 12/3/10	Mon 12/6/10	31	Application Developer
33	User Acceptance Testing	1 day	Tue 12/7/10	Tue 12/7/10	32	ODI IT Staff
34	Deployment	1 day	Wed 12/8/10	Wed 12/8/10	33	Application Architect
35	Sprint #1 Complete	0 days	Wed 12/8/10	Wed 12/8/10	34	

Project: Health Insurance Premium Re
Date: Mon 6/28/10

Task | Progress | Summary | External Tasks | Deadline
Split | Milestone | Project Summary | External Milestone

APPENDIX E - IT PROJECT PLAN

ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
36	**Sprint #2**	**28 days**	**Thu 12/9/10**	**Mon 1/17/11**		
37	Requirements	4 days	Thu 12/9/10	Tue 12/14/10	35	Business Analyst
38	Design	5 days	Wed 12/15/10	Tue 12/21/10	37	Application Architect
39	Development	15 days	Wed 12/22/10	Tue 1/11/11	38	Application Developer
40	Integration Testing	2 days	Wed 1/12/11	Thu 1/13/11	39	Application Developer
41	User Acceptance Testing	1 day	Fri 1/14/11	Fri 1/14/11	40	ODI IT Staff
42	Deployment	1 day	Mon 1/17/11	Mon 1/17/11	41	Application Architect
43	Sprint #2 Complete	0 days	Mon 1/17/11	Mon 1/17/11	42	
44	**Sprint #3**	**28 days**	**Tue 1/18/11**	**Thu 2/24/11**		
45	Requirements	4 days	Tue 1/18/11	Fri 1/21/11	43	Business Analyst
46	Design	5 days	Mon 1/24/11	Fri 1/28/11	45	Application Architect
47	Development	15 days	Mon 1/31/11	Fri 2/18/11	46	Application Developer
48	Integration Testing	2 days	Mon 2/21/11	Tue 2/22/11	47	Application Developer
49	User Acceptance Testing	1 day	Wed 2/23/11	Wed 2/23/11	48	ODI IT Staff
50	Deployment	1 day	Thu 2/24/11	Thu 2/24/11	49	Application Architect
51	Sprint #3 Complete	0 days	Thu 2/24/11	Thu 2/24/11	50	
52	**Sprint #4**	**28 days**	**Fri 2/25/11**	**Tue 4/5/11**		
53	Requirements	4 days	Fri 2/25/11	Wed 3/2/11	51	Business Analyst
54	Design	5 days	Thu 3/3/11	Wed 3/9/11	53	Application Architect
55	Development	15 days	Thu 3/10/11	Wed 3/30/11	54	Application Developer
56	Integration Testing	2 days	Thu 3/31/11	Fri 4/1/11	55	Application Developer
57	User Acceptance Testing	1 day	Mon 4/4/11	Mon 4/4/11	56	ODI IT Staff
58	Deployment	1 day	Tue 4/5/11	Tue 4/5/11	57	Application Architect
59	Sprint #4 Complete	0 days	Tue 4/5/11	Tue 4/5/11	58	
60	Web Application/Consumer Portal Complete	0 days	Tue 4/5/11	Tue 4/5/11	59	

Gantt chart timeline: 1, Aug 8, Sep 5, Oct 3, Oct 31, Nov 28, Dec 26, Jan 23, Feb 20, Mar 20, Apr 17, May 15, Ju — bar labels: Business Analyst; Application Architect; Application Developer; Application Developer; ODI IT Staff; Application Architect; 1/17; Business Analyst; Application Architect; Application Developer; Application Developer; ODI IT Staff; Application Architect; 2/24; Business Analyst; Application Architect; Application Developer; Application Developer; ODI IT Staff; Application Architect; 4/5; 4/5

Project: Health Insurance Premium Re
Date: Mon 6/28/10

Legend: Task, Split, Progress, Milestone, Summary, Project Summary, External Tasks, External Milestone, Deadline

Department of Insurance

Ted Strickland, Governor
Mary Jo Hudson, Director

50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215-4186
(614) 644-2658
www.insurance.ohio.gov

This letter satisfies the Eligibility Requirement as noted on page 10 (section IV.B.3 Applicant's Application Cover Letter) of the Department of Health and Human Services Grants to States for Health Insurance Premium Review – Cycle 1 Grant Announcement CFDA: 93.511 dated June 7, 2010.

Eligible Entity: The Ohio Department of Insurance

Title of Project: Grants to States for Health Insurance Premium Review – Cycle 1

Project Director: Mary Miller, Assistant Director, Product Regulation and Actuarial Services

Date: June 30, 2010

Please be assured that the Ohio Department of Insurance has existing authority to oversee and coordinate the proposed activities included in this grant application. The work plan included in this grant application clearly illustrates the department's authority, capacity, and competency in convening suitable working groups headed by the Project Director, Mary Miller, for all activities associated with this grant.

Best regards,

Mary Jo Hudson
Director
Ohio Department of Insurance

This Budget Narrative satisfies the Requirement as noted on page 18 (section V.A.3 Budget Narrative) of the Department of Health and Human Services Grants to States for Health Insurance Premium Review – Cycle 1 Grant Announcement CFDA: 93.511 dated June 7, 2010.

BUDGET NARRATIVE

Personnel/Fringe Benefits $803,936

To enhance the rate review and approval process we propose to hire a qualified health actuary and an additional actuarial analyst, two additional contract analysts to assist the actuaries in determining if the coverage in contract meets the PPACA requirements and is consistent with the rates the filings propose to implement, and three data analysts to assist in analyzing data and trends, creating an internal database, and to go into the companies to verify that the rates are being applied the way they have been filed so they are able to assist the actuaries in understanding if rates are being calculated as would be expected from the filing.

No.	Job Title	Salary	Fringes	Total
1	Actuary	140,000	36,400	176,400
2	Actuarial Analyst 2	72,842	23,309	96,151
3	Contract Analyst 5	88,462	26,539	115,001
4	Contract Analyst 5	88,462	26,539	115,001
5	Data Analysts 2	76,107	24,354	100,461
6	Data Analysts 2	76,107	24,354	100,461
7	Data Analysts 2	76,107	24,354	100,461
	Total	**618,087**	**185,849**	**803,936**

Information and Technology $99,600

The Ohio Department of Insurance (ODI) will use information technology consulting services to develop an automated process to pull data from the Application Programming Interface (API) provided by the System for Electronic Rate and Form Filing (SERFF). Based on a predetermined transmission frequency, ODI will leverage its current data warehouse and reporting environment to consume, store and interact with SERFF data in order to create appropriate data files to fulfill the Federal reporting requirements. ODI will also develop a consumer friendly Web application, located on ODI's public website, to assist Ohioans in using the product and pricing information.

Role	Hours	Rate	Ext. Amt
Business Analyst	80	$70	$5,600
Application Developer	600	$70	$42,000
Database Administrator	400	$80	$32,000
Application Architect	200	$100	$20,000
		Total:	$99,600

State Electronic Rate and Form Filing System (SERFF) $20,000

Develop enhancements to SERFF to incorporate HHS reporting requirements will be implemented in a phased approach with the first release to occur within 3 months of the receipt of HHS requirements for the uniform template for reporting. The initial release will focus on implementing the means for data collection; subsequent releases will incorporate reporting needs. Based on the requirements known at this time, the development will occur over an 8-month period beginning when the NAIC receives the reporting template and supporting documentation.

Health Cost Index $50,000

The purchase of a subscription to am health cost index, i.e. Towers Perrin Health Maps, that compiles medical trend data to verify the consistency of company's trend analysis with industry-wide data.

Technical Support $26,464

Engage consulting actuaries to assist with the filing review load during peak filing times and assist with training needs.

ATTACHMENT C

This Application Cover Sheet and Check-off List satisfies the Application and Submission Information as noted on page 9 (section IV.B.1.a) of the Department of Health and Human Services Grants to States for Health Insurance Premium Review – Cycle 1 Grant Announcement CFDA: 93.511 dated June 7, 2010.

APPLICATION COVER SHEET AND CHECK-OFF LIST

Identifying Information:

Grant Opportunity: **HHS Health Insurance Rate Review Grants-Cycle I**

DUNS #: **8091719450000**

Grant Award: **$1 million**

Applicant: **Ohio Department of Insurance**

Primary Contact Person, Name: **Mary Miller**

Telephone Number: **614-644-3331**

Fax number: **614-644-3741**

Email address: **Mary.Miller@insurance.ohio.gov**

APPLICATION COVER SHEET AND CHECK-OFF LIST

REQUIRED CONTENTS

A complete proposal consists of the following material organized in the sequence below: Please ensure that the project narrative is page-numbered. The sequence is:

- ☐ Cover Sheet
- ☐ Forms/Mandatory Documents (Grants.gov).

  The following forms must be completed with an original signature and enclosed as part of the proposal:

- ☐ SF-424: Application for Federal Assistance
- ☐ SF-424A: Budget Information
- ☐ SF-424B: Assurances-Non-Construction Programs
- ☐ SF-LLL: Disclosure of Lobbying Activities
- ☐ Additional Assurance Certifications
- ☐ Required Letter of support and Memorandum of Agreement
- ☐ Applicant's Application Cover Letter
- ☐ Project Abstract
- ☐ Project Narrative
- ☐ Work plan and Time Line
- ☐ Proposed Budget (Narrative/Justifications)
- ☐ Required Appendices
- ☐ Resume/Job Description for Project Director and Assistant Director

Department of
Insurance

Ted Strickland, Governor
Mary Jo Hudson, Director

50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215-4186
(614) 644-2658
www.insurance.ohio.gov

This letter satisfies the Eligibility Requirement as noted on page 7 (section III; A. Eligible Applicants) and on page 18 (section V.A.4.a Letter of Support from State) of the Department of Health and Human Services Grants to States for Health Insurance Premium Review – Cycle 1 Grant Announcement CFDA: 93.511 dated June 7, 2010.

June 30, 2010

Re: Grants to States for Health Insurance Premium Review – Cycle 1

Please be assured that all funding obtained through the Department of Health and Human Services ***Grants to States for Health Insurance Premium Review – Cycle 1*** will *only* be used to enhance Ohio's existing rate review efforts. The funding obtained will *not* be used as a substitute for or supplant in any way existing rate review funding.

Sincerely,

Jianming Xia
Assistant Director, Fiscal Division
Ohio Department of Insurance

Department of Insurance

Ted Strickland, Governor
Mary Jo Hudson, Director

50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215-4186
(614) 644-2658
www.insurance.ohio.gov

The attached letter from Governor Strickland satisfies the Eligibility Requirement as noted on page 10 (section IV.B.2 – Required Letter of Support) and on page 18 (section V.A.4.a Letter of Support from State) of the Department of Health and Human Services <u>Grants to States for Health Insurance Premium Review – Cycle 1</u> Grant Announcement CFDA: 93.511 dated June 7, 2010.

TED STRICKLAND
GOVERNOR
STATE OF OHIO

June 29, 2010

The Honorable Kathleen Sebelius
Secretary, U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Re: Ohio Is Interested in Applying for a Grant for Health Insurance Premium Review Enhancement – Cycle 1

Dear Secretary Sebelius,

Thank you for your leadership in implementing federal health care reform and for working quickly to make grant opportunities available to states to improve our health care and coverage system. I am writing in support of the Ohio Department of Insurance's application for the Grants to States for Health Insurance Premium Review that you announced on June 7, 2010.

I support efforts to make private health insurance more accessible and affordable and to increase the transparency of the health insurance system. I proposed legislation last year which was subsequently enacted into law that expanded the requirements for health insurance carriers to file all premium rates with the Ohio Department of Insurance. This law, which became effective in October of 2009, complements HHS efforts to assist states in the premium review process. With this enhanced state filing requirement, Ohio is able to review all health insurance premium rates, in accordance with federal law, prior to use in Ohio.

I am confident that the health insurance rate review improvements that the Ohio Department of Insurance has outlined in its grant application will help protect Ohioans from unjustified rate increases. I remain committed to work in partnership with you and President Obama to implement the Patient Protection and Affordable Care Act.

Sincerely,

Ted Strickland

Ted Strickland
Governor, State of Ohio

77 SOUTH HIGH STREET • 30TH FLOOR • COLUMBUS, OHIO 43215-6117 • 614.466.3555 • FAX: 614.466.9354

This Project Narrative satisfies the Requirement of the Department of Health and Human Services Grants to States for Health Insurance Premium Review – Cycle 1 Grant Announcement CFDA: 93.511 dated June 7, 2010 as noted on page 12 section IV.B.5 – Project Narrative; page 12 section V.A.1.a) Current Health Insurance Rate Review Capacity and Process; page 14 section V.A.1.b) Proposed Rate Review Enhancements for Health Insurance; and page 15 section V.A.1.c) Reporting to the Secretary on Rate Increase Patterns.

PROJECT NARRATIVE

SECTION V.A.1.a) CURRENT HEALTH INSURANCE RATE REVIEW CAPACITY AND PROCESS

- **General health insurance rate regulation information**
  - ***Licensed products by market segment***

All insurance carriers selling health insurance in Ohio are licensed and regulated by the Ohio Department of Insurance. Ohio licenses two types of insurers: (1) sickness and accident insurers that are traditional indemnity insurers including insurers selling PPO products; and (2) health insuring corporations (HICs) selling managed care products with closed network plans, commonly known as HMOs.

Ohio has policy and rate approval or disapproval authority over any product that meets the definition of sickness and accident insurance (including insured PPO plans) and HMO plans in all markets.

  - ***Rating rules and case characteristics used***

Ohio allows for but does not require community rating and rating bands. Approved case characteristics are age, gender, industry, geographic location, health status (smoker vs. non-smoker) and any other characteristic that may be objectively defined, is actuarially sound and is non-discriminatory. In addition, group rates may be wholly or partially experience rated.

See ***Appendix A*** for relevant statutes and regulations.

- **Health Insurance rate review and filing requirements including:**
  - ***A description of the type of data included in insurers' rate filings***

There are standardized filing requirements but not a specific format. Ohio requires all rate filings to be submitted through the System for Electronic Rate and Form Filing (SERFF) using the standard filing structure and review elements inherent to that system. In addition, the Ohio Department of Insurance has customized its application of SERFF with "Requirements" for detailed information to support all rate change requests. These Requirements are listed in ***Appendix B***.

In Ohio, sickness and accident insurance and HMO rate review authority may be summarized as follows:

Individual: All individual sickness and accident insurance (including insurance sold to individuals marketed through a group association) and HIC rates must be approved prior to use.

Small Employer Groups (two to 50): Small employer group rates are submitted to the Ohio Department of Insurance on a file and use basis. The Department reviews all filings. Ohio may disapprove small group rates if they are not actuarially justified or do not comply with Ohio's small group rating bands and rules. The Department reviews all such filings for compliance with Ohio law and for actuarial soundness.

Large Group (51 plus): Large group rates are submitted on a file and use basis. Companies are required to file their rating methodology and case characteristics to develop large group rates, and such information must be actuarially justified. The Department reviews all such filings for compliance with Ohio law and actuarial soundness.

The list of filing requirements in ***Appendix B*** is a high level summary. Additional information may be required on a case by case basis for adequate review. *No sample filing is attached as there is not a specified format.*

- ***Ohio's rate review process, including rates subject to review, resources and a breakdown of State staff and private sector consultants***

In general, the rate review process begins when files are received exclusively through SERFF. These file may be Rates, Forms or, Rates and Forms. Regardless of how the file is submitted, if the file contains rates, the file will be reviewed by an actuarial analyst. This process was adopted to ensure a thorough review of all rates received by the Department in whatever format they may arrive. A summary of the products and the laws governing them is attached as ***Appendix C***.

The Ohio Department of Insurance currently has three actuarial analysts who have expertise in all areas of health insurance. Ohio does not currently use private sector consultants.

Rate/form files are first reviewed for completeness. The actuary submitting the rate/form filing is required to provide information about his or her credentials and the rate information specific to the file.

For the individual health policies, components of the file are then checked for the actuarial memorandum, rates, and a sign off by a qualified actuary.

National and Ohio specific information is required for policy counts, inception to date loss ratios, projections (including earned and written premiums, paid and incurred claims along with the reserves), and historical rate increases with implementation dates. This information is used to gauge how the product is performing and to assess needed rate relief for the base rates. Originally filed anticipated loss ratios are checked to ensure that rates are prospective and not recouping past losses. Additionally, factors are checked for the appropriateness of experience adjustments and trends. Rates on individual health insurance may not be unfairly discriminatory.

For employee based group insurance, the laws are stricter for small group (two to 50 eligible employees) than they are for large groups. The specific differences are identified in ***Appendix B*** and include variances of no more than plus or minus 40 percent due to claims experience and no more than plus or minus 15 percent due to industry differences. Filings may include case characteristics other than medical claims such as demographics and industry factors. These items are closely scrutinized for appropriateness. Large group regulation, while less proscriptive than small group, must continue to be actuarially sound and filed prior to use.

All changes to factors such as industry, age, sex, smoking/ non-smoking, underwriting, geographic, and any other acceptable actuarial factor allowed, and/or changes in methodology must be filed prior to use.

- ***Criteria for implementing legal authority for rate review and how rates are evaluated***

The Ohio regulations that concern rate filings are listed below. Due to the length of the statutes, they have been attached as ***Appendix A.*** Following the identification of the Ohio Revised Code Section is a brief statement summarizing the rating authority provided by each statute.

3923.021 *Approval or disapproval of premium rates.* (This statute describes Ohio's authority to disapprove rates if premiums are not reasonable in relation to premium.)

3923.15 *Unfair discrimination prohibited.* (This statute allows Ohio to disapprove individual rates if the rates are unfairly discriminatory.)

3923.58 *Open enrollment coverage* - insurers in the business of issuing individual policies of sickness and accident insurance. (This statute requires Ohio open enrollment Non-FEI plan rates must be no more than 2 times the lowest base rate for similar plan designs.)

3923.581 *Open enrollment coverage* - carriers in the business of issuing health benefit plans to individuals or nonemployer groups. (This statute requires that Ohio open enrollment FEI plan rates must be no more than 2 times the lowest base rate for similar plan designs.)

3924.04 *Limits on premium rates* - low claim rates. (This statute provides the requirements applicable to small group rates. An important stipulation is that a small employer's case characteristic based on their own experience may not increase by more than 15% in a given year.)

1751.12 *Contractual periodic prepayment or premium rate.* (This statute explains Ohio's authority to disapprove HIC (i.e., HMO plan) rates if premiums are not reasonable in relation to coverage, or are not based on sound actuarial principles.)

- ***The grounds for rate approval, modification and rejection***

Reductions or denials of rate increases are not uncommon in day-to-day rate filing reviews. On average, over the last five years, 35 percent of medical plan rate filings have been disapproved. It is estimated that 10 to15 percent of those denials were the result of incomplete documentation to support the request. Many additional filings have been approved only after reduction of the original rate increase requested.

The factors that are considered in a rate review include, but are not limited to those identified in ***Appendix B***. Approval, modification, or rejection of a filing is based on an evaluation of these factors as well as any others that may apply.

- ***An explanation as to whether rates are approved, modified or rejected prospectively (i.e. before implementation) or retrospectively (after implementation)***

Individual and non-employer group rates are approved prospectively. Employer group rates are approved or disapproved retrospectively.

- ***An explanation of the factors that trigger retrospective review, whether or not rebates provided to consumers if rates are determined to be unjustified and, if so, how rebates are calculated and disbursed.***

All rates are reviewed, regardless of whether they are filed on a prospective or retrospective basis. Rebates are not specifically addressed in Ohio Revised Code but the Superintendent is not prohibited from ordering them.

- ***Explicit statutory or regulatory approval authority***

Ohio has explicit statutory approval authority. See 3923.02 in ***Appendix A***.

- **Current level of resources and capacity for reviewing health insurance rates:**
  - ***Information Technology (I) and systems capacity Current IT systems.***

All filings are required to be submitted through SERFF. The system supports our current process but will need to be enhanced to support the PPACA regulations as the reporting requirements included in the grant are not currently supported by SERFF.

- *Annual overall total budget and revenue for the Insurance Department*

For FY 2009, the Ohio Department of Insurance's budget was $33.4 million.

- *The budgetary breakdown for rate review for health insurance coverage in the individual and/or group markets*

ODI's current budget for reviewing Health rates is $461,946. This amount includes the salaries of three actuarial analysts and one credentialed actuary. The credentialed actuary position is currently unfilled but we are interviewing candidates. The actuarial positions in the proposed budget are additional positions.

- *A description of the qualifications (education and professional background) of the Insurance Department staff responsible for rate review*

The current ODI staff responsible for rate review all have an undergraduate degree in mathematics or actuarial science. Two of the three analysts are within one or two exams of attaining Associateship status in the Society of Actuaries (i.e., ASA) and the other analyst has more than 20 years experience in reviewing rate filings. We currently have a position open for a qualified health actuary. To date, we have not contracted out for rate review.

- *Total number of health insurance rate filings and the average amount of time required to complete the review process*

The annual estimated number of rate filings for fiscal year 2009/2010 is 500. The average amount of time required to complete a review is 32 days.

- **Consumer protections:**
  - *Public disclosure of rate filings*

Rate filings are publicly disclosed for HMOs once they are approved. Ohio Revised Code (ORC Section 1751.52) specifically restricts public access to HMO plan rate and form filing materials but only prior to approval of the filing. A copy of this statute is included in ***Appendix A***.

Rate filings for sickness and accident insurers are public when they are filed.

In general, rate filing records are subject to Ohio Revised Code (ORC Section 149.43) regarding the availability of public records for inspection and copying. Due to its length, the following link is being provided to ORC Section 149.43: http//codes.ohio.gov/orc/149.43. The text of the statute is attached in ***Appendix A***.

- ***Summaries of rate changes in plain language for consumers***

No, summaries of rate changes are not offered in plain language to consumers.

- ***Advanced notice to consumers on proposed rate changes, comment periods***

Ohio law does not require the ODI to provide consumers advanced notice of proposed rate changes.

- ***Processes for public meetings and/or hearings on rate filings***

Ohio Revised Code section 3923.021 governs the public hearing process. In general, the process allows for the filing company to appeal any denial of a rate filing. The text of the statute is attached in ***Appendix A***.

- ***Summary of consumer inquiries and complaints over two years***

There were 178 health premium and rating complaints in the past 24 months. The complaints were related either to unfair, unaffordable or unsubstantiated rate increases.

- **Examination and Oversight**:
  - ***Actions taken against insurance companies over the past two plan years regarding health insurance rates***

Our current rate review process has made rating actions against companies unnecessary. Improper rates or rating algorithms are rejected and/or modified prior to inception.

- ***Formal hearings held over the past two plan years regarding health insurance rates***

There have been no formal hearings held over the past two plan years. However, on June 28, 2010, the Ohio Department of Insurance entered into a Consent Order with Anthem (Community Insurance

Company) because the insurer was charging consumer rates that were not consistent with the rates filed with the Department. The Consent Order required Anthem to refund $6 million to 45,000 Ohioans.

- ***Challenges in the current rate review processes, including whether or not the State has access to and the ability to collect, complete policy forms and the comprehensiveness of the data collected (i.e. Is the State receiving the necessary forms and data it needs from the insurers?)***

Challenges in the current process include a need for additional resources to review rates and to coordinate the review of rates used in the marketplace compared to rates that are actually on file. We need a more comprehensive rate and form review coordination to better evaluate the link between benefits identified in the forms and the rates that are being charged. While SERFF is a useful tool, we need enhancements to be able to better track industry and company performance. We also need to be able to better integrate SERFF functionality into our internal systems and databases. We need more and better data as well as skilled actuarial, contract, and market analysts to analyze the data. We need greater IT functionality to support better analysis and to track complaint trends over past few years on issues such as affordability.

SECTION V.A.1.b) PROPOSED RATE REVIEW ENHANCEMENTS FOR HEALTH INSURANCE

Applicants must provide assurances that grant awards will be used to develop or make improvements to their existing rate review and approval practices. States currently reviewing rate filings must propose enhancements that will further strengthen their existing authorities and process.

Applicants must detail the enhancements that they intend to make and explain how these enhancements differ from and improve upon current practices.

The Ohio Department of Insurance intends to use the Grant to States for Premium Review to expand and enhance our current rate review process not only to improve our current process, but also to incorporate key

elements of the web portal requirements into the changes to product filing procedures. We will need to expand our process – including oversight of grandfathered and non-grandfathered policy filings – to achieve totally integrated product and rate filing reforms.

In light of the federal emphasis on transparency and the specific web portal reporting format requirements, we will adopt product filing requirements that allow us to easily report the products in our market to the U.S. Department of Health and Human Services in an acceptable format. Ohio also intends to use the Grant to coordinate our rate and form review with our data reporting and market analysis to ensure that our review will be as comprehensive as possible. By creating a rate and policy data base, Ohio will be positioned to meet consumer protection and transparency goals.

By hiring additional contract and actuarial analysts, we will be able to require filings to be made in a more complete and comprehensive manner with all applicable forms and associated rates in a single filing, rather than the matrix approach that currently is allowed. Filings will now be reviewed in concert by both contract and actuarial analysts to verify grandfathered status as well as to assess the reasonableness of rate increases.

The additional data analysts we intend to hire will provide the Department with the opportunity to conduct more robust data analysis while simplifying and improving our ability to exchange data with HHS.

A policy and rate specific database will also allow us to synchronize our internal data with the information published by HHS for the public, and this database will support our efforts to conduct company examinations to ensure that rates are being properly calculated in the marketplace. Ohio will support NAIC initiatives and SERFF system enhancements to create nationally consistent filing requirements, data collection, and public access to filing information. We also intend to acquire access to national insurance industry pricing assumptions to validate that what is filed in Ohio is consistent with aggregate industry data.

To accomplish these goals, the Ohio Department of Insurance will:

1. Increase product review staffing by hiring two additional actuarial analysts and two additional contract analysts to perform the integrated rate and policy form reviews.

2. Contract with actuarial consulting firms to augment our current review and assist during high volume filing times.

3. Hire an additional data analyst in product regulation to enable us to collect, analyze and report data internally to the product regulation staff as well externally to the public and HHS.

4. Hire two additional data analysts to perform market conduct reviews to ensure that rates are being properly calculated according to the filings.

5. Upgrade our internal IT capacity to: 1) create the appropriate interfaces, data warehousing and reporting platforms to fulfill the HHS reporting requirements and to support integration of policy and rate filing data; and 2) develop a consumer friendly web application, located on the Department's public website, to assist Ohioans in using the product and pricing information.

6. Contract with NAIC/SERFF for the development of system modifications and enhancements to: address data collection and reporting requirements; submission of a federally mandated Rate Filing Disclosure Form and Justification; support for consumer friendly rate disclosure and publicly available rate filing information; and support for the reporting requirements of the uniform template for data reporting.

7. Acquire access to national insurance industry pricing assumptions to validate that what is filed in Ohio is consistent with aggregate industry data.

Ohio will start hiring additional staff and contracting with consultants upon notification of the awarding of the grants. We immediately will upgrade our filing requirements to eliminate the matrix filings and require complete and specific rate and form filings going forward. We will work with the NAIC to accomplish the necessary SERFF upgrades to support our enhanced requirements and make the changes to our internal systems to facilitate data reporting and a consumer-friendly web application. The budget for these items is detailed in the budget narrative.

SECTION V.A.1.c) REPORTING TO THE SECRETARY ON RATE INCREASE PATTERNS

Providing data to the Secretary on trends in premium ratings

The Ohio Department of Insurance will comply with the reporting requirements outlined in statute and the Cycle 1 grant requirement to provide rate filing data to the Secretary for the individual, small and large group market segments within its jurisdiction and approval authority. To accomplish collection and provision of data to the Secretary, we will support the NAIC enhancements to SERFF (see ***Appendix D***) and enhance our internal IT systems to support integration and analysis of rate trends in the specified premium rating areas.

SECTION V.A.1.d) OPTIONAL DATA CENTER FUNDING

The Ohio Department of Insurance did not select to participate in Optional Data Center Funding as part of this grant proposal.

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

Project:

Grants to States for Health Insurance Premium Review Cycle 1: The Ohio Department of Insurance requests $1 million in Cycle 1 funding to enhance and expand the current rate review process.

*** Year:** 1

*** Funding Agency Goal:**

Ohio's objective is to integrate the rate review process using a three-pronged approach involving actuarial rate review, coordinated policy form review, and expanded data analysis.

*** Objective:**

Project/Objective 2: Upgrade internal IT capacity to support analysis and reporting requirements and the integration of System for Electronic Rate and Form Filing (SERFF) policy form and rate data. (See Appendix E - OHIO IT Project Plan in grant package)

*** Results or Benefits Expected:**

Access to data for analysis of product-specific form and rate components to support enhanced file review and market conduct activities and to provide data necessary for Federal reporting and consumer product and pricing information.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Technical consultant procurement process.	Eric James, Assistant Director, Information Technology	08/09/2010	09/02/2010	25
Develop initial SERFF API integration	Eric James, Assistant Director, Information Technology	09/03/2010	09/30/2010	165
Develop Federal reporting framework	Eric James, Assistant Director, Information Technology	10/01/2010	10/21/2010	175

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours

* Criteria for Evaluating Results or Benefits Expected:

Rate and contract analysts and market conduct analysts will have access to product-specific form and rate component data. Data will be accessible for extraction to complete Federal reporting and consumer product and pricing information requirements.

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

Project:

Grants to States for Health Insurance Premium Review Cycle 1: The Ohio Department of Insurance requests $1 million in Cycle 1 funding to enhance and expand the current rate review process.

*** Year:** 1

*** Funding Agency Goal:**

Ohio's objective is to integrate the rate review process using a three-pronged approach involving actuarial rate review, coordinated policy form review, and expanded data analysis.

*** Objective:**

Objective/Project #3: Provide a consumer friendly web application on the Ohio Department of Insurance website that will assist Ohioans in using health insurance product and pricing information. (See Appendix E - OHIO IT Project Plan included in this grant package)

*** Results or Benefits Expected:**

Public availability of online tools that will help consumers understand and make meaningful comparison of Ohio health plan product and pricing information.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Sprint 1 analysis, development, and testing	Eric James, Assistant Director, Information Technology	10/22/2010	12/08/2010	265
Sprint 2 analysis, development, and testing	Eric James, Assistant Director, Information Technology	12/09/2010	01/17/2011	215
Sprint 3 analysis, development and testing	Eric James, Assistant Director, Information Technology	01/18/2011	02/24/2011	230
Sprint 4 final development and testing; project deployment to production environment.	Eric James, Assistant Director,	02/25/2011	04/05/2011	230

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours

* Criteria for Evaluating Results or Benefits Expected:

Stakeholder feedback will be solicited to assess that tools and information provided are easy to use, understandable, and helpful to consumers.

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

Project:

Grants to States for Health Insurance Premium Review Cycle 1: The Ohio Department of Insurance requests $1 million in Cycle 1 funding to enhance and expand the current rate review process.

* Year: 1

* Funding Agency Goal:

Ohio's objective is to integrate the rate review process using a three-pronged approach involving actuarial rate review, coordinated policy form review, and expanded data analysis.

* Objective:

Project/Objective 4: Contract with and support SERFF initiatives for development of system modifications and enhancements to augment rate filing submissions and to facilitate data collection/reporting and transparency. (See Appendix D - OHIO SERFF Leveraging Letter in this grant package)

* Results or Benefits Expected:

Data access to enhance analysis and enable reporting in accordance with Federal requirements. Ability to identify health rate/form filings on a specific product and plan basis. Online access for the public to SERFF filing records.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Participation in NAIC/SERFF working group activities to support and monitor progress of SERFF enhancement project to expand filing data collection.	Mary Miller, Assistant Director, Product Regulation & Actuarial Services	08/09/2010	10/31/2010	40
Participation in NAIC/SERFF working group activities to support and monitor progress of SERFF enhancement project to implement uniform reporting framework and public access to filing records.	Mary Miller, Assistant Director, Product Regulation & Actuarial Services	11/01/2010	04/30/2011	100

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours

* Criteria for Evaluating Results or Benefits Expected:

Filings submitted through SERFF will include data necessary for product identification and reporting of required rating information and the data will be accessible to state regulatory staff. A uniform Federal reporting framework will be facilitated by the SERFF system. A web-based portal will be established by SERFF for public access to SERFF filing records.

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

Project:

Grants to States for Health Insurance Premium Review Cycle 1: The Ohio Department of Insurance requests $1 million in Cycle 1 funding to enhance and expand the current rate review process.

*** Year:** 1

*** Funding Agency Goal:**

Ohio's objective is to integrate the rate review process using a three-pronged approach involving actuarial rate review, coordinated policy form review, and expanded data analysis.

*** Objective:**

Project/Objective 5: Acquire access to national insurance industry pricing assumptions and use this information to validate consistency of Ohio filings to aggregate industry data.

*** Results or Benefits Expected:**

Enhanced rate review process to ensure consistency of pricing assumptions used in Ohio by incorporating examination and comparison against national industry pricing assumptions.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Obtain access to national industry pricing indices from available sources	Mary Miller, Assistant Director, Product Regulation & Actuarial Services	08/09/2010	09/30/2010	20
Develop analysis process for validation	Mary Miller, Assistant Director, Product Regulation & Actuarial Services	10/01/2010	10/29/2010	100
Develop format and tools to implement validation analysis process	Mary Miller, Assistant Director, Product Regulation & Actuarial Services	11/01/2010	12/02/2010	120
Process implementation and training	Mary Miller, Assistant Director, Product Regulation & Actuarial Services	12/05/2010	12/30/2010	30

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours

* Criteria for Evaluating Results or Benefits Expected:

For rate filings submitted starting January 1, 2011, actuarial analysts will have the necessary tools, data, and training to validate the consistency of pricing assumptions.