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.

This opportunity is only open to organizations, applicants who are submitting grant applications on behalf of a company, state, local or tribal government, academia, or other type of organization.

*** Application Filing Name:** Tennessee Dept of Commerce & Insurance

Mandatory Documents

Move Form to Complete

Move Form to Delete

Mandatory Documents for Submission

- Project Abstract
- Project Narrative Attachment Form
- Budget Narrative Attachment Form
- Budget Information for Non-Construction Program
- Assurances for Non-Construction Programs (SF-42
- Disclosure of Lobbying Activities (SF-LLL)

Optional Documents

- Basic Work Plan
- Project Abstract Summary
- Other Attachments Form

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:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

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

4. Applicant Identifier:

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: State of Tennessee, Department of Commerce and Insurance

* b. Employer/Taxpayer Identification Number (EIN/TIN): 626001445

* c. Organizational DUNS: 1489764130000

d. Address:

* Street1: 500 James Robertson Parkway, 5th Floor

Street2:

* City: Nashville

County/Parish:

* State: TN: Tennessee

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 37243-0565

e. Organizational Unit:

Department Name: Commerce and Insurance

Division Name: Division of Insurance

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

Prefix: Ms.

* First Name: Mary

Middle Name: G.

* Last Name: Moody

Suffix:

Title: Deputy Commissioner

Organizational Affiliation: Tennessee Department of Commerce and Insurance

* Telephone Number: 615-741-6007

Fax Number: 615-532-6934

* Email: mary.moody@tn.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:**

Premium Review Grant

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: TN-005   b. Program/Project: TN-005

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	143,528.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,143,528.00

*** 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: Ms.   * First Name: Mary

Middle Name: G.

* Last Name: Moody

Suffix:

* Title: Deputy Commissioner

* Telephone Number: 615-741-6007   Fax Number: 615-532-6934

* Email: mary.moody@tn.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:** State of Tennessee, Department of Commerce and Insurance

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

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

Field	Value
Prefix:	Ms.
* First Name:	Mary
Middle Name:	G.
* Last Name:	Moody
Suffix:	
Title:	Deputy Commissioner
Organizational Affiliation:	State of Tennessee, Department of Commerce and Insurance
* Street1:	500 James Robertson Parkway, 5th Floor
Street2:	
* City:	Nashville
County:	Davidson
* State:	TN: Tennessee
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	37243-0565
* Telephone Number:	615-741-6007
Fax:	615-532-5934
* Email:	mary.moody@tn.gov

Delete Entry

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: State of Tennessee, Department of Commerce and Insurance

DUNS Number: 1489764130000

* Street1: 500 James Robertson Parkway

Street2:

* City: Nashville   County: Davidson

* State: TN: Tennessee

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 37243-0565   * Project/ Performance Site Congressional District: TN-005

Project/Performance Site Location 1

☐ 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	Project_Director_resume.doc	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	Applicant's Application Cove	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	TN Governor support letter Cl	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4	Organization Chart.pdf	Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5	TCA 10-7-503 public records	Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6	TCA 56-1-212 non-profit hosp	Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7	TCA 56-2-105 cert of auth re	Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8	TCA 56-2-125 all payer claim	Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9	TCA 56-7-2209 small empl gro	Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10	TCA 56-26-102 A&H filing of	Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11	TCA 56-26-103 withdrawal of	Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12	TCA 56-29-108 non-profit hos	Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13	TCA 56-29-116 non-profit hos	Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14	Cover_Sheet_and_CheckOff_Lis	Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15	TCA 56-32-107 HMO evidence o	Add Attachment	Delete Attachment	View Attachment

MARY G. MOODY
(b)(6)
615-253-2058 (work)
(b)(6) (cell)

EDUCATION

Cecil C. Humphreys School of Law, University of Memphis
Memphis, Tennessee
Juris Doctorate, December 1981

Mississippi University for Women
Columbus, Mississippi
Bachelor of Science, May 1973 (Psychology/Education)

BAR ADMISSIONS

Tennessee, 1982, BPR No. 009822
Georgia, 1991 (inactive)

EMPLOYMENT

Tennessee Department of Commerce and Insurance
Nashville, Tennessee
Deputy Commissioner, March 2007 to Present
Provide policy guidance and management support to the Administrative Division, the Division of Regulatory Boards, the Fire Prevention Division, the Division of Consumer Affairs, the Tennessee Law Enforcement Academy, and the Tennessee Fire Service and Codes Enforcement Academy.

General Counsel, January 2003 to March 2007
Supervised twenty-three attorneys, four secretaries and one administrative services assistant providing all necessary legal services to the Department. Provided legal advice directly to the Commissioner and other senior staff. Served as the department's Ethics Compliance Officer.

Tennessee Department of Transportation
Nashville, Tennessee
General Counsel, October 1999 to January 2003
Supervised six attorneys, two paralegals and two secretaries providing all necessary legal services to the Department, including drafting and reviewing contracts, handling personnel matters, conducting regulatory activities, communicating with the General Assembly regarding legislation affecting the department, developing policies and procedures, and providing legal advice to the Commissioner and senior management.

Office of the Attorney General and Reporter for the State of Tennessee
Nashville, Tennessee
Senior Counsel, January 1997 to October 1999
Assistant Attorney General, September 1990 to January 1997
Represented the state and its employees in litigation at the trial and appellate levels in all state and federal courts and the Tennessee Claims Commission. Subject matter included civil rights, torts, contracts, construction disputes, workers' compensation and employment discrimination.

Supervised a team of six lawyers and two paralegals defending actions involving the Department of Transportation and the Department of Safety. (January 1995-July 1999)

Harris & Harris
Macon, Georgia
Of Counsel, October 1989 to September 1990
Researched and prepared legal memoranda, pleadings and briefs in condemnation proceedings and in disputes regarding the sale and lease of mineral rights.

Trabue, Sturdivant & DeWitt
Nashville, Tennessee
Associate, May 1984 to September 1989
Engaged in general civil practice including both corporate matters and litigation

Howser, Thomas, Summers, Binkley & Archer
Nashville, Tennessee
Associate, June 1982 to May 1984
Engaged in general civil practice.

Burch, Porter & Johnson
Memphis, Tennessee
Law Clerk, August 1981 to January 1982
Prepared memoranda on a variety of legal issues and drafted pleadings.

STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
500 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243-5065
615-741-6007

PHIL BREDESEN
GOVERNOR

LESLIE A. NEWMAN
COMMISSIONER

July 7, 2010

The Honorable Kathleen Sebelius
Secretary, Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Grants to States for Health Insurance Premium Review-Cycle I
CFDA: 93.511
Project Title: Premium Review Grant

Dear Secretary Sebelius:

Enclosed is the application of the Tennessee Department of Commerce and Insurance for the above-referenced grant. Pursuant to Tennessee Code Annotated, Title 56, The Department of Commerce and Insurance has statutory authority to oversee and coordinate the activities proposed by the grant application and is capable of convening a suitable working group of all relevant members. I also certify that, if awarded this grant, the grant funds will not supplant existing state expenditures dedicated to premium review. The Project Director will be:

Mary G. Moody
Deputy Commissioner
500 James Robertson Parkway, 5th Floor
Nashville, TN 37243-5065
615-741-6007 (phone)
615-532-5964 (fax)
Mary.Moody@tn.gov (email)

Very truly yours,

Leslie A. Newman

Leslie A. Newman
Commissioner

PHIL BREDESEN
THE GOVERNOR OF TENNESSEE

07 July 2010

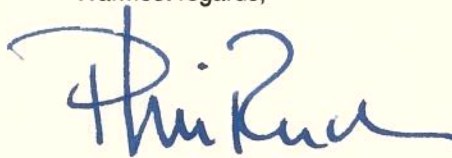
The Honorable Kathleen Sebelius
Secretary, Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Grants to States for Health Insurance Premium Review-Cycle I
CFDA: 93.511

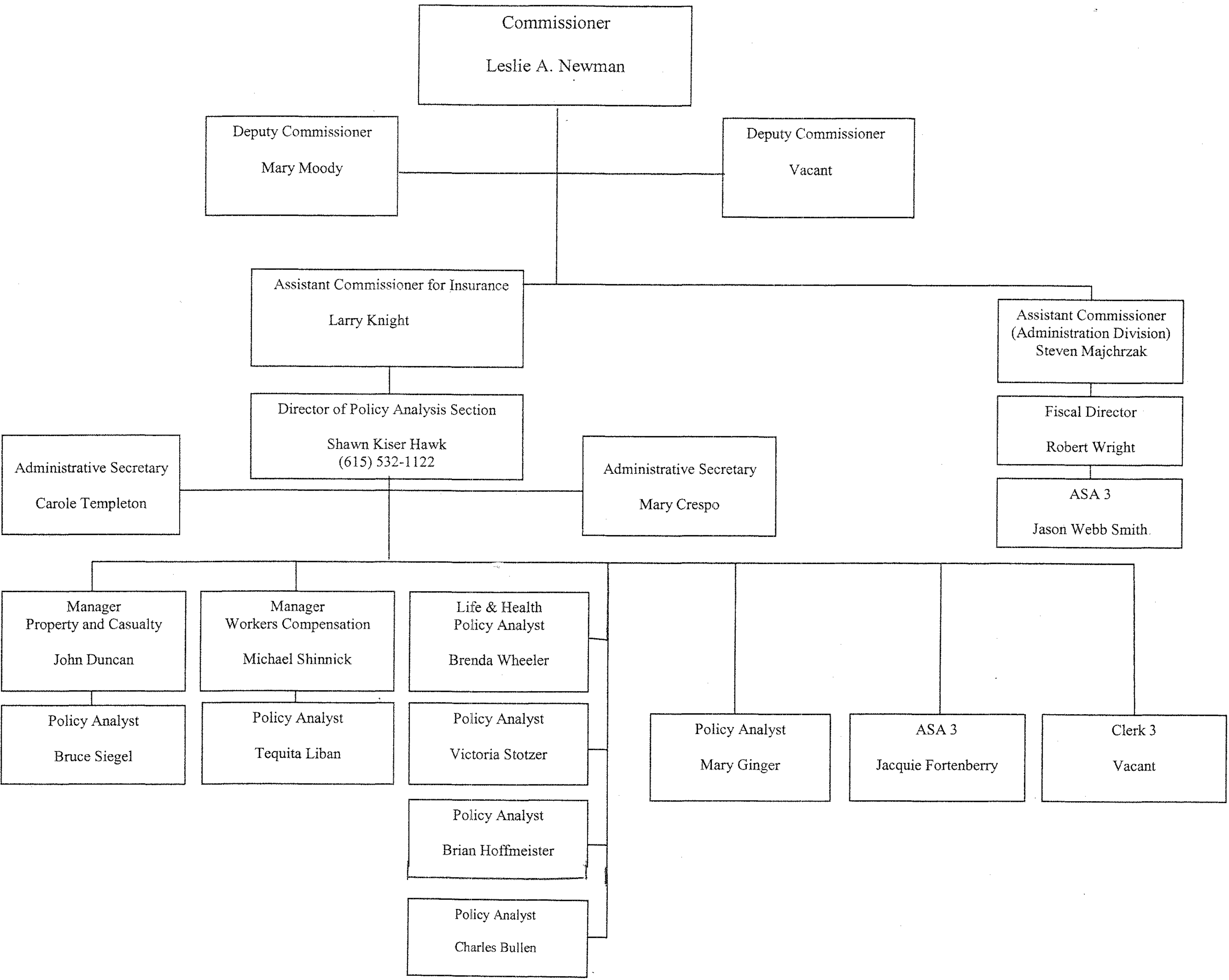
Dear Secretary Sebelius:

I am writing in support of the application of the Tennessee Department of Commerce and Insurance for the above-referenced grant. I fully endorse this grant application and the proposed enhancements to our existing premium review activities. My office will ensure close coordination of all state agencies that are involved in implementation of the Affordable Care Act in Tennessee.

Warmest regards,



Phil Bredesen


Commissioner
Leslie A. Newman
Deputy Commissioner
Mary Moody
Deputy Commissioner
Vacant
Assistant Commissioner for Insurance
Larry Knight
Assistant Commissioner
(Administration Division)
Steven Majchrzak
Fiscal Director
Robert Wright
ASA 3
Jason Webb Smith
Director of Policy Analysis Section
Shawn Kiser Hawk
(615) 532-1122
Administrative Secretary
Carole Templeton
Administrative Secretary
Mary Crespo
Manager
Property and Casualty
John Duncan
Policy Analyst
Bruce Siegel
Manager
Workers Compensation
Michael Shinnick
Policy Analyst
Tequita Liban
Life & Health
Policy Analyst
Brenda Wheeler
Policy Analyst
Victoria Stotzer
Policy Analyst
Brian Hoffmeister
Policy Analyst
Charles Bullen
Policy Analyst
Mary Ginger
ASA 3
Jacquie Fortenberry
Clerk 3
Vacant

10-7-503. Records open to public inspection — Schedule of reasonable charges — Costs. —

(a) (1) As used in this part and title 8, chapter 4, part 6, "public record or records" or "state record or records" means all documents, papers, letters, maps, books, photographs, microfilms, electronic data processing files and output, films, sound recordings or other material, regardless of physical form or characteristics, made or received pursuant to law or ordinance or in connection with the transaction of official business by any governmental agency.

(2) (A) All state, county and municipal records shall, at all times during business hours, which for public hospitals shall be during the business hours of their administrative offices, be open for personal inspection by any citizen of this state, and those in charge of the records shall not refuse such right of inspection to any citizen, unless otherwise provided by state law.

(B) The custodian of a public record or the custodian's designee shall promptly make available for inspection any public record not specifically exempt from disclosure. In the event it is not practicable for the record to be promptly available for inspection, the custodian shall, within seven (7) business days:

(i) Make the information available to the requestor;

(ii) Deny the request in writing or by completing a records request response form developed by the office of open records counsel. The response shall include the basis for the denial; or

(iii) Furnish the requestor a completed records request response form developed by the office of open records counsel stating the time reasonably necessary to produce the record or information.

(C) [Deleted by code commission.]

(3) Failure to respond to the request as described in subdivision (a)(2) shall constitute a denial and the person making the request shall have the right to bring an action as provided in § 10-7-505.

(4) This section shall not be construed as requiring a governmental entity or public official to sort through files to compile information; however, a person requesting the information shall be allowed to inspect the nonexempt records.

(5) This section shall not be construed as requiring a governmental entity or public official to create a record that does not exist; however, the redaction of confidential information from a public record or electronic database shall not constitute a new record.

(6) A governmental entity is prohibited from avoiding its disclosure obligations by contractually delegating its responsibility to a private entity.

(7) (A) A records custodian may not require a written request or assess a charge to view a public record unless otherwise required by law; however, a records custodian may require a request for copies of public records to be in writing or that the request be made on a form developed by the office of open records counsel. The records custodian may also require any citizen making a request to view a public record or to make a copy of a public record to present a photo identification, if the person possesses a photo identification, issued by a governmental entity, that includes the person's address. If a person does not possess a photo identification, the records custodian may require other forms of identification acceptable to the records custodian.

(B) Any request for inspection or copying of a public record shall be sufficiently detailed to enable the records custodian to identify the specific records to be located or copied.

(C) **(i)** A records custodian may require a requestor to pay the custodian's reasonable costs incurred in producing the requested material and to assess the reasonable costs in the manner established by the office of open records counsel pursuant to § 8-4-604.

(ii) The records custodian shall provide a requestor an estimate of the reasonable costs to provide copies of the requested material.

(b) The head of a governmental entity may promulgate rules in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, to maintain the confidentiality of records concerning adoption proceedings or records required to be kept confidential by federal statute or regulation as a condition for the receipt of federal funds or for participation in a federally funded program.

(c) **(1)** Except as provided in § 10-7-504(g), all law enforcement personnel records shall be open for inspection as provided in subsection (a); however, whenever the personnel records of a law enforcement officer are inspected as provided in subsection (a), the custodian shall make a record of such inspection and provide notice, within three (3) days from the date of the inspection, to the officer whose personnel records have been inspected:

(A) That such inspection has taken place;

(B) The name, address and telephone number of the person making such inspection;

(C) For whom the inspection was made; and

(D) The date of such inspection.

(2) Information made confidential by this chapter shall be redacted whenever possible, but the costs associated with redacting records or information, including the cost of copies and staff time to provide redacted copies, shall be borne as provided by current law.

(3) Any person making an inspection of such records shall provide such person's name, address, business telephone number, home telephone number, driver license number or other appropriate identification prior to inspecting such records.

(d) **(1)** All records of any association or nonprofit corporation described in § 8-44-102(b)(1)(E)(i) shall be open for inspection as provided in subsection (a); provided, that any such organization shall not be subject to the requirements of this subsection (d) so long as it complies with the following requirements:

(A) The board of directors of the organization shall cause an annual audit to be made of the financial affairs of the organization, including all receipts from every source and every expenditure or disbursement of the money of the organization, made by a disinterested person skilled in such work. Each audit shall cover the period extending back to the date of the last preceding audit and it shall be paid out of the funds of the organization;

(B) Each audit shall be conducted in accordance with the standards established by the comptroller of the treasury pursuant to § 4-3-304(9) for local governments;

(C) The comptroller of the treasury, through the department of audit, shall be responsible for ensuring that the audits are prepared in accordance with generally accepted governmental auditing standards, and determining whether the audits meet minimum audit standards which shall be prescribed by the comptroller of the treasury. No audit may be accepted as meeting the requirements of this section until such audit has been approved by the comptroller of the treasury;

(D) The audits may be prepared by a certified public accountant, a public accountant or by the department of

audit. If the governing body of the municipality fails or refuses to have the audit prepared, the comptroller of the treasury may appoint a certified public accountant or public accountant or direct the department to prepare the audit. The cost of such audit shall be paid by the organization;

(E) Each such audit shall be completed as soon as practicable after the end of the fiscal year of the organization. One (1) copy of each audit shall be furnished to the organization and one (1) copy shall be filed with the comptroller of the treasury. The copy of the comptroller of the treasury shall be available for public inspection. Copies of each audit shall also be made available to the press; and

(F) In addition to any other information required by the comptroller of the treasury, each audit shall also contain:

(i) A listing, by name of the recipient, of all compensation, fees or other remuneration paid by the organization during the audit year to, or accrued on behalf of, the organization's directors and officers;

(ii) A listing, by name of recipient, of all compensation and any other remuneration paid by the organization during the audit year to, or accrued on behalf of, any employee of the organization who receives more than twenty-five thousand dollars ($25,000) in remuneration for such year;

(iii) A listing, by name of beneficiary, of any deferred compensation, salary continuation, retirement or other fringe benefit plan or program (excluding qualified health and life insurance plans available to all employees of the organization on a nondiscriminatory basis) established or maintained by the organization for the benefit of any of the organization's directors, officers or employees, and the amount of any funds paid or accrued to such plan or program during the audit year; and

(iv) A listing, by name of recipient, of all fees paid by the organization during the audit year to any contractor, professional advisor or other personal services provider, which exceeds two thousand five hundred dollars ($2,500) for such year. Such listing shall also include a statement as to the general effect of each contract, but not the amount paid or payable thereunder.

The provisions of this subsection (d) shall not apply to any association or nonprofit corporation described in § 8-44-102 (b)(1)(E)(i), that employs no more than two (2) full-time staff members.

(2) The provisions of this subsection (d) shall not apply to any association, organization or corporation that was exempt from federal income taxation under the provisions of § 501(c)(3) of the Internal Revenue Code (26 U.S.C. § 501(c)(3)) as of January 1, 1998, and which makes available to the public its federal return of organization exempt from income tax (Form 990) in accordance with the Internal Revenue Code and related regulations.

(e) All contingency plans of law enforcement agencies prepared to respond to any violent incident, bomb threat, ongoing act of violence at a school or business, ongoing act of violence at a place of public gathering, threat involving a weapon of mass destruction, or terrorist incident shall not be open for inspection as provided in subsection (a).

(f) All records, employment applications, credentials and similar documents obtained by any person in conjunction with an employment search for a director of schools or any chief public administrative officer shall at all times, during business hours, be open for personal inspection by any citizen of Tennessee, and those in charge of such records shall not refuse such right of inspection to any citizen, unless otherwise provided by state law. For the purposes of this subsection (f), the term “person” includes a natural person, corporation, firm, company, association or any other business entity.

[Acts 1957, ch. 285, § 1; T.C.A., § 15-304; Acts 1981, ch. 376, § 1; 1984, ch. 929, §§ 1, 3; 1991, ch. 369, § 7; 1993, ch. 475, § 1; 1998, ch. 1102, §§ 2, 4; 1999, ch. 514, § 1; 2000, ch. 714, § 1; 2005, ch. 263, § 1; 2007, ch. 425, § 1; 2008, ch. 1179, § 1.]

56-1-212. Commissioner's authority to regulate — Conversion of health insurance business. —

(a) Notwithstanding any provision of this title to the contrary, the commissioner shall have the same authority to regulate and shall apply the same substantive standards to hospital and medical service corporations licensed pursuant to chapter 29 of this title as shall apply to health insurers doing business pursuant to chapter 26, part 1 of this title.

(b) **(1)** Prior to engaging in any transaction or series of transactions the net effect of which shall be to effectuate the conversion by any method, directly or indirectly, of all or substantially all of the health insurance business of the nonprofit hospital and medical service corporation, as measured by annual revenue on a consolidated basis, to a for-profit entity of any kind the equity interest of which is not wholly owned by the corporation or its insureds, the service corporation shall file with the commissioner a written notice of its intention to do so. The commissioner shall, upon receipt of the notice, forward a copy of the notice to the governor and to the speaker of the house of representatives and the speaker of the senate. The service corporation shall take no action to effectuate the completion of the conversion for a period of one (1) year from the date of the filing, or until the end of the next regular session of the general assembly in the year following the year in which the notice is given in the event the one-year period does not include a full, regular legislative session of the general assembly.

(2) For the purposes of subdivision (b)(1):

(A) "All or substantially all of the health insurance business" shall not include the sale of all or part of the assets of equity interest in a subsidiary company unless the subsidiary company constitutes in excess of seventy-five percent (75%) of the total consolidated annual revenue of the service corporation as reflected on its annual statement for the preceding year; and

(B) The transfer of health insurance business of the service corporation shall not be deemed to include the contracting or subcontracting of business or business functions.

(c) Notwithstanding any law to the contrary, the board of directors of the service corporation licensed pursuant to chapter 29 of this title, shall meet all of the requirements for boards of directors of nonprofit corporations pursuant to title 48, chapter 58, part 1. To the extent that chapter 29 of this title conflicts with title 48, chapter 58, title 48, chapter 58 shall control.
[Acts 2003, ch. 96, § 1.]

56-2-105. Certificate of authority required — Exceptions. —

It is unlawful for any company to enter into a contract of insurance as an insurer or to transact insurance business in this state without a certificate of authority from the commissioner; provided, that this section shall not apply to:

(1) Contracts procured by agents or brokers under the authority of the Surplus Lines Insurance Act, compiled in chapter 14 of this title;

(2) Contracts of reinsurance;

(3) Transactions in this state involving policies lawfully solicited, written and delivered outside of this state covering only subjects of insurance not resident, located or expressly to be performed in this state at the time of issuance or covering property in the course of transportation by land, air or water, to, from or through this state and including any preparation or storage incidental thereto, and which transactions are subsequent to the issuance of those policies;

(4) Transactions in this state involving group or blanket insurance and group annuities where the master policy of the groups was lawfully issued and delivered in a state in which the company was authorized to transact insurance business;

(5) Transactions in this state involving a policy issued prior to April 3, 1968;

(6) Any life insurance or annuity company that holds a certificate of exemption from the commissioner as provided in § 56-2-106; or

(7) **(A)** The procuring of contracts of insurance issued to an industrial insured;

(B) For the purposes of subdivision (7)(A), an “industrial insured” is an insured:

(i) Who procures the insurance of any risk or risks by use of the services of a full-time employee acting as an insurance manager or buyer;

(ii) Whose aggregate annual premiums for insurance on all risks total at least twenty-five thousand dollars ($25,000); and

(iii) Who has at least twenty-five (25) full-time employees.

[Acts 1968, ch. 536, § 1; 1969, ch. 270, § 19; T.C.A., § 56-205.]

56-2-125. Establishment and maintenance of an all payer claims database — Establishment of Tennessee health information committee. —

(a) As used in this section, unless the context otherwise requires:

(1) "All payer claims database" means a database comprised of health insurance issuer and group health plan claims information that excludes the data elements in 45 CFR 164.514(e)(2);

(2) "Commissioner" means the commissioner of commerce and insurance;

(3) "Department" means the department of commerce and insurance;

(4) "Group health plan" means an employee welfare benefit plan, as defined in § 3(1) of the Employee Retirement Income Security Act of 1974 (ERISA), codified in 29 U.S.C. § 1002(1), to the extent that the plan provides medical care to employees or their dependents, as defined under the terms of the plan, or an administrator of the plan. For purposes of this section, "group health plan" shall not mean any plan that is offered through a health insurance issuer;

(5) "Health insurance coverage" means health insurance coverage as defined in § 56-7-2902, as well as medicare supplemental health insurance; and

(6) "Health insurance issuer" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide health insurance coverage, including, but not limited to, an insurance company, a health maintenance organization and a nonprofit hospital and medical service corporation. "Health insurance issuer" also means a pharmacy benefits manager, a third party administrator and an entity described in § 56-2-121.

(b) **(1)** The commissioner shall establish and maintain an all payer claims database to enable the commissioner of finance and administration to carry out the following duties:

(A) Improving the accessibility, adequacy and affordability of patient health care and health care coverage;

(B) Identifying health and health care needs and informing health and health care policy;

(C) Determining the capacity and distribution of existing health care resources;

(D) Evaluating the effectiveness of intervention programs on improving patient outcomes;

(E) Reviewing costs among various treatment settings, providers and approaches; and

(F) Providing publicly available information on health care providers' quality of care.

(2) Nothing in this section shall preclude a health insurance issuer from providing information on health care providers' quality of care in accordance with § 56-32-130(e).

(c) There is established a Tennessee health information committee, referred to as the committee in this section. The commissioner of finance and administration shall give all consideration to policies and recommendations formed by the committee, including those formed by the committee on any issues in response to a request of the commissioner of finance and administration in the commissioner's discretion. Any recommendations developed by the committee shall, to the largest extent possible, be consistent with those of nationally recognized standard setting and accrediting bodies.

(1) **(A)** **(i)** The public release of any report utilizing data derived from the all payer claims database on quality, effectiveness, or cost of care of health care providers or provider shall require a two-thirds (2/3) affirmative vote of the committee members present.

(ii) Health insurance issuers that contribute data to the all payer claims database and providers who are subjects of reports on quality, effectiveness or cost of care that utilize data derived from the all payer claims database shall be given access to the reports sixty (60) days prior to the public release of the reports for the review and submission of comments prior to the public release.

(B) Any other committee action shall require a simple majority affirmative vote of the committee members present.

(C) Neither the committee nor the commissioner is authorized to make public release of individual patient level claims data.

(2) The committee shall develop for the commissioner of finance and administration:

(A) A description of the data sets, based on national standards, if and when available, that will be included in the all payer claims database; and

(B) A method for submission of data.

(3) The committee shall develop for the commissioner of finance and administration security measures for ensuring compliance with:

(A) The federal requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), compiled in 42 U.S.C. § 1320d et seq., and implementing federal regulations; and

(B) Other state and federal privacy laws.

(4) The committee shall regularly evaluate the integrity and accuracy of the all payer claims database.

(5) The committee shall develop policies to make reports from the all payer claims database available as a resource for insurers, employers, providers and purchasers of health care, to continuously review health care utilization, expenditures and performance in this state. Such uses shall be subject to restrictions required by HIPAA and other applicable privacy laws and policies as well as to reasonable charges recommended by the committee and set by rule.

(6) The committee shall be chaired by the commissioner of finance and administration or designee and attached to the department of finance and administration for administrative purposes. The committee members shall serve without compensation and travel expenses.

(7) **(A)** The committee shall include:

(i) The commissioner or the commissioner's designee;

(ii) The commissioner of health or the commissioner of health's designee;

(iii) The commissioner of mental health and developmental disabilities or the commissioner of mental health and developmental disabilities' designee;

(iv) The commissioner of finance and administration or the commissioner of finance and administration's designee;

(v) The director of the state division of health planning or equivalent;

(vi) The director of the office of e-health initiatives or equivalent; and

(vii) The deputy commissioner of the bureau of TennCare or the deputy commissioner of the bureau of TennCare's designee.

(B) The committee shall include the following members to be appointed by the commissioner of finance and administration:

(i) Two (2) physician members. The Tennessee Medical Association is authorized to submit to the commissioner a list of nominees from which the physicians may be selected;

(ii) Two (2) members to represent hospitals. The Tennessee Hospital Association and the Hospital Alliance of Tennessee are authorized to submit to the commissioner a list of nominees from which the representatives may be selected;

(iii) One (1) pharmacist member. The Tennessee Pharmacists Association is authorized to submit to the commissioner a list of nominees from which the pharmacist may be selected;

(iv) Two (2) members to represent the health insurance industry;

(v) One (1) member to represent a hospital and medical service corporation;

(vi) One (1) member to represent a coalition of businesses who purchase health services;

(vii) One (1) member to represent a self-insured employer;

(viii) One (1) member to represent health care consumers; and

(ix) One (1) member to represent ambulatory surgical treatment centers.

(8) The committee may appoint one (1) or more subcommittees to provide advice and recommendations related to the operations and use of the all payer claims database, including, but not limited to, advisory committees on:

(A) Research;

(B) Technology;

(C) Participation by health insurance issuers in the all payer claims database; and

(D) Such other matters as the committee may approve in its discretion.

(9) The members of the Tennessee health information committee appointed by the commissioner of finance and administration as provided in subdivision (b)(7)(B) shall serve one-year terms and shall be eligible for reappointment to subsequent terms; provided, however, that five (5) of the initial members shall serve an initial term of two (2) years. Vacancies shall be filled for any unexpired terms, and members shall serve until their successors are appointed. The initial term of such members shall be deemed to commence on July 1, 2009.

(10) The committee shall terminate on June 30, 2011, pursuant to § 4-29-232(b). The committee may be continued, reestablished or restructured in accordance with title 4, chapter 29.

(d) **(1)** As required by HIPAA, the all payer claims database shall not publicly disclose any individually identifiable health information as defined in 45 CFR 160.103. Use of the all payer claims database shall be subject to restrictions required by HIPAA and other applicable privacy laws and policies. The all payer claims database shall be accessed

only by staff or a designated entity authorized in writing by the commissioner of finance and administration to perform the analyses contemplated by this section. The commissioner shall collaborate with the Tennessee health information committee in developing procedures and safeguards to protect the integrity and confidentiality of any data contained in the all payer claims database.

(2) **(A)** The all payer claims database, summaries, source or draft information used to construct or populate the all payer claims database, patient level claims data, reports derived from the all payer claims database, unless public release of reports is authorized by the Tennessee health information committee, and other information submitted under this section, whether in electronic or paper form:

(i) Shall not be considered a public record and shall not be open for inspection by members of the public under § 10-7-503(a)(1). Further, such information contained in the all payer claims database shall be considered confidential and not subject to subpoena; and

(ii) Reports derived from the information shall only be released pursuant to rules adopted by the commissioner subsequent to consultation with the Tennessee health information committee. Any release of reports shall not result in such information losing its confidentiality or cause it to be admissible, except in administrative proceedings authorized under the rules adopted by the commissioner.

(B) The commissioner shall, through memoranda of understanding and after consultation with the Tennessee health information committee, allow the use of the all payer claims database by the department of finance and administration, the department of health, the department of mental health and developmental disabilities and other departments of state government for the purposes listed in subdivision (b)(1).

(C) Except for officials of the state or those officials' designees as permitted by subdivision (d)(1), nothing within this section shall be construed as permitting access to or discovery of the source or draft information used to construct or populate the all payer claims database.

(e) The all payer claims database shall contain unique health care provider identifiers that may be used in public reports; provided, however, that no information that could reveal the identity of any patient from the all payer claims database shall be made available to the public. To ensure that individual patients are not identified, the following data shall not be included in any transmission by a group health plan or health insurance issuer to the state or designated entity for the all payer claims database or in any source or draft information used to construct or populate the all payer claims database:

(1) Patient names;

(2) Patient street addresses;

(3) All elements of patient birth dates, except year of birth;

(4) Patient telephone numbers;

(5) Patient facsimile numbers;

(6) Patient electronic mail addresses;

(7) Patient social security numbers;

(8) Medical record numbers;

(9) Health plan beneficiary numbers;

(10) Patient account numbers;

(11) Patient certificate/license numbers;

(12) Vehicle identifiers and serial numbers including license plate numbers;

(13) Device identifiers and serial numbers;

(14) Web universal resource locators (URLs);

(15) Internet protocol (IP) address numbers;

(16) Biometric identifiers including fingerprints, voiceprints, and genetic code;

(17) Full-face photographic images and any comparable images; or

(18) Any other unique patient identifying number, characteristic or code, except encrypted index numbers assigned prior to the transmission by group health plans or health insurance issuers to the state or designated entity for the purpose of linking procedures by patient; provided, that a patient's identity cannot be known from the encrypted index number.

(f) **(1)** **(A)** No later than January 1, 2010, and every month thereafter, all group health plans and health insurance issuers shall provide electronic health insurance claims data for state residents to the commissioner or a designated entity authorized by the commissioner, in accordance with standards and procedures recommended by the Tennessee health information committee pursuant to subdivision (c)(2) and adopted by the commissioner by rule.

(B) All group health plans and health insurance issuers shall provide additional information as the Tennessee health information committee recommends and the commissioner subsequently establishes by rule for the purpose of creating and maintaining an all payer claims database.

(C) The Tennessee health information committee and the commissioner shall strive for standards and procedures that are the least burdensome for data submitters.

(2) The collection, storage and release of health and health care data and statistical information that is subject to the federal requirements of HIPAA shall be governed by the rules adopted in 45 CFR parts 160 and 164.

(3) All group health plans and health insurance issuers that collect the health employer data and information set (HEDIS) shall annually submit the HEDIS information to the commissioner in a form and in a manner prescribed by the National Committee for Quality Assurance (NCQA).

(4) If any group health plan or health insurance issuer fails to submit required data to the commissioner on a timely basis, the commissioner may impose a civil penalty of up to one hundred dollars ($100) for each day of delay.

(g) The commissioner, in the commissioner's discretion, may allow some group health plans and health insurance issuers to submit data on a quarterly basis. The commissioner may also establish by rule exceptions to the reporting requirements of this section for entities based upon an entity's size or amount of claims or other relevant factors deemed appropriate.

(h) **(1)** The commissioner may, subject to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, promulgate rules and regulations for purposes of implementing this section. The commissioner is authorized to promulgate the initial rules as emergency rules pursuant to the Uniform Administrative Procedures Act prior to January 1, 2010, for the purpose of creating the all payer claims database.

(2) The commissioner of finance and administration may, subject to the Uniform Administrative Procedures Act,

compiled in title 4, chapter 5, promulgate rules and regulations concerning the operation of the all payer claims database and the distribution and use of information maintained or created thereby. The commissioner of finance and administration is authorized to promulgate the initial rules as emergency rules pursuant to the Uniform Administrative Procedures Act prior to January 1, 2010, for the purpose of creating the all payer claims database.

[Acts 2009, ch. 611, § 3.]

56-7-2209. Health benefit plans — Preexisting conditions — Late enrollees — Premiums — Transfers — Place of business — Filings — Documentation. —

(a) Health benefit plans covering small employers are subject to the following:

(1) Except in the case of a late enrollee, any preexisting conditions provision may not limit or exclude coverage for a period beyond twelve (12) months following the insured's effective date of coverage, and may only relate to conditions manifesting themselves in a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment; for which medical advice, diagnosis, care or treatment was recommended or received during the twelve (12) months immediately before the effective date of coverage, or as to a pregnancy existing on the effective date of coverage;

(2) In determining whether a preexisting conditions provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous group health benefit plan if the previous coverage was continuous to a date not more than thirty (30) days before the effective date of the new coverage, exclusive of any applicable waiting period under the plan;

(3) **(A)** The health benefit plan is renewable with respect to all eligible employees or dependents at the option of the policyholder or contract holder except:

(i) For nonpayment of the required premiums by the policyholder or contract holder;

(ii) For fraud or misrepresentation of the policyholder or contract holder or, with respect to coverage of individual enrollees, the enrollees or their representatives;

(iii) For noncompliance with plan provisions that have been approved by the commissioner;

(iv) When the number of enrollees covered under the plan is fewer than the number of insureds or percentage of enrollees required by participation requirements under the plan;

(v) When the policyholder or contract holder is no longer actively engaged in the business in which it was engaged on the effective date of the plan; or

(vi) When the small employer carrier stops writing new business in the small employer market, if the employer:

(a) Provides notice to the department and either to the policyholder, contract holder or employer of its decision to stop writing new business in the small employer market; and

(b) Does not cancel health benefit plans subject to this part for one hundred eighty (180) days after the date of the notice required under subdivision (a)(3)(A)(vi)(*a*); and for that business of the carrier that remains in force, the carrier shall continue to be governed by this part with respect to business conducted under this part;

(B) A small employer carrier that stops writing new business in the small employer market in this state after January 1, 1993, shall be prohibited from writing new business in the small employer market in this state for a period of five (5) years from the date of notice to the commissioner. In the case of an HMO doing business in the small employer market in one (1) service area of this state, the rules set forth in this subdivision (a)(3) shall apply to the HMO's operations in the service area, unless § 56-7-2208(g) applies;

(4) Late enrollees may be excluded from coverage for the greater of eighteen (18) months or an eighteen-month

preexisting condition exclusion; however, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed eighteen (18) months;

(5) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage; however, participation and contributions requirements may vary among small employers only by the size of the small employer group; and

(6) If a small employer carrier offers coverage under a basic or standard plan to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of the small employer and their dependents. A small employer carrier shall not offer the coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees, as provided in subdivision (a)(4).

(b) Premium rates for health benefit plans subject to this part are subject to the following:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty-five percent (25%), adjusted pro rata for any rating period of less than one (1) year;

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system for that class of business shall not vary from the index rate by more than thirty-five percent (35%) of the index rate, adjusted pro rata for any rating period of less than one (1) year;

(3) The percentage increase in the premium rate charged to a small employer for a new rating period, adjusted pro rata for any rating period of less than one (1) year, may not exceed the sum of the following:

(A) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. If a small employer carrier is not issuing any new policies, but is only renewing policies, the carrier shall use the percentage change in the base premium rate;

(B) Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for any rating period of less than one (1) year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business;

(C) Any adjustment because of a change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business;

(4) Any adjustment in rates charged by a small employer carrier electing to be a reinsuring carrier that is caused by reinsurance is subject to the rating limitations set forth in this section;

(5) Premium rates for health benefit plans shall comply with the requirements of this section, notwithstanding any reinsurance premiums and assessments paid or payable by small employer carriers in accordance with § 56-7-2221;

(6) In any case where a small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the arithmetic average of the rate factors associated with all industry classifications by greater than fifteen percent (15%) of coverage; and

(7) Small employer carriers shall apply rating factors including case characteristics consistently with respect to all small employers in a class of business. Adjustments in rates for claims experience, health status and duration from issue may not be applied individually. Any such adjustment must be applied uniformly to the rate charged for all participants of the small employer.

(c) A small employer carrier shall not involuntarily transfer a small employer into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless the carrier offers to

transfer all small employers in the class of business without regard to case characteristics, claims experience, health status or duration of coverage since issue.

(d) In connection with the offering for sale of any health benefit plan to a small employer, each small employer carrier shall make a reasonable disclosure as part of its solicitation and sales materials of:

(1) The extent to which premium rates for a specified small employer are established or adjusted in part based upon the actual or expected variation in claims costs, or actual or expected variation in health condition of the eligible employees and dependents of the small employer;

(2) Provisions concerning the small employer carrier's right to change premium rates and the factors other than claims experience that affect changes in premium rates;

(3) Provisions relating to renewability of policies and contracts; and

(4) Provisions affecting any preexisting conditions provision.

(e) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(f) Each small employer carrier shall file with the commissioner annually, on or before March 15, an actuarial certification certifying that it is in compliance with this part and that its rating methods are actuarially sound. The small employer carrier shall retain a copy of the certification at its principal place of business.

(g) A small employer carrier shall make the information and documentation described in subsection (e) available to the commissioner upon request. Except in cases of violations of this part, the information is proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(h) Subdivisions (a)(1), (3) and (5) and subsections (b)-(g) apply to health benefit plans delivered, issued for delivery, renewed or continued in this state or covering persons residing in this state on or after January 1, 1993. Subdivisions (a)(2) and (4) apply to health benefit plans delivered, issued for delivery, renewed or continued in this state or covering persons residing in this state on or after the date the plan becomes operational, as designated by the commissioner. For purposes of this subsection (h), the date a health benefit plan is continued is the anniversary date of the issuance of the health benefit plan.

[Acts 1992, ch. 808, § 9; 1993, ch. 228, § 1.]

56-26-102. Filing and approval of policy forms — Loss ratio guarantee. —

(a) No policy of accident and sickness insurance shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application that becomes a part of any such policy be used in connection therewith until a copy of the form and of the premium rates and of the classifications of risk pertaining thereto has been filed with the commissioner of commerce and insurance, and unless the commissioner finds that the benefits provided in the policy are reasonable in relation to the premium charged, based upon such reasonable regulations as the commissioner may promulgate; provided, that in the case of experience-rated group insurance, premium rates and classifications of risks need not be filed but shall be maintained by the insurance company and made available for review by the commissioner upon the commissioner's request; nor shall any such policy, endorsement, rider or application be so used until the expiration of thirty (30) days after the form has been filed, unless the commissioner sooner gives the commissioner's written approval. The commissioner shall notify, in writing, the insurer that has filed any such form if it does not comply with this chapter, specifying the reasons for the commissioner's opinion. After the notice, it is unlawful for the insurer to issue the form in this state. In the notice, the commissioner shall state that a hearing shall be granted within twenty (20) days upon written request of the insurer.

(b) At the time of filing new premium rates on any previously approved form, the benefits provided by the policy are deemed to be reasonable in relation to the premium charged so long as the insurer complies with the terms of the loss ratio guarantee accompanying the filing. The loss ratio guarantee shall be in writing and shall include at least the following:

(1) A recitation of the anticipated annual loss ratio standards included in the original actuarial memorandum filed with the policy form at the time of the initial approval of the policy form;

(2) A guarantee that the actual loss ratios in this state for the experience period in which the rates take effect, and for each experience period thereafter, will meet or exceed the anticipated annual loss ratio standards as recited in accordance with subdivision (b)(1). If the annual earned premium volume in this state under a policy form is less than one million dollars ($1,000,000), the loss ratio guarantee shall be based on the actual nationwide loss ratio for the policy form. If the annual earned premium volume nationwide is less than one million dollars ($1,000,000), the experience period shall be extended until the end of the calendar year in which one million dollars ($1,000,000) of earned premiums is attained;

(3) A guarantee that the actual loss ratio results for each calendar year the rates are in effect shall be independently audited during the second quarter of the following year at the expense of the insurer. The audited results shall be reported to the commissioner no later than the date for filing the applicable accident and health policy experience exhibit;

(4) A guarantee that affected policyholders in this state shall be issued a proportional refund of premiums paid in the amount necessary to bring the actual loss ratio up to the anticipated annual loss ratio standards as recited in accordance with subdivision (b)(1). If national loss ratios are used, the total amount refunded in this state shall equal the dollar amount necessary to achieve the loss ratio standards, multiplied by the total premium earned in this state on the policy form and divided by the total premiums earned in all states on the policy form. The refund shall be made to all policyholders insured under the applicable policy form as of the last day of the experience period at issue and whose individual refund would equal ten dollars ($10.00) or more. The refund shall include interest at the rate of five and one-half percent (5 ½%) per year calculated from the last day of the experience period at issue until the date of payment, and shall be paid no later than ninety (90) days after the audit results are reported to the commissioner;

(5) A guarantee that refunds of less than ten dollars ($10.00) shall be aggregated by the insurer and paid to the department of commerce and insurance; and

(6) No review may be filed of any order or decision of the commissioner pursuant to § 56-26-105 unless the refund required in subdivision (b)(4) has been paid.

(c) As used in this section, “loss ratio” means the ratio of incurred claims to earned premium by number of years of policy duration, for all combined durations.

(d) As used in this section, “incurred claims” means claims actually paid during the reporting period, plus reported claims in the process of settlement. “Incurred claims” does not include legal expenses, claims adjustment costs and other administrative expenses associated with claims paid.

(e) In order for an insurer to submit a loss ratio guarantee as provided in this subsection (e), an insurer shall:

(1) Make a deposit of five hundred thousand dollars ($500,000) in cash, securities issued by an institution approved by the commissioner, or a combination thereof, which shall serve as security for payment of the premium refunds set forth in this section, provided any interest thereon shall accrue to the sole benefit of the insurer;

(2) Hold and maintain an “A.M. Best rating” of at least “A” or a rating determined by the commissioner to be equivalent, issued by an independent insurance company rating organization; or

(3) Request and receive the express written consent of the commissioner to submit loss ratio guarantees.

(f) The commissioner, after a public hearing of which at least thirty (30) days' written notice has been given, may withdraw approval of rates previously deemed approved pursuant to the loss ratio guarantee provisions of this section if the commissioner determines that the insurer is no longer complying with the terms of the loss ratio guarantee.
[Acts 1955, ch. 4, § 2; 1976, ch. 590, § 1; 1978, ch. 513, § 3; T.C.A., § 56-3302; Acts 1995, ch. 323, § 1.]

56-29-108. Issuance of license by commissioner — Prerequisites. —

The commissioner shall issue a license upon compliance with this chapter and other proper requirements of the commissioner, and upon being satisfied that:

(1) The applicant is established as a bona fide nonprofit hospital service corporation with or without the right to provide medical expense indemnity; the hospital service benefits provided by the corporation are not an unnecessary duplication of similar service in the community served; it is desirable for public necessity and convenience; hospital contracts have been obtained, if possible, in the findings of the commissioner, with hospitals representing a majority of the bed capacity in the area where members are to be enrolled; and a fair opportunity has been given to all institutions of standing in the area to be served, to become member hospitals;

(2) A provision has been made in the subscriber's contract authorizing hospital service in hospitals other than participating hospitals, in which case money benefits shall be provided as specified in the subscriber's contract and approved as fair by the commissioner;

(3) Member hospitals of a hospital service plan agree to render service benefits of the plan of which it is a member at the agreed payment schedule to all subscribers; and

(4) The rates charged are fair, reasonable, adequate and not unfairly discriminatory. Benefits to be provided are to be fair, reasonable and not unfairly discriminatory. Rates may differ between subscribers in recognized groups and subscribers not in groups, all subject as above to the approval of the commissioner.

[Acts 1949, ch. 234, § 6; C. Supp. 1950, § 4186.48 (Williams, § 4186.51); T.C.A. (orig. ed.), § 56-3108.]

56-29-116. Subscription contracts — Liability of hospitals — Rates — Approval of commissioner. —

(a) The corporation may enter into contracts for the rendering of hospital service to the subscribers only with hospitals approved by the commissioner.

(b) All contracts issued by the corporation to the subscribers shall constitute individually and jointly direct obligations of the hospital or hospitals with which the corporation has contracted for hospital service. The rates charged to the subscriber for hospital service, the rates of payment by the corporation to the contracting hospital or hospitals, and the rates charged for medical expense indemnity at all times shall be subject to the approval or disapproval of the commissioner; provided, that in the case of experience-rated group insurance, premium rates and classifications of risks need not be filed but shall be maintained by the hospital and medical service corporations and made available for review by the commissioner upon the commissioner's request.

[Acts 1949, ch. 234, § 4; C. Supp. 1950, § 4186.46 (Williams, § 4186.49); Acts 1978, ch. 513, § 2; T.C.A. (orig. ed.), § 56-3116.]

ATTACHMENT C

APPLICATION COVER SHEET AND CHECK-OFF LIST

Indentifying Information:

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

DUNS #:_____148976413______________________________ Grant Award: $1 million__________

Applicant: Tennessee Department of Commerce and Insurance, Division of Insurance__________

Primary Contact Person, Name:__Mary G. Moody __________________________________

Telephone Number:_615-741-6007________________Fax number:__615-532-6934_________

Email address:_____mary.moody@tn.gov____

56-32-107. Evidence of coverage. —

(a) (1) Every enrollee residing in this state is entitled to evidence of coverage.

(2) No evidence of coverage, or amendment to the evidence of coverage, shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage, or amendment to the evidence of coverage, has been filed and approved by the commissioner.

(3) (A) An evidence of coverage shall contain:

(i) No provisions or statements that are unjust, unfair, inequitable, misleading, deceptive, that encourage misrepresentation, or that are untrue, misleading or deceptive as defined in § 56-32-113(a);

(ii) A clear and concise statement if a contract, or a reasonably complete summary if a certificate, of:

(a) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(b) Any limitation on the services, kind of services, benefits, or kind of benefits to be provided, including any deductible, copayment or coinsurance feature;

(c) Where and in what manner information is available as to how services may be obtained; and

(d) The total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(iii) A clear and understandable description of the HMO's method for resolving enrollee complaints.

(B) Any subsequent change may be evidenced in a separate document issued to the enrollee.

(4) A copy of the form of the evidence of coverage to be used in this state, and any amendment to the evidence of coverage, shall be subject to the filing and approval requirements of subdivision (a)(2), unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance or hospital medical service corporations, in which event the filing and approval provisions of those laws shall apply. To the extent, however, that the provisions do not apply, the requirement in subsection (c) shall be applicable.

(b) (1) No schedule of charges for enrollee coverage for health care services, or amendment to the schedule, may be used until a copy of the schedule, or amendment to the schedule, has been filed and approved by the commissioner.

(2) The charges may be established in accordance with actuarial principles for various categories of enrollees; provided, that charges applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. However, the charges shall not be excessive, inadequate or unfairly discriminatory. A certification by a qualified actuary or other qualified person acceptable to the commissioner of the appropriateness of the use of the charges, based on reasonable assumptions, shall accompany the filing together with adequate supporting information.

(c) The commissioner shall, within a reasonable period, approve any form if the requirements of subsection (a) are met. It is unlawful to issue the form or to use the schedule of charges until approved. The commissioner, if disapproving the filing, shall notify the filer. In the notice, the commissioner shall specify the reasons for disapproval. A hearing will be granted within thirty (30) days after a request in writing by the person filing. The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

[Acts 1986, ch. 713, § 7; 2001, ch. 151, § 3; T.C.A. § 56-32-207.]

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

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

Objective Work Plan

Project:

Premium Review Grant

* Year:

1

* Funding Agency Goal:

The primary goal of the Cycle I grants is to provide awards to states to enhance their current rate review process for health insurance premiums.

* Objective:

Increases in health insurance premiums and rate filings will be thoroughly evaluated and, to the extent permitted by law, approved or disapproved through a comprehensive rate review process that is meaningful and transparent to the public, enrollees, policyholders and the Secretary.

* Results or Benefits Expected:

Rates for individual and group health insurance markets should become more reasonably related to the actual cost of providing benefits to the policyholders.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Contract for research and drafting of proposed changes to statutes and administrative regulations to enhance rate review process	Project Director Mary G. Moody	08/09/2010	09/30/2011	0
Contract with Department of Finance and Administration for reports from all-payer claims database.	Project Director Mary G. Moody	08/09/2010	09/30/2011	0
Study the feasibility and efficacy of using all-payer claims data in rate review.	Project Director Mary G. Moody	08/09/2010	09/30/2011	0
Improve expertise of staff through education.	Project Director Mary G. Moody	08/09/2010	09/30/2011	0

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
Improve electronic filing and data collection authorized by state law through contract with SERFF.	Project Director Mary G. Moody	08/09/2010	09/30/2011	0
Contract as necessary to electronically collect data and generate reports as required by the Secretary.	Project Director Mary G. Moody	08/09/2010	09/30/2011	0
Provide for public participation in premium review process by holding monthly public meetings.	Project Director Mary G. Moody	08/09/2010	09/30/2011	0
Improve information systems resources to accommodate increase in filing volume and rate review activities through purchase of additional hardware and software.	Project Director Mary G. Moody	08/09/2010	09/30/2011	0

* Criteria for Evaluating Results or Benefits Expected:

Was legislation proposed to increase the DOI's ability to review proposed rate increases and disapprove them if unreasonable? Was the DOI's Information Systems infrastructure improved to allow for enhanced data collection, reporting and rate review? Were there public meetings held to allow for public participation in 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 Abstract 7-07-2010.doc

PROJECT ABSTRACT

The project that will be funded by this grant will be the enhancement of the existing premium review process conducted by the Tennessee Department of Commerce and Insurance, Division of Insurance ("DOI").

Grant funds will be used to draft legislative proposals to strengthen the legal authority of the DOI to collect information relevant to setting of premiums, to expand the review of that information and to disallow proposed premiums that are not properly supported. Grant funds will be used to improve the DOI's information systems infrastructure to support more electronic collection of premium-related information, the electronic analysis of that information, and the publication of appropriate premium-related information.

Grant funds will also be used to improve the skills of the existing premium review staff, to establish public meetings regarding proposed premium increases and to study the usefulness of all-payer claims data in premium analysis.

The DOI believes that, if this project is funded and these proposal are implemented, the result will be a more robust, effective and transparent premium review process.

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** Project Narrative 7-07-2010 (final).doc

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

PROJECT NARRATIVE

I. Current health insurance rate review capacity and process

In Tennessee, insurance regulation primarily originates with the issuance of a certificate of authority or license to the entity providing the benefits under the policy contract. The Commissioner for the Tennessee Department of Commerce and Insurance grants certificates of authority or licenses to insurance companies (TCA § 56-2-105), health maintenance organizations ("HMOs" in accordance with TCA §§ 56-32-103 and 104), and non-profit hospital medical corporations (TCA § 56-29-108) upon a demonstration of compliance with applicable law. Such companies and organizations provide benefits under their policy contracts using various types of health care provider network systems commonly used to characterize the products available.

Insurance companies holding a certificate of authority may transact the business of insurance in the individual market or the group market, small or large. HMOs holding a certificate of authority only exist in the large group market even though the law permits their activity in the small group market, as well. Non-profit hospital medical service corporations (BlueCross BlueShield of Tennessee, Inc. is the only one) that are granted a license to issue contracts to subscribers/members/customers providing medical and hospital benefits are permitted to operate in the individual and group markets, small and large.

The laws and rules regulating the price of health coverage do not address the various types of networks or products that may be available in the marketplace. The regulation of the price of health coverage is connected primarily with the benefits provided under the particular policy contract form – i.e. the premium must be reasonable in relation to the benefits provided. TCA § 56-26-102.

All policy contract forms issued in Tennessee require filing and approval prior to issuance in this state. All companies filing new forms for use in any market segment, must include the

applicable rates and classifications except in the case of experience-rated group policies. Nothing in the law requires insurers to file rates (or forms) with any particular frequency.

There are no restrictions on rating structures, so long as they are reasonable in relation to the benefits provided under the form. As such, age, gender, dependent status, geographic location, tobacco use, etc. are commonly used as rating factors. The law prohibits the use of the health status of a particular group enrollee in determining that enrollee's eligibility or premium. Health status is a permitted basis on which to determine eligibility and price of individual health insurance except when HIPAA laws apply in continuation circumstances. In those circumstances, health status may only be considered in determining the price of the individual policy.

The primary focus of the current rate review is verification of the assumptions used to set the rates and that the proper anticipated loss ratio is being used to determine the premium for the form. An actuarial memorandum is required only for individual health insurance.

Premium rate issues are primarily addressed in the following statutes and regulations, and copies are attached:

- TCA § 56-26-102 and Tenn. Comp. R. & Regs. 0780-1-20 for all insurers
- TCA § 56-7-2209 for rating of small groups of 3-25
- TCA §§ 56-29-116 and 56-1-212(a) for all non-profit hospital medical corporations
- TCA § 56-32-107(b) for all HMOs

As mentioned previously, all policy forms issued in Tennessee require filing and approval prior to issuance. All companies filing new forms, regardless of the market segment, must include the applicable rates and classifications except in the case of experience-rated small or large group policies.

As to experience-rated group insurance, rates and classifications need not be filed and need only be made available for review by the Commissioner upon request. All other group

insurance premium rates and classifications must accompany the form filing, but the actuarial data and experience need not be filed and need only be maintained by the company and available for review by the Commissioner upon request. Each rate submission, which as explained will generally only involved individual health insurance products, shall include an actuarial memorandum describing the basis on which the rates were determined and shall indicate and describe the calculation of the anticipated loss ratio which is the ratio of the present value of the expected benefits to the present value of the expected premiums over the entire period for which the rates are computed to provide coverage.

Also required is a certification by a qualified actuary that the filing is in compliance with the applicable laws and regulations and that the benefits are reasonable in relation to the premiums.

Filings of rate revisions for previously approved forms must also include:

- A statement of the scope and reason for the revision, and an estimate of the expected average effect on premiums, including the anticipated loss ratio for the form.
- A statement as to whether the filing applies only to new business, only to in-force business, or both, and the reasons therefore.
- A history of the experience under existing rates.
- The date and magnitude of each previous rate change.

In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, such as:

- Statistical credibility of premiums and benefits, e.g. low exposure, low loss frequency
- Experienced and projected trends relative to the kind of coverage, e.g. inflation in medical expenses, economic cycles affecting disability income experience.

- The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially lower than at later policy durations.
- The mix of business by risk classification

With respect to a new form, benefits are deemed reasonable in relation to premiums provided the anticipated loss ratio for the entire period for which the rates are computed is at least as great as shown in the regulation. Those minimum loss ratios are: 50% for policies where renewal cannot be declined nor can rates be revised by the insurance company (non-cancellable), 55% for policies where renewal can be declined by the insurance company only for states reasons other than health reasons (conditionally renewable) and where renewal cannot be declined by the insurer for any reason but the insurer can revise rates on a class basis (guaranteed renewable), and 60% for policies renewable at the option of the insurer (optionally renewable).

The average annual premium per policy and the average anticipated loss ratio must be computed by the insurer based on an anticipated distribution of business by all applicable criteria having a price difference, such as age, gender, amount, dependent status, rider frequency, etc. except when assuming an annual mode for all policies. Fractional premium loading must not affect the average annual premium or anticipated loss ratio calculation.

With respect to rate revisions on a previously approved form, benefits are deemed reasonable in relation to the premiums on policies issued on or after the effective date of the revision, if the minimum loss ratios will be maintained. However, the average annual premiums must be determined based on an actual rather than anticipated distribution of business.

With respect to rate revisions on a previously approved form, benefits are deemed reasonable in relation to the premiums on policies issued prior to the effective date of the rate revision, if the minimum loss ratios have been maintained over the entire period for which the revised rate and computed and so long as the minimum ratio is maintained for the accumulated benefits to the accumulated premiums. Those accumulations are from the original effective date of the form to

the effective date of the rate revision plus the present value of the future amount or benefits or premiums, respectively.

If any of the required information is absent, a letter of objection is issued to the company. The filing is then put in suspense until a response is received. If no response is received after six (6) months, the file is closed without approval. If satisfactory response is received, filing is approved via SERFF or stamped approved on paper and logged to the rate increase database.

If response is received but information is sufficient to justify a smaller increase, discussion ensues. Our experience has demonstrated an ability to reach agreement on these issues. However, Commissioner may disapprove any rate filing for failure to comply with applicable law or regulations. Additionally, Commissioner may withdraw approval of any form, after proper notice and hearing, when she determines that the benefits are unreasonable in relation to the premium charged. TCA § 56-26-103.

The vast majority of insurance companies submit their filings via the National Association of Insurance Commissioners' (NAIC's) System for Electronic Rate and Form Filing (SERFF), although Tennessee law does not require that filings be submitted electronically.

We use one policy analyst position and one administrative secretary position to process the intake of all individual rate filings. There are two policy analysts available to review rate filings, and they spend approximately half of their time reviewing filings including rates. We have a consulting actuary who reviews the rate portion of the filings on a weekly or bi-weekly basis dependent upon the volume of filings received. The pre-review by our staff reduces correspondence and saves valuable time for the consulting actuary.

We review all individual rate filings, both new rates and rate change requests. The group rates don't require actuarial or other close review, because they are certified in accordance with the language in Tenn. Comp. R. & Regs. 0780-1-20-.01(9). Verification of the certification is generally consumer complaint driven.

Small group rates (3-25 employees) are not required to be submitted. If they are submitted upon request to verify compliance with TCA § 56-7-2209, they must be kept confidential. Additionally, each small employer must file annually by March 15th an actuarial certification that it is in compliance with the law regarding its rates and that its rating practices are actuarially sound.

We maintain a separate database of all approved increases by policy form number in the individual market along with Medicare supplement and long term care policies. This information is routinely posted on our website.

For insurance companies, the law provides that no policy of accident and sickness insurance shall be delivered or issued for delivery until a copy of the form and its premium rates and classifications of risk have been filed with the Commissioner and unless she finds that the benefits provided in the policy are reasonable in relation to the premium charged, based upon reasonable regulations (which are found at Tenn. Comp. R. & Regs. 0780-1-20). Such policy and rates may not be used until the expiration of thirty (30) days after filing, unless Commissioner sooner grants written approval. Commissioner must provide written notice of the specific reasons the filing does not comply with the law, and in such notice Commissioner must state that a hearing will be granted within twenty (20) days if requested in writing by the insurer. However, in the case of experience-rated group insurance, premium rates and classifications of risks need not be filed but shall be maintained by the company and made available for review upon Commissioner's request. TCA § 56-26-102(a). Commissioner may withdraw approval of any form, after proper notice and hearing, when she determines that the benefits are unreasonable in relation to the premium charged. TCA § 56-26-103.

For non-profit hospital medical corporations, the rates charged for hospital service, the amount paid to the hospitals, and the rates charged for medical expense indemnity are subject to approval or disapproval of the Commissioner, except that experience-rated group rates and classifications of risks need not be filed but need only be maintained and made available for

review by Commissioner upon request. TCA § 56-29-116. Such corporation must file specimen copies of contracts and the associated schedules of rates it proposes to use in this state. TCA § 56-29-117. However, regardless of any law to the contrary, Commissioner has the same authority to regulate and must apply the same substantive standards to such corporations as she must apply to ordinary health insurers. TCA § 56-1-212(a).

For small group carriers (3-25), premium index rates cannot vary by more than 25% between the classes of business, by more than 35% between similar employers having similar coverage, and annual premium increases and other rating issues have certain defined limitations. However, small group carriers need not file their rates. Every small employer carrier must maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles. It must also make this information and documentation available to Commissioner upon request. Except in cases of violations of the law (which become public record), the information is proprietary and trade secret information and is not subject to disclosure to persons outside the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction. TCA § 56-7-2209.

For HMOs, no schedule of charges for enrollee coverage for health care services, or amendment to the schedule, may be used until a copy of the scheduled or amendment has been filed and approved by the Commissioner. Those charges may be established in accordance with actuarial principles for various categories of enrollees, provided that charges applicable to an enrollee shall no be individually determined based on their health status. The charges shall not be excessive, inadequate, or unfairly discriminatory. A certification by a qualified actuary or other qualified person acceptable to the Commissioner of the appropriateness of the charges based on reasonable assumptions shall accompany the filing with adequate supporting

information. Commissioner may require the submission of whatever relevant information she deems necessary in determining whether to approve or disapprove a filing. Commissioner must notify the filer of the specific reasons if disapproving the filing, and a hearing must be granted within thirty (30) days upon written request of the filer. TCA § 56-32-107(b).

We rely on the consulting actuary's judgment and experience to assess each filing for approval, modification, or denial.

Relevant information received from consumers or others that indicates the benefits provided by the policy are unreasonable in relation to the premium charged would trigger a retrospective review of rates.

The current consultant for Tennessee is Wakely Consulting. Their website is http://www.wakelyconsulting.com/content.htm. The actuary who physically comes to the Department is Ronald D. Burkhart. He works in partner with D. Dale Hyers who is the back up actuary and sounding board for Mr. Burkhart. Their biographical information is at http://www.wakelyconsulting.com/actuaries.htm.

The current analyst responsible for rate review is Victoria Stotzer. She has a Bachelor of Science degree in mathematics and has worked for the Department for 20 years. Charles Bullen, an analyst very recently transferred from another section is currently in the process of learning health insurance regulation and assisting in review of some health insurance filings. He has a degree in mathematics and philosophy and has passed one of the actuarial examinations. He has worked for the Insurance Division for 8 years in other areas, and we anticipate using Mr. Bullen extensively in the review of health insurance rate filings.

An administrative secretary has assisted the analyst and actuary in filing intake, handling, and correspondence in the past, so her role has been included here from the standpoint of the current budget, despite the fact she is currently out of the office on extended sick leave.

The 2009-2010 Spending-Receipt Plan for the Insurance Division was $12,832,200. The total currently attributable to health rate review is $143,528:

Contract for actuarial services	66,000
Analyst staff – ½ position	29,272
Admin staff – ¼ of one position	11,771
Management – 1/10 of Director	8,885
Upper level management	10,000
Travel	1,400
Supplies	1,000
Equipment	1,000
Training	700
State professional services	13,500
(phone, rent, secy state legal fees . . .)	

In 2009, we received 704 filings that contained rates. Of those, 446 were rate revisions not associated with form revisions. The average review time period for individual filings is approximately 60 days. A filing with no correspondence is usually completed within 2 weeks.

All state, county, and municipal records not identified as specifically exempt by law must at all times during business hours be open for personal inspection by any citizen of Tennessee, and those in charge of such records cannot refuse such right of inspection to any citizen, unless otherwise provided by state law. TCA § 10-7-503(a). Rate filings are made available for inspection or are copied on paper or electronically for any citizen requesting a copy. Electronic document creation and delivery via email or by download to a flash drive is fast and economical compared to photocopying paper filings and mailing them.

A spreadsheet of rate changes is posted on our website for public awareness. No other summary of rate changes is provided. No advance notice is given to consumers by this

Department regarding proposed rate changes. We do not believe that insurers provide such advance notice, either.

No public meetings or hearing have been held about rate filings in the recent past , but nothing in the law prohibits Commissioner from holding them regarding matters subject to public inspection. Although hearings are required to disapprove certain filings, our experience is that agreements have been reached that eliminated the need for a hearing.

Complaints and inquiries about major medical health insurance rates have been received over the years. We received approximately 50-75 each year. Many are appeased with an explanation of the approval process and confirmation that their increase was filed and approved. However, many have expressed frustration that the filing review and approval process does not include a public forum. Many have expressed frustration that the price is not related to the income of the policyholder. Many have expressed frustration that their premium continues to increase, although they have made little to no claims. Many have expressed frustration with the "death spiral" associated with closed blocks and that the law permits it to occur. Many have expressed frustration that there are cracks is the system, such that some cannot obtain insurance and others cannot obtain it at a reasonable cost. Many have expressed strong doubts that information provided to us by insurers is accurate, and some of those seem to believe that lack of honesty plays a role in the insurance companies and in the regulation of them.

No actions have been taken by the Department against insurance companies over the past two years regarding health insurance rates. No hearings have been held over the past two years regarding health insurance rates.

II. Proposed rate review enhancements for health insurance

We hereby assure HHS that should Tennessee be awarded this grant, such funds will be used to make improvements to our existing rate review and approval practices. We currently

review many rate filings and propose the following enhancements to further strengthen our existing authorities and processes.

A. Draft Proposals to Increase Statutory Authority to Review and Approve Premiums.

We propose to contract with a vendor to research and draft proposed changes to statutes and administrative regulations to enhance the rate review process. We anticipate that such proposals would include:

1. Requiring the annual filing of all rates and the prior approval of small and large group rates, including experience-rated groups along with the supporting actuarial data.
2. Requiring insurers to submit information not currently required to be submitted such as the product type associated with the form numbers, the total incurred claims in each policy form, and the medical trend factor assumptions by benefit category including hospital inpatient and outpatient, physician services, prescription drugs, radiology, and other ancillary services and the amount of the projected trend attributable to the use of services (claims), price inflation or fees and risk along with a discussion of the comparison of claims costs and rate changes over time, any changes in member cost-sharing and member benefits over the prior year associated with the submitted rate filing.
3. Requiring insurers to separately report and justify administrative expenses including salaries and advertising and take into consideration the company’s overall finances when making rate change determinations.
4. Requiring insurers to post rate increases including accompanying documentation on their websites, to implement public hearing

processes, and to provide customers with increased advance notice before rate changes become effective.

It is our goal to have laws and administrative regulations addressing health insurance rates that are at least as strong as those found in ACA and clarified through federal administrative regulations. Draft legislation should be ready by the end of the calendar year for filing during or prior to January 2011. As such, we hope to complete the contract process by September 30, 2010.

B. Study Use of All-Payer Claims Data in Rate Review

We propose to contract for one year with the Tennessee Department of Finance and Administration for a pilot project to study the use in rate review of reports regarding actual claim payment information they collect from insurers in the all payer claims database in accordance with TCA §56-2-125 enacted in 2009 by Public Chapter 611 and in accordance with the corresponding regulations found at Tenn. Comp. R. & Regs. 0780-01-79. Tennessee requires health insurers to submit data from medical and pharmacy claims, and eligibility files, to the State's all payer claims database. The medical claims data include identifying information on the provider rendering services, the services rendered, the price paid for the service (including all copay, coinsurance, etc.), and encrypted numbers allowing services to be linked by patient. The pharmacy claims data includes identifying information on the pharmacist, the prescribing physician, the number and type of pharmaceuticals purchased, the price paid for the pharmaceuticals (including all copay, coinsurance, etc.), and the same encrypted number for linking services and pharmacy purchases by patient. All payer claims is not currently used to support rate review in Tennessee, but the data present an opportunity for Tennessee to use objective and extremely detailed information on medical expenditures to enhance rate review. The reports of claim payments that we would be receiving from the TN

Department of Finance and Administration are expected to be useful at least in providing some validation of the claim payment information filed by insurers. The program is just getting started, and its first report is expected in August 2010.

C. Improve Expertise of Existing Staff.

We propose to use grant funds to provide relevant education to existing staff to increase expertise and improve their abilities to efficiently and effectively understand, comprehend, evaluate, and communicate, all of the rate information available to them and the work of our contract actuary. This should result in improved quality of review and analysis. Educational opportunities are anticipated throughout the fiscal year and some will build on others. As such, we anticipate enrolling both analysts and one administrative staff person in meaningful classes at least quarterly beginning August 2010 through September 2011.

D. Acquire Analytical Software.

We propose to contract with a vendor for the purchase and/or development of software that analyzes rate information in numerous ways including assessing the validity of rate information. A suitable product may not be currently available for purchase. If not, we will contract for development of a suitable product. Such software is expected to promote consistency and transparency in rate review and analysis.

E. Improve Electronic Filing and Data Collection

A contract with SERFF to enhance its system to collect additional rate and information and report on behalf of the state to HHS is anticipated. We also propose to contract with NAIC's SERFF program, as may be necessary, to make available to the public through the internet all rate filing information available that is not confidential or trade secret by law or regulation. SERFF is also working on ways to make rate information and rate filings more easily understood.

We also propose to plan, develop, and implement an electronic filing mechanism, which may require a contract with a vendor for such services, whereby such electronically filed information can and would be incorporated into the SERFF system for the purpose of consolidating all filed rate information and for the purposes of accomplishing the required reporting to HHS. We expect this contract to include services to enhance our website to permit us to post filings on our web site, should SERFF not be able to perform this function toward transparency.

F. Provide For Public Participation in the Premium Review Process

We propose to begin holding monthly public hearings and meetings regarding rate filings and information to enhance transparency in the rate filing process and for the purpose of permitting the public and other stakeholders or interested parties to testify regarding health insurance rates. Notice of such would be posted on our website and on other public websites as may be identified as appropriate. Such meetings and hearing are expected to begin in August 2010.

G. Improve Information Systems Resources

We propose to purchase additional hardware such as computer equipment, scanners, and printers, along with appropriate corresponding software packages to accommodate the increase in filing volume and rate review activities before and after successful passage of legislation and promulgation of administrative regulations enhancing the filings requirements. Such purchases would begin by June 2011 and be completed by September 2011.

III. Reporting to the Secretary on Rate Increase Patterns

We hereby attest that we will comply with the reporting requirements outlined in ACA. It is anticipated that grant funds will be used to upgrade SERFF such that rate information is collected from the insurers and reported to HHS as required. A description of those plans by way of memo from Julienne Fritz, Director of Insurance Products and Services of the NAIC is attached.

IV. Optional Data Center Funding

We propose to contract, alone or in concert with other states, with an academic or non-profit research institution to establish a data center to compile and publish fee schedule information. Tennessee hereby assures that all data centers that receive grant funding will meet the requirements set forth in the law and by HHS through administrative regulation or otherwise. We plan to identify and contact all eligible institutions in Tennessee along with other state Departments to identify others before narrowing the scope of our search for those eligible. The procurement process used will include a requirement that each institution provide proof that it meets eligibility requirements.

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** Budget_Narrative_ 7-07-2010.doc

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Budget Narrative 7-07-2010

The goal of this grant is to enhance our current process for reviewing health insurance premiums. The review of premiums requires the review of the forms and the rates. The total funding necessary for these purposes is estimated at $1,143,528, including maintaining our current level of funding for this function. The bulk of these expenses are for vendor contracts to improve our information systems and electronic data capture.

Review activities to be enhanced are divided into four (4) categories as follows:

- Receipt and review of forms and proposed rate changes
- Contract for research and drafting proposed legislation and regulations
- Improvements to information systems and electronic data capture
- Conduct monthly public meetings

Funding in the total amount of $273,528 is needed for basic receipt and review of forms and rates. Current funding is in the amount of $143,528 and is broken down on Page 9 of the Project Narrative. Additional funding needed to enhance the processes involved in the receipt and review of forms and rates includes $80,000 for relevant and meaningful education of existing staff and $50,000 for the management of grant funds and coordination of this project.

Funding needed to enhance our laws and regulations by way of contracting for research and drafting of proposed legislation and administrative regulations is estimated in the amount of $150,000.

Funding in the amount of $670,000 is needed to improve our information systems and electronic data capture and includes contracts as follows:

- $20,000 with SERFF to enhance their systems
- $300,000 for the purchase or development of analytical software
- $100,000 to accommodate the electronic receipt and publishing of filings and data
- $50,000 for the non-profit institutional or educational data center
- $150,000 with TN Department of Finance and Administration for all payer claims data
- $50,000 for the purchase of additional hardware such as computers, printers and scanners

Conducting monthly public hearings and meetings is expected to cost approximately $50,000. Such needed funding is broken down as follows:

- $24,000 for personnel – legal and analyst staff
- $2,000 for travel
- $6,000 for supplies for publishing notices and relevant materials and documents
- $18,000 for contract services of reporter for recording of meetings / hearings

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. Rate Review-receive and review forms and proposed rate changes.	93.511	$ 130,000.00	$ 143,528.00	$	$	$ 273,528.00
2. Rate Review-Contract for research and drafting proposed legislation and regulations	93.511	150,000.00				150,000.00
3. Rate Review-Improvements to Information Systems and Electronic Data Capture	93.511	670,000.00				670,000.00
4. Rate Review-Conduct monthly public meetings.	93.511	50,000.00				50,000.00
5. **Totals**		$ 1,000,000.00	$ 143,528.00	$	$	$ 1,143,528.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1) Rate Review-receive and review forms and proposed rate changes.	(2) Rate Review-Contract for research and drafting proposed legislation and regulations	(3) Rate Review-Improvements to Information Systems and Electronic Data Capture	(4) Rate Review-Conduct monthly public meetings.	(5)
a. Personnel	$ 177,852.00	$	$	$ 24,000.00	$ 201,852.00
b. Fringe Benefits	12,776.00				12,776.00
c. Travel	1,400.00			2,000.00	3,400.00
d. Equipment	1,000.00		50,000.00		51,000.00
e. Supplies	1,000.00			6,000.00	7,000.00
f. Contractual	66,000.00	150,000.00	620,000.00	18,000.00	854,000.00
g. Construction					
h. Other					
i. Total Direct Charges (sum of 6a-6h)	260,028.00	150,000.00	670,000.00	50,000.00	$ 1,130,028.00
j. Indirect Charges	13,500.00				$ 13,500.00
k. TOTALS (sum of 6i and 6j)	$ 273,528.00	$ 150,000.00	$ 670,000.00	$ 50,000.00	$ 1,143,528.00
7. Program Income	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8.	$	$	$	$
9. Rate Review-Contract for research and drafting proposed legislation and regulations	0.00	0.00	0.00	0.00
10. Rate Review-Improvements to Information Systems and Electronic Data Capture	0.00	0.00	0.00	0.00
11. Rate Review-Conduct monthly public meetings.	0.00	0.00	0.00	0.00
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.	$ 0.00	$ 0.00	$ 0.00	$
17. Rate Review-Contract for research and drafting proposed legislation and regulations	0.00	0.00	0.00	
18. Rate Review-Improvements to Information Systems and Electronic Data Capture	0.00	0.00	0.00	
19. Rate Review-Conduct monthly public meetings.	0.00	0.00	0.00	
20. TOTAL (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks:

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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	Deputy Commissioner
* APPLICANT ORGANIZATION	* DATE SUBMITTED
State of Tennessee, Department of Commerce and 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: State of Tennessee, Department of Commerce and Insurance
* Street 1: 500 James Robertson Parkway, 5th Floor
Street 2:
* City: Nashville
State: TN: Tennessee
Zip: 37243-0565

Congressional District, if known: TN-005

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* N/A
Middle Name
* *Last Name* N/A
Suffix
* *Street 1*
Street 2
* *City*
State
Zip

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

Prefix
* *First Name* N/A
Middle Name
* *Last Name* N/A
Suffix
* *Street 1*
Street 2
* *City*
State
Zip

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* Ms. * *First Name* Mary *Middle Name* G.
* *Last Name* Moody *Suffix*

Title: Deputy Commissioner **Telephone No.:** 615-741-6007 **Date:** Completed on submission to Grants.gov

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