TEXAS

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:** Health Insurance Premium Review Grant

Mandatory Documents

Move Form to Complete

Move Form to Delete

Mandatory Documents for Submission

Optional Documents

Move Form to Submission List

Move Form to Delete

Optional Documents for Submission

Instructions

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

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

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

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

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

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

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

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

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

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

Application for Federal Assistance SF-424

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

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

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

State Use Only:

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

8. APPLICANT INFORMATION:

* a. Legal Name:	Texas Department of Insurance
* b. Employer/Taxpayer Identification Number (EIN/TIN):	74-6000-121
* c. Organizational DUNS:	0950810010000

d. Address:

* Street1:	333 Guadalupe
Street2:	PO Box 149104
* City:	Austin
County/Parish:	Travis
* State:	TX: Texas
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	78701-9104

e. Organizational Unit:

Department Name:	Division Name:
Life, Health, and Licensing	Life/Health

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

Prefix:	Ms.	* First Name:	Jan
Middle Name:			
* Last Name:	Graeber		
Suffix:			

Title:	Chief Actuary
Organizational Affiliation:	
* Telephone Number:	512-305-7317
Fax Number:	512-322-3552
* Email:	jan.graeber@tdi.state.tx.us

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: Tx-025 | b. Program/Project: TX-001

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

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

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

18. Estimated Funding ($):

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

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

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

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

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

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

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

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

☒ ** I AGREE

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

Authorized Representative:

Prefix:	Ms.
* First Name:	Karen
Middle Name:	A.
* Last Name:	Phillips
Suffix:	
* Title:	Chief of Staff
* Telephone Number:	512-305-7249
Fax Number:	512-475-2005
* Email:	karen.phillips@tdi.state.tx.us
* 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:**

Texas Department of Insurance

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

*** Contact 1 Project Role:** Project Manager

Prefix:	Ms.
* First Name:	Jan
Middle Name:	
* Last Name:	Graeber
Suffix:	
Title:	Chief Actuary

Organizational Affiliation:

Employee

* Street1:	333 Guadalupe, PO Box 149104
Street2:	Mail Code: 106-1A
* City:	Austin
County:	Travis
* State:	TX: Texas
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	78681-9104
* Telephone Number:	512-305-7317
Fax:	
* Email:	jan.graeber@tdi.state.tx.us

Delete Entry | Previous Person | Next Person

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

Key Contacts Form

*** Applicant Organization Name:**

Texas Department of Insurance

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

*** Contact 2 Project Role:** Fiscal Contact

Prefix: Mrs.

* First Name: Jacque

Middle Name:

* Last Name: Canady

Suffix:

Title: Chief Financial Officer

Organizational Affiliation:

* Street1: 333 Guadalupe

Street2: PO Box 149104

* City: Austin

County: Travis

* State: TX: Texas

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 78704-9104

* Telephone Number: 512-463-6143

Fax: 512-463-6181

* Email: jacque.canady@tdi.state.tx.us

Delete Entry | Previous Person | Next Person

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

Key Contacts Form

*** Applicant Organization Name:**

Texas Department of Insurance

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

*** Contact 3 Project Role:** Grant Coordinator

Prefix:	Mrs.
* First Name:	Regina
Middle Name:	
* Last Name:	Durden
Suffix:	
Title:	Operations Coordinator

Organizational Affiliation:

* Street1:	333 Guadalupe
Street2:	
* City:	Austin
County:	Travis
* State:	TX: Texas
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	78704-9104
* Telephone Number:	512-475-1782
Fax:	512-465-6159
* Email:	regina.durden@tdi.state.tx.us

Delete Entry | Previous Person | Next Person

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

Project/Performance Site Location(s)

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

Organization Name: Texas Department of Insurance

DUNS Number: 0950810010000

* Street1: 333 Guadalupe

Street2: PO Box 149104

* City: Austin County: Travis

* State: TX: Texas

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 78701-9104 * Project/ Performance Site Congressional District: Tx-025

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	FHR_RFA_FD_10_999_CoverSheet	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	FHR_RFA_FD_10_999_Cover_ Lett	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	FHR_RFA_FD_10_999_Governors_	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

APPLICATION COVER SHEET AND CHECK-OFF LIST

Indentifying Information:

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

DUNS #: 0950810010000 Grant Award: $1,000,000.00

Applicant: Texas Department of Insurance

Primary Contact Person, Name: Jan Graeber

Telephone Number: (512) 305-7317 Fax number: (512) 327-3552

Email address: Jan.Graeber@tdi.state.tx.us

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

Texas Department of Insurance

Administrative Operations – Senior Associate Commissioner/Chief of Staff
Mail Code 113-1C • 333 Guadalupe • P. O. Box 149104, Austin, Texas 78714-9104
512-305-7249 telephone • 512-475-2005 fax • www.tdi.state.tx.us

July 6, 2010

Office of Consumer Information and Insurance Oversight
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Grants to States for Health Insurance Premium Review

Dear Sir/Madam:

The Texas Department of Insurance (TDI) has been designated as the lead agency with authority to oversee and coordinate the proposed activities and is pleased to submit this application for a Grant to States for Health Insurance Premium Review (Grant) on behalf of the State of Texas.

TDI assures that grant funds will only be used to enhance the TDI's existing rate review efforts and will not be used as a substitute for existing funding for such efforts.

TDI proposes to use this grant to develop and implement the state process for health insurance rate review for the Federal Fiscal Years (FFY) 2010 and 2011, including a plan for disclosing rates to the public and the Secretary of the U.S. Department of health and Human Services (HHS). This will allow us to achieve the following objectives:

- Ensure that increases in health insurance premiums and rate filings are thoroughly evaluated through a comprehensive rate review process that is meaningful and transparent to the public, enrollees, policyholders the HHS Secretary.

- Develop the infrastructure to collect, analyze and report to the HHS critical information about rate filings and the review.

We are requesting $1 million for Cycle 1.

We appreciate this opportunity to apply for the Grant. Please contact Jan Graeber, Chief Actuary, if you require any additional information concerning this application at (512) 305-7317 or jan.graeber@tdi.state.tx.us.

Sincerely,

Karen A. Phillips
Chief of Staff CAR

OFFICE OF THE GOVERNOR

RICK PERRY
GOVERNOR

July 7, 2010

Office of Consumer Information and Insurance Oversight
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Sir/Madam:

Currently, Texas reviews individual, small group and large group health insurance filings. Our state laws and regulations dictate which premium rates are subject to review.

The Texas Department of Insurance (TDI) proposes to use the grant funding from the first cycle of Health Insurance Premium Review Grants provided under the Affordable Care Act to augment the state process for health insurance rate review for the federal Fiscal Years 2010 and 2011, including a plan for disclosing rates to the public and the secretary of the U.S. Department of Health and Human Services.

With this letter, I am expressing support for TDI's grant proposal, which will ensure that increases in health insurance premiums and rate filings are thoroughly evaluated through a rate review process, which is transparent to all stakeholders. This grant will also improve TDI's ability to develop infrastructure to collect, analyze and report critical information about rate filings and the review.

Sincerely,

Rick Perry

Rick Perry
Governor

Appendices

- **Appendix 1 – Relevant Statutory and Regulatory Authority**
- **Appendix 2 – Excerpt from a comprehensive medical rate filing in which the proposed increase was successfully reduced.**
- **Appendix 3 – Organizational Chart and Job Descriptions**

Appendix 1 – Relevant Statutory and Regulatory Authority

All Rates

Texas Insurance Code Sec. 560.002. USE OF CERTAIN RATES PROHIBITED; RATE REQUIREMENTS.

(a) An insurer may not use a rate that violates this chapter.
(b) A rate used under this code:
(1) must be just, fair, reasonable, and adequate; and
(2) may not be:
(A) confiscatory;
(B) excessive for the risks to which the rate applies; or
(C) unfairly discriminatory.
(c) For purposes of this section, a rate is:
(1) inadequate if the rate is insufficient to sustain projected losses and expenses to which the rate applies, and continued use of the rate:
(A) endangers the solvency of an insurer using the rate; or
(B) has the effect of substantially lessening competition or creating a monopoly in any market;
(2) excessive if the rate is likely to produce a long-term profit that is unreasonably high in relation to the insurance coverage provided; or
(3) unfairly discriminatory if the rate:
(A) is not based on sound actuarial principles;
(B) does not bear a reasonable relationship to the expected loss and expense experience among risks; or
(C) is based wholly or partly on the race, creed, color, ethnicity, or national origin of the policyholder or an insured.

Individual Accident and Health

28 Texas Administrative Code, Chapter 3, §3.4(p) – Relevant sections are bolded.

(p) Rates. Initial and subsequent rate filings shall include all specific descriptions and required information as follows:
(1) policy forms for which the rate filing applies shall be specified on the transmittal checklist or the transmittal form, as applicable;
(2) credit life and credit accident and health filings submitted under Insurance Code Article 3.53 and Subchapter FF of this chapter shall include the rate information;
(3) group and individual Medicare supplement filings submitted under Insurance Code Article 3.74 §4, and Subchapter T of this chapter (relating to Minimum Standards for Medicare Supplement Policies) shall include the applicable rate schedule and experience by plan;
(4) group and individual long-term care forms submitted under Insurance Code Article 3.70-12 and Chapter 3, Subchapter Y of this chapter (relating to Standards for Long-Term Care Insurance Coverage Under Individual and Group Policies) shall include the rate schedule;
(5) all individual accident and health filings submitted under Insurance Code Article 3.42 shall include the rate schedule; and
(6) rate schedules submitted shall be accompanied by the actuarial information set forth in subsection (q) of this section.
(**q) Actuarial Information.**

(1) Each life filing, including riders, insert pages, or limited partial refilings, which changes the non-forfeiture values of a particular policy or certificate shall be accompanied by the information set forth in subparagraphs (A) - (C) of this paragraph:

(A) The mathematical formulas and sample calculations for the items set forth in clauses (i) - (iv) of this subparagraph.

(i) net premiums for the specimen age and plan of insurance;

(ii) specimen non-forfeiture calculations necessary to verify consistency between the non-forfeiture values and the text of the form for years one, 20, and 50;

(iii) terminal reserves for the specimen age and plan; and

(iv) any other calculations necessary to verify non-forfeiture values and reserves.

(B) An actuarial memorandum as specified in clauses (i) and (ii) of this subparagraph, as applicable:

(i) for universal life and interest sensitive forms:

(I) an actuarial memorandum shall provide the mortality table, guaranteed interest rates, maximum surrender charges, maximum expense charges, maximum risk rates (cost of insurance rates), maximum loads, and maximum fees at issue. Upon a change in basic coverage, bands and risk classes for all ages shall be provided.

(II) actuarial proof shall be provided that:

(-a-) cash surrender values meet the minimum requirements of Insurance Code Article 3.44a;

(-b-) cash surrender values will always equal or exceed the minimum values required by law; and

(-c-) provide a comparison table of all guaranteed cash surrender values, standard nonforfeiture law minimum cash surrender values, guaranteed death benefits, and reserves. Such comparison should be based on the fill-in issue age (usually age 35) as defined in subsection (d) of this section, a premium which will provide coverage to the latest available maturity date, the minimum issue amount, minimum guaranteed interest rates, maximum guaranteed cost of insurance rates (mortality rates), maximum guaranteed charges, and a month-by-month calculation of the values shown in the comparison for the first and fiftieth years.

(ii) for variable life forms, actuarial information shall be provided as required by §3.804 of this chapter (relating to Insurance Contract and Filing Requirements), and as required by this section.

(C) A statement shall be provided certifying that all policies or certificates, in addition to the specimen language and fill-in material, will have premiums, reserves, and non-forfeiture values calculated in a manner consistent with the information furnished with the specimen language and fill-in material. Any qualifications to such certification shall be specified, including any variation in formulas at different ages at issue or at time of a change.

(2) For each annuity filing, an actuarial memorandum shall be provided to meet the minimum requirements of Insurance Code Article 3.44b and specify the guaranteed interest rates, the maximum surrender charges, and any other maximum charges applicable in the determination of non-forfeiture values. If the company intends to change the guaranteed interest rates specified in the form, notification shall be submitted to the department prior to the change. The notification shall specify the new guaranteed interest rate and the date when the new guaranteed interest rate will be effective for new issues of a specified policy form, as required by §3.1004 of this chapter (relating to Policy Form Review).

(A) For variable annuities, the actuarial information shall provide the information required in this paragraph and the information required by §3.705 of this chapter (relating to Contract Requirements), to the extent such material is applicable.

(B) For policies or contracts that contain a market-value adjustment, the actuarial memorandum shall:

(i) identify the name of the separate account;

(ii) indicate the basis for the market-value adjustment formula and that the formula provides reasonable equity to both the contract holder and the company;

(iii) detail that the reserve liabilities are established in accordance with actuarial procedures that recognize that assets of the separate account are based on market values, the variable nature of the benefits provided, and any mortality guarantees;

(iv) include a table of minimum guaranteed policy values and cash surrender values which:

(I) are based on the longest guaranteed investment period,

(II) reflect both upward and downward market-value adjustments; and

(III) show that the minimum guaranteed values prior to the adjustment are not less than the minimum non-forfeiture values required by law; and

(v) provide a numerical illustration reproducing the values shown in the table for the first, second, and third years of investment, and at the end of the guaranteed investment period.

(3) Group and individual Medicare supplement (including Medicare SELECT) rate filings shall be accompanied by supporting actuarial information as required by Subchapter T of this chapter.

(4) Group and individual long-term care:

(A) rate filings shall be accompanied by supporting actuarial information as required by Subchapter Y of this chapter; and

(B) annual reports shall include the rates, rating schedule, and supporting documentation as required by Insurance Code Article 3.70-12, §4(b).

(5) Individual accident and health premium rate increases which result in any policyholder experiencing an increase in premium rate greater than or equal to 50% in any 12-month period must be accompanied by actuarial information which includes, at a minimum, the items of information specified in subparagraphs (A) - (E) of this paragraph. For the purpose of this paragraph, an increase in premium rate greater than or equal to 50% in any 12-month period shall mean the cumulative increase with respect to such premium considered over a 12-month period.

(A) The form number or numbers to which the submitted rate increase applies.

(B) The planned effective date of the increased rate.

(C) The schedule or schedules of rates to be used.

(D) A concise explanation of the rating process, including assumptions, claims data, methodology, and formulas used in development of gross premium rates.

(E) A statement of actual and projected experience as a basis for the rate adjustments.

(6) Discretionary group filings shall be accompanied by supporting actuarial information as required by Insurance Code Articles 3.50 §1(6) and 3.51-6 §1(a)(6).

Health Maintenance Organizations

28 Texas Administrative Code, Chapter 11

RULE §11.701 Must Be Filed Prior to Use

(a) No schedule of charges, formula or method for calculating the schedule of charges, as defined in §11.2(b) of this title (relating to Definitions), may be used until a copy of such formula or method for calculating the schedule of charges with supporting documentation as required by §11.703 of this title (relating to Supporting Documentation) has been filed with the commissioner.

(b) The schedule of charges shall include all charges made for group, conversion or individual coverage, except for any fee collected as an administrative-service only fee, whereby the HMO assumes no risk.

(c) Each filing must be accompanied by the HMO reconciliation of benefits to schedule of charges form. This information may be substituted in the form of a computer printout.

RULE §11.702 Actuarial Certification

Each formula or method for calculating the schedule of charges must be accompanied by the certification of a qualified actuary that, based on reasonable assumptions, the formula is appropriate to produce rates that are not excessive, inadequate, or unfairly discriminatory. An actuary is considered qualified if he or she:

(1) is a member of the American Academy of Actuaries; or
(2) is a fellow of the Society of Actuaries.

RULE §11.703 Supporting Documentation

Each formula or method for calculating the schedule of charges must be accompanied by adequate detail including assumptions to justify that the charges produced by the formula or method are not excessive, inadequate, or unfairly discriminatory as defined in §11.706 of this title (relating to Factors To Be Considered in Determination of Reasonability of Rates).

(1) The calculations used to produce any schedule of charges as defined in §11.2(b) of this title (relating to Definitions) must be available at the HMO's office.
(2) Any changes in the assumptions in the formula or method for calculating the schedule of charges due to special characteristics of a particular group need not be filed, but justification of the variances must be retained at the HMO's office so that compliance with §11.706 of this title (relating to Factors To Be Considered in Determination of Reasonability of Rates) may be checked.

RULE §11.704 Charges for Individuals

(a) Charges for any individual's coverage may not be based on the individual's health status.
(b) The charge by an HMO for individual coverage which has been converted from group coverage shall not exceed 200% of the HMO's group community rate for comparable coverage. The phrase "group community rate" as used herein is the rate which would be charged all persons in the service area if all persons were members of one group, within the parameters set out in §11.706 of this title (relating to Factors To Be Considered in Determination of Reasonability of Rates). The conversion rate is, therefore, based on the experience of all persons in the service area and not on the converting individual's characteristics.

RULE §11.705 Enrollment Fees

An HMO may charge a one-time enrollment fee or a reinstatement fee for lapsed contracts to offset the costs of initial enrollment or reinstatement, but said fee shall not exceed:

(1) for basic health care plans, the monthly rate attributable to administrative costs for a period of one month; or
(2) for single service health care plans, two months' premium.

RULE §11.706 Determination of Reasonability of Rates

(a) A rate is presumed inadequate if, after consideration of all factors including the financial support of a parent company or sponsoring organization, the rate anticipated results in lower per-member-per-month revenue than required for the HMO to reach and maintain financial break-even within three years of the commencement of operations. For HMOs that have been in operation for at least three years, any rate deficiency must be recorded in the form of a deficiency reserve liability. The deficiency reserve liability amount shall be derived from the difference between the proposed rate to be charged and the rate that would need to be charged to cover all expenses without consideration of any parental or sponsoring

organization's support. The assumptions for enrollment and expenses shall be based upon the current experience of the HMO. A deficiency reserve liability must be funded with cash or other admitted assets in an amount equal to or greater than the deficiency reserve liability. Such funding must take place prior to implementation of the proposed rates. Any HMO required to establish a deficiency reserve liability under this subsection shall provide a plan whereby the rates actually charged by the HMO would be increased over a 24-month period to a level adequate to support benefits and the expenses of the HMO. Such a plan and any deficiency reserve liability must be developed and certified annually as actuarially sound by a qualified actuary in conjunction with the actuarial certification regulation under §11.702 of this title (relating to Actuarial Certification). An HMO may apply to the commissioner for relief from the requirement to establish and fund a deficiency reserve by specifying unusual or extraordinary circumstances by which the above provisions are not appropriate. In no circumstances shall such relief result in the lowering of existing rates.

(b) The following factors shall be considered in any review of rates under the Insurance Code Chapter 1271 Subchapter F:

(1) the cost of the health care services and benefits provided by the coverage if the same coverage were provided on a private pay basis, considering community average rates for such services and benefits within the service area of the plan;

(2) the expenses of initial enrollment. This can be expressed as the one-time enrollment fee under §11.705 of this title (relating to Enrollment Fees);

(3) administrative expenses;

(4) assumed or actual utilization levels;

(5) group demographics;

(6) other factors as appropriate.

(c) In the event the commissioner considers an HMO's rates to be in potential violation of the standards set out by this section, the commissioner shall notify the HMO of the potential violation. It will be the responsibility of the HMO to demonstrate that the rates in question are not excessive, inadequate, or unfairly discriminatory using the factors reflected in subsection (b) of this section and other factors which the HMO deems pertinent.

RULE §11.707 Subsequent Review of the Formula or Method for Calculating the Schedule of Charges

If the formula or method for calculating the schedule of charges, or the resulting rates is to be continued beyond a one-year period, the HMO must file with the commissioner, by each anniversary of the effective date of the original filing, an actuarial statement stating that the previously filed formula or method has been consistently applied, and that the rates charged have proven and are expected to continue to be adequate, not excessive, nor unfairly discriminatory. This statement must be accompanied by reconciliation of benefits to schedule of charges form.

Small Group

28 Texas Administrative Code, Chapter 11

RULE §11.707 Restrictions Relating to Premium Rates

(a) A small employer carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small

employer carrier shall be computed solely from the applicable rate manual developed pursuant to this subsection. To the extent that a portion of the premium rates charged by a small employer carrier is based on objective criteria established by the small employer carrier consistent with the criteria set out in the Insurance Code, Article 26.02(5) and Article 26.36, the manual shall specify the criteria and factors considered by the health carrier in exercising such discretion.

(b) A small employer carrier shall file with the department, at least 60 days prior to the proposed date of the change, any proposed change to the rating method used in the rate manual for a class of business. The small employer carrier shall ensure that the rating method used is actuarially sound and appropriate to assure compliance with Insurance Code, Chapter 26, and this chapter, and that differences in rates charged for each small employer health benefit plan are reasonable and reflect objective differences in plan design. The commissioner may disapprove a change to the rating method that does not meet the requirements of this chapter. At the expiration of 60 days from the filing of the form with the department the proposed change shall be deemed compliant unless prior thereto the commissioner has disapproved it by written order.

(1) The filing shall contain at least the following information:

(A) the reasons the change in rating method is being requested;

(B) a complete description of each of the proposed modifications to the rating method;

(C) a description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals and a description of the types of groups or individuals whose premium rates may change by more than 10% due to the proposed change in rating method (not including general increases in premium rates applicable to all small employers in a health benefit plan);

(D) a certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and

(E) a certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of the Insurance Code, Chapter 26, Subchapter D.

(2) For the purpose of this section a change in rating method shall mean:

(A) a change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business;

(B) a change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business;

(C) a change in the method of allocating expenses among health benefit plans in a class of business; or

(D) a change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds 10%. For the purpose of this paragraph, a change in a rating factor shall mean the cumulative change with respect to such factor considered over a 12-month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a 12-month period, the health carrier shall consider the cumulative effect of all such changes in applying the 10% test under this paragraph.

(c) Each rate manual developed pursuant to subsection (a) of this section shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business.

(1) A small employer carrier may not use case characteristics other than those specified in the Insurance Code, Article 26.36(c), without the prior approval of the commissioner. A small employer carrier seeking such an approval shall make a filing with the commissioner for a change in rating method under subsection (b) of this section.

(2) A small employer carrier shall use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and shall apply them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics may include the employer's industry classification consistent with the Insurance Code, Article 26.33(c). Case characteristics shall be applied without regard to the risk characteristics of a small employer.

(3) The rate manual developed pursuant to subsection (a) of this section shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate the difference.

(4) Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and shall not be based in any way on the actual or expected health status related factors of the small employer groups that choose or are expected to choose a particular health benefit plan. A small employer carrier shall apply case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status related factors of the small employer groups that choose or are expected to choose a particular health benefit plan.

(5) Each rate manual developed pursuant to subsection (a) of this section shall provide for premium rates to be developed in a two-step process. In the first step, the small employer carrier shall develop a base premium rate for the small employer group without regard to any risk characteristics of the group. In the second step, the small employer carrier may adjust the resulting base premium rate by the risk load of the group, subject to the provisions of Insurance Code, Chapter 26, Subchapter D, to reflect the risk characteristics of the group.

(6) Except as provided in this subsection, a premium charged to a small employer for a health benefit plan shall not include a separate application fee, underwriting fee, or any other separate fee or charge. A small employer carrier may charge a separate fee with respect to a health benefit plan (but only one fee with respect to such plan) provided the fee is no more than $5.00 per month per covered employee and is applied in a uniform manner to each health benefit plan in a class of business.

(7) A small employer carrier shall allocate administrative expenses to the small employer health benefit plans on no less favorable of a basis than expenses are allocated to other health benefit plans in the class of business. The rate manual developed pursuant to subsection (a) of this section shall describe the method of allocating administrative expenses to the health benefit plans in the class of business for which the manual was developed.

(8) The health carrier shall retain each rate manual developed pursuant to subsection (a) of this section for a period of six years. The health carrier shall maintain all updates and changes with the manual.

(9) Each rate manual and the rating practices of a small employer carrier shall comply with any applicable rules.

(d) If a small employer carrier uses the number of employees and dependents of a small employer as a case characteristic, the highest rate factor associated with a classification based on the number of employees and dependents of a small employer shall not exceed the lowest rate factor associated with such a classification by more than 20%.

(e) The restrictions related to changes in premium rates in the Insurance Code, Article 26.33 and Article 26.34, shall be applied as follows.

(1) A small employer carrier shall revise its rate manuals each rating period to reflect changes in base premium rates and changes in new business premium rates.

(2) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate shall be deemed to be the change in the base premium rate for the purposes of the Insurance Code, Article 26.33 and Article 26.34.

(3) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan shall be considered a health benefit plan into which the small employer carrier is no longer enrolling new small employers for the purposes of the Insurance Code, Article 26.33 and Article 26.34.

(4) If, for any rating period, the change in the new business premium rate for a health benefit

plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than 20%, the health carrier shall make a filing with the commissioner containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing shall be made at least 60 days prior to the beginning of the rating period when the change would be applicable. The filing is for the purpose of allowing the commissioner to determine whether the methodology used is actuarially sound and appropriate to insure compliance with the Insurance Code, Chapter 26.

(5) A small employer carrier shall keep on file for a period of at least six years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period.

(f) Changes in premium rates and revised premium rates shall comply with the following.

(1) Except as provided in subsection (e) of this section, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the base premium rate for the small employer (as shown in the rate manual as revised for the rating period), multiplied by one plus the sum of:

(A) the risk load applicable to the small employer during the previous rating period; and

(B) 15% (prorated for periods of less than one year).

(2) In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the base premium rate for the small employer (given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period), multiplied by one plus the lesser of:

(A) the change in the base rate; or

(B) the percentage change in the new business premium for the most similar health benefit plan into which the small employer carrier is enrolling new small employers, multiplied by one plus the sum of:

(i) the risk load applicable to the small employer during the previous rating period; and

(ii) 15% (prorated for periods of less than one year).

(3) In the case of a health benefit plan described in the Insurance Code, Article 26.33(c), if the current premium rate for the health benefit plan exceeds the ranges set forth in the Insurance Code, Article 26.32(b), the formulae set forth in paragraphs (1) and (2) of this subsection will be applied as if the 15% adjustment provided in paragraphs (1)(B)(ii) and (2)(C)(ii) of this subsection were a 0% adjustment.

(4) Notwithstanding the provisions of paragraphs (1) and (2) of this subsection, a change in premium rate for a small employer shall not produce a revised premium rate that would exceed the limitations on rates provided in the Insurance Code, Article 26.32(c).

(g) An HMO offering any state approved, federally qualified plan described in Insurance Code Article 26.48 and §26.14 of this chapter (relating to Coverage) shall establish premium rates for those plans in accordance with formulae or schedules of charges filed with the department under the procedures set forth in Insurance Code Article 20A.09(b), and Chapter 11, Subchapter H of this title (relating to Schedule of Charges). An HMO shall follow the rating requirements set out in this section for any plan it offers that is not federally qualified.

(h) An HMO participating in a purchasing cooperative that provides employees of small employers a choice of benefit plans, that has established a separate class of business as provided by the Insurance Code, Article 26.31, and that has established a separate line of business as provided under the Insurance Code, Article 26.48(a), and 42 United States Code §§300e et seq. may use rating methods in accordance with this subchapter that are used by other small employer carriers participating in the same purchasing cooperative, including rating by age and gender. This subsection applies to all employer health benefit plans offered, issued or delivered for issue to small employers and their employees on or after September 1, 1995.

(i) When seeking to obtain information relating to a small employer group, including the risk characteristics of the small employer group, a small employer carrier shall comply with §26.13(m) of this chapter (relating to Rules Related to Fair Marketing).

Texas Insurance Code, Chapter 1501, Subchapter E – Underwriting and Rating of Small Employer Health Benefit Plans

Sec. 1501.201. DEFINITIONS. In this subchapter:

(1) "Base premium rate" means, for each class of business and for a specific rating period, the lowest premium rate that is charged or that could be charged under a rating system for that class of business by a small employer health benefit plan issuer to small employers with similar case characteristics for small employer health benefit plans that provide the same or similar coverage.

(2) "Case characteristics" means, with respect to a small employer, the geographic area in which the employer's employees reside, the age and gender of the individual employees and their dependents, the number of employees and dependents, the appropriate industry classification as determined by the small employer health benefit plan issuer, and other objective criteria established by the issuer that are considered by the issuer in setting premium rates for the employer. The term does not include:

(A) health status related factors;

(B) duration of coverage since the date of issuance of a health benefit plan; or

(C) whether a covered individual is or may become pregnant.

(3) "Class of business" means all small employers or a separate grouping of small employers established under this subchapter.

(4) "Index rate" means, for each class of business and for a specific rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and corresponding highest premium rate.

(5) "New business premium rate" means, for each class of business and for a specific rating period, the lowest premium rate that is charged or offered or that could be charged or offered by a small employer health benefit plan issuer to small employers with similar case characteristics for newly issued small employer health benefit plans that provide the same or similar coverage.

(6) "Rating period" means a calendar period during which premium rates established by a small employer health benefit plan issuer are assumed to be in effect.

Sec. 1501.202. ESTABLISHMENT OF CLASSES OF BUSINESS. (a) Except as otherwise provided by this subchapter, a small employer health benefit plan issuer may not establish a separate class or classes of business for small employers.

(b) A small employer health benefit plan issuer may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(1) the issuer uses more than one type of system to market and sell small employer health benefit plans to small employers;

(2) the issuer has acquired a class of business from another small employer health benefit plan issuer; or

(3) the issuer provides coverage to one or more employer-based association groups.

(c) Except as provided by Subsection (e), a small employer health benefit plan issuer may not establish more than nine separate classes of business under this section.

(d) The commissioner may adopt rules to provide for a transition period to permit a small employer health benefit plan issuer to comply with Subsection (c) after acquiring an additional class of business from another small employer health benefit plan issuer.

(e) On application to the commissioner, the commissioner may approve the establishment of additional classes of business if the commissioner finds that the establishment

of additional classes would enhance the efficiency and fairness of the health coverage market for small employers.

Sec. 1501.203. ESTABLISHMENT OF CLASSES OF BUSINESS ON CERTAIN BASES PROHIBITED. (a) A small employer health benefit plan issuer may not establish a separate class of business based on:

(1) participation requirements; or

(2) whether the coverage provided to a small employer group is provided on a guaranteed issue basis or is subject to underwriting or proof of insurability.

(b) A small employer health benefit plan issuer may not directly or indirectly use as a criterion for establishing a separate class of business:

(1) the number of employees and dependents of a small employer; or

(2) except as provided by Section 1501.202(b)(3), the trade or occupation of the employees of a small employer or the industry or type of business of the small employer.

Sec. 1501.204. INDEX RATES. Under a small employer health benefit plan:

(1) the index rate for a class of business may not exceed the index rate for any other class of business by more than 20 percent; and

(2) premium rates charged during a rating period to small employers in a class of business with similar case characteristics for the same or similar coverage, or premium rates that could be charged to those employers under the rating system for that class of business, may not vary from the index rate by more than 25 percent.

Sec. 1501.205. PREMIUM RATES: ESTABLISHMENT. (a) In this section:

(1) "Risk characteristic" means:

(A) a health status related factor;

(B) the duration of coverage; or

(C) any characteristic similar to a characteristic described by Paragraph (A) or (B) that is related to the health status or experience of a small employer group or of any member of a small employer group.

(2) "Risk load" means the percentage above the applicable base premium rate a small employer health benefit plan issuer charges to a small employer to reflect the risk characteristics associated with that particular small employer group.

(b) Small employer health benefit plan issuers shall develop premium rates for each small employer group in a two-step process. In the first step, the small employer health benefit plan issuer shall develop a base premium rate for each small employer group without regard to any risk characteristic of the group. In the second step, the small employer health benefit plan issuer may adjust the resulting base premium rate by the risk load of the group, subject to this subchapter, to reflect the risk characteristics of the group.

(c) The risk load assessed to a particular group shall reflect the risk characteristics of the particular group.

Sec. 1501.206. PREMIUM RATES: ADJUSTMENTS. (a) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

(1) the percentage change in the new business premium rate, measured from the first day of the preceding rating period to the first day of the new rating period;

(2) any adjustment, not to exceed 15 percent annually and adjusted pro rata for a rating period of less than one year, due to the claims experience, health status, or duration of coverage of the employees or dependents of employees of the small employer, as determined under the small employer health benefit plan issuer's rate manual for the class of business; and

(3) any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined under the issuer's rate manual for the class of business.

(b) An adjustment in the premium rate for claims experience, health status, or duration of coverage:

(1) may not be charged to individual employees or dependents; and

(2) must be applied uniformly to the rates charged for all employees and dependents of employees of the small employer.

Sec. 1501.207. PREMIUM RATE ADJUSTMENT IN CLOSED PLAN. For a closed health benefit plan under which a small employer health benefit plan issuer is no longer enrolling new small employers, the issuer shall use the percentage change in the base premium rate to adjust premium rates under Section 1501.206(a)(1). The portion of change in premium rates computed under that subdivision may not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan under which the issuer is enrolling new small employers.

Sec. 1501.208. PREMIUM RATES: INDUSTRY CLASSIFICATION. A small employer health benefit plan issuer may use the industry classification to which a small employer belongs as a case characteristic in establishing the premium rate, but the highest rate factor associated with any industry classification may not exceed by more than 15 percent the lowest rate factor associated with any industry classification.

Sec. 1501.209. PREMIUM RATES: NUMBER OF EMPLOYEES. A small employer health benefit plan issuer may use the number of employees and dependents of a small employer as a case characteristic in establishing premium rates for the group. The highest rate factor associated with a classification based on the number of employees and dependents of a small employer may not exceed by more than 20 percent the lowest rate factor associated with a classification based on the number of employees and dependents of a small employer.

Sec. 1501.210. PREMIUM RATES: NONDISCRIMINATION. (a) A small employer health benefit plan issuer shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premium rates for identical groups that:

(1) differ only by the amounts attributable to health benefit plan design; and

(2) do not reflect differences because of the nature of the groups assumed to select particular health benefit plans.

(b) A small employer health benefit plan issuer shall treat each health benefit plan issued or renewed in the same calendar month as having the same rating period.

(c) Without the prior approval of the commissioner, a small employer health benefit plan issuer may not use case characteristics other than:

(1) the geographic area in which the small employer's employees reside;

(2) the age and gender of the individual employees and their dependents;

(3) the number of employees and dependents; and

(4) the appropriate industry classification.

(d) Premium rates for a small employer health benefit plan must comply with the requirements of this chapter, notwithstanding any assessment paid or payable by a small employer health benefit plan issuer.

(e) A small employer health benefit plan issuer may not transfer a small employer involuntarily into or out of a class of business. The issuer may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all other small employers in the employer's class of business without regard to case characteristics, claims experience, health status, or duration of coverage since the issuance of the health benefit plan.

Large Group

Texas Insurance Code, Chapter 1501, Subchapter M - Large Employer Health Benefit Plans

Sec. 1501.610. PREMIUM RATES; ADJUSTMENTS. (a) A large employer health benefit plan issuer may charge premiums in accordance with this section to the group of employees or dependents who meet the participation criteria and do not decline coverage.

(b) A large employer health benefit plan issuer may not charge an adjustment to premium rates for individual employees or dependents for health status related factors or duration of coverage. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of employees of a large employer.

(c) Subsection (b) does not restrict the amount that a large employer may be charged for coverage.

Appendix 2 – Excerpt from a comprehensive medical rate filing in which the proposed increase was successfully reduced.

Appendix 2

From: Dewayne Matthews
To:
Date: 8/8/2007 3:34:41 PM
Subject: Re: Filing ID 2689708 S [3]

Mr. we noted that a 20% increase will be implemented in the highest premium state (New York, which makes up roughly 40% of nationwide premium), and an increase has not yet been filed in the third highest premium state (Florida). These two states combined make up a little over half of the total earned premium.

In light of this, we are suggesting that the increase be limited to 20% in Texas. Please provide revised proposed rate sheets reflecting a 20% increase.

Please respond to my attention.

Sincerely,

Dewayne Matthews
Life/Health Division
Texas Department of Insurance
Phone: 512-305-7280
Fax: 512-322-3552
Email: dewayne.matthews@tdi.state.tx.us

>>> > 8/2/2007 3:52 PM >>>
Dear Mr. Matthews:

This is in response to your E-mail regarding the above mentioned filing.

We generally keep increases at least 12 months apart. Therefore, if a state is late in approving the increase one year, the increase in future years will likewise be later (unless we skip a year). Hence, we spread out rate increase filing throughout the year, according to the effective date of the last increase in that state. In the two weeks since I had sent you the list of filings, we have already filed in five additional states (Alaska, Indiana, Iowa, Nebraska and Wisconsin). We plan to file in almost all of the states.

As per the Settlement Agreement, we base our calculation on the nationwide Adjusted Earned Premium; we adjust all premiums to the level of the last (2006) rate increase. Hence, if some states are late in approving the increase, it will not affect the rate increase calculated for other states.

Dewayne Matthews - Re: Filing ID 2689708 S [3] S [3]

From:
To: "Dewayne Matthews" <Dewayne.Matthews@tdi.state.tx.us>
Date: 8/9/2007 10:30 AM
Subject: Re: Filing ID 2689708 S [3] S [3]
CC: "Jan Graeber" <Jan.Graeber@tdi.state.tx.us>, "Scott Helmcamp" <Scott.Helmcamp@tdi.state.tx.us>

Dear Mr. Matthews:

This in response to your August 8, 2007 E-mail regarding the above mentioned filing.

We are willing to accept your proposal for an increase of 20%. Attached please find new revised rate sheets, reflecting the 20% increase.

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Appendix 3 – Organizational Chart and Job Descriptions

The Texas Department of Insurance (TDI) will provide project oversight for the Grant program under the direction of a Project Director. TDI will be responsible for providing budget oversight, administrative services and support, and assisting in administering the contracts issued as part of the project.

Serving as Director of the project will be Jan Graeber, ASA, MAAA, an Actuary with the Life/Health Division at TDI. Ms. Graeber graduated from the University of Texas at Austin with a Bachelor's of Business Administration in Actuarial Science. She has been with the Department since 1994 and serves as the lead actuary of the Life/Health Division. Ms. Graeber has extensive experience in the review and analysis of Medicare supplement and Medicare Select rates and refund calculations, long term care initial rates and rate increase filings, HMO rate and rating methodology filings, Accident and Health rate increases, Small Group rating requirements, calculations demonstrating compliance with the Standard Nonforfeiture Law for Life Insurance and Annuities, collection and analysis of credit life and credit accident and health data submitted in connection with the Department's Credit Life and Credit Accident and Health Data Call, and the development and recommendation of credit life and credit accident and health presumptive rates. In addition, Ms. Graeber provides comments and recommendations regarding legislative implementation, rule and bulletin development and assistance to Consumer Protection and Government Relations with the resolution of consumer and legislative inquires and complaints regarding rating issues. This employee will devote 50% of their time to duties associated with this Grant project.

Ms. Karen Phillips, Chief of Staff, Texas Department of Insurance, will be responsible for budget oversight of the grant project. Ms. Phillips has extensive knowledge of federal grant requirements and experience administering grant funds. She is well prepared to provide administrative and logistical support in managing and accounting for all grant funds provided in relation to this project.

Additional grant program staff will be hired and assigned full time to the program. These staff members will be responsible for facilitating the ongoing day-to-day activities required to complete all work tasks identified. Staff members that will be hired are as follows:

Program Specialist V: This employee will be primarily responsible for improving the IT infrastructure that supports health insurance rate review functions, including improving its ability to collect, analyze and review information related to proposed health insurance rate increases, and developing an approach that will enhance its current data collection capacity and provide the required data to the Secretary in the prescribed format. This employee will devote 100% of their time to duties associated with this Grant project.

Actuary III and IV: these employees will be primarily responsible for providing actuarial expertise in the development of the improved IT infrastructure including the identification of the additional data needed to conduct annual reviews of health insurance rates in accordance with federal statutory requirements and the terms of the Grant announcement. In addition, these employees will be responsible for the analysis and review of individual, small group and large group rate filings. Each of these employees will devote 50% of their time to duties associated with this Grant project.

Attorney III – this employee will be responsible for assistance with the notification to issuers of the requirement to report data. Once HHS finalizes regulations this employee will provide specific guidance as to what information issuers are required to submit and develop rules to address the data collection process, incorporating HHS requirements. In addition, this employee will be responsible for taking any necessary enforcement action relating to the implementation of an unreasonable rate increase. This employee will devote 50% of their time to duties associated with this Grant project.

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

Objective Work Plan

Project:

Premium Review Grant

*** Year:** *** Funding Agency Goal:**

* Year:	* Funding Agency Goal:
1	Develop and implement the state process for health insurance rate review for Federal FY 2010 and 2011, including a plan for disclosing rates to the public and the Secretary.

*** Objective:**

Implement the requirements of PHSA §2794 in phases to the extent funds are available, thereby: 1) ensuring increases in health insurance premiums and rate filings are thoroughly evaluated through a comprehensive rate review process that is meaningful and transparent to the public, enrollees, policyholders the HHS Secretary; and 2) developing the infrastructure to collect, analyze and report to the Secretary critical information about rate filings and the review.

*** Results or Benefits Expected:**

More robust reporting requirements, data exchange and rate analysis to provide user-friendly, comparative and accurate information to promote informed insurance decisions.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Phase I Organize •Hire project staff • Purchase equipment	Project Director	08/16/2010	11/15/2010	0
• Distribute relevant information • Hold organizational meetings • Develop detailed work plan	Project Director	08/16/2010	09/30/2010	0
• Purchase actuarial software	Project Director	08/16/2010	12/31/2010	0
• Train staff on actuarial software	Hired Consultant	01/03/2011	02/01/2011	24

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
• Contract with Expert in market to develop collection parameters	Project Director	09/12/2010	11/01/2010	125
Phase II Develop Items to be collected: o Individual o Small Group o Large Group	Project Director Actuary IV Program Specialist V	11/01/2010	12/01/2010	0
• Develop notification to companies	Project Director Program Specialist V Attorney III	12/01/2010	12/31/2010	0
• Notify companies	Actuary IV	01/03/2011	01/10/2011	0

* Criteria for Evaluating Results or Benefits Expected:

Achieving the goal of having rating information readily available in a user friendly format by the project completion date.

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	FHR_RFA_FD_10_999_Project_W	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	FHR_RFA_FD_10_999_Project_W	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: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

Project:

Continuation Work plan document part II.

*** Year:** 1

*** Funding Agency Goal:**

Develop and implement the state process for health insurance rate review for the Federal Fiscal Years (FFY) 2010 and 2011, including a plan for disclosing rates to the public and t

*** Objective:**

Implement the requirements of PHSA §2794 in phases to the extent funds are available, thereby: 1) ensuring increases in health insurance premiums and rate filings are thoroughly evaluated through a comprehensive rate review process that is meaningful and transparent to the public, enrollees, policyholders the HHS Secretary; and 2) developing the infrastructure to collect, analyze and report to the Secretary critical information about rate fil

*** Results or Benefits Expected:**

More robust reporting requirements, data exchange and rate analysis to provide user-friendly, comparative and accurate information to promote informed insurance decisions.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
• Collect/compile company contact information	Program Specialist V	12/01/2010	12/31/2010	0
• Develop infrastructure to collect data and report, including developing error checks and testing	Program Specialist V	09/15/2010	12/15/2010	0
• Develop consumer-friendly format for reporting data	Actuary IV Program Specialist V	09/15/2010	12/15/2010	0
• Develop strategies to monitor the individual market regarding potential destabilization	Project Director Actuary IV Attorney III	09/15/2010	12/15/2010	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
• Analyze HHS rules	Attorney III	10/01/2010	12/31/2010	0
• Make modifications to data collection process to incorporate new HHS rules	Program Specialist V Actuary IV	01/03/2011	03/01/2011	0
Phase III Collect • Notify companies	Program Specialist V	03/01/2011	03/15/2011	0
• Monitor responses	Actuary III	03/15/2011	04/29/2011	0

* Criteria for Evaluating Results or Benefits Expected:

Achieving the goal of having rating information readily available in a user friendly format by the project completion date.

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

Objective Work Plan

Project:

Continuation Work plan document part III.

*** Year:** 1

*** Funding Agency Goal:**

Develop and implement the state process for health insurance rate review for Federal FY 2010 and 2011, including a plan for disclosing rates to the public and the Secretary.

*** Objective:**

Implement the requirements of PHSA §2794 in phases to the extent funds are available, thereby: 1) ensuring increases in health insurance premiums and rate filings are thoroughly evaluated through a comprehensive rate review process that is meaningful and transparent to the public, enrollees, policyholders the HHS Secretary; and 2) developing the infrastructure to collect, analyze and report to the Secretary critical information about rate filings and the review.

*** Results or Benefits Expected:**

More robust reporting requirements, data exchange and rate analysis to provide user-friendly, comparative and accurate information to promote informed insurance decisions.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
• Follow up with companies that fail to respond	Actuary III	05/02/2011	05/16/2011	0
• Compile and test data	Program Specialist V	05/16/2011	07/29/2011	0
• Post rate filings on website	Program Specialist V	08/01/2011	08/31/2011	0
Phase IV Review • Review rate filings	Actuary IV, III	08/16/2010	08/31/2011	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
• Review rebate calculations	Actuary IV, III	01/03/2011	08/31/2011	0
• Evaluate and take any necessary enforcement action	Actuary IV Attorney III	08/16/2010	08/31/2011	0
• Monitor individual market for potential destabilization	Program Director Actuary IV Attorney III	08/16/2010	08/31/2011	0
Blank	Blank	08/16/2010	08/31/2010	0

* Criteria for Evaluating Results or Benefits Expected:

Achieving the goal of having rating information readily available in a user friendly format by the project completion date.

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

FHR_RFA_FD_10_999_Project_Abstract.

Project Abstract

Texas' "Grants to States for Health Insurance Premium Review" (Grant) proposal is designed to:

- expand and strengthen the current individual, small group and large group health insurance rate review process in Texas, and
- promote immediate improvements in private health insurance consumer protections and transparency.

The Texas Department of Insurance (TDI) will use Grant funds to build and implement a process targeted at achieving these goals. The process will include collecting relevant data; conducting meaningful and comprehensive rate reviews for individual, small group and large group health insurance products; and disclosing justification for rate increases in a format that is transparent and readily accessible to consumers, the Secretary of the U.S. Department of Health and Human Services (HHS), and other interested parties.

TDI's proposal for implementing a process to make private health insurance more accessible and affordable and increase the transparency of the health insurance system by providing new oversight of health insurance companies, is a scalable approach, implemented in phases to the extent that federal grant funds are available.

TDI will expand the scope of our current rate review activities. The first phase will be to develop and implement a consistent rate review process for all proposed rate increases exceeding certain pre-established thresholds, taking into account the issuer's market share, the rate increase percentage or whether the increase generates a consumer complaint. This phase will focus on ensuring a stable market and mitigating rate volatility.

As part of this process, TDI will:

- Notify issuers of the requirement to report data.
- Improve the IT infrastructure that supports health insurance rate review functions.
- Purchase actuarial software to facilitate a comprehensive rate review.
- Contract with an actuary with expertise in pricing and evaluating rates for individual, small group and large group coverage to ensure that all necessary and appropriate data is captured and evaluated appropriately.
- Compile and analyze data and assess the validity of a proposed rate increase.
- Provide the HHS Secretary with the information required under the Public Health Service Act (PHSA) §2794.
- Develop a format and process for public disclosure of information relating to the increases and justification for all health insurance issuers.
- Develop strategies to monitor the individual market for destabilization.

This process can easily be enhanced and expanded as additional grant funds become available.

TDI's Financial Services Section, which is responsible for overseeing the agency's budget, would manage the grant funds in accordance with the Generally Accepted Accounting Principles and all

applicable state regulations. As a state agency, all of TDI's financial and accounting practices are overseen by the State Legislature and are subject to audit by TDI's Internal Audit Division, the State Auditor's Office and the State Comptroller's Office.

The proposed budget for Cycle 1 of the Grant is $1M which will be allocated among the following three activities:

- Actuarial Review,
- Data Administration, and
- Legal/Enforcement.

Maintenance of Effort (MOE) Assurance

TDI assures HHS that no grant funds awarded will be used to supplant other funding that is currently supporting the work in the State of Texas.

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** FHR_RFA_FD_10_999_Project_Narrative.pdf

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

Texas' "Grants to States for Health Insurance Premium Review" (Grant) proposal is designed for the primary purpose of achieving the following goals:

- expand and strengthen the current individual, small group and large group health insurance rate review process in Texas, and
- promote immediate improvements in private health insurance consumer protections and transparency.

The Texas Department of Insurance (TDI) will use Grant funds to collect relevant data; conduct meaningful and comprehensive rate reviews for individual, small group and large group health insurance products; and disclose justification for rate increases in a format that is transparent and readily accessible to consumers, the HHS Secretary, and other interested parties.

Current Health Insurance Rate Review Capacity and Processes

TDI currently reviews a limited number of individual, small group and large group health insurance rate filings. Texas laws and regulations dictate that the following premium rates are subject to review or approval:

- Health maintenance organizations (HMO) are required to file rates for review. HMOs are also required to file detailed financial reports on a quarterly and annual basis. HMO rates are required to be based on a community rating methodology including both traditional community rating and adjusted community rating.
- Insurance companies are required to file rates for individual accident and health coverage.
    - Rate increases in excess of 50 percent over a 12-month period require actuarial justification and are reviewed by TDI.
    - Rate increases less than 50 percent are filed with TDI for informational purposes. Current resource limitations have prevented TDI from exercising a more rigorous review across a wider range of rate increases.

    - Rate increases on individual accident and health policies that generate a consumer complaint are generally reviewed by TDI for compliance with actuarial principles, regardless of the magnitude of the increase.
- Insurance companies are not required to file rates for small and large group coverage; however, they must file an actuarial certification that small group rates comply with the rating standards outlined in Texas laws and regulations. Acceptable case characteristics under the Texas small group law include age, gender, industry, area and group size. Carriers must comply with +/-25 percent rating bands within the small group market. In addition, small group changes in rating methodology, which are specifically defined in Texas regulations, are filed for approval. Both small and large group regulations require that any risk load be applied uniformly to all members of the group.
- Chapter 560 of the Texas Insurance Code requires all rates to be just, fair, reasonable, and adequate. It also provides that they may not be confiscatory, excessive for the risks to which the rate applies, or unfairly discriminatory.

Copies of relevant statutory and regulatory authority are found in Appendix 1.

Texas regulations do not establish a standardized reporting format for data reported in insurers' rate filings. In general, TDI requires an actuarial memorandum to be included with rate and rate increase filings subject to review or approval. The actuarial memorandum typically includes support for all assumptions contained within the actuarial memorandum. Actuarial memorandums typically include the following information:

- Scope and purpose of the filing
- Reason for the rate increase
- Description of benefits
- Rate guarantees
- Renewability provisions
- Marketing method

- Applicability – new issues verses all rates
- Morbidity assumptions
- Substandard rate up factors (i.e. smoker verses non-smoker)
- Premium modes
- Trend assumptions
- Experience history and projections
- Past and future anticipated loss ratios
- Profit margin
- Actuarial certification regarding the reasonability of premiums in relation to benefits

In addition, the following documents are requested if not initially included in the filing:

- Electronic copies of experience projections, preferably in Excel, including formulas. These experience projections include ratios of incurred claims to earned premiums for the most recent calendar year delineated by calendar year and issue and by policy duration.
- A complete explanation of the rating process, including a credible basis for all assumptions, claims data, methodology, and formulas used in developing the premium rates.

In reviewing rate filings, TDI verifies that:

- Methodologies used in developing premium rates are actuarially sound and comply with generally accepted actuarial principles and practices.
- The actuarial memorandum contains adequate detail including assumptions to justify that the rates are not excessive, inadequate or unfairly discriminatory.

In addition, TDI takes into account:

- Whether the actual loss ratio meets or exceeds the target loss ratio assumed in pricing.

- The financial soundness of the issuer.
- Previous rate increases implemented by the issuer.
- Increases proposed in other states in which the experience underlying the proposed increase in Texas is included.

Due to resource limitations, Texas has not developed a formal comprehensive rate review process for individual, small group and large group health insurance (with the exception of Medicare supplement and long-term care insurance rates which are filed for approval). Currently approximately 7 percent of an actuary's time is devoted to reviewing rates for individual comprehensive, small group and large group coverage. Grant funds will enable Texas to expand the scope of our current review process and devote a much larger percentage of time to these efforts.

Rates that are subject to approval in Texas (e.g. Medicare supplement and long-term care insurance) go through a rigorous review process which encompasses the review and analysis of the information described above. In addition to analyzing the items submitted with the filing, reviewers develop Excel spreadsheets to test issuer calculations and projections for reasonableness.

Insurance issuers are required to file actuarial justification supporting rate increases in excess of 50 percent over a 12-month period. While some comprehensive medical insurance rate increases exceed this 50 percent threshold, the majority of filings triggering an actuarial review are for individual specified disease coverage. Based on TDI's review of these types of filings, approximately 60 percent of the filings reviewed resulted in the proposed increase being reduced prospectively.

An excerpt from a comprehensive medical rate filing in which the proposed increase was successfully reduced is included as Attachment 2.

Consumer complaints regarding a rate increase can generate a retrospective review. In some instances this review uncovered errors made on the part of the issuer which resulted in an excessive rate being charged. When this occurs, restitution is required and reflects the amount of premium overcharges, accumulated with interest.

Individual health insurance rates are filed for informational purposes. TDI currently receives, tracks and stores form and rate filings in multiple formats. While the majority of these filings are received electronically through the SERFF system, approximately 40 percent of filings are still received on paper. For the paper filings, TDI staff must manually enter basic information into an Oracle-based tracking system and then scan the full image for later use. Therefore, TDI does not currently have the ability to provide the complete array of rate filing data required by the Patient Protection and Affordability Act (PPACA) in an efficient manner.

TDI proposes to use a portion of its Cycle I Grant funding to improve its ability to collect, analyze and review information related to proposed health insurance rate increases. TDI is committed to developing an approach that will enhance its current data collection capacity and provide the required data to the HHS Secretary in the prescribed format.

During the term of the Grant, TDI will identify the additional data needed to conduct annual reviews of health insurance rates in accordance with federal statutory requirements and the terms of the Grant announcement. TDI will then evaluate the capabilities of its current rate review staff and information technology infrastructure, and develop potential strategies to enhance these functions to satisfy all federal reporting requirements. These activities will require one additional full-time employee to develop and maintain a reporting database, review and compile rate filing data, and submit a Federal reporting template as required by HHS.

TDI's overall annual budget is $104.3 million. Of this amount, approximately .03 percent (or $31,000) is spent on resources allocated to review rates for comprehensive medical coverage in the individual and group markets.

TDI's Life/Health Actuarial Team will conduct the rate review process. The team currently consists of:

- Two accredited actuaries, both with university degrees in actuarial science or mathematics and each with over 20 years of actuarial experience,
- One accredited actuary, with university degrees in agronomy and biostatistics, and less than five years of actuarial experience,
- One entry-level actuarial student with a degree in actuarial science,

- One senior insurance specialist with a degree in economics and 15 years of experience in the insurance field, and
- One entry-level insurance specialist with a degree in risk management and insurance with approximately five years of experience in the insurance field.

Last year, the actuarial team reviewed approximately 65 individual, small group and large group comprehensive medical coverage filings representing less than 4 percent of the total number of filings reviewed by the entire team in one year.

Grant funds will be used to expand actuarial team staff and resources to accommodate an expanded process of rate review.

Insurance product information filed with TDI, including rate information, is subject to the public information law of Texas, most specifically the Texas Government Code, Chapter 552. Generally, information maintained by state agencies is subject to public access, unless otherwise made confidential by law and therefore subject to mandatory exception to disclosure or release.

Mandatory exceptions protecting confidential information may not be waived by TDI. Among the mandatory exceptions is information that involves property interests, including information claimed to be proprietary and confidential as trade secret information. Texas Government Code, Section 552.110 provides that trade secret information "obtained from a person or entity and that is privileged or confidential by statute or judicial decision is excepted from disclosure."

Procedurally, when a request for insurance product information received by TDI includes information marked as confidential and proprietary, either the person or entity claiming such confidentiality or TDI must present to the Texas Attorney General a *prima facie* case that the information constitutes a trade secret.

When TDI receives a request for insurance product information that has been marked as proprietary or confidential and makes a referral to the Attorney General for determination, it then:

- sends a letter in a prescribed format to the person or entity claiming confidentiality of the information, notifying such person of the request for information received, advising that

an Attorney General's opinion has been requested in the matter, and explaining the process for making arguments to the Attorney General;

- sends both the information requestor and the person claiming confidentiality a copy of TDI's request for an Attorney General opinion;
- withholds release of information while the request for Attorney General's opinion is pending; and
- takes appropriate action upon receipt of opinion from the Attorney General, including providing appropriate written notice to both the information requestor and the person claiming confidentiality, explaining the actions TDI will take based upon Attorney General determination, and the timeframe for such actions.

Currently, summaries of rate changes for individual, small group and large group are not regularly provided to consumers. Responses to consumer complaints regarding rate increases contain a general summary of the reason for the increase, the data supporting any increase and whether or not TDI determined that the rate increase was justified.

Texas law does not require issuers or TDI to notify consumers of a pending or proposed rate increase filing. Texas Insurance Code Section 1254.001 requires an insurer to provide written notice to the policyholder not less than 60 days before a premium rate increase takes effect on a group policy of health insurance, accident and health insurance, or life, health and accident insurance delivered or issued for delivery in this state by an insurer. The notice must include both the amount of the increase and the date on which the increase is to take effect.

There is not a comparable statutory requirement for individual health insurance policies. Insurers commonly include provisions in the individual policies addressing the notice period to which the consumer is entitled under the policy.

Although there is no official comment or review period for consumers to comment on proposed rate changes, consumers may object to rate increases by filing a written complaint with TDI.

The number of consumer inquiries and complaints over the past two years regarding excessive health insurance premiums is summarized below:

Calendar Year	Number of Complaints
2008	189
2009	250
Through 06/22/2010	100

Approximately 4 percent of the above complaints involved issues that resulted in review by the actuarial team. Grant funds will be used to expand resources to incorporate the collection and review of the necessary forms and data to review all individual, small group and large group rate filings in excess of 25 percent.

All complaints were resolved and there were no enforcement actions taken against insurance companies over the past two plan years regarding health insurance rates.

In addition, there have been no formal hearings held over the past two plan years regarding health insurance rates.

Proposed Rate Review Enhancements

TDI assures that Grant awards will be used to expand and enhance our existing rate review practices. A description of our plan to conduct reviews and otherwise enhance our oversight over insures' rating practices is described below:

TDI's proposal for implementing a process to make private health insurance more accessible and affordable and increase the transparency of the health insurance system by providing new oversight of health insurance companies, is a scalable approach, implemented in phases to the extent federal Grant funds are available.

We will expand the scope of our current rate review activities. The first phase will focus on ensuring a stable market and mitigating rate volatility. The emphasis for this phase will be on all proposed rate increases triggering one of the following thresholds:

- all proposed rate increases in excess of 50 percent; or
- all cumulative rate increases of 30 percent over a three-year period.

Retrospective reviews will occur any time a rate increase generates a consumer complaint, regardless of the magnitude of the increase.

Relatedly, TDI will closely monitor all market conditions for stability and disruptions that may adversely impact consumers.

TDI proposes to use its Cycle I Grant funding to:

- Notify issuers of the requirement to report data. Initially, this notification will be made under the authority of Texas Insurance Code Section 38.001. Section 38.001 permits TDI to address a reasonable inquiry to any insurance company or other holder of authorization relating to any matter pertaining to the person's transactions that TDI considers necessary for the public good or for the proper discharge of TDI's duties. Once HHS finalizes regulations giving specific guidance as to what information issuers are required to submit, TDI will develop rules to address the data collection process, incorporating HHS requirements.
- Improve the IT infrastructure that supports health insurance rate review functions, including a more robust data analysis and data exchange capabilities both within the state as well as with the federal government in preparation for enhanced data reporting requirements that will be part of future HHS regulatory requirements. TDI is committed to developing an approach that will enhance its current data collection capacity and provide the required data to the HHS Secretary in the prescribed format.
- Purchase actuarial software to facilitate a comprehensive rate review.
- Contract with an actuary with expertise in pricing and evaluating rates for individual, small group and large group coverage to ensure that all necessary and appropriate data is being captured and evaluated appropriately.
- Compile and analyze data and assess the validity of a proposed rate increase.
- Provide the HHS Secretary with information regarding trends in premium increases in health insurance coverage in premium rating areas in the state.

- Make recommendations about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.
- Develop a format and process for the public disclosure of information relating to the increases and justification for all health insurance issuers.
- Develop strategies to monitor the market in order to report to HHS potential destabilization in the individual market.
- Review all rebate calculations.
- Analyze federal rules once finalized.
- Take any necessary enforcement action relating to the implementation of an unreasonable rate increase.

The process can easily be enhanced as additional grant funds become available.

Please see the "Work Plan and Timeline" and "Budget Narrative" sections of this proposal for a detailed description of the budget and timeline for all proposed rate review enhancements including a description of the additional resources that will be required to complete this project.

Reporting to the Secretary on Rate increase Patterns

TDI attests that we will comply with the reporting requirements outlined in statute. During the term of the Grant, TDI will identify the additional data needed to conduct annual reviews of health insurance rates in accordance with federal statutory requirements and the terms of the Grant announcement. TDI will then evaluate the capabilities of its current rate review staff and information technology infrastructure, and develop potential strategies to enhance these functions to satisfy all federal reporting requirements. These strategies will include a requirement for companies to complete and submit a supplemental file with each rate filing that will capture the specific data elements contained in the final uniform reporting template.

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** FHR_RFA_FD_10_999_budget_Narrative.pdf

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

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

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

Budget Narrative

The proposed budget includes costs related to the following three primary activities:

- actuarial review of rates
- collection and reporting of rate information to the HHS Secretary and consumers
- legal services required to oversee and enforce TDI's rate review activities.

The following categories describe how funds will be allocated for each of these activities.

Personnel: TDI will administer all activities and does not intend to subcontract any services. However, in the event that TDI is unable to hire necessary actuarial staff in a timely manner, TDI may opt to temporarily contract with one or more actuaries to provide rate review services until sufficient staff can be hired. The budget includes funds to hire four actuaries team members who will provide rate review activities described elsewhere in the grant application. Salaries vary based on skill and experience, ranging from $79,631 to $90,206 annually. An additional insurance specialist will be hired to assist with the processing and administrative oversight of the rate review activities, at a cost of approximately $35,000. Total budgeted salaries for actuarial services and rate review oversight are $327,131. One database administrator will be hired at an estimated cost of $40,421 to develop and maintain the data collection and reporting activities. Staff will ensure the appropriate data is collected in a manner consistent with the HHS Secretary's reporting template and will oversee submissions of required data to the Secretary. TDI will hire one attorney and one legal assistant at a cost of $100,486. These employees will oversee legal and enforcement issues related to the rate review process. Total salary costs are $468,038.

Fringe Benefits: All employees will receive fringe benefits, which include retirement, OASDI, Medicare tax contribution, and health insurance.

The budget includes total fringe benefit costs at 0.2857 percent of salary, for a total of $133,718.

Supplies: TDI will purchase a subscription to a commercial health care cost database to obtain the regional health care cost data required to review rates. The cost for the grant period is estimated at $150,000. Actuaries will use the data to determine whether rate increases are

reasonable and justified and to obtain comparative cost and rate information for areas of the state. The supply budget also includes an additional $8,000 for routine office supplies and publications. Total budgeted supplies costs are $158,000.

Equipment: The budget includes funds for the purchase of equipment necessary for the additional personnel to perform activities required in the performance of their job duties. The funds will be used to purchase computers and required software, chairs, cubicle fixtures, and telephone services for each employee. Total funds requested for equipment are $84,600.

Contractual: TDI will contract with one actuarial expert to assist in the development of a rating process to ensure that all necessary and appropriate data is captured and appropriately evaluated. The estimated contract cost for a temporary consultant is $45,000.

Construction: TDI anticipates that some minor building construction will be required to create new office space/cubicles for additional staff. TDI estimates the minor construction costs will total $22,037.

Indirect Costs: Although TDI has a provisional indirect cost rate of 36.13, estimated indirect costs are expected to be lower for this project. Indirect costs are calculated at a rate of 20 percent of personnel costs, for a total of $93,607.

Current State Funding and Maintenance of Effort: TDI currently performs limited rate reviews of health care benefit plans as discussed elsewhere in this application. Current costs allocated to rate review are estimated at $30,840 annually. The state will not use federal grant funds to supplant state funding and will maintain current state funding.

Budget Allocation: Following is a breakdown of allocation of funds by major activities:

Budget Item	Actuarial Review	Data Administration	Legal Enforcement
Personnel	$327,131	$40,421	$100,486
Fringe Benefits	$93,461	$11,548	$28,709
Equipment	$43,500	$23,700	$17,400
Supplies	$155,000	$1,000	$2,000
Contractual	$40,000	$0	$0
Construction	$22,037	$0	$0
Indirect costs	$65,426	$8,084	$20,097
Total	**$746,555**	**$84,753**	**$168,692**

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. ACA Grants to states for Health Insurance Premium Review	93.511	$	$	$ 1,000,000.00	$	$ 1,000,000.00
2.						
3.						
4.						
5. Totals		$	$	$ 1,000,000.00	$	$ 1,000,000.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1)	(2)	(3)	(4)	Total (5)
	ACA Grants to states for Health Insurance Premium Review				
a. Personnel	$ 468,038.00	$	$	$	$ 468,038.00
b. Fringe Benefits	133,718.00				133,718.00
c. Travel	0.00				
d. Equipment	84,600.00				84,600.00
e. Supplies	158,000.00				158,000.00
f. Contractual	40,000.00				40,000.00
g. Construction	22,037.00				22,037.00
h. Other	0.00				
i. Total Direct Charges (sum of 6a-6h)	906,393.00				$ 906,393.00
j. Indirect Charges	93,607.00				$ 93,607.00
k. TOTALS (sum of 6i and 6j)	$ 1,000,000.00	$	$	$	$ 1,000,000.00
7. Program Income	$ 0.00	$	$	$	$

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. ACA Grants to State for Health Insurance Premium Plans	$ 0.00	$	$	$ 0.00
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 1,000,000.00	$ 297,570.00	$ 265,214.00	$ 228,805.00	$ 208,411.00
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$ 1,000,000.00	$ 297,570.00	$ 265,214.00	$ 228,805.00	$ 208,411.00

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

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

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges: Provisional indirect rate

23. Remarks: Indirect rate of 20% of applied to personnel costs of $468,038.

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	Chief of Staff
* APPLICANT ORGANIZATION	* DATE SUBMITTED
Texas Department of Insurance	Completed on submission to Grants.gov

DISCLOSURE OF LOBBYING ACTIVITIES

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

Approved by OMB
0348-0046

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

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

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

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

*Name: Texas Department of Insurance

*Street 1: 333 Guadalupe Drive Street 2: P. O. Box 149104

*City: Austin State: TX: Texas Zip: 78704-9104

Congressional District, if known: Tx-025

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

6. * Federal Department/Agency:

HHS/Consumer Info & Ins Oversight

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 *First Name: Karen Middle Name: P.

*Last Name: Phillips Suffix

Title: Chief of Staff **Telephone No.:** 512-305-7249 **Date:** Completed on submission to Grants.gov

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

Basic Work Plan

1. Estimated date of established funding agreement with State:

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

Describe the tasks in the work plan:

2 a. Describe this task or milestone:

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

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

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

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

Project Abstract Summary

Program Announcement (CFDA)

93.511

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

RFA-FD-10-999

*** Closing Date**

07/07/2010

*** Applicant Name**

Texas Department of Insurance

*** Length of Proposed Project**

Application Control No.

Federal Share Requested (for each year)

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

Non-Federal Share Requested (for each year)

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

*** Project Title**

Premium Review Grant

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

Project Abstract Summary

*** Project Summary**

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

Other Attachment File(s)

*** Mandatory Other Attachment Filename:**

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

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

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