HAWAII

LINDA LINGLE
GOVERNOR

JAMES R. AIONA, JR.
LT. GOVERNOR

RONALD BOYER
DIRECTOR

STATE OF HAWAII
INSURANCE DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
335 MERCHANT STREET, ROOM 213
P.O. Box 3614
HONOLULU, HAWAII 96811
Phone Number: 586-2790
Fax Number: 586-2806
www.hawaii.gov/dcca/ins

July 2, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue
Washington, D.C. 20201

Re: Premium Review Grant

Ladies and Gentlemen:

This is to submit our application for a premium review grant under CFDA: 93.511. We are eligible as the insurance regulatory agency for the State of Hawaii.

The project title is: Information System to Support Health Insurance Rate Review

The Principal Investigator/Project Director is Lloyd Lim who is the Administrator of our Health Insurance Branch.

If you have any questions, please contact me at 808-587-6744.

Sincerely,

Lloyd Lim
Administrator

EXECUTIVE CHAMBERS

HONOLULU

LINDA LINGLE
GOVERNOR

June 25, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue
Washington, D.C. 20201

Dear Secretary Sebelius:

This letter is in reference to the grants offered by the U.S. Department of Health and Human Services to states for health insurance premium review (cycle 1, CFDA: 93.511).

I approve the application of the Hawaii Insurance Division for a grant to finance the development of an information system to support health insurance premium rate review. This system is needed to facilitate the rate review process and to collect and communicate statistical information to your agency.

If moneys are awarded under this grant, such moneys will not be used to supplant existing State expenditures.

Sincerely,

LINDA LINGLE
Governor

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: Commerce and Consumer Affairs, Hawaii Department of

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
99-0319357	9494976140000

d. Address:

* Street1:	335 Merchant St. #213
Street2:	
* City:	Honolulu
County/Parish:	
* State:	HI: Hawaii
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	96813-2921

e. Organizational Unit:

Department Name:	Division Name:
	Hawaii Insurance Division

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

Prefix:	Mr.	* First Name:	Lloyd
Middle Name:			
* Last Name:	Lim		
Suffix:			

Title: Health Branch Administrator

Organizational Affiliation:
Hawaii Insurance Division

* Telephone Number:	808-586-2804	Fax Number:	808-587-5379

* Email: llim@dcca.hawaii.gov

Application for Federal Assistance SF-424

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

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

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

Ofc of Consumer Information & Insurance Oversight

11. Catalog of Federal Domestic Assistance Number:

93.511

CFDA Title:

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

*** 12. Funding Opportunity Number:**

RFA-FD-10-999

* Title:

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

13. Competition Identification Number:

ADOBE-FORMS-B

Title:

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

Add Attachment | Delete Attachment | View Attachment

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

Information System to Support Health Insurance Rate Review

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: HI-001

b. Program/Project: HI-all

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

[Add Attachment] [Delete Attachment] [View Attachment]

17. Proposed Project:

* a. Start Date: 08/09/2010

* b. End Date: 07/01/2011

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: Mr.

* First Name: Lloyd

Middle Name:

* Last Name: Lim

Suffix:

* Title: Health Branch Administrator

* Telephone Number: 808-586-2804

Fax Number: 808-587-5379

* Email: llim@dcca.hawaii.gov

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

* Date Signed: Completed by Grants.gov upon submission.

JUL 0 6 2010

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

Key Contacts Form

*** Applicant Organization Name:**

Commerce and Consumer Affairs, Hawaii Department of

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

*** Contact 1 Project Role:** Health Branch Administrator

Prefix: Mr.

* First Name: Lloyd

Middle Name:

* Last Name: Lim

Suffix:

Title:

Organizational Affiliation:

Hawaii Insurance Division

* Street1: 335 Merchant St. #213

Street2:

* City: Honolulu

County:

* State: HI: Hawaii

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 96813-2921

* Telephone Number: 808-586-2084

Fax: 808-587-5379

* Email: llim@dcca.hawaii.gov

Delete Entry | Next Person

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

Key Contacts Form

*** Applicant Organization Name:** Commerce and Consumer Affairs, Hawaii Department of

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

*** Contact 2 Project Role:** Health Insurance Rate & Policy Analyst

Prefix: Mr.

* First Name: Colin

Middle Name:

* Last Name: Hayashida

Suffix:

Title:

Organizational Affiliation:

* Street1: 335 Merchant St. #213

Street2:

* City: Honolulu

County:

* State: HI: Hawaii

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 96813-2921

* Telephone Number: 808-586-2804

Fax:

* Email: chayashida@dcca.hawaii.gov

Delete Entry | Previous Person | Next Person

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

Project/Performance Site Location(s)

Project/Performance Site Primary Location

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

Organization Name: Hawaii Insurance Division

DUNS Number: 9494976140000

* Street1: 335 Merchant St. #213

Street2:

* City: Honolulu

County:

* State: HI: Hawaii

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 96813-2921

* Project/ Performance Site Congressional District: HI-all

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

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

Objective Work Plan

Project:

Information System to Support Health Insurance Rate Review

*** Year:** 1

*** Funding Agency Goal:**

The Hawaii Insurance Division wishes to enhance its Information Technology (I.T.) capacity for better heath rate analysis and reporting.

*** Objective:**

Grants moneys would be used to develop or purchase a computer system to enable reporting of required statistical information regarding health insurance rates to the federal Department of Health and Human Services. The system would also produce consumer friendly reports on rates, pending and completed filings.

*** Results or Benefits Expected:**

The ability to report statisical data regarding health insurance rates to DHHS and provide consumers with information that can assist them in purchasing health insurance.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Develop business needs for Request for Proposal (RFP).	Health Insurance Branch Administrator	08/09/2010	08/30/2010	0
Issuance of RFP for computer system services.	Health Insurance Branch Administrator	08/30/2010	11/01/2010	0
Finalization of contract with computer system consultant and develop requirements for computer system.	Health Insurance Branch Administrator	11/01/2010	01/01/2011	0
Build computer system.	Consultant	01/01/2011	03/01/2011	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
Test and refine computer system and launch system.	Health Insurance Branch Adminsitrator	03/01/2011	07/01/2011	0

*** Criteria for Evaluating Results or Benefits Expected:**

Ability to send required statistical data regarding health insurance rates to DHHS and provide consumers with qualitative reports on health insurance rates.

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.).

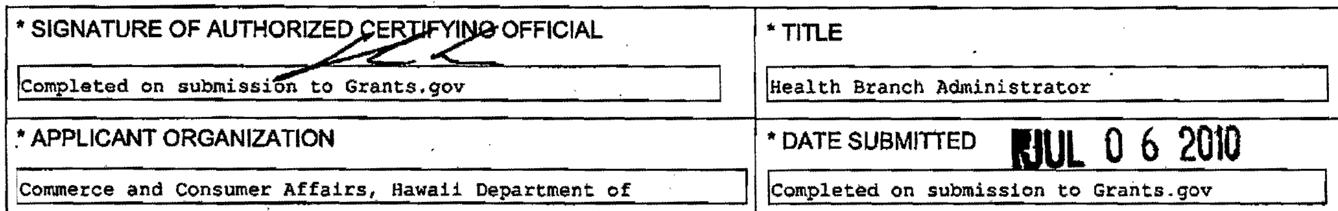
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

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	Health Branch Administrator
* APPLICANT ORGANIZATION	* DATE SUBMITTED JUL 06 2010
Commerce and Consumer Affairs, Hawaii Department of	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: Hawaii Insurance Division
* Street 1: 335 Merchant St. Room 213 Street 2:
* City: Honolulu State: HI: Hawaii Zip: 96813

Congressional District, if known:

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

6. * Federal Department/Agency: Health and Human Services

7. * Federal Program Name/Description: Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

CFDA Number, *if applicable:* 93.511

8. Federal Action Number, *if known:*

9. Award Amount, *if known:* $

10. a. Name and Address of Lobbying Registrant:

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

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

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

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

* Signature: Completed on submission to Grants.gov

*Name: Prefix: * First Name: Lloyd Middle Name:
* Last Name: Lim Suffix:

Title: Telephone No.: Date: Completed on submission to Grants.gov

JUL 06 2010

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

Premium Review Grant

Project Abstract

Since 2003, the Hawaii Insurance Division has regulated health insurance rates pursuant to what is now Hawaii Revised Statutes ("HRS") article 431:14G. All medical rates are reviewed, including all PPO, HMO, and indemnity products. All market segments are included, including large and small group rates and individual non group rates. The rates are reviewed pursuant to HRS section 431:14G-103(a). Rates shall not be excessive, inadequate, or unfairly discriminatory and shall be reasonable in relation to the costs of the benefits provided. All rates are reviewed on a prospective, prior approval basis.

The Hawaii Insurance Division wishes to enhance its Information Technology (I.T.) capacity for better heath rate analysis and reporting. Grants moneys would be used to develop or purchase a computer system to enable reporting of required statistical information regarding health insurance rates to the federal Department of Health and Human Services. The system would also produce consumer friendly reports on rates, pending and completed filings which can be readily accessed by Hawaii's citizens via the Web/Internet. The computer system should also have query and reporting capability to allow detection of rate trend patterns over time.

There should be the ability to track rate and form filings submitted by health insurers. There should also be a "tickler" ability to alert personnel of date-sensitive events, including "deemer" dates. The application should track rate and policy filings and creates an ability to analyze rating trends in the market. There should be support for the reading of barcodes submitted as part of the filing. There should be support for multiple mailings and an ability to track subsequent submissions that amend and update the initial filing. There should be support for the ability to append commentary to mailings and to append "rate impact" states to filings. There should be support for download of SERFF filings. The system should generate a table of approved and disapproved filings by filer. The system should further accommodate statistical reporting required by the federal government.

Consultant costs to develop computer system:	$900,000
Costs for computer system infrastructure:	$100,000

Premium Review Grant

Project Narrative

Eligibility

The applicant is eligible as the State of Hawaii's Insurance Division which regulates insurers and producers in Hawaii and is a member of the National Association of Insurance Commissioners.

Current health insurance rate review capacity and process

Since 2003, the Hawaii Insurance Division has regulated health insurance rates pursuant to what is now Hawaii Revised Statutes ("HRS") article 431:14G. All medical rates are reviewed, including all PPO, HMO, and indemnity products. All market segments are included, including large and small group rates and individual non group rates.

The rates are reviewed pursuant to HRS section 431:14G-103(a). Rates shall not be excessive, inadequate, or unfairly discriminatory and shall be reasonable in relation to the costs of the benefits provided. There are no specific rating rules such as community rating, but practices that violate the primary legal standard can be curtailed.

Health plans typically file a rating methodology which includes a medical loss claims trend, a budget, a description of rating factors and their impact, a description of the extent to which utilization is used in rating, and additional supporting documentation which further substantiates each of the primary elements of the rate filing. The medical loss claims trend incorporates the recent history of medical cost information.

The Hawaii Insurance Division employs two rate and policy analysts and one outside professional actuary to review rate filings for compliance with law. The rate review involves a detailed analysis of the entire rate filing to verify its internal accuracy and consistency and to determine the rate of return (e.g. return on equity or ROE) that would be associated with the filing. The filings are checked to see if there are unfair discriminatory practices, such as cross subsidization between different classes of insureds. Important also in the review is a financial analysis of the company to determine whether its reserves are adequate to avoid insolvencies in light of projected growth in the book of business. Analysts also focus on determining the reasonableness of the loss trend to see if it has been overstated or understated relative to the recent history and taking into consideration different trend periods. Fundamentally, the analysis attempts to determine whether the projected rates are reasonable after considering the need to give a company the ability to pay current claims and administrative costs, and to have a reasonable rate of return to build reserves.

All rates are reviewed on a prospective, prior approval basis. The Hawaii Insurance Division has 60 days to review a rate filing, but that period can be extended if there is a need for an insurer to submit additional information.

Rate analysts use Excel for financial calculations. We currently have an elementary database to support the rate approval process, but it is not enabled for the broader data collection that may be required by the federal government. Although it may be possible to upgrade the existing system, it may be cheaper and more feasible to build a new system dedicated to rate filings from the ground up.

The annual cost of running the Hawaii Insurance Division is about $8 million dollars.

The cost for the actuary is about $150,000 and the cost for the two inside rate analyst is about $150,000, for a total annual cost of about $300,000 to conduct the health insurance rate review process. This represents about 3.75% of the total cost of running the Hawaii Insurance Division.

The professional background of the in house rate analysts are as follows:

Colin Hayashida: Mr. Hayashida is currently a rate and policy analyst with the Hawaii Insurance Division. He previously worked in the Division as a policy analyst and has worked for a health insurance company and the Hawaii State Legislature. He has a B.A. from the University of Hawaii.

Allison Ege: Ms. Ege is currently a rate and policy analyst with the Hawaii Insurance Division. She previously worked for an insurance agency and did rating work with the Hawaii Insurance Bureau. She has a B.A. from the University of Hawaii.

The outside actuarial services are currently performed by Muetterties, Bennett and Associates, specifically by actuary Jim Toole. The contract service is a full review of the rate filings for compliance with law.

The Hawaii Insurance Division processes about thirty (30) rate filings a year and the average review time is about seventy (70) days.

Rate filing disclosure to the public is governed by law. HRS section 431:14G-105(d) provides in relevant part:

> Rates shall be open to public inspection upon filing with the commissioner; provided that the commissioner establishes rules to ensure that confidential and proprietary information is protected and shall not be subject to public inspection.

Hawaii Administrative Rules 16-171-201(c) provides:

> A managed care plan shall not be required to disclose supporting information or supplementary rating information that:

(1) Consists of proprietary information, including trade secrets, commercial information, and business plans that the commissioner deems may result in competitive harm to the managed care plan if disclosed;
(2) Is confidential in accordance with federal or Hawaii law; or
(3) Is exempt from disclosure by federal or Hawaii law.

The Hawaii Insurance Division discloses overall requested rate changes to the press. In addition, individual insurers will normally send notice of rate increases to their employer-customers. These notices are given months in advance of a proposed rate change, but made subject to the final approval of the Insurance Commissioner.

There are no public hearings or meetings prior to a rate approval, but consumers who disagree with a rate decision may contest the decision in an administrative hearing.

For the last two plans years, the Hawaii Insurance Division had received about 25 consumer inquiries on health insurance rate increases. Most of them are general complaints about the fact that health insurance rates continue to rise, but a few consumers also want the Hawaii Insurance Division to check to see if their rates are being calculated in accordance with an approved methodology.

We have not taken significant regulatory action against any Hawaii health insurers for the past two plan years.

There have been no formal hearings held over the past two plan years regarding health insurance rates.

Proposed rate review enhancements for health insurance

The Hawaii Insurance Division wishes to enhance its Information Technology (I.T.) capacity for better heath rate analysis and reporting. Grants moneys would be used to develop or purchase a computer system to enable reporting of required statistical information regarding health insurance rates to the federal Department of Health and Human Services. The system would also produce consumer friendly reports on rates, pending and completed filings which can be readily accessed by Hawaii's citizens via the Web/Internet. The computer system should also have query and reporting capability to allow detection of rate trend patterns over time.

There should be the ability to track rate and form filings submitted by health insurers. There should also be a "tickler" ability to alert personnel of date-sensitive events, including "deemer" dates. The application should track rate and policy filings and creates an ability to analyze rating trends in the market. There should be support for the reading of barcodes submitted as part of the filing. There should be support for multiple mailings and an ability to track subsequent submissions that amend and update the initial filing. There should be support for the ability to append commentary to mailings and to append "rate impact" states to filings. There should be support for download of SERFF filings. The system should generate a table of approved and disapproved filings by filer.

The system should further accommodate statistical reporting required by the federal government.

Work plan and timeline

Grant award:	August 9, 2010
Develop business needs for Request for Proposal (RFP):	August 9, 2010
Issuance of RFP for computer system services:	August 30, 2010
Finalization of contract with computer system consultant:	November 1, 2010
Develop requirements for computer system	November 1, 2010
Build computer system:	January 1, 2011
Test and refine computer system:	March 1, 2011
Go live with computer system:	July 1, 2011

Budget Narrative

Consultant costs to develop computer system:	$900,000
Costs for computer system infrastructure:	$100,000

[ARTICLE 14G]
HEALTH INSURANCE RATE REGULATION

[§431:14G-101] Scope and purpose. (a) This article shall apply to all types of health insurance offered by managed care plans.

(b) The purpose of this article is to promote the public welfare by regulating health insurance rates to the end that they shall not be excessive, inadequate, or unfairly discriminatory. Nothing in this article is intended to:

(1) Prohibit or discourage reasonable competition; or
(2) Prohibit or encourage, except to the extent necessary to accomplish the aforementioned purposes, uniformity in insurance rates, rating systems, rating plans, or practices.

This article shall be liberally interpreted to carry into effect this section. [L 2007, c 175, pt of §2]

Previous Vol09_Ch0431-0435E Next

[§431:14G-102] Definitions. As used in this article:

"Commissioner" means the insurance commissioner.

"Enrollee" means a person who enters into a contractual relationship or who is provided with health care services or benefits through a managed care plan.

"Managed care plan" or "plan" means a health plan as defined in section 431:10A, or chapter 432 or 432D, regardless of form, offered or administered by a health care insurer, including but not limited to a mutual benefit society or health maintenance organization, or voluntary employee beneficiary associations, but shall not include disability insurers licensed under chapter 431.

"Rate" means every rate, charge, classification, schedule, practice, or rule. The definition of "rate" excludes fees and fee schedules paid by the insurer to providers of services covered under this article.

"Supplementary rating information" includes any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, underwriting rule, statistical plan, and any other similar information needed to determine the applicable rates in effect or to be in effect.

"Supporting information" means:

(1) The experience and judgment of the filer and the experience or data of other organizations relied on by the filer;
(2) The interpretation of any other data relied upon by the filer; and
(3) Descriptions of methods used in making the rates and any other information required by the commissioner to be filed. [L 2007, c 175, pt of §2]

Previous Vol09_Ch0431-0435E Next

[§431:14G-103] Making of rates. (a) Rates shall not be excessive, inadequate, or unfairly discriminatory and shall be reasonable in relation to the costs of the benefits provided.

(b) Except to the extent necessary to meet subsection (a), uniformity among managed care plans in any matters within the scope of this section shall be neither required nor prohibited. [L 2007, c 175, pt of §2]

Previous Vol09_Ch0431-0435E Next

[§431:14G-104] Rate adjustment mandates. (a) Except as otherwise provided by law, the commissioner may mandate filings for health insurance under section 431:14G-105 when the commissioner has actuarially sound information that current rates may be excessive, inadequate, or unfairly discriminatory.

(b) Managed care plans shall submit the rate filings within one hundred twenty days of the commissioner's mandate.

(c) The rate filings shall be subject to the rate filing requirements under section 431:14G-105. [L 2007, c 175, pt of §2]

Previous Vol09_Ch0431-0435E Next

[§431:14G-105] Rate filings. (a) Every managed care plan shall file in triplicate with the commissioner, every rate, charge, classification, schedule, practice, or rule and every modification of any of the foregoing that it proposes to use. Every filing shall state its proposed effective date and shall indicate the character and extent of the coverage contemplated. The filing also shall include a report on investment income.

(b) Each filing shall be accompanied by a $50 fee payable to the commissioner and shall be deposited in the commissioner's education and training fund.

(c) At the same time as the filing of the rate, every managed care plan shall file all supplementary rating and supporting information to be used in support of or in conjunction with a rate. The managed care plan may satisfy its obligation to file supplementary rating and supporting information by reference to material that has been approved by the commissioner. The information furnished in support of a filing may include or consist of a reference to:

(1) Its interpretation of any statistical data upon which it relies;
(2) The experience of other managed care plans; or
(3) Any other relevant factors.

(d) When a filing is not accompanied by supporting information or the commissioner does not have sufficient information to determine whether the filing meets the requirements of this article, the commissioner shall require the managed care plan to furnish additional information and, in that event, the waiting period shall commence as of the date the information is furnished. Until the requested information is provided, the filing shall not be deemed complete or filed and the filing shall not be used by the managed care plan. If the requested information is not provided within a reasonable time period, the filing may be returned to the managed care plan as not filed and not available for use. Rates shall be open to public inspection upon filing with the commissioner; provided that the commissioner establishes rules to ensure that confidential and proprietary information is protected and shall not be subject to public inspection.

(e) Rates shall be established in accordance with actuarial principles, based on reasonable assumptions, and supported by adequate supporting and supplementary rating information. After reviewing a managed care plan's filing, the commissioner may require that the managed care plan's rates be based upon the managed care plan's own loss and expense information.

(f) The commissioner shall review filings promptly after the filings have been made to determine whether the filings meet the requirements of this article.

(g) Except as provided herein, each filing shall be on file for a waiting period of sixty days before the filing becomes effective. The period may be extended by the commissioner for an additional period not to exceed fifteen days if the commissioner gives written notice within the waiting period to the managed care plan that made the filing, that the commissioner needs the additional time for the consideration of the filing. Upon written application by the managed care plan, the

commissioner may authorize a filing that the commissioner has reviewed, to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of this article unless disapproved by the commissioner, as provided in section 431:14G-107, within the waiting period or any extension thereof. The rates shall be deemed to meet the requirements of this article until the time the commissioner reviews the filing and so long as the filing remains in effect.

(h) If the commissioner finds that a filing does not meet the requirements of this article, the commissioner, as provided in section 431:14G-107, shall send the managed care plan a notice of disapproval within the applicable sixty-day period or fifteen-day extension provided by subsection (g).

(i) The commissioner, by written order, may suspend or modify the requirement of filing as to any class of health insurance, subdivision, or combination thereof, or as to classes of risks, the rates which cannot practicably be filed before they are used. The order shall be made known to the affected managed care plan. The commissioner may make examinations that the commissioner deems advisable to ascertain whether any rates affected by the order meet the standards set forth in section 431:14G-103.

(j) No managed care plan shall make or issue a contract or policy except in accordance with filings that are in effect for the managed care plan as provided in this article.

(k) The commissioner may make the following rate effective when filed: any special filing with respect to any class of health insurance, subdivision, or combination thereof that is subject to individual risk premium modification and has been agreed to under a formal or informal bid process.

(l) For managed care plans having annual premium revenues of less than $10,000,000, the commissioner may adopt rules and procedures that will provide the commissioner with sufficient facts necessary to determine the reasonableness of the proposed rates without unduly burdening the managed care plan and its enrollees; provided that the rates meet the standards of section 431:14G-103.

(m) Subsections (a) through (l) shall not apply to third party administrator services, prepaid dental insurance offered by managed care plans, prepaid vision insurance offered by managed care plans and disability insurers licensed under chapter 431. For managed care plans with rates based totally or in part on the individual group's claims experience, insurers subject to this subsection shall submit to the commissioner for approval descriptions of the methodology to be used in creating rates and every modification thereof that it proposes to use. The description of methodology shall contain specific information allowing a determination of rates that meet the standards of section 431:14G-103(a) and supporting information and justification. Every filing shall state its proposed effective date and shall indicate the character and extent of the coverage contemplated. Complete supporting and supplementary rating information for rates shall be maintained and made available to the commissioner upon request. [L 2007, c 175, pt of §2]

Previous Vol09_Ch0431-0435E Next

[§431:14G-106] Policy revisions that alter coverage. All plan revisions that alter coverage in any manner shall be filed with the commissioner. After review by the commissioner, the commissioner shall determine whether a rate filing for the plan revision must be submitted in accordance with section 431:14G-105. [L 2007, c 175, pt of §2]

Previous Vol09_Ch0431-0435E Next

[§431:14G-107] Disapproval of filings. (a) If, within the waiting period or any extension of the waiting period as provided in section 431:14G-105, the commissioner finds that a filing does not meet the requirements of this article, the commissioner shall send to the managed care plan that made the filing, written notice of disapproval of the filing specifying in what respects the filing fails to meet the requirements of this article, specifying the actuarial, statutory, and regulatory basis for the disapproval, including an explanation of the application thereof that resulted in disapproval, and stating that the filing shall not become effective.

(b) Whenever a managed care plan has no legally effective rates as a result of the commissioner's disapproval of rates, a finding pursuant to subsection (c) that a filing is no longer effective, or other act, interim rates shall be established within ten days of disapproval, or other act, as follows:

(1) The commissioner shall specify interim rates sufficient to protect the interests of the managed care plan and its enrollees, ensure the solvency of the managed care plan, maintain the plan's health care delivery, and prevent any impairment of enrollees' health care benefits. When a new rate becomes legally effective and the new rate is higher than the interim rate, the commissioner shall allow the managed care plan to retroactively adjust the premiums to the time when the interim rate was first imposed. If the new rate is lower than the interim rate, the commissioner may order that the difference be applied to stabilize future rates or be refunded to current enrollees of the managed care plan;

(2) If a filing is disapproved, in whole or in part, a petition and demand for a contested case hearing may be filed in accordance with chapter 91. The managed care plan shall have the burden of proving that the disapproval is not justified; or

(3) If a filing is approved, a contested case hearing in accordance with chapter 91 may be convened pursuant to subsection (c) to determine if the approved rates comply with the requirements of this article. If an appeal is taken from the commissioner's approval or if subsequent to the approval the commissioner convenes a hearing pursuant to subsection (c), the filing of the appeal or the commissioner's notice of hearing shall not stay the implementation of the rates approved by the commissioner, or the rates currently in effect, whichever is higher.

(c) If at any time subsequent to the applicable review period provided for in section 431:14G-105, the commissioner finds that a filing does not comply with the requirements of this article, the commissioner shall order a hearing upon the filing. The hearing shall be held upon not less than ten days' written notice to every managed care plan that made such a filing. The notice shall specify the matters to be considered at the hearing and state the specific factual and legal grounds to support the commissioner's finding of noncompliance. If, after a hearing the commissioner finds that a filing does not meet the requirements of this article, the commissioner within thirty days of the hearing, shall issue

an order specifying in what respects the filing fails to meet the requirements, and stating when, within a reasonable period thereafter, the filing shall be deemed no longer effective. Copies of the order shall be sent to each managed care plan whose rates are affected by the order. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

(d)(1) Any enrollee of a managed care plan or organization that purchases health insurance from a managed care plan aggrieved with respect to any filing that is in effect may make a written demand to the commissioner for a hearing thereon; provided that the managed care plan that made the filing shall not be authorized to proceed under this subsection;

(2) The demand shall specify the grounds to be relied upon by the aggrieved enrollee or organization and the demand shall show that the enrollee or organization has a specific economic interest affected by the filing;

(3) If the commissioner finds that:

(A) The demand is made in good faith;

(B) The applicant would be so aggrieved if the enrollee's or organization's grounds are established; and

(C) The grounds otherwise justify a hearing;

the commissioner, within thirty days after receipt of the demand, shall hold a hearing. The hearing shall be held upon not less than ten days' written notice to the aggrieved party and to every managed care plan that made the filing. The aggrieved party shall bear the burden of proving that the filing fails to meet the standards set forth in section 431:14G-103; and

(4) If, after the hearing, the commissioner finds that the filing does not meet the requirements of this article, the commissioner shall issue an order specifying in what respects the filing fails to meet the requirements of this article, and stating when, within a reasonable period, the filing shall be deemed no longer effective. Copies of the order shall be sent to the applicant and to every affected managed care plan. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

(e) The notices, hearings, orders, and appeals referred to in this section, in all applicable respects, shall be subject to chapter 91, unless expressly provided otherwise. [L 2007, c 175, pt of §2]

Previous Vol09_Ch0431-0435E Next

[§431:14G-108] Managed care plans; prohibited activity. (a) Except as permitted in this article, no managed care plan shall:

(1) Attempt to monopolize, or combine or conspire with any other person to monopolize an insurance market; or

(2) Engage in a boycott, on a concerted basis, of an insurance market.

(b) Except as permitted in this article, no managed care plan shall make any arrangement with any other person that has the purpose or effect of restraining trade unreasonably or of substantially lessening competition in the business of insurance. [L 2007, c 175, pt of §2]

Previous Vol09_Ch0431-0435E Next

[§431:14G-109] Information to be furnished enrollees; hearings and appeals of enrollees. Every managed care plan that makes its own rates, within a reasonable time after receiving written request therefore and upon payment of reasonable charges as it may make, shall furnish to any enrollee affected by a rate made by it or to the authorized representative of the enrollee, all pertinent information as to the rate; provided that the managed care plan shall not be required to disclose supporting information and supplementary rating information protected pursuant to section 431:14G-105(d). [L 2007, c 175, pt of §2]

Previous Vol09_Ch0431-0435E Next

[§431:14G-110] False or misleading information. No person or organization shall wilfully withhold information from or knowingly give false or misleading information to the commissioner, any statistical agency designated by the commissioner, or any managed care plan, which will affect the rates or premiums chargeable under this article. Violation of this section shall subject the one guilty of the violation to the penalties provided in section 431:14G-111. [L 2007, c 175, pt of §2]

Previous Vol09_Ch0431-0435E Next

[§431:14G-111] Penalties. (a) If the commissioner finds that any person or organization has violated any provision of this article, the commissioner may impose a penalty of not more than $500 for each violation; provided that if the commissioner finds the violation to be wilful, the commissioner may impose a penalty of not more than $5,000 for each violation. The penalties may be in addition to any other penalty provided by law. For purposes of this section, any managed care plan using a rate for which the managed care plan has failed to file the rate, supplementary rating information, underwriting rules or guides, or supporting information as required by this article, shall have committed a separate violation for each day the failure to file continues.

(b) The commissioner may suspend the license or operating authority of any managed care plan that fails to comply with an order of the commissioner within the time limited by the order, or any extension thereof that the commissioner may grant. The commissioner shall not suspend the license of any managed care plan for failure to comply with an order until the time prescribed for an appeal from the order has expired or, if an appeal has been taken, until the order has been affirmed. The commissioner may determine when a suspension of license or operating authority shall become effective and it shall remain in effect for the period fixed by the commissioner unless the commissioner modifies or rescinds the suspension, or until the order upon which the suspension is based is modified, rescinded, or reversed.

(c) No penalty shall be imposed and no license or operating authority shall be suspended or revoked except upon a written order of the commissioner, stating the commissioner's findings, made after a hearing held upon not less than ten days' written notice to the person or organization. The notice shall specify the alleged violation. [L 2007, c 175, pt of §2]

[§431:14G-112] Hearing procedure and judicial review. (a) Any managed care plan aggrieved by any order or decision of the commissioner made without a hearing, within thirty days after notice of the order to the managed care plan, may make written request to the commissioner for a hearing. The commissioner shall hold a hearing within twenty days after receipt of the request, and shall give not less than ten days' written notice of the time and place of the hearing. The commissioner shall promptly conduct and complete the hearing. Within fifteen days after the hearing is completed, the commissioner shall affirm, reverse, or modify the commissioner's previous action, specifying the reasons for the commissioner's decision. Pending the hearing and decision, the commissioner may suspend or postpone the effective date of the commissioner's previous action.

(b) Any final order or decision of the commissioner may be reviewed in the circuit court of the first circuit and an appeal from the decision of the court shall lie to the supreme court. The review shall be taken and had in the manner provided in chapter 91. [L 2007, c 175, pt of §2]

Previous Vol09_Ch0431-0435E Next

LLOYD LIM

(b)(6)

Record of Employment

(1994-Present) **Department of Commerce and Consumer Affairs-State of Hawaii**

(December 2002-Present) **Program Administrator, Health Insurance Branch, Insurance Division.** Supervised health insurance regulation, including rate regulation, financial surveillance, complaints investigation, licensing, the external review of health plan coverage denials, and health insurance legislative matters. Reported to the insurance commissioner.

(September 2002-December 2002) **Staff Attorney III, Insurance Division.**

(July 2000-September 2002; nominally from September 2002-Present) **Acting Executive Director, Hawaii Hurricane Relief Fund.** Managed the Fund's operations, finances, investments, legal and legislative matters. Reported to the Fund's board of directors.

(September 1994-July 2000) **Legal Analyst, Hawaii Hurricane Relief Fund.** In house legal counsel for the Fund. Reported to the Fund's executive director.

(September 1990-May 1993) **Brown & Wood**

Junior Associate Attorney. Assisted on municipal bond and mortgage backed securities transactions.

Education

MBA, University of Hawaii (1998)
JD, UCLA (1990)
BA, Columbia University (1987)
Punahou (1983)

Affiliations/Designations

CPCU (2003)
Beta Gamma Sigma (1997)
Hawaii Bar Association (1993)

Volunteer

Health Planning Council-Honolulu (2008-2012)

Hobby

Classical Piano (since 1983)

COLIN HAYASHIDA

(b)(6)

(b)(6)
Phone No.: (b)(6)

EDUCATION: **Bachelor of Arts**
University of Hawaii at Manoa
Major: Political Science
GPA: 3.0 on a 4.0 scale

EXPERIENCE: **State of Hawaii Insurance Division, Honolulu, Hawaii**
Health Insurance Rate & Policy Analyst III, July 2005 to Present

- Analyzes health insurance rate and form filings.
- Quantitative statistical evaluation of insurers' finances and ratemaking.
- Reviews health insurer's compliance with statutes and regulations.
- Recommends approval or disapproval of health rate and form filings to the Insurance Commissioner based on compliance with the Insurance Code.
- Analyzes and monitors the economic factors of the Hawaii health insurance market.
- Corresponds with insurers, actuaries, agencies, and individuals on health insurance topics and compliance.
- Coordinates with public and private agencies, as well as, individuals on health insurance initiatives.
- Assist in the staffing of legislative task forces.
- Assists the Branch Administrator with administrative duties.
- Provides minor technical computer support to the Health Insurance Branch.

State of Hawaii Insurance Division, Honolulu, Hawaii
Health Insurance Rate & Policy Analyst IV, November 2002 to July 2005

- Analyzes health insurance rate and form filings.
- Quantitative statistical evaluation of insurers' finances and ratemaking.
- Reviews health insurer's compliance with statutes and regulations.
- Recommends approval or disapproval of health rate and form filings to the Insurance Commissioner based on compliance with the Insurance Code.
- Analyzes and monitors the economic factors of the Hawaii health insurance market.
- Corresponds with insurers, actuaries, agencies, and individuals on health insurance topics and compliance.
- Coordinates with public and private agencies, as well as, individuals on health insurance initiatives.
- Assist in the staffing of legislative task forces.
- Provides minor technical computer support to the Health Insurance Branch.

State of Hawaii Insurance Division, Honolulu, Hawaii
Health Insurance Program Analyst, May 2001 to November 2002

- Research, review, and analyze health insurance policy issues and legislation.
- Track and draft legislative proposals.
- Assist in the staffing of legislative task forces.
- Correspond to agencies and individuals on health insurance topics.
- Coordinate with public and private agencies, as well as, individuals on health insurance initiatives.
- Assists consumers in obtaining information regarding health insurance.
- Assists in the investigation of health insurance complaints.
- Provides minor technical computer support to the Health Insurance Branch.

State of Hawaii Insurance Division, Honolulu, Hawaii

Licensing Clerk, October 2000 to May 2001

- Coordinate continuing education program for licensees.
- Coordinate legislative activities for the Division.
- Conduct meetings and informational briefings on licensing issues.
- Assist consumers in obtaining information on insurers and agents.
- Review Hawaii Revised Statutes and Administrative Rules as necessary.

Hawaii State Legislature, Honolulu, Hawaii

Committee Clerk for State Senator David Y. Ige, December 1999 to May 2000

- Coordinates and oversees the activities of the Senate Education and Technology Committee. Including gathering, organizing, and analyzing information for the Senator.
- Digesting and tracking legislation, and performing any other responsibilities assigned by the Senator.

Hawaii Medical Services Association, Honolulu, Hawaii

Provider Services Representative, May 1998 to December 1999

- Provided correspondence and investigated provider's appeals on claim status, benefits, and other information regarding HMSA policies.
- Collaborated on inter-departmental projects, which included data gathering, analysis, and review of plans, policies, & utilization.

COMPUTER SKILLS: Use of Word, Excel, Power Point, Outlook, and Lotus Notes.

REFERENCES: Available upon request.

BUDGET INFORMATION - Non-Construction Programs

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

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. "Grants to States for Health Insurance Premium Review-Cycle I"	93.511	$	$	$ 1,000,000.00	$ 0.00	$ 1,000,000.00
2.						
3.						
4.						
5. Totals		$	$	$ 1,000,000.00	$	$ 1,000,000.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1) "Grants to States for Health Insurance Premium Review-Cycle I"	(2)	(3)	(4)	
a. Personnel	$ 0.00	$	$	$	$
b. Fringe Benefits	0.00				
c. Travel	5,000.00				5,000.00
d. Equipment	20,000.00				20,000.00
e. Supplies	0.00				
f. Contractual	973,000.00				973,000.00
g. Construction	0.00				
h. Other	2,000.00				2,000.00
i. Total Direct Charges (sum of 6a-6h)	1,000,000.00				$ 1,000,000.00
j. Indirect Charges	0.00				$
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. "Grants to States for Health Insurance Premium Review-Cycle I"	$ 0.00	$ 0.00	$ 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	$ 300,000.00	$ 300,000.00	$ 200,000.00	$ 200,000.00
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$ 1,000,000.00	$ 300,000.00	$ 300,000.00	$ 200,000.00	$ 200,000.00

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

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
	(b)First	(c) Second	(d) Third	(e) Fourth
16. "Grants to States for Health Insurance Premium Review-Cycle I"	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00	$ 750,000.00
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00	$ 750,000.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: 0	22. Indirect Charges: 0
23. Remarks:	