MARYLAND

Maryland Insurance Administration

Grants to States for Health Insurance Premium Review-Cycle I

CFDA: 93.511

Appendix 1: Applicable Maryland Statutes and Regulations for Health Insurance Rate Review -- Insurers

Article - Insurance

§12–203.

(a) (1) This section applies to a form for a life insurance or health insurance policy, an annuity contract, an application for that policy or contract that is required to be written, a rider, or an endorsement that:

(i) is delivered or issued for delivery in the State; or

(ii) is used by domestic insurers for delivery in a jurisdiction outside the State, if:

1. the insurance supervisory official of the jurisdiction informs the Commissioner that the form is not subject to approval or disapproval by the official; and

2. the Commissioner requires the form to be submitted to the Commissioner for approval.

(2) This section does not apply to unique riders, endorsements, or forms that are:

(i) designed for and relate to the manner of distribution of benefits or to the reservation of rights and benefits under life insurance or health insurance policies or annuity contracts; and

(ii) used at the request of the individual policyholder, contract holder, or certificate holder.

(b) (1) A form subject to this section may not be delivered or issued for delivery in the State, unless the form has been filed with and approved by the Commissioner.

(2) An individual certificate may not be used in connection with a group or blanket insurance policy or group annuity contract unless the form for the certificate has been filed with and approved by the Commissioner.

(c) (1) The filing of a form with the Commissioner shall be made at least 60 days before delivery.

(2) Approval by the Commissioner of the form constitutes a waiver of any unexpired part of the filing period.

(3) The Commissioner may extend the initial filing period up to an additional 30 days if the Commissioner gives notice of the extension before the initial filing period ends.

(4) The form is deemed approved unless the Commissioner affirmatively approves or disapproves it before the end of the initial filing period or any extended period.

(5) At any time, the Commissioner may withdraw approval of a form, if the Commissioner:

(i) gives prior notice of the withdrawal;

(ii) shows cause for the withdrawal; and

(iii) states the effective date of the withdrawal in the notice.

(6) The withdrawal of approval shall take effect at least 20 days after the withdrawal notice is given.

(d) (1) The Commissioner may order an exemption from this section for as long as the Commissioner considers proper for an insurance document or form or type of insurance document or form if the Commissioner finds that:

(i) this section is not practicably applicable; or

(ii) the filing and approval of the document or form or type of document or form are not desirable or necessary to protect the public.

(2) (i) The Commissioner may adopt regulations to allow a type or kind of form to be effective upon receipt of the filing by the Commissioner.

(ii) If an insurer uses a form which becomes effective in accordance with the provisions of subparagraph (i) of this paragraph and the form would be subject to disapproval under § 12-205(b) of this subtitle, the Commissioner may:

1. subsequently disapprove the form; and

2. impose on the insurer a penalty under § 4-113 of this article.

(iii) If an insurer files a form with the Commissioner which becomes effective in accordance with the provisions of subparagraph (i) of this paragraph, the insurer shall pay the applicable filing fee provided in § 2-112 of this article.

(e) (1) The Commissioner shall approve life insurance policies, health insurance policies, and annuity contracts in loose-leaf form and shall approve alternate pages submitted separately for use with the policies and contracts if their provisions comply with this article.

(2) Whenever alternate pages are filed after the initial policies or contracts are approved, the Commissioner may require that those policies or contracts also be submitted with an explanation of the intended usage of the alternate pages.

(3) A combination of approved pages may form a complete policy or contract if a schedule is filed with the Commissioner that shows the pages to be used to form each particular policy or contract.

(f) The applicable standards for forms used by domestic insurers for delivery in the State shall apply to forms used by domestic insurers for delivery outside the State.

(g) By regulation, the Commissioner shall adopt the language and format for standard provisions required under § 12-102(a) of this title for contracts and policies issued by insurers, nonprofit health service plans, and health maintenance organizations.

COMAR (Regulations)

31.10.01.02

.02 Filing of Health Insurance Forms for Approval.

A. The filing of a form shall be accompanied by the filing of premium rates for it. Subsequent changes in premium rates shall be filed with supporting data at least 90 days before the date any change in the rate is proposed to become effective.

Â-1. An insurer submitting forms for approval, or premiums for forms pending approval or previously approved, shall print or type in a conspicuous manner immediately below the name of the insurer on the letter of transmittal the insurer's National Association of Insurance Commissioners (NAIC) company code number.

B. Any name or title of a policy should be printed in a size of type smaller than that used for the name of the insurer.

C. Reference to a standard of time shall specify time at the place the insured resides, or at the place the accident or illness occurs, or at the place the policy is delivered.

D. A form will not be approved for issuance at any age which does not provide a reasonable period of full coverage before the age at which benefits terminate or are substantially reduced.

E. If a rider or endorsement reduces or eliminates coverage of a policy, signed acceptance by the policyowner at the time of or before delivery of the policy is required.

F. Any form which by its terms provides that only one of several benefits will be payable as a result of any one accident or sickness shall state that the largest of the benefits will be payable.

G. If the claimant has the right to elect alternative benefits, the time allowed for the election shall be not less than 90 days from the date of the accident or commencement of the loss.

H. If payment of benefits is related to the first visit of a physician or the date of the first medical attendance, this stipulation shall appear in the benefit provision to which it applies.

I. Payment of benefits may be limited in duration to the time the insured is under the care of a physician, but may not be conditioned upon any specified frequency of visits or attendance by the physician.

J. Except in the case of group health insurance, if any policy provision terminates upon entry of the insured into military service, or if the policy excludes any coverage while the insured is in military service, the policy shall provide for a refund upon request of the policyowner of pro rata unearned premium for any period during which the insured is not covered. However, if coverage is excluded only for loss resulting from military service while in military service, a refund is not required. In policies of noncancellable or guaranteed renewable health insurance, when the coverage is automatically reinstated upon discharge from military service or within a stated period not exceeding 6 months after discharge, a refund is not required.

K. In lieu of the definitions contained in L, M, and N of this regulation, the policy may contain a definition which, in the opinion of the Commissioner, is not less favorable to the policyholder.

L. During at least the first 12 months, or the first 52 weeks, of disability, total disability for which benefits may become due and payable shall be defined as "inability by reason of injury or sickness to perform each and every duty pertaining to the insured's occupation". After the first 12 months, or the first 52 weeks, of disability, total disability may be defined as "inability to perform each and every duty of any business or occupation for which the insured is reasonably fitted by education, training and experience".

M. Partial disability shall be defined as "inability to perform one or more, but not all, of the important daily duties of the insured's occupation".

N. If a form provides coverage due to the wrecking or disablement of, or material damage to, an automobile, elevator, or other conveyance in which the insured is a passenger at the time of the accident, the wrecking, disablement, or material damage shall be defined substantially as damage which necessitates repair in order to place the conveyance in as good a condition as it was before the accident.

O. An exception excluding liability for chronic or organic disease will not be permitted. Any disease to be excluded from coverage shall be stated with sufficient clarity so as to be readily identifiable.

P. A provision may not contain the words "reimburse" or "reimbursement" or the phrase "amount actually expended". A benefit may not be conditioned on the payment by the claimant of expenses for which the policy provides a benefit.

Q. A form may not contain the phrase "strict compliance" or words of similar import.

R. In any policy form in which the insurer has the right to change premium rates, the policy shall provide that notice of any increase in rates shall be given to the policyholder by mail at least 40 days before the expiration of the grace period applicable to the first increased premium.

S. A noncancellable or guaranteed renewable family health insurance policy which covers the spouse of the insured shall provide that, in the event of the death of the insured applicant, the spouse will become the successor insured.

Maryland Insurance Administration

Grants to States for Health Insurance Premium Review-Cycle I

CFDA: 93.511

Appendix 2: Applicable Maryland Statutes for Health Insurance Rate Review – Nonprofit Health Service Plans

Article - Insurance

§14–126.

(a) (1) A corporation subject to this subtitle may not amend its certificate of incorporation, bylaws, or the terms and provisions of contracts issued or proposed to be issued to subscribers to the plan until the proposed amendments have been submitted to and approved by the Commissioner and the applicable fees required by § 2-112 of this article have been paid.

(2) A corporation subject to this subtitle may not change the table of rates charged or proposed to be charged to subscribers for a form of contract issued or to be issued for health care services until the proposed change has been submitted to and approved by the Commissioner.

(3) The Commissioner shall approve an amendment to the articles of incorporation or bylaws under paragraph (1) of this subsection unless the Commissioner determines the amendment is contrary to the public interest.

(b) (1) (i) An amendment may not take effect until 60 days after it is filed with the Commissioner.

(ii) If an amendment is not accompanied by the information needed to support it and the Commissioner does not have sufficient information to determine whether the filing meets the requirements of this section, the Commissioner shall require the nonprofit health service plan to provide the needed information.

(iii) If the Commissioner requires additional information, the waiting period under this paragraph shall begin again on the date the needed information is provided.

(iv) On written application by the nonprofit health service plan, the Commissioner may authorize an amendment that the Commissioner has reviewed to become effective before the expiration of the waiting period or any extension of the waiting period or at a later date.

(2) A filing is deemed approved unless disapproved by the Commissioner within the waiting period or any extension of the waiting period.

(3) (i) The Commissioner shall disapprove or modify the proposed change if:

1. the table of rates appears by statistical analysis and reasonable assumptions to be excessive in relation to benefits; or

2. the form contains provisions that are unjust, unfair, inequitable, inadequate, misleading, or deceptive or encourage misrepresentations of the coverage.

(ii) In determining whether to disapprove or modify the form or table of rates, the Commissioner shall consider:

1. past and prospective loss experience within and outside the State;

2. underwriting practice and judgment to the extent appropriate;

3. a reasonable margin for reserve needs;

4. past and prospective expenses, both countrywide and those specifically applicable to the State; and

5. any other relevant factors within and outside the State.

(4) On the adoption of an amendment or change, after approval by the Commissioner, the corporation shall file with the Commissioner a copy of the amendment or change that has been certified by at least two executive officers of the corporation.

(c) At any time, the Commissioner may require a nonprofit health service plan in the State to demonstrate that its filings, including the terms and provisions of its contracts, its table of rates, and its method for setting rates, comply with subsections (a) and (b) of this section, notwithstanding that the Commissioner had previously approved the filings.

(d) (1) If, after the applicable review period established under subsection (b) of this section, the Commissioner finds that a filing does not meet the requirements of this section, the Commissioner shall issue to the filer an order that specifies the ways in which the filing fails to meet the requirements of this section and states when, within a reasonable period after the order, the filing will no longer be effective.

(2) (i) The Commissioner shall hold a hearing before issuing an order under paragraph (1) of this subsection.

(ii) The Commissioner shall give written notice of the hearing to the filer at least 10 days before the hearing.

(iii) The written notice shall specify the matters to be considered at the hearing.

(3) An order issued under paragraph (1) of this subsection does not:

(i) affect a contract or policy made or issued before the expiration of the period set forth in the order; or

(ii) directly affect an existing contract or policy between a nonprofit health service plan and a subscriber established in accordance with a collective bargaining agreement.

(e) (1) The Commissioner may adopt regulations to allow a type or kind of form to be effective upon receipt of the filing by the Commissioner.

(2) If a nonprofit health service plan uses a form which becomes effective in accordance with the provisions of subparagraph (i) of this paragraph and the form would be subject to disapproval under subsection (b)(3) of this section, the Commissioner may:

(i) subsequently disapprove the form; and

(ii) impose on the nonprofit service plan a penalty under § 4-113 of this article.

(3) If a nonprofit health service plan files a form with the Commissioner which becomes effective in accordance with paragraph (1) of this subsection, the

nonprofit health service plan shall pay the applicable filing fee provided in § 2-112 of this article.

§14–127.

(a) Each decision or finding of the Commissioner about rates and forms made under § 14-126 of this subtitle is subject to judicial review in accordance with Title 11, Subtitle 5 of this article.

(b) All other decisions and findings of the Commissioner about a corporation subject to this subtitle are subject to judicial review in accordance with § 2-215 of this article.

[Previous][Next][Another Article]

Maryland Insurance Administration

Grants to States for Health Insurance Premium Review-Cycle I

CFDA: 93.511

Appendix 3: Applicable Maryland Statutes and Regulations for Health Insurance Rate Review – Health Maintenance Organizations

Article - Health - General

§19–713.

(a) Each health maintenance organization shall file with the Commissioner and pay the applicable filing fee as provided in § 2-112 of the Insurance Article, before they become effective:

(1) All rates that the health maintenance organization charges subscribers or groups of subscribers; and

(2) The form and content of each contract between the health maintenance organization and its subscribers or groups of subscribers.

(b) (1) Rates of a health maintenance organization may not be excessive, inadequate, or unfairly discriminatory in relation to the services offered.

(2) A health maintenance organization that includes a subrogation provision in its contract as authorized under § 19-713.1(d) of this subtitle shall:

(i) Use in its rating methodology an adjustment that reflects the subrogation; and

(ii) Identify in its rate filing with the Maryland Insurance Administration, and annually in a form approved by the Insurance Commissioner, all amounts recovered through subrogation.

(c) (1) If, at any time, a health maintenance organization wishes to amend any contract with its subscribers or change any rate charged, the health maintenance organization shall file with the Commissioner the number of copies of the amendment or rate change that the Commissioner requires.

(2) The Commissioner shall provide the Department with the number of copies it requires.

(d) The Commissioner shall coordinate the contract and related rate filing review under this section.

(e) (1) If within 60 days after a filing made pursuant to this section, the Commissioner finds the filing does not meet the requirements of subsection (f) of this section, the filer shall be sent notice of disapproval specifying in what respects the Commissioner finds that the filing fails to meet the requirements of this section and stating that the filing shall not become effective.

(2) The Commissioner may not issue a notice of disapproval of a filing under subsection (f) of this section without a statutory or regulatory basis for the disapproval and an explanation of the application of the statutory or regulatory basis which resulted in the disapproval.

(f) The Commissioner shall disapprove any form filed, or withdraw any previous approval, if the form:

(1) Is in any respect in violation or does not comply with this article or applicable regulations;

(2) Contains, or incorporates by reference, any inconsistent or inapplicable clauses, exceptions, or conditions which affect the risk purported to be assumed in the general coverage of the contract;

(3) Has any title, heading, or other indication of its provisions which is likely to mislead the subscriber or member;

(4) Includes provisions that are inequitable, or provisions that lack any substantial benefit to the subscriber or member;

(5) Is printed or otherwise reproduced in a manner as to render any provision of the form substantially illegible; or

(6) Provides benefits that are unreasonable in relation to the premium charged.

(g) (1) Except as provided in paragraph (2) of this subsection, unless the Commissioner disapproves a filing under this section, the filing becomes effective 60 days after the office of the Commissioner receives the filing or on any other date that the Commissioner sets.

(2) The Commissioner may adopt regulations to allow a type or kind of form to be effective upon receipt of the filing by the Commissioner.

(3) If a health maintenance organization uses a form which becomes effective in accordance with the provisions of paragraph (2) of this subsection and the form would be subject to disapproval under subsection (f) of this section, the Commissioner may:

(i) Subsequently disapprove the form; and

(ii) Find the health maintenance organization to be in violation of § 19-729 of this subtitle and impose a penalty as provided in § 19-730 of this subtitle.

(4) If a health maintenance organization files a form with the Commissioner which becomes effective in accordance with the provisions of paragraph (2) of this subsection, the health maintenance organization shall pay the applicable filing fee provided in § 2-112 of the Insurance Article.

31.12.02.08

.08 Charges.

A. The submittal of a form shall be accompanied by the submittal of the rates charged for it, together with detailed supporting actuarial data. Subsequent changes in charged rates shall be submitted with detailed supporting actuarial data at least 60 days before the date that any change in the rate is proposed to become effective.

B. The Commissioner shall approve or disapprove any rate submittal or change in the same manner as prescribed for approval or disapproval of forms.

C. An HMO may not make or permit any differential in charged rates for any reason based on the age or sex of an enrollee unless there is actuarial justification for the differential.

D. Charges may not be excessive, inadequate, or unfairly discriminatory.

Maryland Insurance Administration

Grants to States for Health Insurance Premium Review-Cycle I

CFDA: 93.511

Appendix 4: Applicable Maryland Statutes for Health Insurance Rate Review -- Disclosure

Article - State Government

§10–617.

(a) Unless otherwise provided by law, a custodian shall deny inspection of a part of a public record, as provided in this section.

(b) (1) In this subsection, "disability" has the meaning stated in § 20–701 of this article.

(2) Subject to paragraph (3) of this subsection, a custodian shall deny inspection of the part of a public record that contains:

(i) medical or psychological information about an individual, other than an autopsy report of a medical examiner;

(ii) personal information about an individual with a disability or an individual perceived to have a disability; or

(iii) any report on human immunodeficiency virus or acquired immunodeficiency syndrome submitted in accordance with Title 18 of the Health – General Article.

(3) A custodian shall permit the person in interest to inspect the public record to the extent permitted under § 4–304(a) of the Health – General Article.

(4) Except for paragraph (2)(iii) of this subsection, this subsection does not apply to:

(i) a nursing home as defined in § 19–1401 of the Health – General Article; or

(ii) an assisted living facility as defined in § 19–1801 of the Health – General Article.

(c) If the official custodian has adopted rules or regulations that define sociological information for purposes of this subsection, a custodian shall deny inspection of the part of a public record that contains sociological information, in accordance with the rules or regulations.

(d) A custodian shall deny inspection of the part of a public record that contains any of the following information provided by or obtained from any person or governmental unit:

(1) a trade secret;

(2) confidential commercial information;

(3) confidential financial information; or

(4) confidential geological or geophysical information.

(e) Subject to § 21-504 of the State Personnel and Pensions Article, a custodian shall deny inspection of the part of a public record that contains the home address or telephone number of an employee of a unit or instrumentality of the State or of a political subdivision unless:

(1) the employee gives permission for the inspection; or

(2) the unit or instrumentality that employs the individual determines that inspection is needed to protect the public interest.

(f) (1) This subsection does not apply to the salary of a public employee.

(2) Subject to paragraph (3) of this subsection, a custodian shall deny inspection of the part of a public record that contains information about the finances of an individual, including assets, income, liabilities, net worth, bank balances, financial history or activities, or creditworthiness.

(3) A custodian shall permit inspection by the person in interest.

(g) A custodian shall deny inspection of the part of a public record that contains information about the security of an information system.

(h) (1) Subject to paragraphs (2) through (4) of this subsection, a custodian shall deny inspection of the part of a public record that contains information about the licensing of an individual in an occupation or profession.

(2) A custodian shall permit inspection of the part of a public record that gives:

(i) the name of the licensee;

(ii) the business address of the licensee or, if the business address is not available, the home address of the licensee after the custodian redacts all information, if any, that identifies the location as the home address of an individual with a disability as defined in subsection (b) of this section;

(iii) the business telephone number of the licensee;

(iv) the educational and occupational background of the licensee;

(v) the professional qualifications of the licensee;

(vi) any orders and findings that result from formal disciplinary actions; and

(vii) any evidence that has been provided to the custodian to meet the requirements of a statute as to financial responsibility.

(3) A custodian may permit inspection of other information about a licensee if:

(i) the custodian finds a compelling public purpose; and

(ii) the rules or regulations of the official custodian permit the inspection.

(4) Except as otherwise provided by this subsection or other law, a custodian shall permit inspection by the person in interest.

(5) A custodian who sells lists of licensees shall omit from the lists the name of any licensee, on written request of the licensee.

(i) A custodian shall deny inspection of the part of a public record that contains information, generated by the bid analysis management system, concerning an investigation based on a transportation contractor's suspected collusive or anticompetitive activity submitted to the Department by:

(1) the United States Department of Transportation; or

(2) another state.

(j) (1) Subject to paragraphs (2) through (5) of this subsection, a custodian shall deny inspection of the part of a public record that contains information about the application and commission of a person as a notary public.

(2) A custodian shall permit inspection of the part of a public record that gives:

(i) the name of the notary public;

(ii) the home address of the notary public;

(iii) the home and business telephone numbers of the notary public;

(iv) the issue and expiration dates of the notary public's commission;

(v) the date the person took the oath of office as a notary public; or

(vi) the signature of the notary public.

(3) A custodian may permit inspection of other information about a notary public if the custodian finds a compelling public purpose.

(4) A custodian may deny inspection of a record by a notary public or any other person in interest only to the extent that the inspection could:

(i) interfere with a valid and proper law enforcement proceeding;

(ii) deprive another person of a right to a fair trial or an impartial adjudication;

(iii) constitute an unwarranted invasion of personal privacy;

(iv) disclose the identity of a confidential source;

(v) disclose an investigative technique or procedure;

(vi) prejudice an investigation; or

(vii) endanger the life or physical safety of an individual.

(5) A custodian who sells lists of notaries public shall omit from the lists the name of any notary public, on written request of the notary public.

(k) (1) Except as provided in paragraph (2) of this subsection, a custodian shall deny inspection of the part of an application for a marriage license under § 2-402 of the Family Law Article or a recreational license under Title 4 of the Natural Resources Article that contains a Social Security number.

(2) A custodian shall permit inspection of the part of an application described in paragraph (1) of this subsection that contains a Social Security number to:

(i) a person in interest; or

(ii) on request, the State Child Support Enforcement Administration.

(l) (1) Except as provided in paragraph (2) of this subsection, a custodian shall deny inspection of the part of a public record that identifies or contains personal information about a person, including a commercial entity, that maintains an alarm or security system.

(2) A custodian shall permit inspection by:

(i) the person in interest;

(ii) an alarm or security system company if the company can document that it currently provides alarm or security services to the person in interest;

(iii) law enforcement personnel; and

(iv) emergency services personnel, including:

1. a career firefighter;

2. an emergency medical services provider, as defined in § 13-516 of the Education Article;

3. a rescue squad employee; and

4. a volunteer firefighter, rescue squad member, or advanced life support unit member.

Maryland Insurance Administration

Grants to States for Health Insurance Premium Review-Cycle I

CFDA: 93.511

Appendix 5: Office of the Chief Actuary

The Office of the Chief Actuary has the following positions and staff:

Dennis Yu, Chief Actuary, ASA, MAAA (Resume below)

Joe Lam, Actuary, ASA, MAAA

Robert Katz, Actuarial Assistant

Craig Prem, Actuarial Assistant

Vacant, Actuarial Assistant

Nancy Muehlberger, Administrative Assistant

The FY 2011 budget for the Office of the Actuary is:

Salaries (6 FTE)	$485,889
Fringe benefits	157,866
Communication	6,152
Travel and training	3,000
Contractual services	25,782
Supplies	7,168
Equipment	-0-
Rent and utilities	34,164
Total	**$720,021**

No monies from this grant will be used to support the budget of the Office of the Actuary.

Dennis Yu, ASA, MAAA

Office of the Actuary, Maryland Insurance Administration

200 St. Paul Place, Suite 2700, Baltimore, MD 21202

(410) 468-2041 or dyu@mdinsurance.state.md.us

Summary: Nineteen years of actuarial and financial experience in the insurance industry. Background includes individual life reinsurance, individual health pricing (disability income and long term care), state compliance support, rating system development, group health case rating, in force experience analysis, and cash flow testing.

Work Experience

2007 – Present **Assistant Actuary, OM Financial Life Insurance Company, Baltimore, MD**

Assist management of relationships with both external and internal reinsurance companies. Negotiate treaty terms with reinsurers. Support capital management efforts by securing reinsurance for in force blocks of life insurance. Provide technical actuarial support for valuation of affiliated Irish reinsurer. Execute amendments to existing treaties as necessary for product revisions. Provide ongoing technical support to Reinsurance Administration, as well as other areas as related to reinsurance arrangements.

2001 - 2007 **Assistant Actuary, Munich American Reassurance Company, Atlanta, GA**

Evaluated and priced new business reinsurance prospects and provided support to maintain existing client relationships. Negotiated treaty terms and provisions with ceding companies. Performed competitive comparisons of ceding company product features. Supported business projections for line of business. Gave presentations at industry and client conferences.

1998-2001 **Actuarial Associate, Hartford Life Insurance Company, Simsbury, CT**

Provided assistance for Long Term Care insurance pricing. Provided actuarial support for state compliance efforts. Implemented small group rating system. Produced exhibits for group policyholder reporting. Provided technical support for reinsurance negotiations. Supported public employee defined contribution retirement plan pricing.

1996 - 1998 **Group Underwriter, MedSpan Health Options, Hartford, CT**

Performed case level rating for new business prospects as well as existing clients. Facilitated stop loss reinsurance for self-funded clients. Performed annual state rate filings. Assisted development of rate quotation system. Assisted in preparation of the Medicare Risk Adjusted Community Rating submission to CMS.

1995 - 1996 **Group Underwriter, MD HealthPlan, North Haven, CT**

Performed case level rating for new business prospects as well as existing clients. Produced renewal packages for renewing groups, which included experience exhibits that supported rate actions.

1990 - 1995 **Actuarial Analyst, Travelers Insurance Company / MetraHealth, Hartford, CT**

Experience-rated retroactively rated cases and reported financial results for Traveler's third party administrator. Calculated case level reserves. Supported financial planning and assisted in cash flow testing for group health products.

1988 - 1990 **Actuarial Analyst, Equitable Life Assurance Society of the US, New York, NY**

Assisted asset/liability analysis of traditional life and annuity products. Assisted in the study of the impact of AIDS on insured mortality.

Education Columbia University, BA, Applied Mathematics, 1989

Associate of the Society of Actuaries

Member of the American Academy of Actuaries

Maryland Insurance Administration

Grants to States for Health Insurance Premium Review-Cycle I

CFDA: 93.511

Appendix 6: Project Management

Project Manager: Dennis Yu, Chief Actuary

As Chief Actuary, Mr. Yu is responsible for the day to day activities of the Office of the Actuary. (See Appendix 5 for a complete list of staff, the FY 2011 budget and Mr. Yu's resume.)

None of the money from this grant will be used to support the Office of the Actuary's budget. Rather, the money will be used to retain a consultant to provide recommendations on how to:

1. Implement a more detailed rate review process for the State's largest carriers;
2. Provide information to consumers and public policymakers about changes in rates in the individual and small group market segments over time and the key drivers for these changes; and
3. Improve the data collection and tracking capability to report information required to HHS.

Mr. Yu will be responsible for drafting the Request for Proposal (RFP), evaluating proposals, and coordinating the work of the successful Offeror. This work will be in addition to his normal duties.

Mr. Yu will receive assistance from Luci Sager, Procurement Officer, in the issuance of the RFP and the award and from Charles Spannare, Fiscal Officer, in the management and disbursement of grant funds.

Assistant Director Job Description:

This senior position handles life and health actuarial responsibilities for the MIA with primary focus on health insurance rate filings from non-profits, health maintenance organizations and insurance carriers.

Chief Actuary Job Description-Project Director:

To direct all operations of the Office of Chief Actuary within the Maryland Insurance Administration. The Office of the Chief Actuary has responsibility to evaluate rate filings for health insurance – especially individual and small group, to provide actuarial resources and advice to the Commissioner and agency staff on various insurance industry issues, and to complete actuarial functions related to life company valuations and financial examinations.

Maryland Insurance Administration
Project Narrative:
Grants to States for Health Insurance Premium Review-Cycle I
CFDA: 93.511
Budget Narrative

Estimate budget total: $1 million

Current state funding for health insurance rate review: $720,021[1]

Total estimated funding requirements: Contractual costs

1. Consultant services to recommend a more detailed rate review process for the State's largest carriers and provide information to consumers and public policymakers about changes in rates in the individual and small group market segments over time and the key drivers for these changes: $981,000
2. Payment to defer costs to improve SERFF: $19,000

[1] This is the total budget for FY 2011 for the Office of the Actuary. The Office of the Actuary is responsible for the review of other types of life and health insurance. No estimate has been made for the costs attributable just to the review of rate and rate increase requests for health benefit plans.

09ATTACHMENT C

APPLICATION COVER SHEET AND CHECK-OFF LIST

Indentifying Information:

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

DUNS #: 090603619 Grant Award: $1 million

Applicant: Maryland Insurance Administration

Primary Contact Person, Name: Lynn R. Lederman

Telephone Number: 410-468-2203 Fax number: 410-468-2204

Email address: llederman@mdinsurance.state.md.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:

X Cover Sheet – See Mandatory Attachments Form 1

X Forms/Mandatory Documents (Grants.gov).

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

X SF-424: Application for Federal Assistance

X SF-424A: Budget Information

X SF-424B: Assurances-Non-Construction Programs

X SF-LLL: Disclosure of Lobbying Activities

X Additional Assurance Certifications

X Required Letter of support and Memorandum of Agreement – See Mandatory Attachments Form 2

X Applicant's Application Cover Letter – See Mandatory Attachments Form 3

X Project Abstract

X Project Narrative

X Work plan and Time Line

X Proposed Budget (Narrative/Justifications)

X Required Appendices – See Mandatory Attachments Forms

X Resume/Job Description for Project Director and Assistant Director – See Mandatory Attachments Forms 8 - 13

Maryland Insurance Administration

Project Narrative:

Grants to States for Health Insurance Premium Review-Cycle I

CFDA: 93.511

a) Current health insurance rate review capacity and process

1. General health insurance rate regulation information

No insurer, health maintenance organization ("HMO") or nonprofit health service plan (collectively "carriers") may offer health insurance in Maryland unless the policy form and rate have been approved by the Insurance Commissioner ("Commissioner").[1]

Products sold in the individual and small group[2] market segments must meet certain minimum medical loss ratios ("MLR"): 60 percent in the individual market and 75 percent in the small group market.[3] Each rate for each product in these markets is required to meet these minimum MLR amounts.

In addition, a carrier must submit data to the Maryland Insurance Administration's ("MIA") Office of the Actuary ("OA") to demonstrate its overall MLR for the previous calendar year for each market segment. If a carrier does not meet the minimum MLR for each market segment over a three year period, the Commissioner may order the carrier to reduce its rates.

Maryland law requires carriers to use adjusted community rating when determining a premium for an employer in the small group market. Adjustments may be made to the

[1] Although "health insurance" has a broader meaning under Maryland law, as used here it applies only to health benefit plans issued or delivered in the State to individuals or groups.
[2] The small group market is comprised of employers with two to 50 eligible employees.
[3] Under Maryland law the MLR is calculated by dividing the total amount of incurred claims by the total amount of earned premium. No allowance is made for quality of care improvement activities or premium tax payments.

community rate for age, geographic location, and family tier as long as collectively these adjustments do not result in a premium that is more than 50 percent above or 50 percent below the community rate.[4] There are some exceptions to this general rule. A carrier may:

- Reduce the premium by the value of an administrative discount provided to a small employer that purchases other insurance (e.g., vision, dental, disability, long-term care insurance) from the carrier;
- Provide a further adjustment to the community rate for a small employer who has not offered a health benefit plan to its employees in the last twelve months based on the health status of the employees;[5] or
- Discount the premium by up to 20 percent if the small employer participates in a wellness program.

Each year (no later than March 15th) a carrier must file an actuarial certification with the Commissioner that the carrier is in compliance with these small group market rating rules.

In the individual and large group market segments, adjusted community rating and experience rating are both permissible. Typically, in the individual market segment carriers adjust a product's community rate for age and family tier. In the large group market segment, carriers may use a combination of adjusted community rating or group-specific experience rating to determine premium rates for an employer.[6]

[4] The permissible deviation of +/- 50 percent from the community rate takes effect July 1, 2010; prior to that date the permissible deviation was +40 percent and -50 percent.
[5] The additional adjustment may be up to 10 percent above or below the community rate the first year, five percent the second year, and two percent the third year.
[6] Large employers are defined as those with 51 or more eligible employees.

2. Health insurance rate review and filing requirements

How long a time the Commissioner has to review a proposed rate or rate increase, the permissible reasons for disapproving a rate, and the factors the Commissioner may consider in making a determination vary by type of carrier.

Life insurers and health insurers must file proposed rates for a new policy form at least 60 days before delivery. The Commissioner may extend the initial filing period for an additional 30 days. See *Ins.* §12-203 (c) Rate changes must be filed at least 90 days before the date of the proposed rate change. See COMAR 31.10.01.02 A.

For HMOs, the Commissioner has 60 days to review a proposed rate or a proposed rate change. If the Commissioner fails to either approve or disapprove the filing within 60 days, the proposed rate or proposed rate change is deemed approved. See *Health General* §19-713 and COMAR 31.12.02.08 A.

Similarly, for nonprofit health service plans the Commissioner has 60 days to review a proposed rate or a proposed rate change. If the Commissioner requests additional information, the 60 day period begins again from the date the additional information is provided. Before the Commissioner may disapprove a rate, the Commissioner must hold a hearing. See *Ins.* §14-126

All carriers may submit a rate filing through the System for Electronic Rate and Form Filing ("SERFF"). Although carriers are not required to follow a specific format when

making a rate filing, all carriers are required to submit certain information to allow for a substantive review by the MIA's OA.[7] Each rate filing includes:

- An Actuarial Memorandum which describes the assumptions and methods used in support of the rate change and that conforms to the requirements of Actuarial Standard of Practice #8, "Regulatory Filings for Health Plan Entities;"[8] and
- Experience data to support and justify any increases to the premium rates documenting historical claims experience that shows actual loss ratio performance, as well as data that supports claim trend analysis and projection.

Filings for a proposed rate increase provide a projection of claims and premium revenue for a future rating period. To project claims during the rating period, the carrier uses data regarding overall health care expenditures for a historical period with a trend assumption applied to a future rating period. The trend assumption is derived from the historical experience data. This analysis is performed at an aggregate level, so it reflects the utilization rates of the carrier's insured population, the unit costs per claim, and benefit plan features. In projecting future trends, the carrier uses the historical experience adjusting for changes in anticipated demand, market changes, and regulatory changes.

Thus, the OA considers any proposed rate changes based on the relationship between anticipated future claims and projected rates. For the individual and small group market

[7] The OA has two full-time Life and Health actuaries and three actuarial assistants. It reviews all proposed rates and rate increases for the small group market segments and all proposed rate increases in the individual and large group market segments. In addition, the OA reviews all proposed rates and rate increases for the subsidiaries of CareFirst, Inc. ("CareFirst") in all market segments. Proposed rates for new products in the individual and large group market segments for any other carrier except those affiliated with CareFirst are reviewed by the Life and Health Division.

[8] The carrier's pricing actuary has a professional obligation to set rates at a level that will cover projected medical claims, expected expenses, and provisions for profit, while simultaneously complying with State and federal law.

segments, any proposed rate change that will not result in the minimum statutory MLR is considered excessive or unreasonable.

As part of the review process, the OA frequently corresponds with carriers. The correspondence includes requests for additional information (including why the filing complies with Maryland law), further clarification, and validation of assumptions. As part of these discussions, the OA may indicate that certain portions of the rate filing may not be approved. It is not unusual for carriers to revise their rate filing as a result of these discussions.[9]

The permissible reasons for the Commissioner to disapprove a rate increase vary by carrier type. The Commissioner may disapprove a rate increase for:

- Life insurers and health insurers if the benefits are unreasonable in relationship to the premium charged;
- HMOs if the rate is excessive, inadequate, or unfairly discriminatory; or
- Nonprofit health service plans if the rate appears to be excessive.

The Commissioner may consider a wide range of factors to assess if a rate increase proposed by a nonprofit health service plan is excessive. The factors include loss experience, underwriting practice and judgment, reserves, expenses and *any other relevant factor*.

3. Current level of resources and capacity: Information Technology (IT)

Carriers may submit rate filings electronically through SERFF. No other provisions are made for the electronic submission of filings.

4. Current level of resources and capacity: Budget and Staffing

[9] This is especially true for carriers with large in force blocks, where the MIA will have the carrier modify assumptions for a portion of the filing, and the carrier will accordingly revise their rate filing.

The OA has six full-time staff members. The overall budget for the OA for FY 2011 is $720,021. The positions and credentials and budget details are shown in Appendix 5.

5. Consumer protections

Under the Maryland Public Information Act, Title 10, Subtitle 6 of the State Government Article, Annotated Code of Maryland ("PIA"), a state agency is required to deny inspection of records that contain trade secrets, confidential commercial information, confidential financial information, or confidential geological or geophysical information. See *State Government* § 10-617(d). This general rule applies unless otherwise provided by a more specific state statute. See *State Government* § 10-617(a).

It has long been the position of the MIA that no state statute specifically addresses the disclosure of rate filings for health insurance.[10] In the absence of specific authority to make the rate filing information open to the public, the general prohibition against disclosure of confidential business information applies. As a result, the MIA does not make that portion of rate filings that contain confidential information public. Those portions of rate filings that do not contain confidential business information are made available to the public.

No hearing is required before the Insurance Commissioner makes a rate determination for insurers and HMOs. If the Insurance Commissioner finds that a rate

[10] Although rate filings under Title 11, Subtitle 3 of the Insurance Article, which relates to competitive rating, are open to public inspection as soon as filed (See *Ins.* § 11-307(a)), the subtitle specifically does not apply to health insurance. See *Ins.* § 11-303(a)(3); *see also* § 11-202(a)(2). Similarly, the statutes relating to the review of rates for health maintenance organizations and non-profit health service plans do not require the disclosure of the information submitted to the Commissioner. See *Ins.* § 14-126 and *Health-General* § 19-713.

filing for an insurer or HMO does not meet the statutory requirements, the insurer or HMO must cure the deficiency and may not use the rate until the Insurance Commissioner has granted approval.

If the Insurance Commissioner intends to disapprove a rate for a nonprofit health service plan (e.g., the BlueCross/BlueShield plans), the Commissioner must first hold a hearing before issuing the order disapproving the rate. See *Ins.* §14-126 (d) If the Insurance Commissioner disapproves a rate for a nonprofit health service plan, the nonprofit health service plan may appeal the decision in court. See *Ins.* §14-127

From time to time, consumers will contact the MIA with concerns about their health insurance premium. These are most common in the individual and small group market segments.

Consumers typically are surprised by the annual increase in their premium and want to know why their premium increased. For the most part, consumers are unaware of the impact age has in the individual and small group market segments on the annual premium. A jump from one age group (e.g., under 40) to another (e.g., over 40) can result in premium increases of over 30 percent even when the overall premium increase for the benefit plan is below 15 percent.

6. Examination and Oversight

As stated previously, the MIA reviews rates prospectively in the individual and small group market. Annually, the MIA reviews data submitted by each carrier to ensure each carrier is in compliance with the applicable minimum MLR for the respective market segment (e.g., individual or small group).

Overall, premium rate increases in the individual and small group markets ranged from about seven percent to 13 percent in each of the last two years. There is a notable exception to this pattern. The nonprofit health service plans affiliated with CareFirst (BlueCross/BlueShield plans)– CareFirst of Maryland, Inc. ("CFMI") and Group Hospitalization and Medical Services, Inc. ("GHMSI") – and the HMO CareFirst BlueChoice ("BlueChoice") provided actuarial justification for premium increases well above 30 percent for their high deductible health benefit plans sold in the individual and small group market segments to complement health savings accounts or health reimbursement accounts.

Because the higher than expected rate increase for high deductible plans was primarily attributable to erroneous assumptions made by management regarding health care trends for high deductible health benefit plans versus traditional health benefit plans at the time these health benefit plans were developed, the Commissioner determined that a return to adequate rates for these health benefit plans had to be phased in over time and thus capped the overall annual rate increase at 24 percent.

Collectively, CFMI, GHMSI and CareFirst BlueChoice write about 60 percent of all the health insurance subject to State regulation. Their market share is particularly pronounced in the individual market (over 90 percent) and the small group market (over 75 percent) segments.[11] The significant premium increase for these carriers' high deductible plans was keenly felt in the individual market where nearly one-third of the subscribers had enrolled in a high deductible plan and in the small group market where about 50 percent of all small employer groups offered high deductible plans to their

[11] About 160,000 individuals purchase health benefits in Maryland's regulated individual market; about 410,000 in the small group market. The individual market also includes group association plans that are subject to another State's oversight.

employees. Even with an annual rate increase cap of 24 percent, individuals and small groups moving from one age bracket to another received premium increases close to 50 percent. Despite these increases, the high deductible health benefit plans remain the lowest priced plans in the market and enrollment continues to increase, prolonging the time period needed to restore these plans to adequate rates.

b) Proposed rate review enhancements for health insurance

As noted previously, the MIA's OA requires a carrier to provide a detailed breakdown of the factors driving observed and expected claims trends (e.g., unit costs vs. utilization). The OA is already taking steps to more closely scrutinize trend assumption for hospital services submitted by carriers, but particularly CFMI, GHMSI and BlueChoice. The MIA has focused its attention on the carriers affiliated with CareFirst for two reasons: (1) these carriers dominate the market; and (2) the Commissioner has the most explicit authority to consider a wide range of factors in determining whether a proposed rate increase is reasonable.

Last year, the MIA reviewed the surplus levels of CFMI and GHMSI. Through this process, the MIA concluded the contribution to surplus in the rate filing for CFMI or GHMSI should vary based on whether each held surplus in an amount within the targeted surplus range. CFMI has included a higher factor for contribution to surplus than GHMSI because it holds surplus in an amount less than the targeted surplus range.

The MIA and the Health Services Cost Review Commission ("HSCRC")[12] have entered into a Memorandum of Understanding to assess the feasibility and desirability of

[12] The HSCRC establishes payment levels for regulated inpatient and outpatient hospital services, which apply to all carriers. The HSCRC also approves year-to-year increases in hospital average Charge per Case (CPC) for inpatient services and Charge per Visit (CPV) for outpatient services. Additionally, the HSCRC collects detailed data on hospital utilization and volumes. Hospital expenditures account for between 35-40

more coordination between the HSCRC and the MIA in reviewing a rate filing submitted by CFMI, GHMSI or BlueChoice and determining whether the requested increase is reasonable. The HSCRC has engaged the University of Maryland Baltimore County HillTop Institute to provide this assessment and make recommendations to the MIA and the HSCRC.

Other enhancements may be made to the review process for proposed rate increases from CFMI, GHMSI and BlueChoice. The Maryland Health Care Commission ("MHCC") collects non-hospital claims information from all carriers in the State. It is possible this data may be used to develop statewide trends for non-hospital services such as physician services, prescription drugs, laboratory services and radiology services that the MIA could use to assess the appropriateness of the trend assumptions used by CFMI, GHMSI and BlueChoice in these areas. But to do so, CFMI, GHMSI and BlueChoice must submit more detailed information with a request for a rate increase.

Carriers are required to give policyholders 40 to 45 days notice of a change in premium. No policyholder can tell from this renewal notice if, or to what extent, the premium change is a result of an approved rate increase, benefit changes or a change in the policyholder's age or the average age of the policyholder's group. While the MIA does disclose information about overall premium volume, loss ratio and complaints for the largest carriers, it does not disclose to consumers information about rate increase requests and the key drivers for these requests or the MIA's action.

Thus, the MIA proposes to use the monies available through this grant to accomplish three enhancements:

---

percent of all private health expenditures and, thus, may constitute a significant driver of the premium costs and premium rate increase requests of carriers in the State.

1. **Implement a more detailed rate review process for the State's largest carriers.**
2. **Provide information to consumers and public policymakers about changes in rates in the individual and small group market segments over time and the key drivers for these changes.**
3. **Improve the data collection and tracking capability to report the information required to the Department of Health and Human Services ("HHS") as a condition of receipt of this grant.**

To implement these enhancements, the MIA proposes to use federal grant funds for the following activities:

1. *Within 30 days of receipt of the award of the federal grant, issue a Request for Proposal ("RFP") for consultant services to recommend: (a) the data elements needed for a more detailed rate review process for CFMI, GHMSI and CareFirst BlueChoice; (b) if these are the same data elements needed to disclose the key drivers for rate changes in the individual and small group market segments and thus should be required with all filings requesting a rate increase in these market segments; (c) whether information from the HSCRC and MHCC should be used in the rate review process, the public disclosure process, or both; (d) how the OA should incorporate more detailed information in its review of a proposed rate increase filing, including whether additional staff is needed; (e) the policies and*

procedures the MIA should implement to carry out a more detailed rate review process and provide more relevant information to consumers and to policymakers; and (f) how best to provide and present information to consumers and to policymakers about rate increases and the key drivers for these increases.

The small actuarial staff working on rate reviews at MIA does not have adequate time or expertise to produce the research, planning, and proposed implementation strategies that would be possible with this additional, one-time grant. In a very difficult budgetary climate, it has not been possible to secure additional funding that would pay for a consultant to adequately address the issues that we believe will improve the ratemaking process going forward. As described in our application, the ability to secure the necessary consulting services on these issues will allow us to better prioritize our staff resources in the future, increasing the ability to deliver the promised benefits of the health care reform legislation to our constituents.

It is the MIA's experience that it takes about six months from the issuance of an RFP to the actual award of the RFP. Thus, the MIA anticipates having a consultant engaged by January 2011 with a requirement for the consultant to report its findings and recommendations by July 2011. The MIA estimates such services would cost about $981,000.

2. *Support the improvement of SERFF to facilitate the electronic submission of the data elements required to be reported to HHS for each carrier's proposed rate increase.*

Through SERFF, the MIA will be able to electronically obtain and report the following information for each carrier's proposed rate increase:

- Company name and contact information
- Number of policy forms covered by the filing
- Policy form number(s) covered by the filing
- Product types
- Market segment
- Type of insurer
- Whether the products are opened or closed
- Enrollment in each policy and rating form
- Member months in each policy form
- Annual rate
- Total earned premiums in each policy form
- Total incurred claims in each policy form
- Average rate increase initially requested
- Rate review category
- Average rate increase approved
- Effective date of rate increase
- Number of policyholders or members affected by each policy form
- Overall annual medical trend factor assumptions in each rate filing for *all benefits* and disaggregated by *benefit category*
- Annual medical trends, percentage attributable to use of services, price inflation, fees and risk
- Any changes in member cost-sharing over the prior year associated with the submitted rate filing

- Any changes in member benefits over the prior year associated with the submitted rate filing

This information will be used to report the following aggregate information to HHS:

- Plan year
- Segment type
- Product type
- Number of policyholders
- Number of covered lives affected
- Report on average rate increase by plan year, segment type, and product type

The MIA estimates its contribution to SERFF would be about $19,000.

MARTIN O'MALLEY
Governor

ANTHONY G. BROWN
Lt. Governor

BETH SAMMIS, Ph.D.
Acting Commissioner

KAREN STAKEM HORNIG
Deputy Commissioner

MARYLAND
INSURANCE
ADMINISTRATION

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
Direct Dial: 410-468-2090 Fax: 410-468-2020
Email: bsammis@mdinsurance.state.md.us
1-800-492-6116 TTY: 1-800-735-2258
www.mdinsurance.state.md.us

June 23, 2010

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

Dear Secretary Sebelius:

The Maryland Insurance Administration ("MIA") is pleased to submit this application for "Grants to States for Health Insurance Premium Review – Cycle 1" (CFDA: 93.511). Our current rate review process ensures Maryland consumers pay a fair and reasonable price for their health insurance and we are proud of our strong foundation.

But we can improve our oversight of health insurance rates through a more thorough review of the specific components of the overall trend assumptions used by the largest carriers to develop rates in the individual and small group market segments, by developing a system for tracking changes in rates in the individual and small group market by carrier over time, and by providing information to consumers about rate changes.

The Project Director for this grant is Dennis Yu, Associate Commissioner, Office of the Actuary. He will be responsible for drafting a Request for Proposal to retain a consultant to provide us with recommendations on how best to implement these three improvements. Mr. Yu may be reached by telephone at 410-468-2041 or by e-mail at dyu@mdinsurance.state.md.us.

I am deeply committed to strengthening the MIA's capacity to review and disclose health insurance rates as this will be a key component to Maryland's successful implementation of comprehensive health care reform. Thank you for the opportunity to partner with the federal government to improve states' regulation of health insurance.

Sincerely,

Elizabeth Sammis

Elizabeth Sammis, Ph.D.
Acting Insurance Commissioner

STATE OF MARYLAND
OFFICE OF THE GOVERNOR

MARTIN O'MALLEY
GOVERNOR

STATE HOUSE
100 STATE CIRCLE
ANNAPOLIS, MARYLAND 21401
(410) 974-3901
(TOLL FREE) 1-800-811-8336

June 21, 2010

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

Dear Secretary Sebelius:

Maryland is committed to working closely with your Department to ensure the successful implementation of comprehensive health reform, including increasing the transparency of the insurance system by providing stronger oversight of health insurance companies.

Maryland already requires the prior approval of insurance policy forms and rates and the proposal for funding assistance through the "Grants to States for Health Insurance Premium Review" will allow us to provide an additional level of review on subsequent requests for rate increases beyond the capability of our current actuarial staff.

This grant will allow for a more sophisticated review of rates by specific industry segment that also will provide better data to collectively assess how best to improve the affordability of health insurance both in Maryland and across the country. The grant proposal submitted by the Maryland Insurance Administration (MIA) includes details on how we will improve the rate review process and develop a system to track rate requests over time that provide more options for industry specific analysis than we currently provide.

The MIA has my full support in these specific endeavors as detailed in the grant application. Working together we can build on our strengths and successfully implement comprehensive health reform. If you have any questions, please direct them to Beth Sammis, Acting Maryland Insurance Commissioner at 410-468-2002 or BSammis@mdinsurance.state.md.us.

Sincerely,

Martin O'Malley

C: Beth Sammis, Acting Maryland Insurance Commissioner

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:** CFDA 93.511

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:
07/02/2010	

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:	Maryland Insurance Administration
* b. Employer/Taxpayer Identification Number (EIN/TIN):	1-526002033
* c. Organizational DUNS:	0906036190000

d. Address:

* Street1:	200 St. Paul Place
Street2:	Suite 2700
* City:	Baltimore
County/Parish:	
* State:	MD: Maryland
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	21202-2272

e. Organizational Unit:

Department Name:	Division Name:
Office of the Chief Actuary	

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

Prefix:	Ms.	* First Name:	Lynn
Middle Name:	R.		
* Last Name:	Lederman		
Suffix:			

Title:	Executive Assistant
Organizational Affiliation:	N/A
* Telephone Number:	410-468-2203
Fax Number:	410-468-2204
* Email:	llederman@mdinsurance.state.md.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: MD-007 | b. Program/Project: MD-all

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

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

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

18. Estimated Funding ($):

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

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

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

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

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

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

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

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

☒ ** I AGREE

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

Authorized Representative:

Prefix: Ms. | * First Name: Lynn

Middle Name: R.

* Last Name: Lederman

Suffix:

* Title: Executive Assistant

* Telephone Number: 410-468-2203 | Fax Number: 410-468-2204

* Email: llederman@mdinsurance.state.md.us

* Signature of Authorized Representative: Lynn Lederman | * Date Signed: 07/02/2010

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

Key Contacts Form

*** Applicant Organization Name:**

Maryland Insurance Administration

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

*** Contact 1 Project Role:** Fiscal Contact

Prefix:	Mr.
* First Name:	Charles
Middle Name:	I.
* Last Name:	Spannare
Suffix:	
Title:	Fiscal Administrator

Organizational Affiliation:

Maryland Insurance Administration

* Street1:	200 St. Paul Place
Street2:	Suite 2700
* City:	Baltimore
County:	
* State:	MD: Maryland
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	21202-2272
* Telephone Number:	410-468-2372
Fax:	410-468-2396
* Email:	cspannare@mdinsurance.state.md.us

Delete Entry | Previous Person | Next Person

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

Key Contacts Form

*** Applicant Organization Name:**

Maryland Insurance Administration

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

*** Contact 2 Project Role:** Authorized Organization Representative - AOR

Prefix:	Ms.
* First Name:	Lynn
Middle Name:	R.
* Last Name:	Lederman
Suffix:	
Title:	Executive Assistant

Organizational Affiliation:

Maryland Insurance Administration

* Street1:	200 St. Paul Place
Street2:	Suite 2700
* City:	Baltimore
County:	
* State:	MD: Maryland
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	21202-2272
* Telephone Number:	410-468-2203
Fax:	410-468-2204
* Email:	llederman@mdinsurance.state.md.us

Delete Entry | Previous Person | Next Person

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

Key Contacts Form

*** Applicant Organization Name:**

Maryland Insurance Administration

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

*** Contact 3 Project Role:** Project Director

Prefix:	Mr.
* First Name:	Dennis
Middle Name:	
* Last Name:	Yu
Suffix:	
Title:	Chief Actuary

Organizational Affiliation:

Maryland Insurance Administration

* Street1:	200 St. Paul Place
Street2:	Suite 2700
* City:	Baltimore
County:	
* State:	MD: Maryland
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	21202-2272
* Telephone Number:	410-468-2041
Fax:	410-468-2038
* Email:	dyu@mdinsurance.state.md.us

Delete Entry | Previous Person | Next Person

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

Key Contacts Form

*** Applicant Organization Name:**

Maryland Insurance Administration

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

*** Contact 4 Project Role:** Project Assistant Director

Prefix: Mr.

* First Name: Joe

Middle Name:

* Last Name: Lam

Suffix:

Title: Actuary

Organizational Affiliation:

Maryland Insurance Administration

* Street1: 200 St. Paul Place

Street2: Suite 2700

* City: Baltimore

County:

* State: MD: Maryland

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 21202-2272

* Telephone Number: 410-468-2040

Fax: 410-468-2038

* Email: jlam@mdinsurance.state.md.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: Maryland Insurance Administration

DUNS Number: 0906036190000

* Street1: 200 St. Paul Place

Street2: Suite 2700

* City: Baltimore County:

* State: MD: Maryland

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 21202-2272 * Project/ Performance Site Congressional District: MD-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: Maryland Insurance Administration

DUNS Number: 0906036190000

* Street1: 200 St. Paul Place

Street2: Suite 2700

* City: Baltimore County:

* State: MD: Maryland

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 21202-2272 * Project/ Performance Site Congressional District: MD-all

Additional Location(s) Add Attachment | Delete Attachment | View Attachment

ATTACHMENTS FORM

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

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

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

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

Objective Work Plan

Project:

Premium Review Grant

* Year: | * Funding Agency Goal:

1 | To provide awards to states to enhance their current rate review process for health insurance premiums.

* Objective:

To implement a more detailed review process for rate filings from the major insurers in Maryland and to provide information to consumers and public policy makers about changes in health insurance premium rates.

* Results or Benefits Expected:

1. Recommendations from consultant on how to enhance the rate review process in Maryland & how to make the rate filing process more transparent to consumers. 2. Enhanced computer capability to capture data elements for reporting to HHS.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Consultants will evaluate six issues regarding premium rate review in Maryland and provide recommendations and update SERFF computer system.	Project Director, Dennis Yu	08/09/2010	09/30/2011	0

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

Objective Work Plan

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

* Criteria for Evaluating Results or Benefits Expected:

The consultant's report on the rate review process will provide specific recommendations for improvement of the rate review process and will include justification of the recommendations. MIA's implementation of the enhancements to the rate review process will be compared to the consultant's recommendations to measure the effectiveness of this grant proposal. The enhancement to the computer system shall provide the ability to capture the data elements that HHS is requiring.

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

Objective Work Plan

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

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

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

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

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

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

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

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

Select to extract the Objective Work Plan Attachment

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

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

Project Abstract

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

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

Add Attachment | Delete Attachment | View Attachment

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:**

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

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

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

Budget Narrative File(s)

* Mandatory Budget Narrative Filename:

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

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

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

BUDGET INFORMATION - Non-Construction Programs

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

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Affordable Care Act (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)
	Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review				
a. Personnel	$	$	$	$	$
b. Fringe Benefits					
c. Travel					
d. Equipment					
e. Supplies					
f. Contractual	1,000,000.00				1,000,000.00
g. Construction					
h. Other					
i. Total Direct Charges (sum of 6a-6h)	1,000,000.00				$ 1,000,000.00
j. Indirect Charges					$
k. TOTALS (sum of 6i and 6j)	$ 1,000,000.00	$	$	$	$ 1,000,000.00
7. Program Income	$	$	$	$	$

SECTION C - NON-FEDERAL RESOURCES

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

SECTION D - FORECASTED CASH NEEDS

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

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:

23. Remarks:

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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
Lynn Lederman	Executive Assistant
* APPLICANT ORGANIZATION	* DATE SUBMITTED
Maryland Insurance Administration	07/02/2010

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:* Maryland Insurance Administration

** Street 1:* 200 St. Paul Place *Street 2:* Suite 2700

** City:* Baltimore *State:* MD: Maryland *Zip:* 21202-2272

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 (HSS)

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:*
$ 1,000,000.00

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:** Lynn Lederman

***Name:** *Prefix:* Ms. ** First Name:* Lynn *Middle Name:* R.

** Last Name:* Lederman *Suffix:*

Title: Executive Assistant **Telephone No.:** 410-468-2203 **Date:** 07/02/2010

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**

Maryland Insurance Administration

*** 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

Maryland Insurance Administration

Project Abstract:

Grants to States for Health Insurance Premium Review-Cycle I

CFDA: 93.511

Goals of Project—There are three goals of the project--to enhance the premium rate review process by implementing a more detailed review process for the State's largest carriers; to provide information to consumers and public policymakers about changes in rates in the individual and small group market segments over time and the key drivers for these changes; and to improve data collection and tracking capability to report the information required to the Department of Health and Human Services.

Total Budget: $1,000,000

Description of How Grant Will Be Used to Enhance Rate Review in Maryland--The grant will be used to secure consultant services to provide recommendations on: (a) the data elements needed for a more detailed rate review of the State's largest insurers; (b) if these same data elements should be included with all rate increase filings in these markets; (c) whether information from other state sources should be used in the rate review process, (d) how the State should incorporate more detailed information in its review of rate increase filings, including whether additional staff is needed; (e) the policies and procedures that should be implemented to carry out a more detailed rate review process and provide more relevant information to consumer and to public policymakers; and (f) how best to provide and present information and consumers and to policymakers about the rates increases and key drivers for these increases. It will also be used to contract with the NAIC to improve the SERFF electronic reporting functions to facilitate the electronic submission of data elements to the Department of Health and Human Services.

Maryland Insurance Administration
Project Narrative:
Grants to States for Health Insurance Premium Review-Cycle I
CFDA: 93.511
Work Plan and Timeline

- **Task 1: Implement a more detailed review process for rate filings from CFMI, GHMSI and BlueChoice and provide information to consumers and public policymakers about changes in rates in the individual and small group market segments over time and the key drivers for these changes.**

Project lead:	Dennis Yu, Associate Commissioner Office of the Actuary
August 2010:	Draft RFP
September 2010:	Issue RFP
October 2010:	Establish RFP review panel
November 2010:	Review RFPs and interview finalists
December 2010:	Select consultant
January 2011:	Present to Board of Public Works for approval
April 2011:	Consultant's final report
May 2011:	Public hearing on consultant's recommendations
July/August 2011:	Finalize and implement rate review changes and improved consumer communication

- **Task 2: Improve the data collection and tracking capability to report the information required to the Department of Health and Human Services ("HHS") as a condition of receipt of this grant.**

Project lead:	Dennis Yu, Associate Commissioner Office of the Actuary
August 2010:	Establish contract with NAIC to implement SERFF changes

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

MD

Dennis Yu, ASA, MAAA

(b)(6)

Telephone: (b)(6)

Email: (b)(6)

Summary: Twenty two years of actuarial and financial experience in the insurance industry. Background includes state regulation, individual life reinsurance, individual health pricing (disability income and long term care), company state compliance support, rating system development, group health case rating, in force experience analysis, and cash flow testing.

Work Experience

2010 – Present **Chief Actuary, Maryland Insurance Administration, Baltimore, MD**

Direct all operations of the Office of Chief Actuary. Oversee the evaluation of rate filings for health insurance. Provide actuarial resources and advice to the Commissioner and agency staff on various insurance industry issues. Oversee actuarial functions related to life company valuations and financial examinations.

2008 – 2009 **Actuary, Maryland Insurance Administration, Baltimore, MD**

Reviewed individual and group health insurance rate filings for compliance with state laws and regulations. Provided actuarial support and advice to various MIA departments.

2007 – 2008 **Assistant Actuary, OM Financial Life Insurance Company, Baltimore, MD**

Assisted management of relationships with both external and internal reinsurance companies. Provided ongoing technical support to Reinsurance Administration, as well as other areas as related to reinsurance arrangements.

2001 - 2007 **Assistant Actuary, Munich American Reassurance Company, Atlanta, GA**

Evaluated and priced new business reinsurance prospects and provided support to maintain existing client relationships. Negotiated treaty terms and provisions with ceding companies. Supported business projections for line of business. Gave presentations at industry and client conferences.

1998 – 2001 **Actuarial Associate, Hartford Life Insurance Company, Simsbury, CT**

Provided assistance for Long Term Care insurance pricing. Provided actuarial support for state compliance efforts. Implemented small group rating system. Provided technical support for reinsurance negotiations. Supported public employee defined contribution retirement plan pricing.

1996 - 1998 **Group Underwriter, MedSpan Health Options, Hartford, CT**

Performed case level rating for new business prospects as well as existing clients. Facilitated stop loss reinsurance for self-funded clients. Performed annual state rate filings. Assisted development of rate quotation system. Assisted in preparation of the Medicare Risk Adjusted Community Rating submission to CMS.

1995 - 1996 **Group Underwriter, MD HealthPlan, North Haven, CT**

Performed case level rating for new business prospects as well as existing clients. Produced renewal packages for renewing groups, which included experience exhibits that supported rate actions.

1990 - 1995 **Actuarial Analyst, Travelers Insurance Company / MetraHealth, Hartford, CT**

Experience-rated retroactively rated cases and reported financial results for Traveler's third party administrator. Calculated case level reserves. Supported financial planning and assisted in cash flow testing for group health products.

1988 - 1990 **Actuarial Analyst, Equitable Life Assurance Society of the US, New York, NY**

Assisted asset/liability analysis of traditional life and annuity products. Assisted in the study of the impact of AIDS on insured mortality.

Education Columbia University, BA, Applied Mathematics, 1989

Associate of the Society of Actuaries

Member of the American Academy of Actuaries

JOE LAM

(b)(6)

(b)(6)

WORK EXPERIENCE:

2009 – Present **AEGON, Baltimore, MD / Cedar Rapids, IA**

Actuary

- Seek reinsurance (internal & external) for surplus relief
- Involve with all aspects of reinsurance from putting together request for proposals to treaty negotiations.

2006 – 2009 **OLD MUTUAL FINANCIAL NETWORK,** Baltimore, MD

Director of Reinsurance

- Seeked reinsurance (internal & external) as needed for surplus relief and risk mitigation
- Involved with all aspects of reinsurance from putting together request for proposals to treaty negotiations.
- Involved with all types of reinsurance from YRT, FDQS, excess, coinsurance, modco, securitization, life, and annuities.
- Maintained relationship with reinsurers
- Assisted reinsurance administration area for complex transactions
- Analyzed block deals to determine if they are appropriate for the company to take on the business

2001 – 2005 **MUNICH AMERICAN REASSURANCE COMPANY,** Chicago, IL

Associate Actuary

- Managed guaranteed minimum death benefit reinsurance including pricing, treaty drafting, quarterly profit reporting, financial projections, working with clients directly, reserving, and hedging strategy
- Priced asset based type of reinsurance including fixed and variable annuities
- Worked with Munich Re's capital management subsidiary to ensure that assets are invested in accordance with the liabilities' characteristics
- Developed a model to measure longevity risk
- Reviewed life pricing models
- Assisted the Chief Investment Officer on an adhoc basis

2000 – 2001 **GE FINANCIAL ASSURANCE,** Schaumburg, IL

Associate Actuary

- Developed new products such as critical illness, accidental death, and simplify issued term life insurance in the mass market and direct response channels
- Responsibilities were pricing, rate filing, and product design

1994 – 2000 **CNA INSURANCE COMPANY,** Chicago, IL

Actuarial Manager

- Managed both individual life reinsurance on inforce blocks and guaranteed minimum death benefit (GMDB) reinsurance
- Performed new business and renewal quotes
- Followed up the quotes by contacting clients directly
- Worked with several departments such as corporate finance, data processing, customer services and sales on both products
- Produced quarterly claims and premiums forecasting reports
- Performed business projections in terms of sales, capital requirements and return on equity
- Updated GMDB pricing system and set up hedging strategy

- Maintained profitability in both products

Senior Actuarial Analyst

- Priced group products such as indemnity medical, PPO, POS, HMO, term life, AD&D, dental, prescription drug, and long term care
- Supported four business units: Health Benefits, Mass Markets (Association Groups), Group Reinsurance, and Special Markets
- Tested for compliance and provided actuarial certification for small group rating reform
- Performed rate and benefit competitive studies
- Developed small group products such as term life and medical
- Analyzed experience and determined renewal premium rates
- Filed rates with state departments of insurance

1991 – 1994 **PAN AMERICAN LIFE INSURANCE COMPANY,** New Orleans, LA

Assistant Actuary

- Modified small group renewal rating system to comply with small group rating reform in 49 states
- Updated area, deductible, trend and duration factors
- Performed compliance and certification for small group rates within the small group rating reform
- Projected unpaid claim liabilities and determined new business rates
- Priced traditional medical, PPO and dental products

1988 – 1991 **METLIFE, Aurora, IL**

Actuarial Assistant

- Projected managed care membership, cost containment expenses, and underwriting gains and losses

- Underwrote major group life and medical insurance

COMPUTER SKILLS: Microsoft Office, AXIS and TAS pricing models

EDUCATION: Illinois State University, Normal, IL

M.S. in Mathematics 1988

University of Illinois, Chicago, IL

B.S. in Mathematics 1986

PROFESSIONAL Associate of the Society of Actuaries (A.S.A.) 1992

AFFILIATIONS: Member of the American Academy of Actuaries (M.A.A.A.) 1994