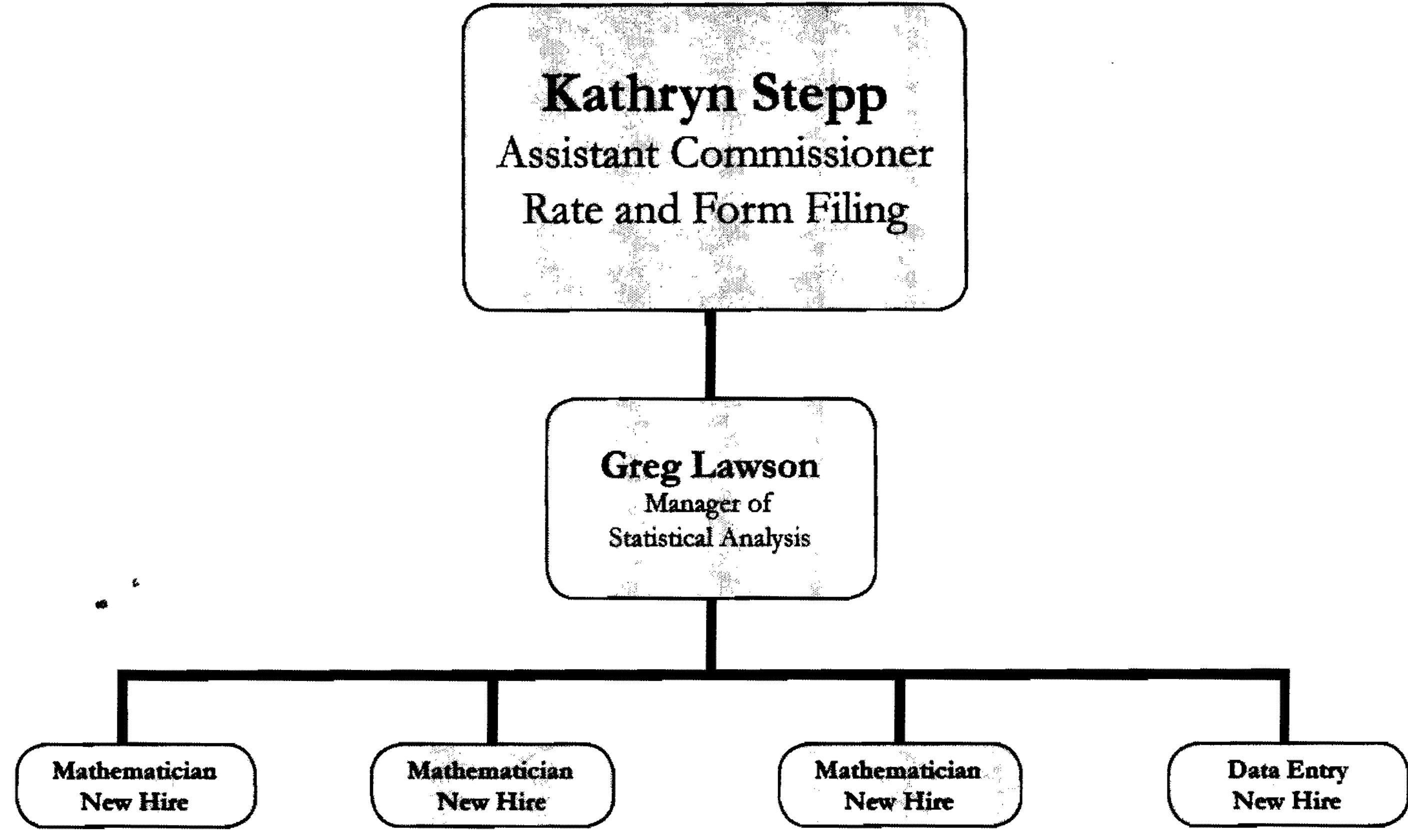
OKLAHOMA



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PREMIUM REVIEW GRANT

PROJECT ABSTRACT

The Oklahoma Insurance Department (OID) has long been concerned about the cost drivers associated with health care. We understand that health insurance premium rates are a reflection of these cost drivers, but have been unable to undertake an in-depth analysis of the problem because of limited statutory authority and resources. The most succinct description of our proposed project is that we intend to end our current process of very limited review of health insurance rates and move toward the collection of extensive data from insurers during every rate filing, initial and renewal, and then use that data to: 1) determine whether the rate increase is appropriate; 2) report as required to the Secretary; 3) enhance transparency in the rate making process in a meaningful, understandable way; and 4) incorporate the data we've gleaned from rate filings with data gleaned from our propose data center activities in order to achieve a better understanding of the relationship between the cost of health care and the cost of health insurance.

The basis of this new extensive review will be 36 O. S. § 3611 B 5, which provides the Department with the authority to disapprove any form found to be unjust, unfair or inequitable to the policyholder. As outlined in the narrative, the Department will issue a bulletin advising insurers that rate filings are required to be submitted for review beginning September 1, 2010. Based on past experience, insurers will adhere to the provisions outlined in the bulletin.

The project proposes a total budget of $1 million to be spent during the first grant cycle, FFY 2010 and FFY 2011. However, if all grant funds are not expended in the first grant cycle, we request the opportunity to either request a cost extension at the end of the project period for Cycle I grants or to carryover grant funds forward to subsequent grant cycles. If grant funds are carried forward to a subsequent grant cycle, we understand that the use of funding must be in compliance with the terms and conditions dictated in the subsequent grant cycle. The grant funds will be used to develop a best process of data collection and review. We intend to contract with knowledgeable third parties to develop the process and to provide training to OID staff. Information technology infrastructure will also be upgraded and improved to support the new rate review and reporting requirements.

PREMIUM REVIEW GRANT

PROJECT NARRATIVE

a) Current health insurance rate review capacity and process

As part of the grant application, states that currently review rate filings must provide a description of their current rate review practices for health insurance, including the information described below (to the extent available). States that do not currently review rate filings must describe their current oversight process over insurers' rating practices or indicate that they do not review rates and provide the reasoning for why they do not review rates.

- General health insurance rate regulation information:
  - Which health insurance products (HMO, PPO etc) are licensed and regulated by the States' DOI or the relevant state agency by market segment (e.g. small group, large group, individual markets, not for profit as applicable).

The Oklahoma Insurance Department (OID) regulates all types of health insurance products, including HMOs, PPOs, as well as major medical, individual and group products. The entities that offer these products must be authorized (licensed) by OID before the entity offers any insurance product within the state. 36 O.S. §§ 606, 6903. Entities licensed to offer insurance products in the state must file and receive approval of their policy forms before those forms are used within the state. 36 O.S. § 3610 provides, in part, that no insurance policy form shall be issued, delivered, or used unless filed with and approved by the Insurance Commissioner. A "policy" is defined, at 36 O.S. § 3602, as a contract of or agreement for effecting insurance, or the certificate thereof, by whatever named called, and includes all clauses, riders, endorsements and papers attached thereto and a part thereof. Although approval of all policy forms is specifically required, rate review and approval authority varies depending on the product line as further discussed below.

  - Rating rules (e.g. adjusted commuting rating, rating bands, and actuarial justification) and case characteristics used (e.g. geographic location and age) for rate regulation by market segment

together with a description of the rating rules in the narrative and including copies of any relevant statutory and regulatory authority as an appendix to the application.

INDIVIDUAL HEALTH INSURANCE: The insurer must file the classification of risks and the premium rates when the form is filed, (36 O.S. § 4402), but rate increases are not required to be filed. Individual health insurance products are not subject to any specific loss ratio requirement . 36 O.S. § 3611 does allow OID to disapprove a form if the form is unjust, unfair, or inequitable to the insured. Two individual products, Medicare supplement and long term care insurance, are required to file for approval both initial rates and rate increases, but those products are outside the scope of this grant opportunity.

SMALL GROUP (2 TO 50 EMPLOYEES) INSURANCE: Rates are subject to review and prior approval. Each small employer insurer is required to file their rate manual for approval prior to use and any change to the rate manual must be filed and approved prior to use. The rate filing must be made no less than 30 days before the insurer intends to implement the rate manual. 36 O.S. § 6515. Section 6515 includes a number of restrictions on an insurer's rate setting. For example, the filing must demonstrate that the form is expected to pay aggregate benefits of at least 60% of the aggregate amount of premiums earned. The index rate for any class of business shall not exceed the index rate for any other class of business by more than 20%. Within a class of business the premiums rates charged to small employers with similar case characteristics for the same or similar coverage may not vary from the index rate by more than 25% of the index rate. Further, the percentage increase for a new rating period may not exceed an amount determined according to a statutory formula found in Section 6515. Small employer insurers must file an annual actuarial certification that it is in compliance with the Small Employer Health Insurance Reform Act and verify that the rating methods of the insurer are actuarially sound. 36 O.S. § 6518. Regulations that more specifically implement the Act are found at OAC 365:10-5-150 et seq (sections relevant to rating, 365:10-5-151, -153, -155 attached).

LARGE GROUP INSURANCE: Oklahoma does not currently require the filing or approval of rates either at the time that a form is submitted for approval or at the time of any rate increase.

HMO (INDIVIDUAL AND GROUP): Forms are subject to prior approval pursuant to 36 O.S. § 6908. Initial and renewal premium rates, or a methodology for determining premiums rates, must be filed and approved before use. The premium rate may not be excessive, inadequate, unfair or discrimination and must be supported by a certification from a qualified actuary as to the appropriateness of the methodology based on reasonable assumptions, along with adequate supporting information. 36 O.S. § 6916. HMOs must calculate premiums under either a system of community rating, community rating by class, adjusted community rating, or under all three systems, but may use only one system for setting rates for any group at one time. OAC 365:40-5-10. More complete descriptions of those rating systems are found at OAC 365:40-5-11 to -13.

- Health Insurance rate review and filing requirements including:
    - A description of the type of data included in insurers' rate filings. If there is a standardized filing format, if permitted under State Law, provide a sample health insurance rate filing as an appendix to the application, a redacted version is acceptable.

Because Oklahoma has not previously required rate increases to be filed, except with regard to small group and HMOs, this description is limited to those products. HMO products are subject to rate filing and rate review, but it should be noted that those products make up only a very small portion of the Oklahoma health insurance marketplace. There is no standardized filing format for small employer rates, although all rates must be filed electronically, through the System for Electronic Rate and Form filing (SERFF). Since both small group and HMO filings are confidential pursuant to 36 OS §§6518, 6916A, we are unable to provide a sample health insurance rate filing.

- A comprehensive description of the rate review process, including rates subject to review, resources and a breakdown of State staff and private sector consultants, if any employed in the review process.

When a SERFF filing arrives in the Intake area, it is assigned to a Rate and Form Analyst for review. Insurance product assignments are based on the NAIC Uniform Life, Accident & Health, Annuity and Credit Product Coding Matrix. The rate review process consists of a compliance analysis of the filing with the appropriate statutory and regulatory provisions including an actuarial certification.

- The criteria for implementing legal authority for rate review and how rates are evaluated.

The Oklahoma Insurance Department (OID) regulates all types of health insurance products, including HMOs, PPOs, as well as major medical, individual and group products. The entities that offer these products must be authorized (licensed) by OID before the entity offers any insurance product within the state. 36 O.S. §§ 606, 6903. Entities licensed to offer insurance products in the state must file and receive approval of their policy forms before those forms are used within the state. 36 O.S. § 3610 provides, in part, that no insurance policy form shall be issued, delivered, or used unless filed with and approved by the Insurance Commissioner. A "policy" is defined, at 36 O.S. § 3602, as a contract of or agreement for effecting insurance, or the certificate thereof, by whatever named called, and includes all clauses, riders, endorsements and papers attached thereto and a part thereof. Although approval of all policy forms is specifically required, rate review and approval authority varies depending on the product line as further discussed below.

- The grounds for rate approval, modification and rejection. Discuss the factors that are considered in rate review, for example, medical loss ratios, the costs of medical care, the financial history of the company and previous rate changes.

SMALL GROUP: Section 6515 includes a number of restrictions on an insurer's rate setting. For example, the filing must demonstrate that the form is expected to pay aggregate benefits of at least 60% of the aggregate amount of premiums earned. The index rate for any class of business shall not exceed the index rate for any other class of business by more than 20%. Within a class of business the premiums rates charged to small employers with similar case characteristics for the same or similar coverage may not vary

from the index rate by more than 25% of the index rate. Further, the percentage increase for a new rating period may not exceed an amount determined according to a statutory formula found in Section 6515. Small employer insurers must file an annual actuarial certification that it is in compliance with the Small Employer Health Insurance Reform Act and verify that the rating methods of the insurer are actuarially sound. 36 O.S. § 6518. Regulations that more specifically implement the Act are found at OAC 365:10-5-150 et seq (sections relevant to rating, 365:10-5-151, -153, -155 attached).

HMO: The premium rate may not be excessive, inadequate, unfair or discrimination and must be supported by a certification from a qualified actuary as to the appropriateness of the methodology based on reasonable assumptions, along with adequate supporting information. 36 O.S. § 6916. HMOs must calculate premiums under either a system of community rating, community rating by class, adjusted community rating, or under all three systems, but may use only one system for setting rates for any group at one time. OAC 365:40-5-10. More complete descriptions of those rating systems are found at OAC 365:40-5-11 to -13.

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

Small group and HMO rates are deemed approved if not disapproved within thirty days 36 OS §§6515, 6916.

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

Retrospective review is not a part of the current rate review process.

- If the applicant lacks explicit statutory or regulatory approval authority, evidence of instances where requested rate modification and/or negotiation resulted in demonstrably lower rate/s. Discussion of rate modification should include additional contextual information such as the market share of the insurance product and the number of affected policyholders.

This information is not captured at this time.

- An explanation of current level of resources and capacity for reviewing health insurance rates: Information Technology (IT) and systems capacity
  - A description of the extent to which current IT systems such as the System for Electronic Rate and Form Filing (SERFF), support the State's rate review process, cross-referencing planned systems enhancements proposed elsewhere in the application.

All filings, form and rate, are made through the SERFF system. Oklahoma will contract with NAIC/SERFF or an independent firm to update the SERFF system to post rate filings on the OID website and to collect for reporting purposes the data required by future HHS regulatory requirements.

- An explanation of current level of resources and capacity for reviewing health insurance rates: Budget and Staffing
  - A description of annual overall total budget and revenue for the Insurance Department.

The Department's annual budget for the fiscal year 2010 (July 2009 – June 2010) is $14.1 million. Sources of Revenue are State appropriated dollars $2.3million, Federal Grants $1.2million, Fees and Taxes $10.1million and private grants $0.5million.

  - The budgetary breakdown for resources allocated to rate review for health insurance coverage in the individual and/or group markets.

The budget allocated to Rate and Form Compliance Division is $1.3 million.

  - A description of the qualifications (education and professional background) of the Insurance Department staff responsible for rate review. To the extent that actuarial services are contracted, please provide the name of the company and description of the nature of the contract service.

The qualifications (education and professional background) of the Insurance Department staff responsible for rate review follows: Kathie Stepp, Assistant Commissioner/Director: 24 years with OID, plus 13 years in

the insurance industry, BA ED, CIC; Greg Lawson, Manager of Statistical Analysis: 16 years with OID, BS, CIC; Bill Davenport, less than 1 year with OID, plus 26 years in the insurance industry, BS, FSA, Frank Stone, Chief Actuary: 11 years with OID, plus 41 years in the insurance industry, ASA, MAAA, EA.

- If available, provide the total number of health insurance rate filings that are received for the individual and/or group markets (annually and/or monthly), and the average amount of time that is required to complete the review process.

An estimated 350 rate filings were received in 2009 for all types of insurance identified in the Health category of the NAIC Uniform Life, Accident and Health, Annuity and Credit Product Coding Matrix. The average amount of time for the completion of the review process for the life and health products is 30 days.

Consumer protections:

- Are rate filings publicly disclosed? If so, what is the mechanism for public access to rates and rate filings? Describe the State laws and regulations that govern disclosure and public access and disclosure to rate filings and public access to the Insurance Department in general.

Public access to all filings is available through written request for the information or by visiting the OID office and reviewing information through a dedicated computer located in the Rate and Form Compliance Division. Rate filings are open public records except as specifically provided in statute. The annual actuarial certification of small employer insurers, that the insurance is in compliance with the Small Employer Health Insurance Reform Act and the rating methods of the insurer are actuarially sound, is not subject to disclosure pursuant to 36 O.S. § 6518. Premium rates filed by HMOs are, pursuant to 36 O.S. § 6916, confidential and not subject to public disclosure.

- Are summaries of rate changes offered in plain language for consumers? Please provide an example.

At this time, summaries of rate changes are not offered for consumers.

- How much advanced notice is given to consumers prior to proposed rate changes? Are consumers provided with official comment periods to review and comment on proposed rate changes?

No advance notice is given to consumers prior to a proposed rate change, nor are they allowed an official comment period to review and comment.

- What processes exist for public meetings and/or hearings on rate filings?

There is no process in place for public meetings and/or hearings on rate filings.

- Provide the number and summarize the nature of consumer inquiries and complaints related to health insurance rates that have been received for the past two plan years.

OID received 185 requests for assistance applicable to health insurance products. The requests specifically addressed increases in the premium and how the premiums were developed.

- Examination and Oversight:
  - Describe actions taken against insurance companies over the past two plan years regarding health insurance rates; include in the description a discussion of the market share and the number of affected policyholders for the cited insurance company.

In the lines of business where OID does have rate approval authority, each rate filing is carefully scrutinized. If the analyst has any concern about any aspect of the rates, additional information is requested from the insurer. If, even with the additional information, the rate appears unjustified, the analyst may begin an informal negotiation that results in the insurer receiving approval of a rate lower than initially filed. As an example of the process, in late fall 2009, OID had a concern about an HMO's rate filing on a large block of business. The company was required to provide additional supporting information, including an updated mapping of its geographic service area and copies of all its provider contracts. Company representatives were required to come into OID to discuss the basis for their assumptions and their plans for growth of the product before the rate was filed.

- Describe formal hearings held over the past two plan years regarding health insurance rates.

No administrative action has been taken against an insurance company regarding rates within the last two years; all issues have resolved through negotiation.

When possible, applicants should incorporate additional summary statistics related to rate review and approval activities in order to highlight accomplishments and to provide context for the scope of existing activities. The description should also discuss challenges in the current rate review processes, including whether or not the State has access to and the ability to collect, complete policy forms and the comprehensiveness of the data collected (i.e. is the State receiving the necessary forms and data it needs from the insurers)?

At present, OID's rate review process is quite limited. While the limited nature of our current process may not be considered a positive, it will not hamper our efforts to develop a comprehensive system of rate review. This new system will collect the detailed data necessary to not only determine when a rate increase is unjustified or unreasonable, but will also provide the OID and the Secretary with information about rate trends in health insurance coverage. The tools that we do have in place will serve as a spring board for the development of new comprehensive processes to collect the data necessary to improve our review of rate filings and to provide meaningful information to insurance consumers. Although it is clear to OID that we do not now receive all of the necessary data from insurers, one of our first steps will be to evaluate what additional information must be collected and then what infrastructure and staff additions must be made to collect and process the information. We will also consider the appropriate legislative and regulatory steps necessary to accomplish our goals.

b) Proposed rate review enhancements for health insurance

Applicants must provide assurances that grant awards will be used to develop or make improvements to their existing rate review and approval practices. States currently reviewing rate filings must propose enhancements that will further strengthen their existing authorities and process. States that do not currently review rate filings must describe their plans to conduct reviews or otherwise enhance their

oversight over insurers' rating practices. Examples of acceptable uses of grant funds are included below. States are encouraged to submit rate review plans beyond those characterized below:

- **Expanding the scope of current review and approval activities:** States may use grant funds to increase the number and/or scope of reviews that they are currently conducting. For example, States without explicit statutory rate review and approval authority could discuss plans to obtain such authority.

The award will be used to develop and make improvements to our existing rate review and approval practices. In order to expand the scope of our review authority OID:

- Has already taken initial steps to advise insurers that rate filings must be submitted for review during a meeting with insurance leaders held on May 25th.
- Plans to issue a bulletin advising insurers that rate filings are required to be submitted for review beginning September 1, 2010. The basis of the new extensive review will be 36 O. S. § 3611 B 5, which provides the Department with the authority to disapprove any form found to be unjust, unfair or inequitable to the policyholder. Based on past experience, insurers will adhere to the provisions outlined in the bulletin.
- Will seek the necessary statutory changes to provide specific authority for rate review including approval authority during the 2011 legislative session; assuming statutory authority is granted, OID will promulgate rules necessary to implement the approval authority.
- Will organize educational seminars to inform insurers of the new filing requirements
- Will hire actuarial analyst(s) (mathematicians) to assist in the in-house process of reviewing rates, including correspondence with consulting actuaries and training to take over the review process prior to the end of the grant period.

- **Improving rate filing requirements:** States may use grant funds to develop and implement more rigorous rate filing requirements that better document the underlying factors that influence proposed rate

increases. For example, States may require more comprehensive supporting documentation and actuarial attestations such as exhibits that describe the underlying assumptions and factors used to derive medical trend estimates, require companies to separately report and justify administrative expenses (salaries, advertising, etc.) and take into consideration an insurance company's overall finances (profits/investment income) when making rate change determinations. States without current rate review and approval authority may propose to use grant funds to require the submission of actuarially certified rate filings and other reporting requirements that expand the scope of current review.

As OID changes from its current state of a limited rate review to a more robust review process, we want to make sure that we are developing procedures that will collect the necessary information to develop meaningful information about trends in health care costs and premium rates. To accomplish this, we plan to:

- Develop a rate review procedures manual for use by Department staff to study the historical rate levels and reasons for them in the state
- Contract with consulting actuaries to develop rate filing submission requirements and rate analysis tools and to train Department personnel in the use of those tools.

- **Enhancing rate review process-Staffing:** Permitted use of funds includes enhanced insurance department staffing and consultant expertise through qualified actuaries familiar with the Actuarial Standards of Practice (ASOPs) and Guidelines for Professional Conduct.

  - Oklahoma has already taken steps to identify the additional staff necessary to meet our obligation under the Affordable Care Act during an internal meeting on May 14, 2010. At that time, it was decided the Manager of Statistical Analysis primary responsibilities would be shifted to health insurance products. His mathematical expertise will enhance the review process. Effective July 1, 2010 all health rate filings are being assigned to him for review.

- Contract with consulting actuaries to review rate filings to determine whether request is unreasonable, when to request additional information and develop a process to train Department personnel so that responsibility can be transferred to the Department prior to the end of the grant period.
- Hiring of actuarial analyst(s) (mathematicians) to assist in the in-house process of reviewing rates, including correspondence with consulting actuaries and training to take over the review process prior to the end of the grant period.
- Entering into agreement with outside vendor (SERFF or others) to facilitate compilation and dissemination of rate filing material from insurers.
- Hiring of program manager (data entry) to set up statistical department within the Department to collect, analyze, and report health trends and other reporting requirements

- **Enhancing rate review process-IT capacity:** States may develop new analytic capacities to assess the validity of rate increases and improve the IT infrastructure that supports health insurance rate review functions, including more robust data analysis and data exchange capabilities both within the State as well as with the Federal government in preparation for enhanced data reporting requirements that will be part of future HHS regulatory requirements. For example, states may request funding to plan, develop and implement, enhanced electronic filing and approval processes for rates and policy forms, electronic reporting of financial data used by insurance regulators and online fraud reporting.

    - Oklahoma has contacted an entity regarding an actuarial automated health insurance premium review system that will allow us to process rate filings efficiently and in accordance with the requirements of PPACA.
    - Contract or hire web/graphics IT staff to develop online fraud reporting mechanism.
    - Upgrade computers and software used by both rate analysts, mathematicians and data entry staff

- Contract with NAIC/SERFF or an independent firm to update SERFF system to collect for reporting purposes the data required by future HHS regulatory requirements.

- Our review processes will be developed to interface with existing statewide health information exchange activities. This will provide a more robust system to: improve health care quality, reduce health care costs, provide more meaningful data and display the true costs of the overall health care system.

- **Enhancing consumer protection standards:** States may enhance transparency in the rate filing process, for example by posting to a public website information about the rate filing and justification in an easy to understand language for the public; requiring insurers to post rate increases, including all accompanying documentation on their website; implementing of a public hearings process; and providing consumers with increased advanced notice before rate changes become effective.

  - Oklahoma has taken an initial step by allocating a portion of the Oklahoma Insurance Department web site to the Affordable Care Act. The site includes an area for consumers to submit questions to us for immediate answers.

  - Advancing the idea of supporting the Ombudsman program at the Department while actively educating our consumer assistance staff on the latest changes to the law in order to best serve Oklahomans

  - Another initiative currently taking place by Commissioner Holland is the multiple monthly presentations on the various pieces of the Affordable Care Act including the premium review responsibilities.

  - Educational sessions targeting the insurance producer community.

- Contract with NAIC/SERFF or an independent firm to update SERFF system to post rate filings on the OID website.

- September 8, 2010, the Insurance Department will host a stakeholder meeting to discuss for the first time the exchange.

- Contract or hire web/graphics IT and communications staff to:
    - Develop a detailed report on the market in the state and provide it to consumers.
    - Develop tools to help consumers understand their rate increase, including a simplified web-based tool to evaluate the value of their benefit levels
    - Develop brochures with easy to understand terms to educate consumers about health insurance purchases.
    - Develop educational seminars regarding health insurance rates and coverage for presentation to consumers throughout Oklahoma.

c) Reporting to the Secretary on Rate Increase Patterns

Section 2794 requires grant participants to provide data to the Secretary on health insurance rate trends in premium rating areas. In the project narrative the applicant must attest that it will comply with the reporting requirements outlined in statute and briefly describe the process that will be used to collect and provide these data to the Secretary. Grant funding may be used to improve current IT systems to prepare for more robust reporting requirements, data exchange and rate analysis.

OID will comply with the reporting requirements outlined in the Patient Protection and Affordable Care Act. As outlined previously in this application, OID intends to contract with third parties for the development of a process to collect and provide the required data to the Secretary. Grant funding will also be used to

improve current IT systems to prepare for more robust reporting requirements, data exchange, and rate analysis.

d) Optional Data Center Funding

In addition to funding State rate review activities, the statute provides that grants can also be used to establish data centers to compile and publish fee schedule information. Because the primary purpose of the grants is the enhancement of the rate review process we are limiting the amount of grant funds that can be allocated to data centers in Grant Cycle I is limited to 5 percent of the total grant award. Applicants must assure that all data centers that receive grant funding under this solicitation meet the following requirements:

The Oklahoma Insurance Department has developed a successful working relationship with the University of Oklahoma, Department of Biostatistics and Epidemiology (BSE). We have contacted them and they confirm, and we are certain, that they can meet the stated requirements of a data center, as spelled out in the Cycle 1 Initial Announcement. The BSE Department was formed in 2002 to coordinate and expand existing biostatistical and epidemiological expertise and collaborative research projects for the OU Health Sciences Center investigators and community partners. OID had a 15 month project with them in 2007-08.

The specific aims of the Data Center are: (1) to develop a website and corresponding database for on-line fee schedule submission; (2) to develop static and dynamic online fee schedule reporting tools in the public domain; and (3) to quantify changes in fee schedules over time and to identify statistically significant trends over time. BSE has the necessary data management, statistical and reporting capabilities to achieve the stated aims. They will utilize the services of three professional personnel and purchase equipment robust enough to accomplish the stated aims.

PREMIUM REVIEW GRANT

V. APPLICATION REVIEW CRITERIA AND INFORMATION

A. Description of Review Criteria

4) Required Supporting Documentation

b) The state must provide a clear delineation of the roles and responsibilities of project staff and how they will contribute to achieving the project's objectives including:

i. As outlined in the Key Contact document, the following individuals will be key to the success of this project: Kathie Stepp and Greg Lawson. Their biographies are included as attachments and outline their experience in the insurance industry. The budget documentation is addressed in the appropriate portion of the application. The Oklahoma Insurance Department has extensive experience to manage grant funds (Senior Health Insurance Program Grants awarded by Centers for Medicare and Medicaid Services and the Senior Medicare Patrol Grants awarded by Administration on Aging).

ii. Organizational charts are attached.

New Hire Job Descriptions:

Three Mathematicians – 100% of their time will be spent on grant activities

One Data Entry - 100% of their time will be spent on grant activities

One Web/Publications Specialist - 100% of their time will be spent on grant activities

One Marketing and Outreach Coordinator - 100% of their time will be spent on grant activities

At this time the Oklahoma Insurance Department has one Manager of Statistical Analysis on staff. Oklahoma has a current state actuary and has the ability to contract with outside independent actuaries. We will rely heavily on the contracted actuarial consultants for training of staff and independent actuarial review in the initial stages of the grant period.

PREMIUM REVIEW GRANT

STATUTES AND REGULATIONS

Oklahoma Statutes Annotated Currentness

Title 36. Insurance (Refs & Annos)

Chapter 1. Insurance Code (Refs & Annos)

Article 6. Authorization of Insurers and General Requirements

→ § 606. Authority to transact insurance required

A. No person shall act as an insurer and no insurer shall transact insurance in Oklahoma except as authorized by a subsisting authority granted to it by the Insurance Commissioner, except as to such transactions as are expressly otherwise provided for in this Code.

B. No such authority shall be required for an insurer, formerly so licensed in Oklahoma and now licensed in another state as a resident insurer or who has merged with an insurer in another state, to enable it to investigate and settle losses under its policies lawfully written in Oklahoma, or to liquidate such assets and liabilities of the insurer (other than collection of new premiums) as may have resulted from its former authorized operations in Oklahoma.

C. An insurer, who has relocated in another state or has merged with an insurer in another state and is not transacting new insurance business in Oklahoma but continuing collection of premiums on and servicing of policies remaining in force as to residents of or risks located in Oklahoma, is transacting insurance in Oklahoma for the purpose of premium tax requirements only and is not required to have a certificate of authority therefor. This subsection shall not apply to insurers which have withdrawn from Oklahoma prior to the effective date of this Code. [FN1]

D. As to an insurance coverage on a subject of insurance not resident, located, or expressly to

be performed in Oklahoma at time of issuance, and solicited, written, and delivered outside Oklahoma at the time of issuance, no such authority shall be required of an insurer as to subsequent transactions in Oklahoma on account thereof, and the provisions of this Code shall not apply to such insurance or insurance coverage, except for the purpose of premium tax requirements.

CREDIT(S)

Laws 1957, p. 231, § 606, operative July 1, 1957; Laws 1985, c. 328, § 5, emerg. eff. July 29, 1985.

[FN1] O.S.L.1957, p. 215 et seq., operative July 1, 1957.

Current with emergency effective provisions through Chapter 170 of the Second Regular Session of the 52nd Legislature (2010).

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Oklahoma Statutes Annotated Currentness

Title 36. Insurance (Refs & Annos)

Chapter 2. Miscellaneous Provisions

Health Maintenance Organization Act of 2003

→ § 6903. Certificate of authority--Application requirements--Submission to Insurance Commissioner--Rules

A. Notwithstanding any law of this state to the contrary, any person may apply to the Insurance Commissioner for a certificate of authority to establish and operate a health maintenance organization pursuant to the provisions of the Health Maintenance Organization Act of 2003. No person shall establish or operate a health maintenance organization in this state without obtaining a certificate of authority pursuant to the provisions of this act. [FN1] A foreign corporation may qualify under this act, subject to its registration to do business in this state as a foreign corporation and compliance with all provisions of this act and other applicable state laws. All certificates of authority shall be perpetual and automatically renewed as of March 1 of each year, unless the health maintenance organization fails to qualify for renewal pursuant to the provisions of this act and any other applicable provisions of Title 36 of the Oklahoma Statutes.

B. Any health maintenance organization that has previously received a certificate of authority from the State Commissioner of Health, but has not received a certificate of authority from the Insurance Commissioner to operate as a health maintenance organization as of the effective date of this act shall submit an application for a certificate of authority, as provided in subsection C of this section, by March 1, 2004. Each applicant may continue to operate until such time as the Insurance Commissioner acts upon the application if the applicant continues to comply with the provisions of Title 63 of the Oklahoma Statutes, the rules promulgated pursuant thereto by the State Board of Health as they existed immediately prior to the effective date of this act, [FN2] and administrative orders entered by the State Commissioner of Health prior to the effective date of this act. In the event that an application is denied under

the provisions of Section 4 of this act, [FN3] the applicant shall thereafter be treated as a health maintenance organization whose certificate of authority has been revoked.

C. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the National Association of Insurance Commissioners (NAIC), and shall be accompanied by the following:

1. A copy of the applicant's organizational documents including, but not limited to, the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

2. A copy of the bylaws, rules, regulations or similar document, if any, regulating the conduct of the internal affairs of the applicant;

3. A list of the names, addresses, official positions and biographical information, on forms acceptable to the NAIC, of the persons who are to be responsible for the conduct of the affairs and day-to-day operations of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, and the principal officers in the case of a corporation, or the partners or members in the case of a partnership or association;

4. A copy of any contract form made or to be made between any class of providers and the health maintenance organization, and a copy of any contract made or to be made between third party administrators, marketing consultants or persons listed in paragraph 3 of this subsection and the health maintenance organization;

5. A copy of the form of evidence of coverage to be issued to enrollees;

6. A copy of the form of group contract, if any, to be issued to employers, unions, trustees or other organizations;

7. Financial statements showing the applicant's assets, liabilities and sources of financial support including, but not limited to:

a. a copy of the applicant's most recent, regular certified financial statement,

b. an unaudited current financial statement, and

c. fully audited financial information as to the earnings and financial condition of each person controlling a domestic health maintenance organization pursuant to the provisions of subsection (c) of Section 1651 of Title 36 of the Oklahoma Statutes for the preceding five (5) fiscal years for each such acquiring party, or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence, and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement; provided, however, the Insurance Commissioner shall have the discretionary ability to waive the audit requirement based upon review of substantially similar financial disclosure statements submitted by the acquiring party;

8. A financial feasibility plan that includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first twelve (12) months of operations as certified by an actuary or other qualified person acceptable to the Insurance Commissioner, a projection of balance sheets, cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state, and income and expense statements anticipated from the start of operations until the organization has had net income for at least one year, and a statement as to the sources of working capital as well as any other sources of funding;

9. A power of attorney duly executed by the applicant, if not domiciled in this state, appointing the Insurance Commissioner, his or her successors in office and duly authorized deputies, as

the true and lawful attorney of the applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

10. A statement or map reasonably describing the geographic area or areas to be served;

11. A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances;

12. A description of the proposed quality assurance program, including the formal organizational structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified;

13. A description of the procedures to be implemented to meet the protection against insolvency provisions of Section 13 of this act; [FN4]

14. A list of the names, addresses, and license numbers of all providers with which the health maintenance organization has agreements;

15. Other information the Insurance Commissioner may require to make the determinations required in Section 4 of this act; and

16. An original, along with copies, of all documents required pursuant to the provisions of this subsection, with all required fees.

D. 1. The Insurance Commissioner may promulgate rules for the proper administration of this act and to require a health maintenance organization, subsequent to receiving its certificate of authority, to submit the information, modifications or amendments to the items described in

subsection C of this section to the Insurance Commissioner, either for approval or for information only, prior to the effectuation of the modification or amendment, or to require the health maintenance organization to indicate the modifications to both the State Commissioner of Health and the Insurance Commissioner at the time of the next succeeding site visit or examination.

2. Any modification or amendment for which the Insurance Commissioner's approval is required shall be deemed approved unless disapproved within thirty (30) days, provided that the Insurance Commissioner may postpone the action for such further time, not exceeding an additional sixty (60) days, as necessary for proper consideration.

CREDIT(S)

[FN1] Title 36, § 6901 et seq.

[FN2] O.S.L.2003, c. 197, effective November 1, 2003.

[FN3] O.S.L.2003, c. 197, § 4 [Title 36, § 6904].

[FN4] O.S.L.2003, c. 197, § 13 [Title 36, § 6913].

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Oklahoma Statutes Annotated Currentness

Title 36. Insurance (Refs & Annos)

Chapter 1. Insurance Code (Refs & Annos)

Article 36. The Insurance Contract in General (Refs & Annos)

→ § 3610. Approval of forms

A. No insurance policy form or application form, where written application is required and is to be made a part of the policy, rider or endorsement form other than surety bond forms and such other insurance policy forms as are hereinafter specifically otherwise provided for shall be issued, delivered, or used unless filed with and approved by the Insurance Commissioner. This section shall not apply to policies, riders or endorsements of unique character designed for and used with relation to insurance upon a particular subject or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or accident and health policies, and are used at the request of the individual policyholder, contract holder, or certificate holder.

B. Every such filing shall be made not less than sixty (60) days in advance of any such delivery. At the expiration of such sixty (60) days the form so filed shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the Insurance Commissioner. Approval of any such form by the Commissioner shall constitute a waiver of any unexpired portion of such waiting period. The Insurance Commissioner may extend by not more than an additional thirty (30) days the period within which he may so affirmatively approve or disapprove any such form, by giving notice of such extension before expiration of the initial sixty-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such form shall be deemed approved. The Insurance Commissioner may at any time, after notice and for cause shown, withdraw any such approval.

C. Any order of the Insurance Commissioner disapproving any such form or withdrawing a

previous approval shall state the grounds therefor.

D. The Insurance Commissioner may, by order, exempt from the requirements of this section for so long as he deems proper any insurance document or form or type thereof as specified in such order, to which, in his discretion this section may not practicably be applied, or the filing and approval of which are, in his opinion, not desirable or necessary for the protection of the public.

E. This section shall apply also to any such form used by domestic insurers for delivery in a jurisdiction outside Oklahoma, if the insurance supervisory official of such jurisdiction informs the Insurance Commissioner that such form is not subject to approval or disapproval by such official, and upon the Commissioner's order requiring the form to be submitted to him for the purpose.

CREDIT(S)

Laws 1957, p. 365, § 3610, operative July 1, 1957; Laws 1959, p. 137, § 1, emerg. eff. May 8, 1959; Laws 1987, c. 210, § 35, eff. July 1, 1987.

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Oklahoma Statutes Annotated Currentness

Title 36. Insurance (Refs & Annos)

Chapter 1. Insurance Code (Refs & Annos)

Article 36. The Insurance Contract in General (Refs & Annos)

→ § 3602. "Policy" defined

"Policy" means contract of or agreement for effecting insurance, or the certificate thereof, by whatever name called, and includes all clauses, riders, endorsements and papers attached thereto and a part thereof.

CREDIT(S)

Laws 1957, p. 363, § 3602, operative July 1, 1957.

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Title 36. Insurance (Refs & Annos)

Chapter 1. Insurance Code (Refs & Annos)

Article 44. Individual Accident and Health Insurance (Refs & Annos)

→ § 4402. Accident and health policies--Filing

On and after the effective date of this Code no policy of insurance against loss or expense from the sickness, or from the bodily injury or death of the insured by accident shall be issued or delivered to any person in this state, nor shall any application, rider or endorsement be used in connection therewith until a copy of the form thereof, and of the classification of risks, and the premium rates pertaining thereto, have been filed with the Insurance Commissioner. If the Insurance Commissioner disapproves the policy, application, rider or endorsement form, said Commissioner shall make a written decision stating the reason or reasons therefor, and shall deliver a copy thereof to the company, and it shall be unlawful for any such insurer to use any such form in the state. Any such insurer shall have twenty (20) days from the date of receipt of the notice of disapproval in which to request a hearing on such disapproval.

CREDIT(S)

Laws 1957, p. 388, § 4402, operative July 1, 1957.

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Title 36. Insurance (Refs & Annos)

Chapter 1. Insurance Code (Refs & Annos)

Article 36. The Insurance Contract in General (Refs & Annos)

➡ § 3611. Grounds for disapproval of forms--Prevention of delivery of certain policies--Exemptions

A. The Insurance Commissioner shall disapprove any form of policy, application, rider or endorsement or withdraw any previous approval thereof only:

1. If it is in any respect in violation of or does not comply with this code, including Section 4509 of this title or any other applicable statute in the State of Oklahoma;

2. If it contains or incorporates by reference any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions which deceptively affect the risks purported to be assumed in the general coverage of the contract; and

3. If it has any title, heading, or other indication of its provisions which is misleading.

B. 1. No individual or family accident and health insurance policy, shall be delivered, or issued for delivery, in this state unless:

a. accompanied by an appropriate outline of coverages in plain and simple language, in no less than 10-point type, and provided further, at the top of the front page of the outline of coverage, in no less than 14-point type, shall state the policy described herein is a limited policy or a substandard policy or other appropriate information, as prescribed by the Insurance Commissioner, and

b. an appropriate outline of coverage is completed and delivered to the applicant at the

time application is made, and an acknowledgment of receipt or certificate of delivery of such outline is provided to the insurer with the application.

In the case of a direct response, such as a written application to the insurance company from an applicant, the outline of coverage shall accompany the policy when issued.

2. Such outline of coverage shall contain:

a. a statement identifying the applicable category of coverage afforded by the policy as based on the minimum basic standards set forth in the rules and regulations issued to effect compliance with paragraph 3 of this section and Title 36 of the Oklahoma Statutes,

b. a brief description of the principal benefits and coverage provided in the policy,

c. a summary statement of the principal exclusions and limitations or reductions contained in the policy, including, but not limited to, pre-existing conditions, probationary periods, elimination periods, and any age limitations or reductions,

d. a summary statement of the renewal provision, including any reservation of the insurer of a right to change premiums, and

e. a statement that the outline contains a summary only of the details of the policy as issued or of the policy as applied for and that the issued policy should be referred to for the actual contractual governing provisions.

3. The department shall adopt rules and regulations which establish minimum standards for the general content of forms of individual and family health policies, which shall be inclusive of terms of renewability, initial and subsequent conditions of eligibility, termination of insurance, probationary periods, exclusions, limitations, and reductions. The minimum standards

expressed in such rules and regulations shall be in addition to, and in accordance with, individual accident and sickness policy provisions as provided in this title.

4. The department shall adopt rules and regulations which establish minimum standards of benefits and identification for each of the following categories of coverage in individual and family forms, other than conversion policies, of accident and health insurance:

a. basic hospital expense insurance,

b. basic medical expense insurance,

c. basic surgical expense insurance,

d. hospital confinement indemnity insurance,

e. major medical expense insurance,

f. disability income protection insurance,

g. accident-only insurance, and

h. limited benefit insurance.

Nothing in this section shall preclude the issuance of any policy which combines two or more of the categories of coverage enumerated in subparagraphs a through e, or any policy which does not meet the prescribed minimum standards for categories of coverage in subparagraphs a through g when such policy is, in the opinion of the department, either experimental in nature or is demonstrated to be a type of coverage that will fulfill a reasonable need of the person or persons to be insured. Any policy so approved will be identified as to category only as prescribed by the department.

5. The department may, within such time as provided by law for the disapproval of an individual or family form of accident or health insurance, group accident and health insurance, or life and annuity insurance, disapprove any such form if it finds that it does not comply with applicable law in this state or it finds that such form is unjust, unfair, or inequitable to the policyholder, any person insured thereunder, or any beneficiary. In acting upon any such submission, the Commissioner shall, under this section, consider whether the benefits afforded under the submitted policy or benefit form would fulfill a reasonable need of a policyholder.

CREDIT(S)

Laws 1957, p. 366, § 3611, operative July 1, 1957; Laws 1979, c. 183, § 1, eff. Jan. 1, 1982; Laws 1987, c. 210, § 36, eff. July 1, 1987; Laws 1993, c. 248, § 3, eff. Sept. 1, 1993.

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Oklahoma Statutes Annotated Currentness

Title 36. Insurance (Refs & Annos)

Chapter 2. Miscellaneous Provisions

Small Employer Health Insurance Reform Act

➡ § 6515. Premium rates

A. Premium rates for health benefit plans subject to the Small Employer Health Insurance Reform Act [FN1] shall be subject to the following provisions:

1. The rate manual developed for use by a small employer carrier shall be filed and approved by the Insurance Commissioner prior to use. Any changes to the rate manual shall be filed and approved by the Insurance Commissioner prior to use. Every filing shall be made not less than thirty (30) days prior to the date the small employer carrier intends to implement the rates. The rate manual so filed shall be deemed approved upon expiration of the thirty-day waiting period unless, prior to the end of the period, it has been affirmatively approved or disapproved by order of the Commissioner. Approval of a rate manual by the Commissioner shall constitute a waiver of any unexpired portion of the thirty-day waiting period. The Commissioner may extend the period to approve or disapprove a rate manual by not more than an additional thirty (30) days by giving notice of such extension before expiration of the initial thirty-day period. At the expiration of an extended period, the rate filing shall be deemed approved unless otherwise approved or disapproved by the Commissioner. The Commissioner may at any time, after notice and for cause shown, withdraw approval of a filed rate;

2. A small employer health benefit plan shall not be delivered or issued for delivery unless the policy form or certificate form can be expected to return to policyholders and certificate holders in the form of aggregate benefits provided under the policy form or certificate form at least sixty percent (60%) of the aggregate amount of premiums earned. The rate of return shall be estimated for the entire period for which rates are computed to provide coverage. The rate of return shall be calculated on the basis of incurred claims experience or incurred health

care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period in accordance with accepted actuarial principles and practices;

3. The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%);

4. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent (25%) of the index rate;

5. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

a. the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers,

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

c. any adjustment due to change in coverage or change in the case characteristics of the

small employer, as determined from the small employer carrier's rate manual for the class of business;

6. Adjustments in rates for claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer;

7. Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to Section 6523 of this title;

8. A small employer carrier may utilize industry as a case characteristic in establishing premium rates; provided, the highest rate factor associated with any industry classification shall not exceed the lowest rate factor associated with any industry classification by more than fifteen percent (15%);

9. In the case of health benefit plans issued prior to the effective date of the Small Employer Health Insurance Reform Act, [FN2] a premium rate for a rating period may exceed the ranges set forth in paragraphs 3 and 4 of this subsection for a period of three (3) years following the effective date of the Small Employer Health Insurance Reform Act. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

a. the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers,

and

b. any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the carrier's rate manual for the class of business;

10. Small employer carriers shall:

a. apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups within the same class of business which differ only by amounts attributable to plan design and do not reflect differences due to claims experience, health status and duration of coverage,

b. treat all health benefit plans issued or renewed in the same calendar month as having the same rating period;

11. For the purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs;

12. The Insurance Commissioner may establish rules to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of the Small Employer Health Insurance Reform Act, including:

a. assuring that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to claims experience, health status or duration of coverage, and

b. prescribing the manner in which case characteristics may be used by small employer carriers.

B. A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage.

C. The Commissioner may suspend for a specified period the application of paragraph 3 of subsection A of this section as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the Commissioner either that the suspension is reasonably necessary in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

CREDIT(S)

Laws 1992, c. 329, § 5, eff. Sept. 1, 1992; Laws 1994, c. 211, § 4, eff. July 1, 1994; Laws 1998, c. 304, § 3, eff. July 1, 1998.

[FN1] Title 36, § 6511 et seq.

[FN2] O.S.L. 1992, c. 329, effective September 1, 1992.

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Oklahoma Statutes Annotated Currentness

Title 36. Insurance (Refs & Annos)

Chapter 2. Miscellaneous Provisions

Small Employer Health Insurance Reform Act

→ § 6518. Maintenance and disclosure of certain information and documents--Filing of actuarial certification

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

B. Each small employer carrier shall file with the Insurance Commissioner annually on or before March 15 an actuarial certification certifying that the carrier is in compliance with this act [FN1] and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the Commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

C. A small employer carrier shall make the information and documentation described in subsection A of this section available to the Commissioner upon request. Except in cases of violations of this act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the Commissioner to persons outside of the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

CREDIT(S)

[FN1] Title 36, § 6511 et seq.

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Title 36. Insurance (Refs & Annos)

Chapter 2. Miscellaneous Provisions

Health Maintenance Organization Act of 2003

➡ § 6908. Group or individual contract--Delivery--Required provisions--Evidence of coverage--Filing and review of forms

A. 1. Every group and individual contract holder is entitled to a group or individual contract which may be delivered through electronic means or methods; provided, a member has given written assurances to the health maintenance organization that the member can view and print such electronic copy.

2. The contract shall not contain provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation as defined by Articles 12 and 12A-1 of the Insurance Code. [FN1]

3. The contract shall contain a clear statement of the following:

a. the name and address of the health maintenance organization,

b. eligibility requirements,

c. benefits and services within the service area,

d. emergency care benefits and services,

e. out of area benefits and services, if any,

f. copayments, deductibles or other out-of-pocket expenses,

g. limitations and exclusions,

h. enrollee termination,

i. enrollee reinstatement, if any,

j. claims procedures,

k. enrollee grievance procedures,

l. continuation of coverage,

m. conversion,

n. extension of benefits, if any,

o. coordination of benefits, if applicable,

p. subrogation, if any,

q. description of the service area,

r. entire contract provision,

s. term of coverage,

t. cancellation of group or individual contract holder,

u. renewal,

v. reinstatement of group or individual contract holder, if any,

w. grace period, and

x. conformity with state law.

An evidence of coverage may be filed as part of the group contract to describe the provisions required in this paragraph.

B. In addition to those provisions required in paragraph 3 of subsection A of this section, an individual contract shall provide for a ten-day period to examine and return the contract and to refund any premiums. If services were received during the ten-day period, and the subscriber returns the contract to receive a refund of the premium paid, he or she must pay for those services.

C. 1. Every subscriber shall receive an evidence of coverage from the group contract holder or the health maintenance organization.

2. The evidence of coverage shall not contain provisions or statements that are unfair, unjust, inequitable, misleading, deceptive, or that encourage misrepresentation as defined by Articles 12 and 12A-1 of the Insurance Code.

3. The evidence of coverage shall contain a clear statement of the provisions required in paragraph 3 of subsection A of this section.

D. Every health maintenance organization doing business in this state shall comply with the provisions of Article 36A of the Insurance Code. [FN2]

E. No group or individual contract, evidence of coverage or amendment thereto, shall be

delivered or issued for delivery in this state, unless its form has been filed with and approved by the Insurance Commissioner, subject to the provisions of subsections F and G of this section.

F. If an evidence of coverage issued pursuant to and incorporated in a contract issued in this state is intended for delivery in another state and the evidence of coverage has been approved for use in the state in which it is to be delivered, the evidence of coverage need not be submitted to the Insurance Commissioner of this state for approval.

G. 1. Every form required by this section shall be filed with the Insurance Commissioner not less than thirty (30) days prior to delivery or issue for delivery in this state. At any time during the initial thirty-day period, the Insurance Commissioner may extend the period for review an additional thirty (30) days. Notice of an extension shall be in writing. At the end of the review period, the form is deemed approved if the Insurance Commissioner has taken no action. The filer must notify the Insurance Commissioner in writing prior to using a form that is deemed approved.

2. At any time, after thirty (30) days' notice and for cause shown, the Insurance Commissioner may withdraw approval of a form, effective at the end of the thirty (30) days.

3. When a filing is disapproved or approval of a form is withdrawn, the Insurance Commissioner shall give the health maintenance organization written notice of the reasons for disapproval and in the notice shall inform the health maintenance organization that within thirty (30) days of receipt of the notice the health maintenance organization may request a hearing. A hearing shall be conducted within thirty (30) days after the Insurance Commissioner has received the request for hearing.

H. The Insurance Commissioner may require the submission of relevant information he or she deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

CREDIT(S)

[FN1] Title 36, § 1201 et seq. and Title 36 § 1250.1 et seq.

[FN2] Title 36, § 3641 et seq.

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Title 36. Insurance (Refs & Annos)

Chapter 2. Miscellaneous Provisions

Health Maintenance Organization Act of 2003

→ § 6916. Premium rates--Approval by Insurance Commissioner

A. No premium rate may be used by a health maintenance organization until such time as a schedule of premium rates or methodology for determining premium rates has been filed with and approved by the Insurance Commissioner. Such premium rates shall be confidential and not subject to public disclosure.

B. Either a specific schedule of premium rates or a methodology for determining premium rates shall be established in accordance with actuarial principles for various categories of enrollees; provided, that the premium applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. Provided further, that the premium rates shall not be excessive, inadequate, unfair or discriminatory. A certification by a qualified actuary or other qualified person acceptable to the Insurance Commissioner as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

C. The Insurance Commissioner shall approve the schedule of premium rates or methodology for determining premium rates if the requirements of subsection B of this section are met. If the Insurance Commissioner disapproves the filing, the Insurance Commissioner shall notify the health maintenance organization. In the notice, the Insurance Commissioner shall specify the reasons for disapproval. A hearing will be conducted within thirty (30) days after a request in writing by the person filing. If the Insurance Commissioner does not take action on the schedule or methodology within thirty (30) days of the filing of the schedule or methodology, it shall be deemed approved.

D. When contracting with educational entities within the meaning of Section 1306 of Title 74 of the Oklahoma Statutes, in setting health insurance premiums for active employees and for retirees under sixty-five (65) years of age, health maintenance organizations shall set the monthly premium for active employees at a maximum of Ninety Dollars ($90.00) less than the monthly premium for retirees under sixty-five (65) years of age.

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Title 365. Insurance Department

Chapter 10. Life, Accident and Health

Subchapter 5. Minimum Standards; Contract Guidelines

Part 15. Small Employer Health Insurance Reform Regulation (Refs & Annos)

➡ 365:10-5-151. Definitions

The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise;

"Act" means the Small Employer Health Insurance Reform Act, 36 O.S.Supp.1994, § 6511 et seq.

"Associate member of an employee organization" means any individual who participates in an employee benefit plan that is a multi-employer plan other than the following:

(A) An individual or the beneficiary of such individual who is employed by a participating employer within a bargaining unit covered by at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or

(B) An individual who is a present or former employee (or a beneficiary of such employee) of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan (or of a related plan).

"New entrant" means an eligible employee, or the dependent of an eligible employee, who becomes part of an employer group after the initial period for enrollment in a health benefit plan.

"Risk characteristic" means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or experience of a small employer group or of any member of a small employer group.

?Risk load" means the percentage above the applicable base premium rate that is charged by a small employer carrier to a small employer to reflect the risk characteristics of the small employer group.

Authority: 36 O.S. 1991, § 307.1, 36 O.S.Supp.1994, § 6526

Source: Added at 12 Ok Reg 3137, eff. 7-31-95

Okla. Admin. Code 365:10-5-151, OK ADC 365:10-5-151

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Title 365. Insurance Department

Chapter 10. Life, Accident and Health

Subchapter 5. Minimum Standards; Contract Guidelines

Part 15. Small Employer Health Insurance Reform Regulation (Refs & Annos)

→ 365:10-5-153. Establishment of classes of business

(a) A small employer carrier that establishes more than one class of business pursuant to the provisions of 36 O.S.Supp.1994, § 6514, shall maintain on file for inspection by the Commissioner the following information with respect to each class of business so established:

(1) A description of each criterion employed by the carrier (or any of its agents) for determining membership in the class of business;

(2) A statement describing the justification for establishing the class as a separate class of business and documentation that the establishment of the class of business is intended to reflect substantial differences in expected claims experience or administrative costs related to the reasons set forth in 36 O.S.Supp.1994, § 6514; and

(3) A statement disclosing which, if any, health benefit plans are currently available for purchase in the class and any significant limitations related to the purchase of such plans.

(b) A carrier may not directly or indirectly use group size as a criterion for establishing eligibility for a health benefit plan or for a class of business.

Authority: 36 O.S. 1991, § 307.1, 36 O.S.Supp.1994, § 6526

Source: Added at 12 Ok Reg 3137, eff. 7-31-95

Okla. Admin. Code 365:10-5-153, OK ADC 365:10-5-153

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Title 365. Insurance Department

Chapter 10. Life, Accident and Health

Subchapter 5. Minimum Standards; Contract Guidelines

Part 15. Small Employer Health Insurance Reform Regulation (Refs & Annos)

➡ 365:10-5-155. Restrictions relating to premium rates

(a) Separate rate manuals required.

(1) A small employer carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the applicable rate manual developed pursuant to 365:10-5-155(a). To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion.

(2) Modification of rating method requirements.

(A) A small employer carrier shall not modify the rating method used in the rate manual for a class of business until the change has been approved as provided in 365:10-5-155(a)(2). The Commissioner may approve a change to a rating method if the Commissioner finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the Act and this Part.

(B) A carrier may modify the rating method for a class of business only with prior approval of the Commissioner. A carrier requesting to change the rating method for a class of business shall make a filing with the Commissioner at least thirty (30) days prior or the proposed date of the change. The filing shall contain at least the following information:

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

(ii) A complete description of each of the proposed modifications to the rating method;

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

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

(v) A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of 36 O.S.Supp.1994, § 6515.

(C) For the purpose of 365:10-5-155 a change in rating method shall mean:

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

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

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

(iv) A "ten percent charge in premium" test.

(I) A change in rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds ten percent (10%).

(II) For the purpose of 365:10-5-155(a)(2)(C)(iv)(I), a change in a rating factor considered over a twelve (12) month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the carrier shall consider the cumulative effect of all such changes in applying the ten percent (10%) test under 365:10-5-155(a)(2)(C)(iv)(I).

(b) Case characteristics and rate factors.

(1) The rate manual developed pursuant to 365:10-5-155(a) shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business.

(2) A small employer carrier may not use case characteristics other than age, gender, industry, geographic area, family composition and group size, as specified in 36 O.S.Supp.1994, § 6512(7), without the prior approval of the Commissioner. A small employer carrier seeking such an approval shall make a filing with the Commissioner for a change in rating method under 365:10-5-155(a)(2).

(3) A small employer carrier shall use the same case characteristics in establishing

premium rates for each health benefit plan in a class of business and shall apply them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics shall be applied without regard to the risk characteristics of a small employer.

(4) The rate manual developed pursuant to 365:10-5-155(a) shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate the difference.

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

(6) The rate manual developed pursuant to 365:10-5-155(a) shall provide for premium rates to be developed in a two step process. In the first step, a base premium rate shall be developed for the small employer group without regard to any risk characteristics of the group. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of 36 O.S.Supp.1994, § 6515, to reflect the risk characteristics of the group.

(7) A premium charged to a small employer for a health benefit plan shall not include a separate application fee, underwriting fee, or any other separate fee or charge.

(8) A small employer carrier shall allocate administrative expenses to the basic and standard health benefit plans on no less favorable of a basis than expenses are allocated to other health benefit plans in the class of business. The rate manual developed pursuant to 365:10-5-155(a) shall describe the method of allocating administrative expenses to the health benefit plans in the class of business for which the manual was developed.

(9) Each rate manual developed pursuant to 365:10-5-155(a) shall be maintained by the carrier for a period of six (6) years. Updates and changes to the manual shall be maintained with the manual.

(10) The rate manual and rating practices of a small employer carrier shall comply with any guidelines issued by the Commissioner.

(c) If group size is used as a case characteristic by a small employer carrier, the highest rate factor associated with a group size classification shall not exceed the lowest rate factor associated with such a classification by more than twenty percent (20%).

(d) The restrictions related to changes in premium rates in 36 O.S.Supp.1994, § 6515(A)(3) and (7), shall be applied as follows:

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

(2) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate shall be deemed to be the change in the base premium rate for the purposes of 36 O.S.Supp.1994, § 6515(A)(3)(c) and 36 O.S.Supp.1994, § 6515(A)(7)(a).

(3) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan shall be considered a health benefit plan into which the small employer carrier is no longer enrolling new small employers for the purposes of 36 O.S.Supp.1994, § 6515(A)(3)(c) and 36 O.S.Supp.1994, § 6515(A)(7)(a).

(4) If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than twenty percent (20%), the carrier shall make a filing with the Commissioner containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing shall be made within thirty (30) days of the beginning of the rating period.

(5) A small employer carrier shall keep on file for a period of at least six (6) years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period.

(e) Revised premium rate.

(1) Except as provided in 365:10-5-155(e)(2) thru (4), a change in premium rate that is no more than the following:

(A) The base premium rate for the small employer (as shown in the rate manual as revised for the rating period), multiplied by

(B) One plus the sum of;

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

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

(2) In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the following:

(A) The base premium rate for the small employer given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period, multiplied by

(B) One plus the lesser of:

(i) The change in the base rate or

(ii) The percentage change in the new business premium for the most similar health benefit plan into which the small employer carrier is enrolling new small employers, multiplied by

(C) One plus the sum of:

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

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

(3) In the case of a health benefit plan described in 36 O.S.Supp.1994, § 6515(A)(6), if the current premium rate for the health benefit plan exceeds the ranges set forth in 36 O.S.Supp.1994, § 6515(A), the formulae set forth in 365:10-5-155(e)(1) and (2) will be applied as if the fifteen percent (15%) adjustment provided in 365:10-5-155(e)(1)(B)(ii)

and 365:10-5-155(e)(2)(C)(ii) were a zero percent adjustment.

(4) Notwithstanding the provisions of 365:10-5-155(e)(1) and (2), a change in premium rate for a small employer shall not produce a revised premium rate that would exceed the limitations on rates provided in 36 O.S.Supp.1994, § 6515(A)(2).

(f) Taft-Hartley trust waiver request.

(1) A representative of a Taft-Hartley trust (including a carrier upon the written request of such a trust) may file in writing with the Commissioner a request for the waiver of application of the provisions of 36 O.S.Supp.1994, § 6515(A), with respect to such trust.

(2) A request made under 365:10-5-155(f)(1) shall identify the provisions for which the trust is seeking the waiver and shall describe, with respect to each provision, the extent to which application of such provision would:

(A) Adversely affect the participants and beneficiaries of the trust; and

(B) Require modifications to one or more of the collective bargaining agreements under or pursuant to which the trust was or is established or maintained.

Authority: 36 O.S. 1991, § 307.1, 36 O.S.Supp.1994, § 6526

Source: Added at 12 Ok Reg 3137, eff. 7-31-95

Okla. Admin. Code 365:10-5-155, OK ADC 365:10-5-155

Current with amendments included in The Oklahoma Register, Volume 27, Number 18, dated June 1, 2010.

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Title 365. Insurance Department

Chapter 40. Health Maintenance Organizations (Hmo)

Subchapter 5. Life, Accident & Health Division and Consumer Assistance and Claims Division Rules

Part 3. Rating System (Refs & Annos)

➜ 365:40-5-10. Definitions

When used in this Part the term "Rating System" means the method or combination of methods which the HMO uses to calculate enrollee premiums, and is limited to community rating, community rating by class, adjusted community rating or a combination of all. An HMO may fix rates of payment under either a system of community rating, community rating by class, adjusted community rating or under all three systems. However, the HMO may use only one such system for setting rates for any group at any one time.

Authority: Insurance Commissioner, 36 O.S. §§ 307.1 and 6923

Source: Added at 21 Ok Reg 77, eff. 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff. 7-14-04

Okla. Admin. Code 365:40-5-10, OK ADC 365:40-5-10

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Title 365. Insurance Department

Chapter 40. Health Maintenance Organizations (Hmo)

Subchapter 5. Life, Accident & Health Division and Consumer Assistance and Claims Division Rules

Part 3. Rating System (Refs & Annos)

→ 365:40-5-11. Community rating

Under community rating, rates of payments may be determined on a per-person or per-family basis and may vary with the number of persons in a family, but except as otherwise authorized in this paragraph, such rates must be equivalent for all individuals and for all families of similar composition. This does not preclude changes in the rates of payments for health services based on a community rating system which are established for new enrollments or re-enrollments and which changes do not apply to existing contracts until the renewal of such contracts. Only the following differentials in rates of payments may be established under such system:

(1) Nominal differentials in such rates may be established to reflect differences in marketing costs and the different administrative costs of collecting payments from the following categories of subscribers:

(A) Individual (non-group) subscribers (including their families).

(B) Small groups of subscribers.

(C) Large groups of subscribers.

(2) Nominal differentials in such rates may be established to reflect the compositing of the rates of payment in a systematic manner to accommodate group purchasing practices of the various employers.

(3) Differentials in such rates may be established for subscribers enrolled under any governmental authority or program authorized by United States Code, or under any health benefits program for employees of States, political subdivisions of States, and other public entities.

(4) An HMO may establish a separate community rate for separate regional components of the organization upon satisfactory demonstration of the following:

(A) Each such regional component is geographically distinct and separate from any other regional component.

(B) Enrollment is established with respect to the individual regional component, rather than with respect to the parent HMO.

(C) Each such regional component provides substantially the full range of basic health care services to its enrollees without extensive referral between components of the organization for such services, and without substantial utilization by any two such components of the same health care facilities. The separate community rate for each such regional component of the HMO must be based on the different costs of providing health services in such regions.

Authority: Insurance Commissioner, 36 O.S. §§ 307.1 and 6923

Source: Added at 21 Ok Reg 77, eff. 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff. 7-14-04

Okla. Admin. Code 365:40-5-11, OK ADC 365:40-5-11

Current with amendments included in The Oklahoma Register, Volume 27, Number 18, dated

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Title 365. Insurance Department

Chapter 40. Health Maintenance Organizations (Hmo)

Subchapter 5. Life, Accident & Health Division and Consumer Assistance and Claims Division Rules

Part 3. Rating System (Refs & Annos)

➡ 365:40-5-12. Community rating by class

Under "community rating by class," rates are fixed by groups for individuals and families, and must be equivalent for all individuals or for all families in the same group. A class is actuarially derived or developed based on factors which reasonably predict differences in the use of HMO services. Age, sex, family size and marital status factors need not be justified.

Authority: Insurance Commissioner, 36 O.S. §§ 307.1 and 6923

Source: Added at 21 Ok Reg 77, eff. 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff. 7-14-04

Okla. Admin. Code 365:40-5-12, OK ADC 365:40-5-12

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Title 365. Insurance Department

Chapter 40. Health Maintenance Organizations (Hmo)

Subchapter 5. Life, Accident & Health Division and Consumer Assistance and Claims Division Rules

Part 3. Rating System (Refs & Annos)

→ 365:40-5-13. Adjusted community rating

Under "adjusted community rating" rates are fixed on the basis of revenue requirements for providing services to the group, except that rates for a group of less than 50 persons may not be fixed at rates greater than 115 percent of the rate that would be fixed under community rating or community rating by class.

Authority: Insurance Commissioner, 36 O.S. §§ 307.1 and 6923

Source: Added at 21 Ok Reg 77, eff. 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff. 7-14-04

Okla. Admin. Code 365:40-5-13, OK ADC 365:40-5-13

Current with amendments included in The Oklahoma Register, Volume 27, Number 18, dated June 1, 2010.

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Oklahoma Insurance Department

State of Oklahoma

PREMIUM REVIEW GRANT
APPLICANT'S APPLICATION COVER LETTER

June 24, 2010

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

Re: Grant Opportunity: HHS Health Insurance Premium Review Grants-Cycle I
DUNS #: 8248000640000
Grant Award: $1 million

Dear Mrs. Melendez-Bohler:

The eligible entity for the HHS Health Insurance Premium Review Grant Cycle I is the Oklahoma Insurance Department.

The primary contact person and project director is Kathryn Stepp. Her contact information is as follows: telephone Number- 405.522.4609, fax number- 405.522.3761 and email address - kathie.stepp@oid.ok.gov.

In addition, the Insurance Commissioner has sufficient authority to apply for and accept grant funds. The Oklahoma Insurance Commissioner is an Executive Officer of the state, OK Const. Art. VI, § 1, charged with performing the duties designated in the Constitution or prescribed by law. Specifically, the Insurance Commissioner is responsible for the administration and enforcement of the provisions of the Insurance Code. Title 36, Okla.Stat. § 307. The regulation of insurance rates falls within their

jurisdiction. Further, state law specifically authorizes the Insurance Commissioner to solicit and accept grant funds.

Sincerely yours,

Kathryn L. Stepp

Assistant Commissioner

Premium Review Grant Project Officer

5 Corporate Plaza, 3625 NW 56th Street. Suite 100, Oklahoma City, OK 73112
(405) 521-3681 • IN STATE 1-800-522-0071 • FAX (405) 522-3761

PREMIUM REVIEW GRANT

APPLICATION COVER SHEET AND CHECK-OFF LIST

Indentifying Information:

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

DUNS #: 8248000640000 **Grant Award:** $1 million

Applicant: Oklahoma Insurance Department

Primary Contact Person, Name: Kathryn Stepp

Telephone Number: 405.522.4609 Fax number: 405.522.3761

Email address: kathie.stepp@oid.ok.gov

Authority to oversee and coordinate the proposed activities: In Oklahoma, the Insurance Commissioner has sufficient authority to apply for and accept grant funds. The Oklahoma Insurance Commissioner is an Executive Officer of the state, OK Const. Art. VI, § 1, charged with performing the duties designated in the Constitution or prescribed by law. Specifically, the Insurance Commissioner is responsible for the administration and enforcement of the provisions of the Insurance Code. Title 36, Okla.Stat. § 307. The regulation of insurance rates falls within their jurisdiction Further, state law specifically authorizes the Insurance Commissioner to solicit and accept grant funds.

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

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

NA Additional Assurance Certifications *(The Additional Assurance Certifications is the Assurances-Non-Construction Programs" form as per Jacqueline Roche)*

X Required Letter of support and Memorandum of Agreement

X Applicant's Application Cover Letter

X Project Abstract

X Project Narrative

X Work plan and Time Line (Objective Work Plan)

X Proposed Budget (Narrative/Justifications)

X Required Appendices

X Resume/Job Description for Project Director and Assistant Director

PREMIUM REVIEW GRANT
BUDGET BREAKDOWN

ACTIVITIES	BUDGET AMOUNT	Explanation
Expand the Scope of Current Review and Approval Activities	$96,700	1/4 Actuarial Services + Overhead (rent/supplies)
Improving Rate Filing Requirements	$96,700	1/4 Actuarial Services + Overhead (rent/supplies)
Enhancing Rate Review Process-Staffing	$331,800	1/4 Actuarial Services + 3 Mathemeticians + $10000 in Travel/Training + Overhead (rent /supplies)
Enhancing Rate Review Process: IT Capacity	$176,600	1/4 Actuarial Services + OID IT Upgrades + Overhead (rent/supplies)
Enhancing Consumer Protection Standards	$145,350	Website Manager + 3/4 Communications Staff + $10,000 in Travel + Overhead (rent/supplies)
Reporting to HHS Secretary on Rate Increase Patterns	$102,850	SERFF enhancements + Data Entry staff + 1/4 Communications Staff + Overhead (rent/supplies)
Optional Data Center	$50,000	University of Oklahoma; Department of Biostatistics and Epidemiology
Total	$1,000,000	

PREMIUM REVIEW GRANT

BUDGET NARRATIVE

The Oklahoma Insurance Department currently has limited rate review and approval authority in the life and health area so we propose using our grant funds to require the submission of actuarially certified with statistically justified rate filings and enhanced transparency of the information. Our budget will address all enhancements detailed in the Cycle 1 Initial Announcement.

Since we have performed limited rate review in the health area, the Oklahoma Insurance Department (OID) will be adding staff and seeking consultant expertise through qualified actuarial services. We have budgeted approximately $420,000 for internal staffing and approximately $360,000 for contracted actuarial services. The latter would be retained for establishing and enhancing (over time) all rate review/filing and approval activities/processes. That would include the training of existing managers and new internal personnel hired pursuant this grant. Ultimately after the necessary and appropriate training, OID staff will assume full responsibility for the rate review process.

The actuarial services would provide individual, small and large group rate review history and prospective rate review information. Additionally, selected actuarially certified rate filings would need to be professionally reviewed. Finally, the actuarial services would include recommendations on enhancements to our IT capacity (new informational systems, searchable databases) and tools to enhance consumer awareness and protection (simplified web-based tools).

Our budget also includes the enhancement of SERFF (System for Electronic Rate and Form Filings) and our internal IT capacity, both hardware and software, as well as future programming maintenance. Since we have a strong IT staff, we envision the actuarial firm(s) consulting/collaborating with our staff to improve consumer protection standards. Database

feasibility and scope studies for all markets (individual, small and large group) would need to be developed.

Finally, the budget reflects travel to obtain the necessary training for internal staff and the required hardware/software to collect and process the rate data as well as web enhancements to provide an easy-to-read display of the rate information for consumers.

The attached Budget Breakdown Exhibit provides the details for the proposed rate review enhancements. The Objective Work Plan provides the timeline and measurable objectives. All activities will begin immediately upon the awarding of the grant. The Attachments Form Document in the application includes organizational charts describing the placement of the additional staff.

Confirmation

Thank you for submitting your grant application package via Grants.gov. Your application is currently being processed by the Grants.gov system. Once your submission has been processed, Grants.gov will send email messages to advise you of the progress of your application through the system. Over the next 24 to 48 hours, you should receive two emails. The first will confirm receipt of your application by the Grants.gov system, and the second will indicate that the application has either been successfully validated by the system prior to transmission to the grantor agency or has been rejected due to errors.

Please do not hit the back button on your browser.

If your application is successfully validated and subsequently retrieved by the grantor agency from the Grants.gov system, you will receive an additional email. This email may be delivered several days or weeks from the date of submission, depending on when the grantor agency retrieves it.

You may also monitor the processing status of your submission within the Grants.gov system by clicking on the "Track My Application" link listed at the end of this form.

Note: Once the grantor agency has retrieved your application from Grants.gov, you will need to contact them directly for any subsequent status updates. Grants.gov does not participate in making any award decisions.

IMPORTANT NOTICE: If you do not receive a receipt confirmation and either a validation confirmation or a rejection email message within 48 hours, please contact us. The Grants.gov Contact Center can be reached by email at support@grants.gov, or by telephone at 1-800-518-4726. Always include your Grants.gov tracking number in all correspondence. The tracking numbers issued by Grants.gov look like GRANTXXXXXXXX.

Contact Center hours of operation are Monday-Friday from 7:00 A.M. to 9:00 P.M. Eastern Time.

The following application tracking information was generated by the system:

Grants.gov Tracking Number :	GRANT10644663
Applicant DUNS:	82-480-0064
Submitter's Name:	Russell S Valleroy
CFDA Number:	93.511
CFDA Description:	Affordable Care Act (ACA) Grants to States for Health Ins
Funding Opportunity Number :	RFA-FD-10-999
Funding Opportunity Description :	"Grants to States for Health Insurance Premium Review-
Agency Name :	Ofc of Consumer Information & Insurance Oversight
Application Name of this Submission :	Oklahoma Premium Review Grant
Date/Time of Receipt :	2010.07.01 5:15 PM, EDT

TRACK MY APPLICATION – To check the status of this application, please click the link below:

https://apply07.grants.gov/apply/checkSingleApplStatus.faces?tracking_num=GRANT10644663

It is suggested you Save and/or Print this response for your records.

PREMIUM REVIEW GRANT
LIST OF KEY CONTACTS

Project Officer: Kathie Stepp
405-522-4609
Kathie.Stepp@oid.ok.gov

Financial Officer: Sherry Marczewski
405-522-4581
Sherry.Marczewski@oid.ok.gov

Assistant Project Officer: Greg Lawson
405-522.4604
Greg.Lawson@oid.ok.gov

Additional Key Contacts for Activities Outlined in the Objective Work Plan

Enhancing Consumer Protection Standards:
Marc Young
405-522-8398
Marc.Young@oid.ok.gov

Optional Data Center: Craig Knutson
405-522-4968
Craig.Knutson@oid.ok.gov

Insurance Commissioner
State of Oklahoma

PREMIUM REVIEW GRANT
LETTER OF SUPPORT AND MEMORANDUM OF AGREEMENT

The Oklahoma Insurance Commissioner is an Executive Officer of the state, OK Const. Art. VI, § 1, charged with performing the duties designated in the Constitution or prescribed by law. Specifically, the Insurance Commissioner is responsible for the administration and enforcement of the provisions of the Insurance Code. Title 36, Okla.Stat. § 307. The regulation of insurance rates falls within their jurisdiction. Further, state law specifically authorizes the Insurance Commissioner to solicit and accept grant funds. Title 36, Okla. Stat. § 307.4 provides as follows:

A. The Insurance Commissioner may solicit, accept and authorize the use of any grant made to the Insurance Department as long as the terms of the grant are carried out and the Insurance Commissioner holds the funds in trust for the purposes of carrying out the terms of the grant.

B. The Insurance Commissioner must annually account to the State Auditor and Inspector for all monies or property received or extended by virtue of this section. The account shall state:

1. The source of the monies or property received with the actual date of its receipt;

2. The particular use or place for which it was expended; and

3. The balance on hand showing the place of deposit of the unexpended balance.

By execution of this grant application, the Insurance Commissioner acknowledges that she will carry out the grant in compliance with state law.

The Insurance Commissioner hereby certifies that the grant funds will not supplant existing state expenditures or any state fiscal constraints.

Sincerely,

Kim Holland
Oklahoma Insurance Commissioner

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:** Oklahoma Premium Review Grant

Mandatory Documents

Move Form to Complete

Move Form to Delete

Mandatory Documents for Submission

Optional Documents

Move Form to Submission List

Move Form to Delete

Optional Documents for Submission

Instructions

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.

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.

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: 07/01/2010	4. Applicant Identifier:
5a. Federal Entity Identifier:	5b. Federal Award Identifier:

State Use Only:

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

8. APPLICANT INFORMATION:

* a. Legal Name: Oklahoma Insurance Department

* b. Employer/Taxpayer Identification Number (EIN/TIN): 73-6017987	* c. Organizational DUNS: 8248000640000

d. Address:

* Street1:	3625 N.W. 56th Street, Suite 100
Street2:	
* City:	Oklahoma City
County/Parish:	
* State:	OK: Oklahoma
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	73112-4511

e. Organizational Unit:

Department Name:	Division Name:
Oklahoma Insurance Department	Rate and Form Compliance Div

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

Prefix:		* First Name:	Kathryn
Middle Name:			
* Last Name:	Stepp		
Suffix:			

Title: Assistant Commissioner/Director

Organizational Affiliation:
Oklahoma Insurance Department

* Telephone Number:	405.522.4609	Fax Number:	405.522.3761

* Email: Kathie.Stepp@oid.ok.gov

Application for Federal Assistance SF-424

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

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

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

Ofc of Consumer Information & Insurance Oversight

11. Catalog of Federal Domestic Assistance Number:

93.511

CFDA Title:

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

*** 12. Funding Opportunity Number:**

RFA-FD-10-999

* Title:

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

13. Competition Identification Number:

ADOBE-FORMS-B

Title:

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

Add Attachment | Delete Attachment | View Attachment

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

Premium Review Grant: The Oklahoma Premium Review Grant to enhance the current rate review process for health insurance premiums.

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: OK-005

b. Program/Project: OK-All

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

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

17. Proposed Project:

* a. Start Date: 08/09/2010

* b. End Date: 09/30/2011

18. Estimated Funding ($):

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

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

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

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

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

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

☐ Yes ☒ No

If "Yes", provide explanation and attach

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

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

☒ ** I AGREE

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

Authorized Representative:

Prefix:

* First Name: Kim

Middle Name:

* Last Name: Holland

Suffix:

* Title: Oklahoma Insurance Commissioner

* Telephone Number: 405.521-2668

Fax Number: 405.521.6635

* Email: kim.holland@oid.ok.gov

* Signature of Authorized Representative: Russell Valleroy

* Date Signed: 07/01/2010

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

Key Contacts Form

*** Applicant Organization Name:**

Oklahoma Insurance Department

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

*** Contact 1 Project Role:** Project Manager/ Project Officer

Prefix:

* First Name: Kathryn

Middle Name:

* Last Name: Stepp

Suffix:

Title: Assistant Commissioner-Rate & Form Compliance

Organizational Affiliation:

Oklahoma Insurance Department

* Street1: 3625 NW 56th, Suite 100

Street2:

* City: Oklahoma City

County:

* State: OK: Oklahoma

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 73112-4511

* Telephone Number: 405.522.4609

Fax: 405.522.3761

* Email: Kathie.Stepp@oid.ok.gov

Delete Entry | Previous Person | Next Person

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

Key Contacts Form

*** Applicant Organization Name:** Oklahoma Insurance Department

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

*** Contact 2 Project Role:** Project Assistant Manager

Prefix:

* First Name: Greg

Middle Name:

* Last Name: Lawson

Suffix:

Title: Manager of Statistical Analysis

Organizational Affiliation: Oklahoma Insurance Department

* Street1: 3625 NW 56th, Suite 100

Street2:

* City: Oklahoma City

County:

* State: OK: Oklahoma

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 73112-4511

* Telephone Number: 405.522.4604

Fax: 405.522.3761

* Email: Greg.Lawson@oid.ok.gov

Delete Entry | Previous Person | Next Person

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

Key Contacts Form

*** Applicant Organization Name:**

Oklahoma Insurance Department

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

*** Contact 3 Project Role:** Financial Officer

Prefix:

* First Name: Sherry

Middle Name:

* Last Name: Marczewski

Suffix:

Title: Comptroller

Organizational Affiliation:

Oklahoma Insurance Department

* Street1: 3625 NW 56th, Suite 100

Street2:

* City: Oklahoma City

County:

* State: OK: Oklahoma

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 73112-4511

* Telephone Number: 405-522-4581

Fax: 405-522-4163

* Email: Sherry.Marczewski@oid.ok.gov

Delete Entry | Previous Person | Next Person

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

Key Contacts Form

*** Applicant Organization Name:**

Oklahoma Insurance Department

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

*** Contact 4 Project Role:** Enhancing Consumer Protection Standards

Prefix:

* First Name: Marc

Middle Name:

* Last Name: Young

Suffix:

Title: Assistant Commissioner - Communications

Organizational Affiliation:

Oklahoma Insurance Department

* Street1: 3625 NW 56th, Suite 100

Street2:

* City: Oklahoma City

County:

* State: OK: Oklahoma

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 73112-4511

* Telephone Number: 405.522.8398

Fax: 405.522.6635

* Email: Marc.Young@oid.ok.gov

Delete Entry | Previous Person | Next Person

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

Project/Performance Site Location(s)

Project/Performance Site Primary Location

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

Organization Name: Oklahoma Insurance Department

DUNS Number:

* Street1: 3625 NW 56th, Suite 100

Street2:

* City: Oklahoma City

County:

* State: OK: Oklahoma

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 73112-4511

* Project/ Performance Site Congressional District: OK-005

Project/Performance Site Location 1

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

Organization Name:

DUNS Number:

* Street1:

Street2:

* City:

County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code:

* Project/ Performance Site Congressional District:

Additional Location(s)

Add Attachment | Delete Attachment | View Attachment

ATTACHMENTS FORM

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

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

1) Please attach Attachment 1		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: The Oklahoma Premium Review Grant to enhance the current rate review process for health insurance premiums.

* Year: 1

* Funding Agency Goal:

To enhance the current rate review process for health insurance premiums.

* Objective:

To collect data from insurers during every rate filing, initial and renewal, and use that data to: 1) determine whether the rate increase is appropriate; 2) report as required to the Secretary; 3) enhance transparency in the rate making process in a meaningful, understandable way; and 4) incorporate the data we've gleaned from rate filings with data gleaned from our proposed data center activities

* Results or Benefits Expected:

To achieve a better understanding of the relationship between the cost of health care and the cost of health insurance by enhancing the current rate review process for health insurance premiums.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Expand the scope of current review and approval activities	Kathie Stepp	09/01/2010	09/30/2011	0
Improving rate filing requirements	Greg Lawson	09/01/2010	09/30/2011	0
Enhancing rate review process staffing	Greg Lawson	09/01/2010	09/30/2011	0
Enhancing rate review process IT - capacity	Kathie Stepp	09/01/2010	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
Enhancing Consumer Protection Standards	Marc Young	09/01/2010	09/30/2011	0
Reporting to the Secretary on Rate Increase Patterns	Greg Lawson	09/01/2010	09/30/2011	0
Optional Data Center	Craig Knutson	09/01/2010	09/30/2011	0

* Criteria for Evaluating Results or Benefits Expected:

Measure the number of filings reviewed, achieve necessary statutory changes, develop a rate review manual, successful reporting to Secretary, track the number of consumers served and develop interactive informational tool for consumers on the Oklahoma Insurance Department web site.

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.	Oklahoma Premium Rate Review Grant	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)
	Oklahoma Premium Rate Review Grant				
a. Personnel	$ 280,000.00	$	$	$	$ 280,000.00
b. Fringe Benefits	140,000.00				140,000.00
c. Travel	20,000.00				20,000.00
d. Equipment	80,000.00				80,000.00
e. Supplies	40,000.00				40,000.00
f. Contractual	440,000.00				440,000.00
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	$ 0.00	$	$	$	$

Authorized for Local Reproduction

SECTION C - NON-FEDERAL RESOURCES

	(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8.	Oklahoma Premium Rate Review Grant	$ 0.00	$ 0.00	$ 0.00	$ 0.00
9.					
10.					
11.					
12. TOTAL (sum of lines 8-11)		$	$	$	$

SECTION D - FORECASTED CASH NEEDS

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

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

	(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
		(b)First	(c) Second	(d) Third	(e) Fourth
16.	Oklahoma Premium Rate Review Grant	$ 1,000,000.00	$ 0.00	$ 0.00	$ 0.00
17.					
18.					
19.					
20. TOTAL (sum of lines 16 - 19)		$ 1,000,000.00	$	$	$

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Russell Valleroy	Oklahoma Insurance Commissioner
* APPLICANT ORGANIZATION	* DATE SUBMITTED
Oklahoma Insurance Department	07/01/2010

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: Oklahoma Insurance Department

*Street 1: 3625 NW 56th, Suite 100 Street 2:

*City: Oklahoma City State: OK: Oklahoma Zip: 73112-4511

Congressional District, if known: OK-005

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

6. * Federal Department/Agency:

Department of Health and Human Services

7. * Federal Program Name/Description:

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

CFDA Number, *if applicable:* 93.511

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix: *First Name: N/A Middle Name:

*Last Name: N/A Suffix:

*Street 1: Street 2:

*City: State: Zip:

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

Prefix: *First Name: N/A Middle Name:

*Last Name: N/A Suffix:

*Street 1: Street 2:

*City: State: Zip:

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

*** Signature:** Russell Valleroy

***Name:** Prefix: *First Name: Kim Middle Name:

*Last Name: Holland Suffix:

Title: Oklahoma Insurance Commissioner **Telephone No.:** 405.521.2668 **Date:** 07/01/2010

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**

Oklahoma Insurance Department

*** 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: The Oklahoma Premium Review Grant to enhance the current rate review process for health insurance premiums.

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