California

GRANTS.GOV™

Grant Application Package

Opportunity Title:	"Grants to States for Health Insurance Premium Review-C
Offering Agency:	Ofc of Consumer Information & Insurance Oversight
CFDA Number:	93.511
CFDA Description:	Affordable Care Act (ACA) Grants to States for Health I
Opportunity Number:	RFA-FD-10-999
Competition ID:	ADOBE-FORMS-B
Opportunity Open Date:	06/07/2010
Opportunity Close Date:	07/07/2010
Agency Contact:	Gladys Melendez-Bohler Grant Specialist E-mail: Gladys.Melendez-Bohler@fda.hhs.gov Phone: 301-827-7168

This electronic grants application is intended to be used to apply for the specific Federal funding opportunity referenced here.

If the Federal funding opportunity listed is not the opportunity for which you want to apply, close this application package by clicking on the "Cancel" button at the top of this screen. You will then need to locate the correct Federal funding opportunity, download its application and then apply.

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

*** Application Filing Name:** CA Application for Rate Review Grant

Mandatory Documents

Move Form to Complete

Move Form to Delete

Mandatory Documents for Submission

Optional Documents

Move Form to Submission List

Move Form to Delete

Optional Documents for Submission

Instructions

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

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

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

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

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

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

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

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

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

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

Application for Federal Assistance SF-424

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

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

5a. Federal Entity Identifier:	5b. Federal Award Identifier:
N/A	

State Use Only:

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

8. APPLICANT INFORMATION:

* a. Legal Name:	Department of Managed Health Care

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
68-0461278	1178946620000

d. Address:

* Street1:	980 9th Street, Suite 500
Street2:	
* City:	Sacramento
County/Parish:	
* State:	CA: California
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	95814-2724

e. Organizational Unit:

Department Name:	Division Name:

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

Prefix:		* First Name:	Gary
Middle Name:			
* Last Name:	Baldwin		
Suffix:			

Title:	Staff Counsel III
Organizational Affiliation:	
* Telephone Number:	916-324-2560
Fax Number:	916-322-3968
* Email:	gbaldwin@dmhc.ca.gov

Application for Federal Assistance SF-424

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

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

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

Ofc of Consumer Information & Insurance Oversight

11. Catalog of Federal Domestic Assistance Number:

93.511

CFDA Title:

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

*** 12. Funding Opportunity Number:**

RFA-FD-10-999

* Title:

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

13. Competition Identification Number:

ADOBE-FORMS-B

Title:

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

Add Attachment | Delete Attachment | View Attachment

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

Premium Review Grant

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: CA-005 b. Program/Project: CA-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: Lucinda

Middle Name:

* Last Name: Ehnes

Suffix:

* Title: Director, DMHC

* Telephone Number: 916-322-2012 Fax Number:

* Email: CEhnes@dmhc.ca.gov

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

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

Key Contacts Form

*** Applicant Organization Name:**

Department of Managed Health Care

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

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

Prefix:

* First Name: Maureen

Middle Name:

* Last Name: McKennan

Suffix:

Title: Assistant Chief Counsel

Organizational Affiliation:

Department of Managed Health Care

* Street1: 980 9th Street, Suite 500

Street2:

* City: Sacramento

County:

* State: CA: California

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 95814-2724

* Telephone Number: 916-445-7976

Fax:

* Email: MMcKennan@dmhc.ca.gov

Delete Entry | Previous Person | Next Person

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

Key Contacts Form

*** Applicant Organization Name:**

Department of Managed Health Care

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

*** Contact 2 Project Role:** Assistant Project Director

* Prefix:

* First Name: Michael

Middle Name:

* Last Name: Cleary

Suffix:

Title: CEA I

Organizational Affiliation:

Department of Managed Health Care

* Street1: 980 9th Street, Suite 500

Street2:

* City: Sacramento

County:

* State: CA: California

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 95814-2724

* Telephone Number: 916-255-2448

Fax:

* Email: mcleary@dmhc.ca.gov

Delete Entry | Previous Person | Next Person

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

Key Contacts Form

*** Applicant Organization Name:**

Department of Managed Health Care

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

*** Contact 3 Project Role:** Dept. of Insurance - Asst. Project Director

Prefix:

* First Name: Julia

Middle Name:

* Last Name: Cross

Suffix:

Title: Chief, Financial Management

Organizational Affiliation:

California Department of Insurance

* Street1: 300 Capitol Mall, 16th Floor

Street2:

* City: Sacramento

County:

* State: CA: California

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 95814

* Telephone Number: 916-492-3264

Fax:

* Email: Julia.Cross@insurance.ca.gov

Delete Entry | Previous Person | Next Person

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

Key Contacts Form

*** Applicant Organization Name:**

Department of Managed Health Care

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

*** Contact 4 Project Role:** Dept. of Insurance - Sr. Staff Counsel

Prefix:

* First Name: Bruce

Middle Name:

* Last Name: Hinze

Suffix:

Title: Senior Staff Counsel

Organizational Affiliation:

California Department of Insurance

* Street1: 45 Fremont Street, 23rd Floor

Street2:

* City: San Francisco

County:

* State: CA: California

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 94105

* Telephone Number: 415-538-4392

Fax:

* Email: HinzeB@insurance.ca.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: Department of Managed Health Care

DUNS Number: 1178946620000

* Street1: 980 9th Street, Suite 500

Street2:

* City: Sacramento County:

* State: CA: California

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 95814-2724 * Project/ Performance Site Congressional District: CA-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: California Department of Insurance

DUNS Number:

* Street1: 45 Fremont Street, 23rd Floor

Street2:

* City: San Francisco County:

* State: CA: California

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 94105-2204 * Project/ Performance Site Congressional District: CA-008

Project/Performance Site Location 2 ☐ 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: California Department of Insurance

DUNS Number:

* Street1: 300 South Spring Street

Street2:

* City: Los Angeles County:

* State: CA: California

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 90013-1230 * Project/ Performance Site Congressional District: CA-034

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	CA SF 424 Application for Fe	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	CA Assurances NonConstructio	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	CA Disclosure of Lobbying Act	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4	sf-424a CDI BUDGET SUMMARY.p	Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5	sf-424a DMHC BUDGET SUMMARY.p	Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6	DMHC Project Director Duty S	Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7	DMHC Asst Project Director D	Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8	DMHC ORGANIZATIONAL CHART.pd	Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9	DMHC Rate Review Project Org	Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10	CDI ORGANIZATIONAL CHART.pdf	Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11	CDI Rate Review Project Staf	Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12	CDI Rate Review Project Org	Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13	Governor's Letter of Support	Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14	COVER SHEET & CHECK LIST.doc	Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15	COVER LETTER.pdf	Add Attachment	Delete Attachment	View Attachment

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

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

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

* If Revision, select appropriate letter(s):

* Other (Specify):

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

4. Applicant Identifier: N/A

5a. Federal Entity Identifier: N/A

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Department of Managed Health Care

* b. Employer/Taxpayer Identification Number (EIN/TIN): 68-0461278

* c. Organizational DUNS: 1178946620000

d. Address:

* Street1: 980 9th Street, Suite 500
Street2:
* City: Sacramento
County/Parish:
* State: CA: California
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 95814-2724

e. Organizational Unit:

Department Name:

Division Name:

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

Prefix:

* First Name: Gary

Middle Name:

* Last Name: Baldwin

Suffix:

Title: Staff Counsel III

Organizational Affiliation:

* Telephone Number: 916-324-2560

Fax Number: 916-322-3968

* Email: gbaldwin@dmhc.ca.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:**

California's Premium Rate Review Program

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

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☐ 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: Lucinda

Middle Name:

* Last Name: Ehnes

Suffix:

* Title: Director, DMHC

* Telephone Number: 916-322-2012 Fax Number:

* Email: CEhnes@dmhc.ca.gov

* Signature of Authorized Representative: Lucinda Ehnes * Date Signed: 7/9/10

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

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

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

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

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

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

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

OMB Approval No. 0348-0040

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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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).

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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
Lucinda A. Ehnes	Director
APPLICANT ORGANIZATION	DATE SUBMITTED
Department of Managed Health Care	7/7/10

Standard Form 424B (Rev. 7-97) Back

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: Department of Managed Health Care

*Street 1: 980 9th Street, Suite 500 Street 2:

*City: Sacramento State: CA: California Zip: 95814

Congressional District, if known:

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

6. * Federal Department/Agency:
Ofc of Consumer Information & Insurance

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

CFDA Number, *if applicable:* 93.511

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*
$ 1,000,000.00

10. a. Name and Address of Lobbying Registrant:

Prefix: * First Name: NA Middle Name:

* Last Name: NA Suffix:

* Street 1: Street 2:

* City: State: Zip:

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

Prefix: * First Name: NA Middle Name:

* Last Name: NA 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: Lucinda A. Ehnes

*Name: Prefix: * First Name: Lucinda Middle Name:

* Last Name: Ehnes Suffix:

Title: Director Telephone No.: 916-322-2012 Date: 5/21/10

Federal Use Only:

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

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

BUDGET INFORMATION - Non-Construction Programs

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. CDI: Enhance IT infrastructure to support SERFF data collection and public disclosure of rates.	93.511	$ 0.00	$ 0.00	$ 81,025.00	$ 0.00	$ 81,025.00
2. CDI: Hire state actuaries to develop premium rate review process and review rate filings.	93.511	0.00	0.00	157,146.00	0.00	157,146.00
3. CDI: Obtain contractual actuarial services to develop premium rate review process and review	93.511	0.00	0.00	153,831.00	0.00	153,831.00
4.						
5. Totals		$ 0.00	$ 0.00	$ 392,002.00	$ 0.00	$ 392,002.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1) CDI: Enhance IT infrastructure to support SERFF data collection and public disclosure of rates.	(2) CDI: Hire state actuaries to develop premium rate review process and review rate filings	(3) CDI: Obtain contractual actuarial services to develop premium rate review process and review	(4)	Total (5)
a. Personnel	$ 0.00	$ 118,744.14	$ 0.00	$	$ 118,744.14
b. Fringe Benefits	0.00	38,401.86	0.00		38,401.86
c. Travel	0.00	0.00	0.00		0.00
d. Equipment	2,225.00	0.00	0.00		2,225.00
e. Supplies	0.00	0.00	0.00		0.00
f. Contractual	78,800.00	0.00	153,831.00		232,631.00
g. Construction	0.00	0.00	0.00		0.00
h. Other	0.00	0.00	0.00		0.00
i. Total Direct Charges (sum of 6a-6h)	81,025.00	157,146.00	153,831.00		$ 392,002.00
j. Indirect Charges	0.00	0.00	0.00		$ 0.00
k. TOTALS (sum of 6i and 6j)	$ 81,025.00	$ 157,146.00	$ 153,831.00	$	$ 392,002.00
7. Program Income	$ 81,025.00	$ 157,146.00	$ 153,831.00	$	$ 392,002.00

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. Not applicable	$	$	$	$
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	$ 392,002.00	$ 158,769.25	$ 77,744.25	$ 77,744.25	$ 77,744.25
14. Non-Federal	$ 0.00	0.00	0.00	0.00	0.00
15. TOTAL (sum of lines 13 and 14)	$ 392,002.00	$ 158,769.25	$ 77,744.25	$ 77,744.25	$ 77,744.25

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. CDI: Enhance IT infrastructure to support SERFF data collection and public disclosure of rates.	$ 81,025.00	$ 0.00	$ 0.00	$ 0.00
17. CDI: Hire state actuaries to develop premium rate review process and review rate filings	157,146.00	0.00	0.00	0.00
18. CDI: Obtain contractual actuarial services to develop premium rate review process and review	153,831.00	0.00	0.00	0.00
19.				
20. TOTAL (sum of lines 16 - 19)	$ 392,002.00	$ 0.00	$ 0.00	$ 0.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks: This budget reflects the program budget for California Department of Insurance grant activities.

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

BUDGET INFORMATION - Non-Construction Programs

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. DMHC: Enhance IT infrastructure to support SERFF data collection and public disclosure of rates.	93.511	$ 0.00	$ 0.00	$ 55,688.00	$ 0.00	$ 55,688.00
2. DMHC: Hire state actuaries to develop premium rate review process and review rate filings.	93.511	0.00	0.00	408,778.00	0.00	408,778.00
3. DMHC: Obtain contractual actuarial services to develop premium rate review process and review	93.511	0.00	0.00	124,724.00	0.00	124,724.00
4. Improvement of NAIC's SERFF to support the aggregation, analysis and reporting of rate data	93.511	0.00	0.00	18,808.00	0.00	18,808.00
5. Totals		$ 0.00	$ 0.00	$ 607,998.00	$ 0.00	$ 607,998.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1) DMHC: Enhance IT infrastructure to support SERFF data collection and public disclosure of rates.	(2) DMHC: Hire state actuaries to develop premium rate review process and review rate filings.	(3) DMHC: Obtain contractual actuarial services to develop premium rate review process and review	(4) Improvement of NAIC's SERFF to support the aggregation, analysis and reporting of rate data	(5)
a. Personnel	$ 13,297.57	$ 308,884.69	$ 0.00	$ 0.00	$ 322,182.26
b. Fringe Benefits	4,300.43	99,893.31	0.00	0.00	104,193.74
c. Travel	0.00	0.00	0.00	0.00	0.00
d. Equipment	3,000.00	0.00	0.00	0.00	3,000.00
e. Supplies	0.00	0.00	0.00	0.00	0.00
f. Contractual	32,000.00	0.00	124,724.00	18,808.00	175,532.00
g. Construction	0.00	0.00	0.00	0.00	0.00
h. Other	3,090.00	0.00	0.00	0.00	3,090.00
i. Total Direct Charges (sum of 6a-6h)	55,688.00	408,778.00	124,724.00	18,808.00	$ 607,998.00
j. Indirect Charges	0.00	0.00	0.00	0.00	$ 0.00
k. TOTALS (sum of 6i and 6j)	$ 55,688.00	$ 408,778.00	$ 124,724.00	$ 18,808.00	$ 607,998.00
7. Program Income	$ 55,688.00	$ 408,778.00	$ 124,724.00	$ 18,808.00	$ 607,998.00

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. Not Applicable	$	$	$	$
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	$ 607,998.00	$ 207,871.50	$ 133,375.50	$ 133,375.50	$ 133,375.50
14. Non-Federal	$ 0.00	0.00	0.00	0.00	0.00
15. TOTAL (sum of lines 13 and 14)	$ 607,998.00	$ 207,871.50	$ 133,375.50	$ 133,375.50	$ 133,375.50

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. DMHC: Enhance IT infrastructure to support SERFF data collection and public disclosure of rates.	$ 55,688.00	$ 0.00	$ 0.00	$ 0.00
17. DMHC: Hire state actuaries to develop premium rate review process and review rate filings.	408,778.00	0.00	0.00	0.00
18. DMHC: Obtain contractual actuarial services to develop premium rate review process and review	124,724.00	0.00	0.00	0.00
19. Improvement of NAIC's SERFF to support the aggregation, analysis and reporting of rate data	18,808.00	0.00	0.00	0.00
20. TOTAL (sum of lines 16 - 19)	$ 607,998.00	$ 0.00	$ 0.00	$ 0.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks: This budget reflects the program budget for Department of Managed Health Care grant activities.

Current

Career Executive Assignment
Duty Statement

Department of Managed Health Care

I. Position Identification:

Classification:	**Career Executive Assignment (CEA)**
Working Title:	**Chief, Office of Health Plan Oversight**
Position Number	**410-151-7500-001**
Location:	**Sacramento**
Date Prepared:	**December 7, 2007**

Function:
Functions as the Assistant Deputy Director, Office of Health Plan Oversight (OHPO), and is responsible for managing and directing the statewide activities of the OHPO. As a key member of the Department of Managed Health Care's (DMHC) executive management team, the incumbent is charge with ensuring that all managed care health plans in California are in compliance with all licensing requirements and meet specific standards for financial viability and health care delivery.

Reporting Relationships:
Reports directly to the Director and Chief Deputy Director, Department of Managed Health Care.

II. Program Identification

The DMHC was established as part of a sweeping package of reforms designed to ensure high quality prevention and health care for the 62 million Californians enrolled in managed care health plans. The DMHC is a first-in-the nation in providing an innovative approach toward ensuring aggressive prevention and high quality health care under managed care.

Approximately 325 employees at the DMHC work in seven offices and the Director's Office: the Office of Enforcement, the HMO Help Center, the Office of Administration, the Office of Technology and Innovation, the Office of Legal Services, the Office of Health Plan Oversight, and the Office of Provider Oversight.. The DMHC works in tandem with the Office of the Patient Advocate to ensure that the needs of managed care consumers are heard and met.

III. Essential and Non-Essential Job Functions

Essential Functions:

30% Manages and directs all activities of the office, including overseeing the development and implementation of policies and procedures to ensure compliance with licensing requirements, standards of financial integrity and stability/viability, and health care delivery programs; sets broad priorities for completion of the responsibilities of staff; examines in-depth, and revises as necessary, policies and procedures used by staff; reviews program evaluation reports, legislative reports, privileged legal correspondence, and proposed regulations having significant policy impact; identifies programs, recommends changes and approves reports and proposals; consults with the Director and the executive management team regarding the implementation of proposed or pending legislation, budget items, and other policy actions with potential impact to division and departmental policies and/or operations; delegates development and implementation of specific policies, procedures and priorities for the efficient administration of the various functions under the OHPO through subordinate managers and supervisors.

25% Manages and directs, through an Assistant Chief Counsel, the activities of staff attorneys in the Division of Licensing whose specific responsibilities include legal review and analysis of license applications, material modifications, and amendments; conducting pre-filing conferences; consulting with licensees, their attorneys, regulatory agencies, consumer groups and others concerning licensing and compliance activities; responding to licensing related inquiries from outside attorneys, plan representatives, members of the public and staff of other governmental agencies; providing legal research and analysis of selected provisions of the Knox-Keene Act, selected federal and State statutes and regulations relating to managed care, and issues presented in the preparation of required reports to the Legislature; determining legal compliance by plans with provisions of the Act in areas that affect many plans (such as prescription drug formulary practices; and determining the legal adequacy of medical survey reports through legal review pursuant to the Act.

25% Manages, plans and directs, through a CEA, the activities of professional and technical examiners and auditors in the Division of Financial Oversight whose responsibilities include the licensing of managed care health plans, the fiscal review and analysis of license applications, material modifications, and amendments; ongoing monitoring of health care service plans' financial statements; conducting financial examinations of managed care health plan financial records; and issuing public reports.

15% Represents the DMHC before other State, local or federal governmental agencies in matters relating to the office's managed care programs; maintains positive working relationships with organizations interested in the offices's activities.

5% Provides special assistance to the Director and/or Chief Deputy Director and other programs, as needed, on issues considered out-of-the-ordinary or highly controversial or sensitive.

Non-Essential Functions:
N/A

IV. Work Environment

The duties of this function are performed indoors up to 80% of the time. The incumbent may be expected to travel via commercial providers approximately 20% of the time.

_____ _____

*Employee Signature (Date) Supervisor Signature (Date)

*Duties of this position are subject to change and may be revised as needed or required.

Duty Statement

Department of Managed Health Care

CLASSIFICATION: CEA I

WORKING TITLE: Chief Examiner
POSITION: 121-7500-001

OFFICE/DIVISION: Office of Health Plan Oversight,
Division of Financial Oversight

SECTION A: General Description

Under the general direction of the Assistant Deputy Director, Office of Health Plan Oversight, the Chief Examiner in the Division of Financial Oversight (Division) is responsible for coordinating the regulatory financial examination requirements of the Knox-Keene Health Care Service Plan Act of 1975; managing program activities including the examination of health care service plans and their financial arrangements, claims payment activities, financial statements and reports, and license documents; ensuring that all policies and operations protect consumers by assuring accessible, available, and medically necessary health care through financially sound managed care systems; acting as an advisor of financial matters for executive management; and periodically travels as necessary between office locations.

SECTION B: Essential Functions

Candidates must be able to perform the following functions with or without reasonable accommodations.

40% Plan, organize and direct the statewide examination program of the Division; oversee the outcomes of other staff including the direct supervision of supervising examiners; and provide updates of financial issues and identify issues proactively for the Director and other key department leadership members regarding industry trends and matters involving health plans and medical groups.

30% Formulate short and long-range objectives; direct and coordinate matters requiring action or policy determination and disposition of these matters; develop methods, auditing procedures and techniques for regulatory examinations and related activities; and maintain examination cycles and timely production of reports and other compliance work products.

15% Represent the Division in a variety of forums in matters related to the financial examination program of the Division; conduct hearings and meetings with

interested stakeholders and others; and handle other critical matters assigned by the Assistant Deputy Director.

15% Advise the Assistant Deputy Director on highly complex or unusual problems relating to the formulation of departmental policy, legislative proposals, regulations and procedures; and recommend necessary changes in law and program.

SECTION C: Non-Essential or Marginal Functions

N/A

SECTION D: ADA Requirement

Alternatives may be provided for incumbents who are unable to perform the non-essential functions of the job due to a disability covered under the Americans with Disabilities Act.

SECTION E: Signature

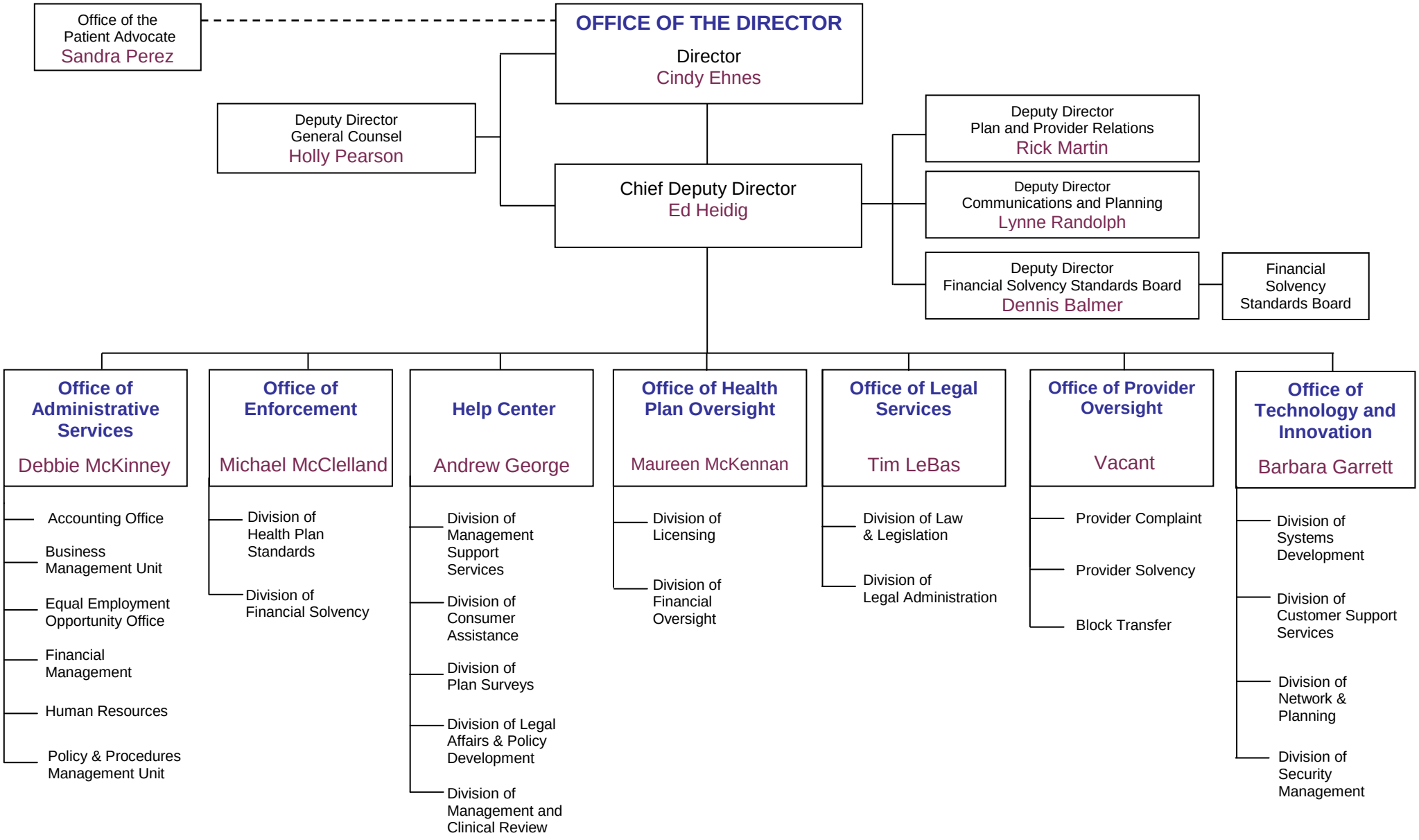
I can perform the above essential functions with or without reasonable accommodation.

By signing this document, I acknowledge that I understand all the requirements and information stated above and will receive a copy of this duty statement.

Employee Signature **Date**

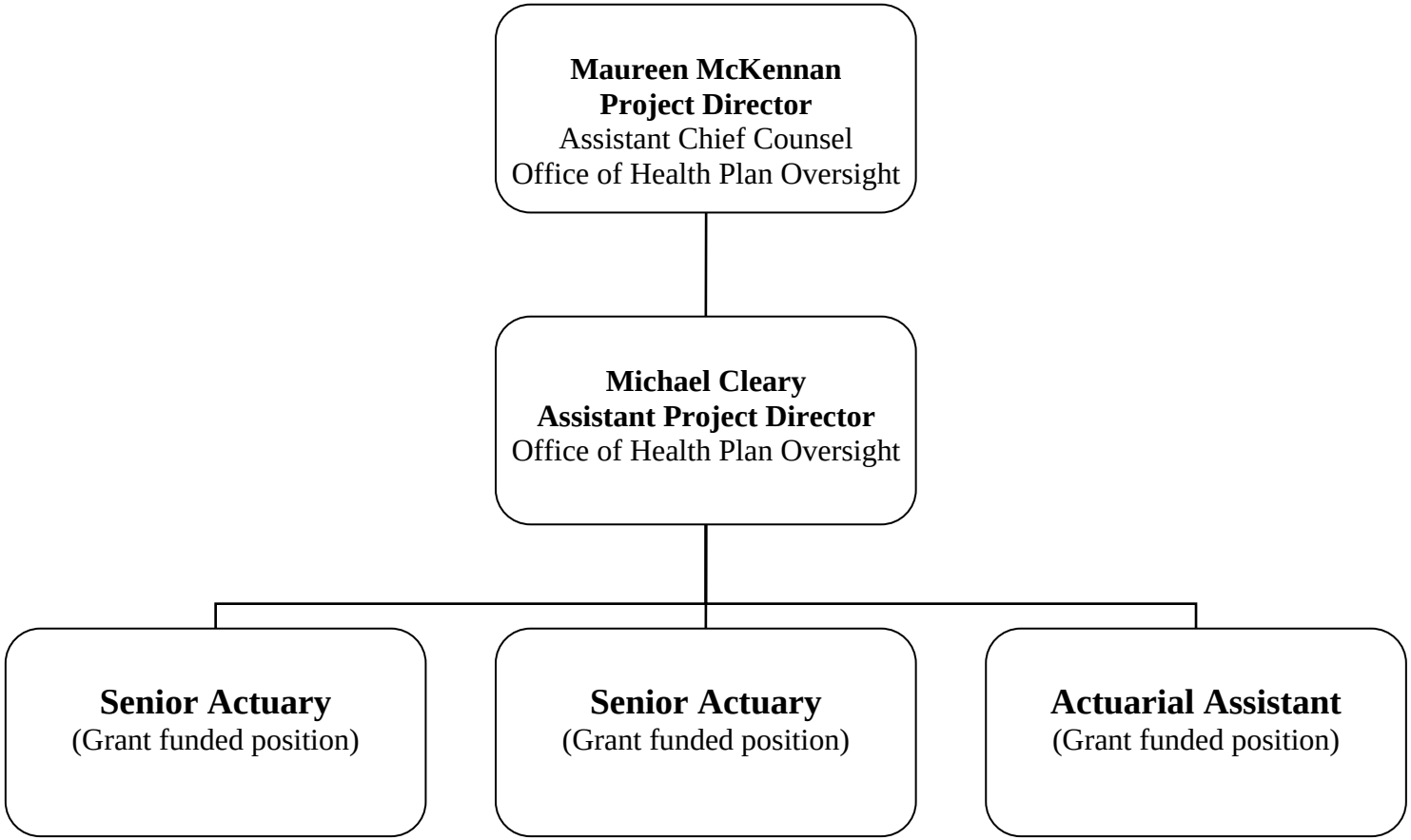
Business, Transportation and Housing Agency

Department of Managed Health Care



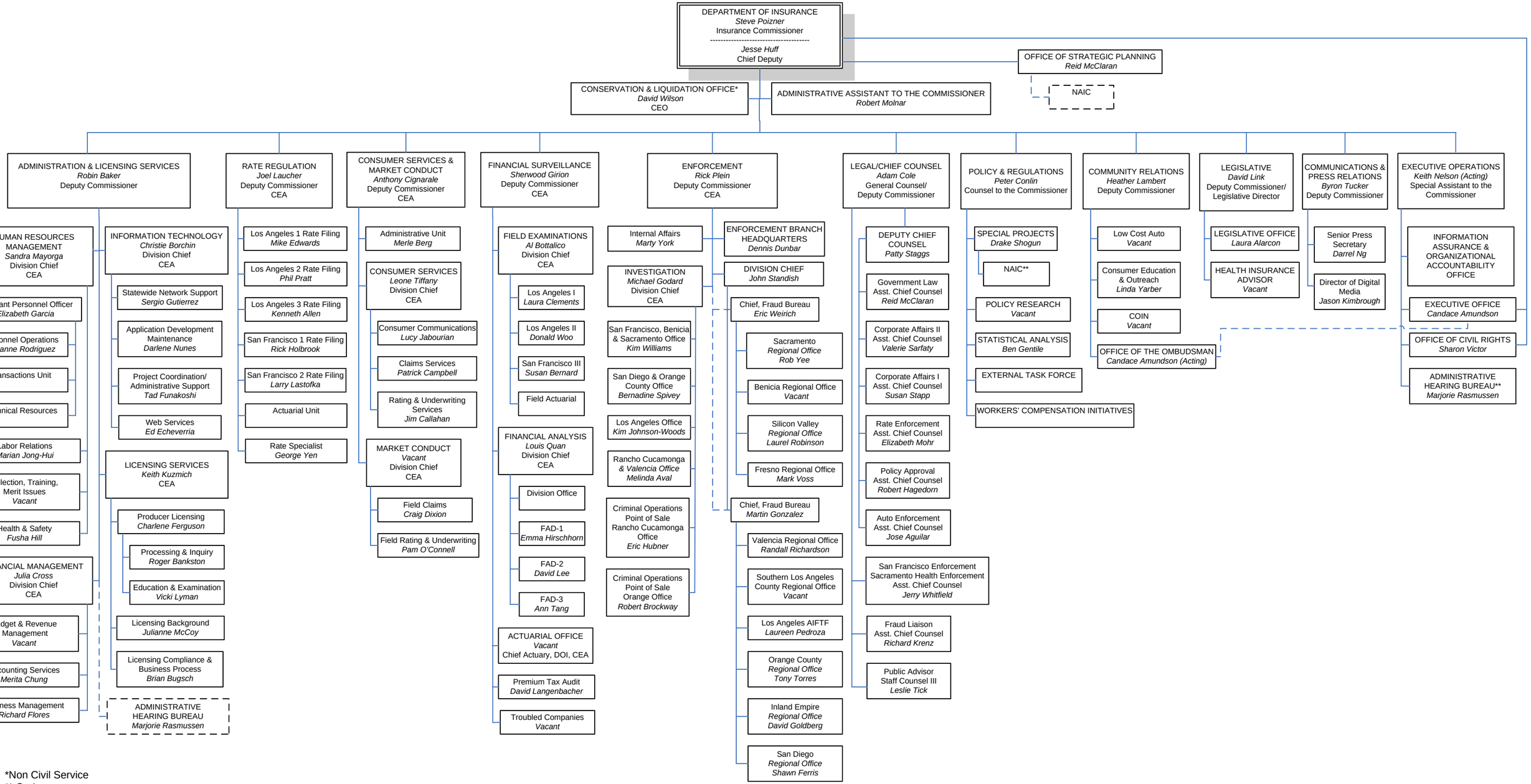
June 16, 2010

Department of Managed Health Care
California Health Insurance Rate Review
Proposed Organization Chart



April 19, 2010

DEPARTMENT OF INSURANCE



*Non Civil Service
** On Loan

Original Signed by

STEVE POIZNER
Insurance Commissioner

DATE

041910.vsd

California Department of Insurance
Education and Professional Background
Of Staff Responsible for Rate Review

- **Julia Cross, Chief, Financial Management**. Provides direct management of all areas of financial management and business services. Responsible for the overall development and administration of CDI's budget including planning, organizing and directing the operations of the Division which included the Budget and Revenue Management Bureau, Accounting Services Bureau and Business Management Bureau.

- **Perry Kupferman, Supervising Life Actuary.** B.S., M.A., Mathematics, California Polytechnic University, San Luis Obispo. Fellow of the Society of Actuaries (1980), Member of the American Academy of Actuaries (1979).Actuary at Occidental Life 1970-1974, SVP and Chief Life Actuary at Balboa Insurance Group 1974-1987, SVP Risk Management and Chief Actuary at Lyndon Insurance Group 1987-2004, SVP, Chief Actuary and Chief Underwriter at Resource Life/Virginia Surety 2004-2006, Supervising Life Actuary at California Department of Insurance 2007-present

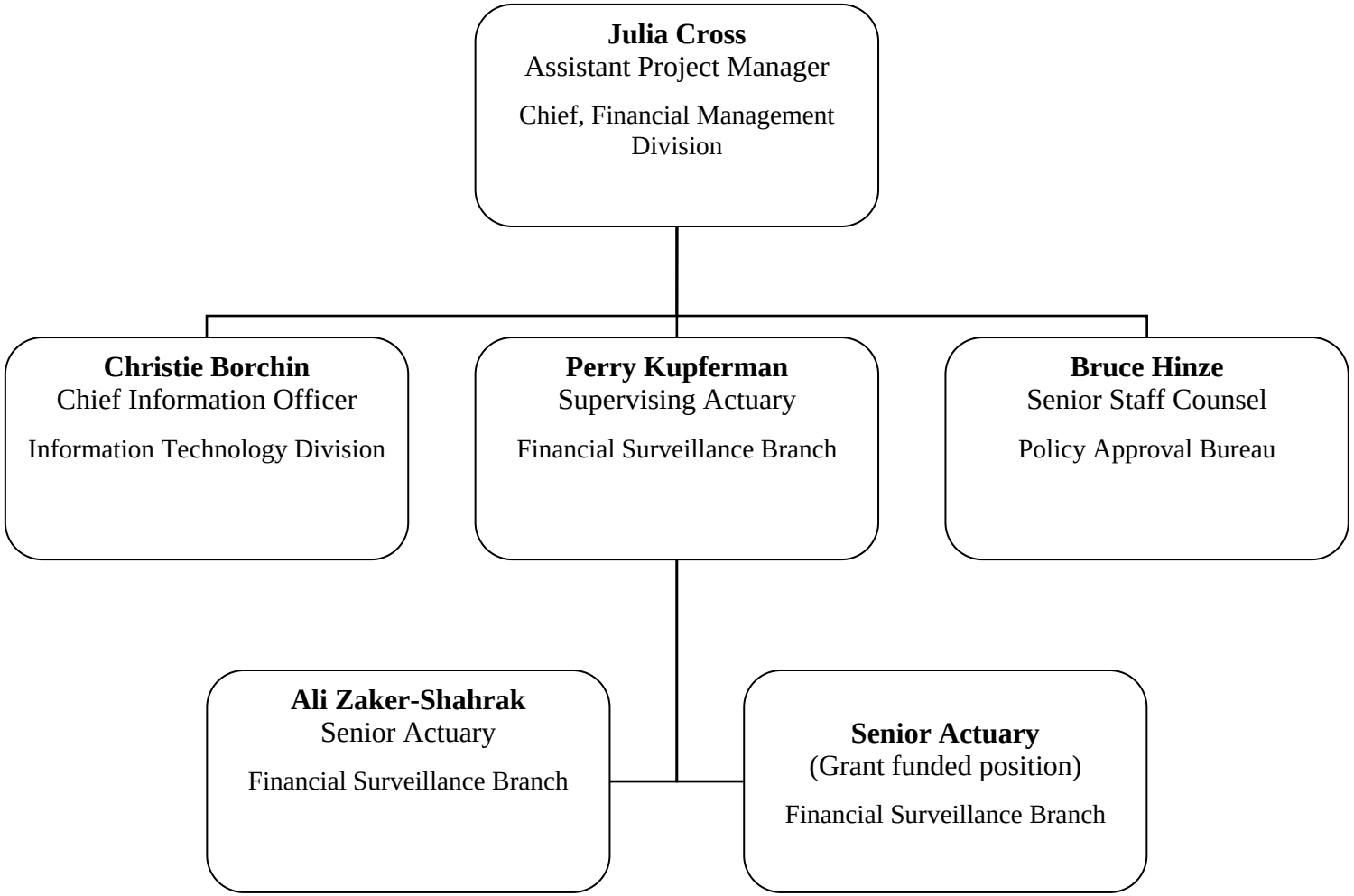
- **Ali A. Zaker-Shahrak, Senior Life Actuary.** B.Sc., M.Sc., Ph.D. (Economics), The London School of Economics, London, England. Fellow of the Society of Actuaries (2000), Member of the American Academy of Actuaries (1999), Chartered Financial Analyst (2001). Actuarial experience: Manager, Horizon Blue Cross Blue Shield of New Jersey, NJ – (August 2003 – May 2004), Metropolitan Life Insurance Company, New York, NY – (November 1996 – June 2002), Allstate Research and Planning Center, Menlo Park, CA – (July – October 1994), Delta Dental Plan of California, San Francisco, CA – (July – December 1993). Academic positions: New York Institute of Finance, New York, NY – (September 1996 – June 2001), Pace University, New York, NY - (September – December 1996), Stanford University – Stanford, CA – (September – December 1992 and January – March 1994), University of California, Santa Cruz, CA - (September – December 1996), Santa Clara University, Santa Clara, CA – (June 1998 – August 1992), The London School of Economics, University of London, London, England – Academic Year 1972/73.

- **Marsha Seeley, Senior Staff Counsel**. B.A., Southern Illinois University (Carbondale), 1976, J.D., Golden Gate University, 1980. Member, State Bar of California. Legal Division, California Dept. of Insurance, 1990-present.

- **Kim Morimoto, Senior Staff Counsel**. AB, University of California, Berkeley, JD, University of the Pacific, McGeorge School of Law. Member, State Bar of California. 9 years of insurance regulatory law practice at private law firms, 5 years with the Legal Division, California Department of Insurance.

- **Bruce Hinze, Senior Staff Counsel.** AB (Botany), University of California, Berkeley, BS (Nursing), University of California, San Francisco, JD, University of San Francisco. Member, State Bar of California. 14 years of private practice, specializing in defense of medical malpractice actions, 10 years of California state service at the Department of Corporations, Department of Managed Health Care, Commission on Judicial Performance, and the Legal Division, California Department of Insurance (4 years).

California Department of Insurance
California Health Insurance Rate Review
Proposed Organization Chart



GOVERNOR ARNOLD SCHWARZENEGGER

July 7, 2010

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

Dear Madam Secretary,

I am pleased to partner with you to implement important reforms to our health care system. Affordability remains key to ensuring access to health care for all Americans and the rate reviews contained in federal health care reform, along with the medical loss ratio, offer significant hope by increasing cost transparency in the system.

For that reason, I am submitting a joint rate review proposal on behalf of the California Department of Managed Health Care and the California Department of Insurance. As you are aware, some significant premium rate filings proposed by California insurers have been recently rejected due to arithmetic and other errors. These errors would have unjustly subjected California policyholders to higher than necessary, and in some instances, exorbitant premium increases. California's rate review proposal goes beyond federal requirements by requiring that all premium filings be reviewed and certified by an independent actuary. The filings, if found to be unreasonable by federal regulation and guidance, will also be reviewed further by the state. This rate review proposal also goes beyond federal law by posting proposed rate increases on both Department and insurer websites.

I remain concerned that rate regulation is a blunt instrument that does nothing to contain the underlying cost drivers in the system. The medical loss ratio will significantly limit the administrative costs of insurers, but little has been done to expose and examine the other cost drivers in the system. I am pleased that the proposed rate review system will allow states not to look just at premiums, but the cost trends that drive those premiums, including physician, hospital and pharmacy costs. The combination of a rigorous medical loss ratio and rate review system, in my view, provide a solid foundation to move forward in promoting higher value and higher quality health care.

Thank you for the opportunity to respond to this grant and I look forward to our further collaborations.

Sincerely,

Arnold Schwarzenegger

STATE CAPITOL • SACRAMENTO, CALIFORNIA 95814 • (916) 445-2841

ATTACHMENT C

APPLICATION COVER SHEET AND CHECK-OFF LIST

Indentifying Information:

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

DUNS #: 117894662 Grant Award: $1 million

Applicant: California Department of Managed Health Care

Primary Contact Person, Name: Gary Baldwin

Telephone Number: 916-324-2560 Fax number: 916-322-3968

Email address: GBaldwin@dmhc.ca.gov

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

☐ ~~Additional Assurance Certifications~~

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

X Proposed Budget (Narrative/Justifications)

X Required Appendices

X Resume/Job Description for Project Director and Assistant Director

X *Project/Performance Site Locations*

X *Key Contacts*

DEPARTMENT OF
Managed
Health Care

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

July 7, 2010

Ms. Gladys Bohler
Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
200 Independence Avenue SW, Room 738F-02
Washington, D.C. 20201

Ms. Jacqueline Roche
Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
200 Independence Avenue SW, Room 738F-06
Washington, D.C. 20201

RE: **CALIFORNIA PREMIUM REVIEW GRANT**

Dear Ms. Bohler and Ms. Roche:

The California Department of Managed Health Care (DMHC) appreciates the opportunity to participate in the grant program established under Section 1003 of the Patient Protection and Affordable Care Act (PPACA) to assist in developing a comprehensive health insurance premium review process. California's application for "Grants to States for Health Insurance Premium Review – Cycle I," with the DMHC acting as the lead agency, is attached in PDF format.

The program activities outlined in the attached application package will be carried out in collaboration with the California Department of Insurance (CDI), as the health insurance market in California is regulated by two separate agencies – the DMHC and the CDI. Under the executive authority of the Governor, the DMHC oversees health care services for more than 21 million insured Californians in the individual, small employer group, large group, Medicare Select, Medicare Supplement, and specialized health care service plans, regulating 108 health care service plans and certain preferred provider organization products operating in California. Under the authority of the Insurance Commissioner, who is an elected independent state constitutional officer, the CDI regulates all other PPO and indemnity health products with approximately 9.3 million

ARNOLD SCHWARZENEGGER
GOVERNOR

BUSINESS, TRANSPORTATION AND HOUSING AGENCY

980 9th Street
Suite 500
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covered lives in the in the individual, small employer group, large group, Medicare Select, Medicare Supplement markets.

In addition to the required forms, the application package includes California's proposal for the development of a premium rate review process, and its proposal for the enhancement of the State's information technology capacity, which will allow it to collect, analyze, and publish premium rate data. The proposal also includes both the DMHC and the CDI budget for each program activity.

Thank you for this opportunity to apply for the first round of grant funds under the PPACA. Should you have questions, please do not hesitate to contact Maureen McKennan, Project Director, at (916) 445-7976, or via email at MMcKennan@dmhc.ca.gov, or Gary Baldwin, Senior Counsel, at (916) 322-6727, or via email at gbaldwin@dmhc.ca.gov.

Sincerely,

Cindy Ehnes

Lucinda A. Ehnes, Esq.
Director
California Department of Managed Health Care

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

Objective Work Plan

Project:

Premium Review Grant

* Year: 1

* Funding Agency Goal: Premium Rate Review and the Identification of Unreasonable Rate Increases

* Objective:

Department of Managed Health Care (DMHC) - Obtain Actuarial Services

* Results or Benefits Expected:

To obtain actuarial services. The DMHC does not currently employ actuaries or have actuarial services available to perform premium rate review. Actuarial services are a necessary part of any premium rate review process.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Determine whether to hire actuaries or to establish a contract for actuarial services. In light of current demand, hiring an actuary may be problematic.	Chief Financial Examiner	08/09/2010	08/30/2010	0
If hiring actuaries, go through the hiring process: including listing the position, interviews, offer, etc.	Chief Financial Examiner	08/30/2010	11/30/2010	0
If contracting for services, go through the Request For Proposal (RFP) process including: drafting the RFP, answering questions, reviewing submissions, selecting the winner, entering a contract, etc.	Chief Financial Examiner	08/30/2010	11/30/2010	0
Assure that the actuaries (either employees or contracted) have sufficient access to the SERFF.	Chief Financial Examiner	08/30/2010	11/30/2010	0

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

Objective Work Plan

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

* Criteria for Evaluating Results or Benefits Expected:

Determine whether the DMHC has obtained actuarial services.

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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	DMHC Workplan_IT Enhancemen	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	DMHC Workplan_Develop rate	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	DMHC Workplan_Implement and	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4	CDI Workplan_IT Enhancement	Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5	CDI Workplan_Rate Review Pr	Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6		Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7		Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment
16) Please attach Attachment 16		Add Attachment	Delete Attachment	View Attachment
17) Please attach Attachment 17		Add Attachment	Delete Attachment	View Attachment

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

Objective Work Plan

Project:

Rate Review Grant

* Year: 1

* Funding Agency Goal:

Premium Rate Review and the Identification of Unreasonable Rate Increases.

* Objective:

Department of Managed Health Care (DMHC) - Make necessary information technology (IT) improvements for health plans to submit premium rate information to the DMHC through SERFF, issue required reports HHS, and place premium rate information on the DMHC's web site.

* Results or Benefits Expected:

Have the IT infrastructure to review premium rate filings and place premium rate information on the DMHC's web site.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Purchase necessary IT hardware and software for SERFF. Assure ability for the DMHC to interface with the SERFF system.	DPM II Office of Technology and Innovation	08/09/2010	10/31/2010	0
Develop ability to place premium rate information on the DMHC's web site.	DPM II Office of Technology and Innovation	08/09/2010	11/30/2010	0
Establish a database to warehouse SERFF data on DMHC servers.	DPM II Office of Technology and Innovation	08/09/2010	01/31/2011	0
Develop IT infrastructure to collect, analyze, and report on premium trends.	DPM II Office of Technology and Innovation	08/09/2010	02/28/2011	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
Facilitate NAIC's SERFF upgrade on behalf of California.	DPM II Office of Technology and Innovation	08/09/2010	10/31/2010	0

* Criteria for Evaluating Results or Benefits Expected:

Determine if the DMHC has the IT infrastructure to appropriately review premium rates.

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

Objective Work Plan

Project:

Rate Review Grant

* Year: 1

* Funding Agency Goal:

Premium Rate Review and the Identification of Unreasonable Rate Increases

* Objective:

Department of Managed Health Care (DMHC) - To develop a program to review premium rate increases to assure compliance with PPACA. (Caveat. This process can be impacted by the Department's ability to obtain actuarial services or the promulgation of regulations defining the term "unreasonable increases in premiums".)

* Results or Benefits Expected:

For the DMHC to have a program in place to review premium rate increases.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Get trained on SERFF and develop any necessary protocols regarding the types of documentation to be submitted by health plans through the NAIC SERFF system as well as the frequency of such submissions.	Chief Financial Examiner and two future California actuarial positions.	12/01/2010	12/31/2010	0
Develop a new California program for rate review. Such program will determine the whether each premium filing will be reviewed and to what extent.	Chief Financial Examiner and two future California actuarial positions.	12/01/2010	12/31/2010	0
For health plans not in compliance, develop program to address non-compliance, including potential enforcement action and posting of identified unreasonable rates to the world wide web.	Chief Financial Examiner and two future California actuarial positions.	12/01/2010	12/31/2010	0
Determine if any additional statutory or regulatory law is needed and take steps necessary to make those changes.	Chief Financial Examiner and two future California actuarial positions.	12/01/2010	12/31/2010	0

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

Objective Work Plan

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

* Criteria for Evaluating Results or Benefits Expected:

Determine whether the DMHC has created a program to review premium rate increases.

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

Objective Work Plan

Project:

Premium Review Grant

* Year: 1

* Funding Agency Goal:

Premium Rate Review and the Identification of Unreasonable Rate Increases

* Objective:

Department of Managed Health Care (DMHC) - To implement and evaluate the DMHC's premium rate review program. (Caveat. This process can be impacted by the DMHC's ability to obtain actuarial services and the promulgation of regulations defining the term "unreasonable increases in premiums".)

* Results or Benefits Expected:

Reviewing health plan premium filings to assure compliance with PPACA identification of unreasonable rates and the publishing of these unreasonable rates to the world wide web via our State Departmental web site.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Implement the premium rate review program developed by the DMHC.	Chief Financial Examiner and two future California actuarial positions.	01/01/2011	09/30/2011	0
Review premium rate filings to assure compliance with PPACA and any other applicable laws.	Chief Financial Examiner and two future California actuarial positions.	01/01/2011	09/30/2011	0
On an ongoing basis, evaluate the program and make necessary changes. Evaluate whether additional statutory or regulatory changes are necessary.	Chief Financial Examiner and two future California actuarial positions.	01/01/2011	09/30/2011	0
Publish unreasonable rates on the DMHC's web site.	Chief Financial Examiner and two future California actuarial positions.	01/01/2011	09/30/2011	0

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

Objective Work Plan

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

* Criteria for Evaluating Results or Benefits Expected:

Determine the number of premium rate filings reviewed by the DMHC and the number of unreasonable rates posted on the DMHC's web site.

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

Objective Work Plan

Project:

Premium Review Grant

* Year: 1

* Funding Agency Goal:

Premium Rate Review and the Identification of Unreasonable Rate Increases.

* Objective:

California Department of Insurance (CDI)- make necessary information technology (IT) improvements to expand rate review capability on SERFF, expand IT infrastructure to collect, analyze, and report premium rate trends and other PPACA-required data to DHHS, improve IT systems to post premium rate information to the CDI website by making SERFF rate filings retrievable by the public through the CDI website and enhance the existing public-comment functionality.

* Results or Benefits Expected:

A robust IT infrastructure will enhance CDI's ability to analyze individual rate filings for compliance with state law regarding loss ratios, develop data for submission to DHHS, and to optimize public transparency of the rate filings.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Purchase additional IT hardware and software for review of rate filings on SERFF system.	Chief Information Officer	08/09/2010	02/01/2011	0
Develop IT systems to post premium rate information to the CDI website by making SERFF rate filings retrievable through the CDI website and enhance the existing public-comment functionality.	Chief Information Officer	08/09/2010	01/31/2011	0
Expand IT infrastructure to collect, analyze, and report premium rate trends and other PPACA-required data to DHHS.	Chief Information Officer	11/01/2010	03/01/2011	0
				0

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

Objective Work Plan

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

* Criteria for Evaluating Results or Benefits Expected:

(1) Whether rate filings are timely available upon filing through the CDI website, (2) Whether rate trends and other required data are developed and properly reported to DHHS within DHHS-specified time parameters.

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

Objective Work Plan

Project:

Premium Review Grant

* Year: 1

* Funding Agency Goal:

Premium Rate Review and the Identification of Unreasonable Rate Increases

* Objective:

California Department of Insurance (CDI) - expand present actuarial reviews of individual health rate filings to include detailed examination of underlying calculation accuracy and data integrity for all filings. Also develop processes to aggregate, identify, and report data for group, small employer group, and individual filings including trend increase patterns and unreasonable rate increases as defined to DHHS as required by PPACA.

* Results or Benefits Expected:

More extensive actuarial reviews will improve accuracy of state's determination of the submitted rate's compliance with state law regarding loss ratios, resulting in increased protection of consumers from improper rate increases.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Expand detailed examination of actuarial assumptions, actuarial formulations, and underlying calculation accuracy and data integrity for each individual health insurance rate filing.	Supervising Life Actuary, Senior Life Actuary,outside actuarial consultants	08/09/2010	09/30/2011	0
Review group, small employer group, and individual premium rate filings to assure compliance with PPACA and other applicable laws.	Supervising Life Actuary, Senior Life Actuary, outside actuarial consultants	01/01/2011	09/30/2011	0
On an ongoing basis, evaluate the program and make necessary modifications, recommend additional statutory or regulatory changes.	Supervising Life Actuary, Senior Staff Counsel, outside actuarial consultants	08/09/2010	09/30/2011	0
Publish unreasonable rates, as defined by DHHS, on the CDI web site.	Supervising Life Actuary, Senior Life Actuary,Senior Staff Counsel	01/01/2011	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
Development of processes to obtain information from current individual filings, and for the additional filings that will be submitted pursuant to PPACA, for regulatory oversight, rate trend analysis, and reporting to HHS.	Supervising Life Actuary, Senior Life Actuary, outside actuarial consultants	11/01/2010	09/30/2011	0

* Criteria for Evaluating Results or Benefits Expected:

Determine the number of premium rate filings reviewed by the CDI, the extent of the reviews, and the number of unreasonable rates posted on the CDI's web site.

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.

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PROJECT ABSTRACT.DOC

Project Abstract

The regulation of health insurance in California is divided between two agencies, the Department of Managed Health Care (DMHC) which regulates HMOs and some PPOs comprising approximately 61percent of the California regulated insured market, and the Department of Insurance (CDI) regulating indemnity coverage and some PPOs, with approximately 39 percent of the California regulated insured market. This grant application is made jointly by the two agencies, with the DMHC as the lead agency. The enhancements to state health insurance rate reviews proposed by this project reflect the differences in state law underlying the reviews currently performed by each department.

The proposed project seeks to improve the premium rate data collection, analysis, and reporting capabilities for both departments. The grant funds will allow both departments (as discussed separately below) to improve the collection of premium rate information; to enhance the depth and breadth of current rate reviews; and, to build the infrastructure necessary to enable each department to perform the expanded range and significantly greater volume of rate reviews required by the Patient Protection and Affordable Care Act (PPACA). The proposed project includes a total budget of $1 million.

The DMHC performs limited reviews of rate filings for small employer group and HIPAA guaranteed-issue products, and does not receive rate filings through the NAIC System for Electronic Rate and Form Filing (SERFF). The DMHC, therefore, proposes to use the requested grant funds for equipment and other costs involved in adopting the SERFF system for rate filings. The DMHC also proposes to use grant funds to develop processes and capacity for the actuarial analysis of rate filings by hiring actuaries, and/or retaining outside consultants to conduct the reviews. Additionally, the funds will allow enhancement of the DMHC's own information technology infrastructure, in order to collect, analyze, and report premium trend and other data required by PPACA. Further, the DMHC and the CDI together will share the state's costs involved in improving the SERFF system nationally to capture, aggregate, and report PPACA-compliant data.

Unlike the DMHC, the CDI performs an actuarial analysis of individual health insurance rate filings, and negotiates modifications to rate proposals, as part of its regulation of loss ratios in the individual market. The CDI, like the DMHC, also reviews HIPAA and small employer health rate filings. It receives 80 percent of its rate filings through SERFF; will require that all submissions be made through SERFF in 2011; and, manually posts all rate filings on its website. It proposes to use a portion of the proposed grant funds for additional equipment to expand its rate review capability; for infrastructure improvements to speed the public availability of rate filings by making them available directly through SERFF; and for additional information technology infrastructure for collecting, analyzing, and reporting premium trends and other PPACA-related data to the United States Department of Health and Human Services.

The CDI also proposes to use grant funds to expand its existing actuarial capability to review actuarial assumptions within each rate filing. It proposes to hire an additional actuary, and/or retain its outside consultants, in order to broaden this in-depth review to encompass data integrity and calculation accuracy in all rate filings, and to develop analytic processes to accommodate the forthcoming filing and data reporting requirements for group health products required by PPACA.

The CDI recently made headlines when it used its outside actuarial consultants to undertake more extensive analyses of the underlying data integrity to calculate the accuracy of filings from two major insurers. The consultants found fundamental errors in the underlying data, fueling a nationwide outcry against rising premium rates.

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** PROJECT NARRATIVE.DOC

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Project Narrative,
Health Insurance Premium Review Grant – Cycle 1

1. Project narrative

In California, the health insurance market is regulated by two separate agencies—the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI). Under the executive authority of the Governor, the DMHC oversees health care services for more than 21 million insured Californians in the individual, small employer group, large group markets, Medicare Select, Medicare Supplement, and specialized health care service plans, and regulates 108 health care service plans (health plans or plans) and certain preferred provider organization products operating in California. Under the authority of the Insurance Commissioner, who is an elected independent state constitutional officer, the CDI regulates all other PPO and indemnity health products with approximately 9.3 million covered lives in the in the individual, small employer group, large group, Medicare Select, Medicare Supplement markets.

The DMHC is pursuing a joint grant proposal with the CDI for $1 million to implement the rate review provisions of the Patient Protection and Affordable Care Act (PPACA), with the DMHC as the lead agency. This proposal is based on the needs of both agencies and focuses on two areas: (1) information technology (IT) and (2) actuarial services that will need to be added and/or enhanced at both agencies to conduct the rate review activities contemplated by the PPACA.

This request details the limited and differing rate review authority of the two regulators as well as the unique need of each agency to implement expanded rate review activities consistent with the PPACA. Detail is also provided regarding the DMHC's intention to adopt the National Association of Insurance Commissioners (NAIC) System for Electronic Rate and Form Filing

(SERFF), which is used by health plans and health insurers nationally to submit rate information to their regulators, and CDI's plan to require exclusive use of the SERFF system by insurers starting in 2011. The CDI currently receives 80 percent of its rate filings through the SERFF; the DMHC does not utilize the SERFF, since it is not a member of the NAIC. The CDI and the DMHC further plan to participate in the NAIC proposed enhancements to the SERFF system in order to generate the data needed by PPACA, as further discussed herein.

Governor Schwarzenegger will propose legislation to amend the laws regulating health care service plans and health insurers in order to ensure that both the DMHC and the CDI have the authority necessary to review the rate filings for all markets consistent with the requirements of the PPACA. The Governor will also propose statutory changes that go beyond federal law by: (1) requiring health plans to submit all rates filings with a certification from a third party independent actuary; (2) specifically granting the DMHC authority to post rate filing information on its public website[1]; and (3) granting the DMHC authority to collect, review, and post underlying trend data consistent with the requirements of this proposal. The Schwarzenegger Administration will also propose similar statutory changes for the CDI.

Information Technology

As indicated above, the DMHC does not use the SERFF, since it is not part of the NAIC. This grant proposal will request funds to give the DMHC access to this system, and to cover all costs associated with operating the SERFF, as well as any other IT costs associated with

[1] Pursuant to Insurance Code section 12956 , the CDI has authority to publicly post all rate filings submitted. The Health and Safety Code, which governs the DMHC's authority, does not contain a similar provision granting it the authority to publicly post all health plan filings.

conducting rate review activities. The DMHC further proposes to use a total of $55,688 for developing and enhancing IT capacity to perform rate review, as well as developing and creating the infrastructure for collecting, analyzing and reporting premium trends. The CDI proposes to use a total of $81,025 of the grant fund for IT costs associated with additional equipment for the expanded rate review activities, as well as money to develop and create the infrastructure for collecting, analyzing and reporting premium trends.

In addition, the NAIC also plans on updating the SERFF system to meet the requirements of the PPACA, at an estimated cost per state of $18,808. The DMHC and the CDI will split the costs for the enhancements to the SERFF system equally.

Actuarial Services

The remainder of the $1 million will be spent on actuarial services necessary for developing and conducting California's rate review processes. The DMHC's rate review process is limited to HIPAA health plan products and products sold in the small group market and does not employ any actuaries. The DMHC proposes to use $408,778 of the grant funds to hire two senior actuaries and one actuary statistician and $310,977to contract for additional actuarial services that will be needed to conduct rate review activities. If the DMHC cannot hire for the positions, it will use the grant funds to contract for those actuarial services. The CDI employs one full-time actuary and two half-time equivalents to review individual health insurance policy rate filings. However, the PPACA provisions regarding premium rates apply not only to the individual market, but to the small group and large group markets as well. Further, recent CDI experience has demonstrated the need for analyzing data integrity and calculation accuracy in rate filings, as well as actuarial assumptions. Accordingly, the CDI proposes to use $348,978 of the grant funds to hire an additional senior actuary, and/or to contract with outside actuaries to

review individual-market rate filings in greater depth and detail, and to conduct the expanded rate review for the small group and large group market consistent with the PPACA.

As the activities discussed above are either entirely new activities for the DMHC and the CDI, or an expansion of existing activities, none of the grant funds will be used to supplant existing state expenditures.

(a) Current health insurance rate review capacity and process

(1) General health insurance rate regulation information:

(A) Overview of California Health Coverage Regulation

(i) Department of Managed Health Care (DMHC)

The DMHC regulates health plans through the Knox-Keene Health Care Service Plan Act of 1975 (Act), which generally prohibits the DMHC from establishing the rates health plans charge to subscribers and enrollees for contractual health care services.[2] However, with respect to a few very limited types of products, HIPAA Guarantee Issue products and small employer group rates, the Act dictates the methodology by which allowable rates must be calculated. The DMHC currently receives approximately 60 of these reviewable rate filings annually. HIPAA rates are posted on the DMHC website.

First, the allowable premiums for HIPAA products are limited based on the premiums charged to similarly situated enrollees in California's Major Risk Medical Insurance Program (MRMIP), which is California's high risk pool. Specifically, for enrollees in a preferred provider organization (PPO), the maximum HIPAA premium may not exceed the average premium paid by a MRMIP enrollee who is of the same age, and resides in the same geographic

[2] California Health and Safety Code section 1367, subdivision (j). All California laws and regulations referenced in this document are attached in Appendix 1.)

region, as the HIPAA enrollee.[3] For HMO enrollees, the maximum HIPAA premium cannot exceed 170 percent of the standard premium charged to an individual of same age and residing in the same geographic location as the HIPAA enrollee..[4]

Second, a plan may not vary the premium rates for any particular small employer group (2-50 employees) by more than ten percent from a standard rate that is based on the specific risk adjustment factors of the employees.[5] The risk factors that a plan can consider are age (but limited to age bands[6]), family size[7], and geographic region within the state.[8] The DMHC's review of small group rates is limited to verifying compliance with the above-defined standards. In addition, the Knox-Keene Act's allowable review does not include a comparison of rates from the prior year when assessing rate increases for small employer groups.[9]

(ii) Department of Insurance (CDI)

Health insurance policies for the individual market are subject to actuarial review for compliance with a 70 percent medical loss ratio requirement (Insurance Code section 10293, 10 California Code of Regulations section 2222.10 et seq.), as well as legal review for compliance with guaranteed-renewability requirements (Insurance Code sections 10273.3, 10273.6). The

[3] California Health and Safety Code section 1399.811, subdivision (a)(1).

[4] California Health and Safety Code section 1399.811, subdivision (a)(2).

[5] California Health and Safety Code sections 1357, subdivision (j), and 1357.12, subdivision (a)(1).

[6] The allowable age bands are: under 30, 30-39, 40-49, 50-54, 55-59, 60-64, and 65 and over.

[7] The allowable family size categories are: single, married couple, one adult and child or children, and married couple and child or children.

[8] A plan that operates state-wide may have no more than nine geographic regions in the state. Plans also must not divide a county into more than two regions.

[9] In addition to the rate limits discussed above, health plans must also comply with certain statutory limits on premium rates for individual conversion coverage (Health and Safety Code section 1373.621) and Cal-COBRA products. Cal-COBRA stands for the "California Continuation Benefits Replacement Act", and provides benefits to small employer groups (fewer than 20 employees) that are similar to those available under federal COBRA. (Health and Safety Code section 1366.26.)

CDI recently improved its processes for individual market rate filings to enhance transparency and consumer participation by: (1) immediately posting rate increase filings on the CDI website; (2) soliciting public comments as an integral part of the actuarial and legal analysis of the submission; and (3) announcing that all new rate increase requests from the insurers with the largest market share will undergo a detailed examination by an outside actuary , including an examination of underlying data integrity and calculations.

Small employer group rating plans are filed with the CDI whose attorneys review them to determine compliance with statutory case characteristics (consisting of a "risk category" defined as age, geographic region, and family size of the employee (Insurance Code section 10700(v)), as well as with rating bands (a "risk adjustment factor" of plus or minus 10 percent (Insurance Code section 10700(u)). The calculation of the risk adjustment factor is not presently subject to actuarial analysis. The CDI regulates HIPAA rates in the same manner as described above for the DMHC.

California law does not require that group health rates be filed; therefore, CDI does not review group rates.

(B) Health Insurance Rate Review and Filing Requirements: Rate filings, Data Type, and Format

(i) Department of Managed Health Care (DMHC)

Health plans submit the required limited rate filings to the DMHC via its electronic e-filing system, although the DMHC proposes to begin using the NAIC's SERFF as part of this proposal. The DMHC reviews filings for strict compliance with the specific language of the applicable section. If the rate is not compliant, the health plan is requested to modify its rates as required for compliance. For small employer group rating filings, health plans are required to

demonstrate, and attest to, compliance with the required risk categories and risk adjustment factors (Health and Safety Code section 1357(j)(k)).

- **Rate Filings: Rate Review Process (DMHC)**

For the small employer group rating filings, a Corporations Examiner reviews the filing to determine whether the premium for an eligible employee in a particular risk category, after applying the risk adjustment factor to the plan's standard employee risk rates, is consistent with the law. If the rate is not compliant, the health plan is requested to modify its rates to become compliant.

The DMHC's review of HIPAA rate filings is also based on a review of whether the rates filed exceed the statutory caps described above for PPO filings and HMO filings.

All DMHC rate reviews are conducted by Corporations Examiners. In addition, all rate filings are accompanied by an actuarial certification of compliance. However, the DMHC does not validate actuarial supporting assumptions or analysis.

(ii) California Department of Insurance (CDI)

There is no specified standardized filing format for CDI rate filings. The CDI currently receives approximately 80 percent of its health rate filings through SERFF, with the remainder on paper, and is in the midst of a rulemaking to require all submissions be made through SERFF, starting in 2011. The CDI and the DMHC plan to participate in the NAIC's enhancements to the SERFF to generate the data required by the PPACA, as further discussed herein.

For small employer group rating plans, companies are required to demonstrate, and attest to, compliance with the required risk categories and risk adjustment factors (Insurance Code section 10700(v)(u)). Companies in the individual health insurance market that submit new rates, or rate increases, must submit the rates, an actuarial memorandum, and other supporting

documentation that demonstrates compliance with a 70 percent lifetime anticipated loss ratio requirement (Insurance Code section 10293, 10 California Code of Regulations section 2222.10 et seq.). Section 2214 of Title 10 of the California Code of Regulations, subdivisions (a) and (b), specify the general contents and form of a rate filing. A copy of the regulation is attached in Appendix 1.

- **Rate Filings: Rate Review Process (CDI)**

California Insurance Code section 10290 requires that the rates pertaining to an individual policy form must be filed with the Commissioner, and that such policy cannot be issued or delivered until 30 days after filing. If the Commissioner notifies the insurer that the filing does not comply with the requirements of law, it is unlawful thereafter for the insurer to issue the policy form (Insurance Code section 10291).

(Insurance Code section 10291).

The CDI actuaries review the submitted individual health rate filings for compliance with the Department's 70 percent loss ratio requirement. By regulation, the loss ratio used is a lifetime anticipated loss ratio; therefore, the trend projections used by the company, particularly the projected rate of medical care cost inflation, are also evaluated during actuarial review for reasonableness. Companies whose filings do not satisfy the 70 percent loss ratio, or whose actuarial assumptions and trend projections are unreasonable, are contacted by the CDI's actuarial staff. For almost all filings, insurers are contacted, and two-thirds then re-file lower rates.

In practice, rates are reviewed and modified prospectively. However, if subsequent to rate implementation it is determined that the actuarial assumptions made were incorrect, or if the medical cost trend or anticipated claims experience prove to be other than estimated,

retrospective review is available by notice and hearing under Insurance Code section 10293, which, in combination with Title 10 of the California Code of Regulations sections 2222.10, et seq., provide for withdrawal of approval of the underlying form if the loss ratio requirement is not met. There is no statutory provision for rebates to consumers.

Over the last three years, the CDI has achieved the rate reductions or withdrawals of proposed rate increases in individual health insurance on more than 50 occasions, with proposed rate increases of up to 50 percent being substantially negotiated downwards by CDI, or withdrawn entirely by the insurer. Representative examples are shown in Appendix 2.

- **Current resources and capacity for reviewing health insurance rates**

(i) Department of Managed Health Care (DMHC)

The DMHC's total FY 09/10 budget is $43.099 million, with revenue of $43.109 million. Annually, the resources used to perform very limited review of approximately 60 filings are approximately 900 personnel hours in the Corporation Examiner classification, which equates to $41,679 annually. In addition, a person in the Health Program Specialist I classification and a person in the Staff Services Manager II classification also review portions of the HIPAA rate filings. The Health Program Specialist I spends approximately 64 hours reviewing rate filings for a total annual salary cost of $2,842 and the Staff Services Manager II spends approximately 20 hours for a total annual salary cost of $1,040.

The DMHC employs 22 Corporations Examiners, each assigned to specified health plans, reviewing all of these health plan financial filings, including rate filings. There are a total of 108 health plans licensed in California and the health plan rate review filings are split among seven Corporations Examiners. Copies of the duty statements for the Corporations Examiner, the Health Program Specialist I and the Staff Services Manager II are attached in Appendix 5.

(ii) Department of Insurance (CDI)

The CDI's total FY 09/10 budget is $151.9 million, with projected revenue of $161.4 million. Rate review in the individual and small employer health markets accounts for a current personnel cost of $388,316 per year, as detailed in Appendix 3. Approximately 240 individual health filings are received each year. Review time for each file ranges from one hour to one week, with a ten hour average review time per filing.

The following staff is responsible for the review of health rates (further details in Appendix 4):

- **Perry Kupferman, Supervising Life Actuary.** Education: Masters Degree in Mathematics, Fellow of the Society of Actuaries (1980), Member of the American Academy of Actuaries (1979). 40 years experience as an insurance actuary.
- **Ali A. Zaker-Shahrak, Senior Life Actuary**. Education: Doctorate in Economics. Fellow of the Society of Actuaries (2000), Member of the American Academy of Actuaries (1999), Chartered Financial Analyst (2001). 17 years experience as an insurance actuary.
- **Marsha Seeley, Senior Staff Counsel**. Education: Juris Doctor, Member, State Bar of California, Legal Division, California Department of Insurance, 20 years experience in insurance regulation.
- **Kim Morimoto, Senior Staff Counsel**. Education: Juris Doctor, Member, State Bar of California, 14 years experience in insurance litigation and regulation.
- **Bruce Hinze, Senior Staff Counsel.** Education: Juris Doctor, Member, State Bar of California, 24 years experience in insurance litigation and regulation.

Contracted actuarial services are provided by Axene Health Partners. Contracted actuaries are retained to provide a detailed actuarial analysis of selected individual health rate

submissions, including testing the validity of actuarial assumptions, the accuracy of calculations, and the integrity of the data used by the insurer to arrive at its actuarial conclusions.

- **Consumer protections:**

The CDI posts rate filings for individual health insurance policies on its public website upon receipt, and provides for submission of public comments regarding the rates through its public website. Pending and past rate filings are also made available for public inspection at a CDI office. State law (Insurance Code section 12956) provides that all policies and associated writings are open to public inspection unless the Commissioner determines that the welfare of the public or any insurer demands that any portion not be made public.

- **Examination and Oversight:**

The CDI regularly reviews individual health insurance rate filings, and obtains rate revisions in 2/3 of rate filings. The CDI has the authority under Insurance Code section 733 to conduct such examinations of any insurer, and has announced its intention to conduct intensive actuarial examinations using an outside consultant for the four largest insurers in the individual insurance market, which, in aggregate, have a 90.6 percent share of the individual health insurance market in California. The CDI has not held any formal hearings over the past two years regarding health insurance rates.

The DMHC does not currently have the authority to conduct similar examinations.

(b) Proposed rate review enhancements for health insurance

- **Expanding the scope of current review and approval activities, improving rate filing requirements:**

(i) Department of Managed Health Care (DMHC)

Other than in the limited circumstances described above, the DMHC does not have authority to review rates. As indicated above, Governor Schwarzenegger will propose legislation

to amend California laws to permit the DMHC to review rate filings consistent with the PPACA, and as otherwise discussed above.

(ii) California Department of Insurance (CDI)

The Schwarzenegger Administration will propose statutory changes for the CDI similar to those of the DMHC.

- **Enhancing Rate Review Processes-Staffing (DMHC and CDI)**

The premium submission requirements of the PPACA apply to large and small group and individual markets. Premium rates are based on actuarial assumptions. Accordingly, a key component of any rate review mechanism must include actuarial analysis, and the balance of the grant would be used to obtain actuarial services by both departments. The DMHC has no actuaries on staff, and the CDI has two. The DMHC will hire actuaries or use external sources, depending on cost and availability; the CDI will hire one senior actuary and will use outside actuarial consultants, as described above. Activities that are proposed to be funded by the grant will be used to: (1) help determine and establish data submission and data elements that are not already part of the SERFF filings, including development of a work flow process with an electronic "sorting" process to identify "unreasonable rates" (as defined by federal regulation), as well as providing trending information as required by the federal government; (2) develop standards for the proposed independent, third-party actuarial review of rate filings for accuracy, as well as developing criteria to ensure that the actuarial assumptions are valid and appropriate; (3) develop standards or criteria for publication of rates and any related information deemed appropriate for publication; (4) conduct random reviews of independent actuarial analyses and all "unreasonable rates" per federal requirements; and (5) develop processes for data analysis for the group market filings resulting from the PPACA, as neither department currently receives or analyzes such information.

- **Enhancing Rate Review Process-IT capacity, Consumer Protection Standards:**

The NAIC maintains a database, SERFF, which is used by health plans and health insurers nationally to submit rate information to their regulators. The DMHC does not utilize SERFF since it is not a member of the NAIC. The grant proposal requests funds to allow the DMHC access to this system, which will include purchasing necessary hardware and training.

The NAIC also plans on updating the SERFF to make the system consistent with the requirements of the PPACA, at an estimated cost per state of $18,808. The update will enable the SERFF to deliver the aggregate and filing-specific information and trend data specified in Section V, subsections A.1(c) (1) and A.1(c) (2) of the Initial Announcement, as well as incorporating the federally mandated Rate Filing Disclosure Form, a uniform template for reporting to the U.S. Department of Health and Human Services, and providing for public availability of rate filing information. This grant proposal requests funds to pay for this update, and for user training regarding the upgrade. The DMHC and the CDI will also incur costs for website modifications/improvements and for the ongoing posting on their respective websites the rates and "unreasonable" rates as required by the federal government, and for enhancing the opportunities for consumer review and comment.

The CDI also proposes to purchase additional equipment to expand its existing rate review activities, and will share with the DMHC the expansion of the capabilities of SERFF to generate required data regarding rate increase patterns for submission to the Secretary of the U.S. Department of Health and Human Services.

(c) Reporting to the Secretary on Rate Increase Patterns

Both the DMHC and the CDI attest that they will comply with the reporting requirements outlined in the relevant federal statutes. Existing IT systems at each department will be enhanced to develop, aggregate, and report on the analysis of data from rate filings received for

individual and small employer group market segments currently under the respective jurisdictions of each department, and for the forthcoming group market filings that will be submitted pursuant to the PPACA. Both the DMHC and the CDI will utilize the uniform reporting template specified by the Secretary, utilizing the SERFF platform where appropriate.

(d) Conclusion

The availability of grant funding will enable the DMHC and the CDI to begin to develop a more robust rate oversight capability to ensure that consumers are confident that the rates they are paying for their health benefits are truly reflective of the underlying cost factors. Consumer confidence will be further enhanced by state legislation to provide cost data on underlying factors in a readily accessible format so that consumers are better informed about the costs of their health care and health care coverage choices. Further, these funds will allow both departments to better coordinate and integrate information gathering and rate oversight functions. Finally, the ability to purchase greater access to actuarial services will permit both departments to increase the level of sophistication with which they are able to fulfill their joint mission of consumer protection.

APPENDIX #1
California Statutes and Regulations Applicable
to the Review and Regulation of Health Coverage Rates

1) Statutes and Regulations Applicable to the Department of Managed Healthcare

Applicable Law

California Health & Safety Code § 1357. Definitions, Small Employer Group

As used in this article:

(a) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health care plan contract covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (o).

(b) "Eligible employee" means either of the following:

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of at least 30 hours, at the small employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer's business and included as employees under a health care plan contract of a small employer, but does not include employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. Permanent employees who work at least 20 hours but not more than 29 hours are deemed to be eligible employees if all four of the following apply:

(A) They otherwise meet the definition of an eligible employee except for the number of hours worked.

(B) The employer offers the employees health coverage under a health benefit plan.

(C) All similarly situated individuals are offered coverage under the health benefit plan.

(D) The employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The health care service plan may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

(2) Any member of a guaranteed association as defined in subdivision (o).

(c) "In force business" means an existing health benefit plan contract issued by the plan to a small employer.

(d) "Late enrollee" means an eligible employee or dependent who has declined enrollment in a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association's plan contract and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, any other person eligible for coverage through a guaranteed association pursuant to subdivision (o), or an eligible dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) He or she was covered under another employer health benefit plan, the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, or the Medi-Cal program at the time the individual was eligible to enroll.

(B) He or she certified at the time of the initial enrollment that coverage under another employer health benefit plan, the Healthy Families Program, the AIM Program, or the Medi-Cal program was the reason for declining enrollment, provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) He or she has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of the person through whom the individual was covered as a dependent, legal separation, divorce, loss of coverage under the Healthy Families Program, the AIM Program, or the Medi-Cal program.

(D) He or she requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan, or requests enrollment within 60 days after termination of Medi-Cal program coverage, AIM Program coverage, or Healthy Families Program coverage.

(2) The employer offers multiple health benefit plans and the employee elects a different plan during an open enrollment period.

(3) A court has ordered that coverage be provided for a spouse or minor child under a covered

employee's health benefit plan.

(4) (A) In the case of an eligible employee, as defined in paragraph (1) of subdivision (b), the plan cannot produce a written statement from the employer stating that the individual or the person through whom the individual was eligible to be covered as a dependent, prior to declining coverage, was provided with, and signed, acknowledgment of an explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion, unless the individual meets the criteria specified in paragraph (1), (2), or (3).

(B) In the case of an association member who did not purchase coverage through a guaranteed association, the plan cannot produce a written statement from the association stating that the association sent a written notice in boldface type to all potentially eligible association members at their last known address prior to the initial enrollment period informing members that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the member's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the member can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) or meets the requirements of paragraph (2) or (3).

(C) In the case of an employer or person who is not a member of an association, was eligible to purchase coverage through a guaranteed association, and did not do so, and would not be eligible to purchase guaranteed coverage unless purchased through a guaranteed association, the employer or person can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1), or meets the requirements of paragraph (2) or (3), or that he or she recently had a change in status that would make him or her eligible and that application for enrollment was made within 30 days of the change.

(5) The individual is an employee or dependent who meets the criteria described in paragraph (1) and was under a COBRA continuation provision and the coverage under that provision has been exhausted. For purposes of this section, the definition of "COBRA" set forth in subdivision (e) of Section 1373.621 shall apply.

(6) The individual is a dependent of an enrolled eligible employee who has lost or will lose his or her coverage under the Healthy Families Program, the AIM Program, or the Medi-Cal program and requests enrollment within 60 days after termination of that coverage.

(7) The individual is an eligible employee who previously declined coverage under an employer health benefit plan and who has subsequently acquired a dependent who would be eligible for coverage as a dependent of the employee through marriage, birth, adoption, or placement for adoption, and who enrolls for coverage under that employer health benefit plan on his or her behalf and on behalf of his or her dependent within 30 days following the date of marriage, birth, adoption, or placement for adoption, in which case the effective date of coverage shall be the first day of the month following the date the completed request for enrollment is received in the case of marriage, or the date of birth, or the date of adoption or placement for adoption, whichever applies. Notice of the special enrollment rights contained in this paragraph shall be

provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(8) The individual is an eligible employee who has declined coverage for himself or herself or his or her dependents during a previous enrollment period because his or her dependents were covered by another employer health benefit plan at the time of the previous enrollment period. That individual may enroll himself or herself or his or her dependents for plan coverage during a special open enrollment opportunity if his or her dependents have lost or will lose coverage under that other employer health benefit plan. The special open enrollment opportunity shall be requested by the employee not more than 30 days after the date that the other health coverage is exhausted or terminated. Upon enrollment, coverage shall be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(e) "New business" means a health care service plan contract issued to a small employer that is not the plan's in force business.

(f) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the employee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(g) "Creditable coverage" means:

(1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(5) 10 U.S.C. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Sec. 2504(e)).

(11) Any other creditable coverage as defined by subdivision (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

(h) "Rating period" means the period for which premium rates established by a plan are in effect and shall be no less than six months.

(i) "Risk adjusted employee risk rate" means the rate determined for an eligible employee of a small employer in a particular risk category after applying the risk adjustment factor.

(j) "Risk adjustment factor" means the percentage adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard cost of services. This factor may not be more than 120 percent or less than 80 percent until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent.

(k) "Risk category" means the following characteristics of an eligible employee: age, geographic region, and family composition of the employee, plus the health benefit plan selected by the small employer.

(1) No more than the following age categories may be used in determining premium rates:

Under 30

30-39

40-49

50-54

55-59

60-64

65 and over

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the plan contract will be primary or secondary to benefits provided by the federal Medicare program pursuant to Title XVIII of the federal Social Security Act.

(2) Small employer health care service plans shall base rates to small employers using no more than the following family size categories:

(A) Single.

(B) Married couple.

(C) One adult and child or children.

(D) Married couple and child or children.

(3)(A) In determining rates for small employers, a plan that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county, and divide no county into more than two regions. Plans shall be deemed to be operating statewide if their coverage area includes 90 percent or more of the state's population. Geographic regions established pursuant to this section shall, as a group, cover the entire state, and the area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.

(B)(i) In determining rates for small employers, a plan that does not operate statewide shall use no more than the number of geographic regions in the state that is determined by the following formula: the population, as determined in the last federal census, of all counties that are included in their entirety in a plan's service area divided by the total population of the state, as determined in the last federal census, multiplied by nine. The resulting number shall be rounded to the nearest whole integer. No region may be smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and no county may be divided into more than two regions. The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous. No plan shall have less than one geographic area.

(ii) If the formula in clause (i) results in a plan that operates in more than one county having only one geographic region, then the formula in clause (i) shall not apply and the plan may have two geographic regions, provided that no county is divided into more than one region.

Nothing in this section shall be construed to require a plan to establish a new service area or to offer health coverage on a statewide basis, outside of the plan's existing service area.

(l) "Small employer" means either of the following:

(1) Any person, firm, proprietary or nonprofit corporation, partnership, public agency, or

association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least two, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, a health care service plan shall use the test that ensures eligibility if only one test would establish eligibility. However, for purposes of subdivisions (a), (b), and (c) of Section 1357.03, the definition shall include employers with at least three eligible employees until July 1, 1997, and two eligible employees thereafter. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health care service plan contract to a small employer pursuant to this article, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this article, provisions of this article that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this paragraph who purchases coverage through a guaranteed association, and any employer purchasing coverage for employees through a guaranteed association.

(2) Any guaranteed association, as defined in subdivision (n), that purchases health coverage for members of the association.

(m) "Standard employee risk rate" means the rate applicable to an eligible employee in a particular risk category in a small employer group.

(n) "Guaranteed association" means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria, and that (1) includes one or more small employers as defined in paragraph (1) of subdivision (l), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered to the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has included health insurance as a membership benefit for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any plan contract that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the plan contracts offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the health care service plan with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

This subdivision applies regardless of whether a contract issued by a plan is with an association or a trust formed for, or sponsored by, an association to administer benefits for association

members.

For purposes of this subdivision, an association formed by a merger of two or more associations after January 1, 1992, and otherwise meeting the criteria of this subdivision shall be deemed to have been in active existence on January 1, 1992, if its predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and otherwise met the criteria of this subdivision.

(o) "Members of a guaranteed association" means any individual or employer meeting the association's membership criteria if that person is a member of the association and chooses to purchase health coverage through the association. At the association's discretion, it also may include employees of association members, association staff, retired members, retired employees of members, and surviving spouses and dependents of deceased members. However, if an association chooses to include these persons as members of the guaranteed association, the association shall make that election in advance of purchasing a plan contract. Health care service plans may require an association to adhere to the membership composition it selects for up to 12 months.

(p) "Affiliation period" means a period that, under the terms of the health care service plan contract, must expire before health care services under the contract become effective.

California Health & Safety Code § 1357.12. Requirements for premiums

Premiums for contracts offered or delivered by plans on or after the effective date of this article shall be subject to the following requirements:

(a)(1) The premium for new business shall be determined for an eligible employee in a particular risk category after applying a risk adjustment factor to the plan's standard employee risk rates. The risk adjusted employee risk rate may not be more than 120 percent or less than 80 percent of the plan's applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent.

(2) The premium charged a small employer for new business shall be equal to the sum of the risk adjusted employee risk rates.

(3) The standard employee risk rates applied to a small employer for new business shall be in effect for no less than six months.

(b)(1) The premium for in force business shall be determined for an eligible employee in a particular risk category after applying a risk adjustment factor to the plan's standard employee risk rates. The risk adjusted employee risk rates may not be more than 120 percent or less than 80 percent of the plan's applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent. The factor effective July 1, 1996, shall apply to in force business at the earlier of either the time of renewal or July 1, 1997. The risk adjustment factor applied to a small employer may not increase by more than 10 percentage points from the risk adjustment factor applied in the prior rating period.

The risk adjustment factor for a small employer may not be modified more frequently than every 12 months.

(2) The premium charged a small employer for in force business shall be equal to the sum of the risk adjusted employee risk rates. The standard employee risk rates shall be in effect for no less than six months.

(3) For a contract that a plan has discontinued offering, the risk adjustment factor applied to the standard employee risk rates for the first rating period of the new contract that the small employer elects to purchase shall be no greater than the risk adjustment factor applied in the prior rating period to the discontinued contract. However, the risk adjusted employee risk rate may not be more than 120 percent or less than 80 percent of the plan's applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent. The factor effective July 1, 1996, shall apply to in force business at the earlier of either the time of renewal or July 1, 1997. The risk adjustment factor for a small employer may not be modified more frequently than every 12 months.

(c)(1) For any small employer, a plan may, with the consent of the small employer, establish composite employee and dependent rates for either new business or renewal of in force business. The composite rates shall be determined as the average of the risk adjusted employee risk rates for the small employer, as determined in accordance with the requirements of subdivisions (a) and (b). The sum of the composite rates so determined shall be equal to the sum of the risk adjusted employee risk rates for the small employer.

(2) The composite rates shall be used for all employees and dependents covered throughout a rating period of no less than six months nor more than 12 months, except that a plan may reserve the right to redetermine the composite rates if the enrollment under the contract changes by more than a specified percentage during the rating period. Any redetermination of the composite rates shall be based on the same risk adjusted employee risk rates used to determine the initial composite rates for the rating period. If a plan reserves the right to redetermine the rates and the enrollment changes more than the specified percentage, the plan shall redetermine the composite rates if the redetermined rates would result in a lower premium for the small employer. A plan reserving the right to redetermine the composite rates based upon a change in enrollment shall use the same specified percentage to measure that change with respect to all small employers electing composite rates.

California Health & Safety Code § 1366.26. Rate limits

A qualified beneficiary electing continuation coverage shall pay to the health care service plan, on or before the due date of each payment but not more frequently than on a monthly basis, not more than 110 percent of the applicable rate charged for a covered employee or, in the case of dependent coverage, not more than 110 percent of the applicable rate charged to a similarly situated individual under the group benefit plan being continued under the group contract. In the case of a qualified beneficiary who is determined to be disabled pursuant to Title II or Title XVI of the United States Social Security Act, the qualified beneficiary shall be required to pay to the health care service plan an amount no greater than 150 percent of the group rate after the first 18 months of continuation coverage provided pursuant to this section. In no case shall a health care

service plan charge an employer an additional fee for administering Cal-COBRA other than those incorporated in the risk adjusted employee risk rate as provided for in subdivision (i) of Section 1357.tract become effective.

General No Premium Requirements

California Health & Safety Code § 1367. Requirements for health care service plans

A health care service plan and, if applicable, a specialized health care service plan shall meet the following requirements:

(a) Facilities located in this state including, but not limited to, clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State Department of Health Services, where licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(b) Personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.

(c) Equipment required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law.

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

(e)(1) All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03.

(2) To the extent that telemedicine services are appropriately provided through telemedicine, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, these services shall be considered in determining compliance with Section 1300.67.2 of Title 28 of the California Code of Regulations.

(3) The plan shall make all services accessible and appropriate consistent with Section 1367.04.

(f) The plan shall employ and utilize allied health manpower for the furnishing of services to the extent permitted by law and consistent with good medical practice.

(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

(h)(1) Contracts with subscribers and enrollees, including group contracts, and contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter. All contracts with providers shall contain provisions requiring a fast, fair, and cost-effective dispute resolution

mechanism under which providers may submit disputes to the plan, and requiring the plan to inform its providers upon contracting with the plan, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted.

(2) A health care service plan shall ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.

(3) On and after January 1, 2002, a health care service plan shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall include information on the number of providers who utilized the dispute resolution mechanism and a summary of the disposition of those disputes.

(i) A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service that health care service plans are required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

(j) A health care service plan shall not require registration under the Controlled Substances Act of 1970 (21 U.S.C. Sec. 801 et seq.) as a condition for participation by an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 of the Business and Professions Code.

Nothing in this section shall be construed to permit the director to establish the rates charged subscribers and enrollees for contractual health care services.

The director's enforcement of Article 3.1 (commencing with Section 1357) shall not be deemed to establish the rates charged subscribers and enrollees for contractual health care services.

The obligation of the plan to comply with this section shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.

California Health & Safety Code § 1373.621. Additional benefits for former employee meeting tenure and age requirements and for employee's spouse or former spouse; Applicability

(a) Except for a specialized health care service plan, every health care service plan contract that is issued, amended, delivered, or renewed in this state on or after January 1, 1999, that provides hospital, medical, or surgical expense coverage under an employer-sponsored group plan for an employer subject to COBRA, as defined in subdivision (e), or an employer group for which the plan is required to offer Cal-COBRA coverage, as defined in subdivision (f), including a carrier providing replacement coverage under Section 1399.63, shall further offer the former employee the opportunity to continue benefits as required under subdivision (b), and shall further offer the former spouse of an employee or former employee the opportunity to continue benefits as

required under subdivision (c).
(b)(1) In the event a former employee who worked for the employer for at least five years prior to the date of termination of employment and who is 60 years of age or older on the date employment ends is entitled to and so elects to continue benefits under COBRA or Cal-COBRA for himself or herself and for any spouse, the employee or spouse may further continue benefits beyond the date coverage under COBRA or Cal-COBRA ends, as set forth in paragraph (2). Except as otherwise specified, continuation coverage shall be under the same benefit terms and conditions as if the continuation coverage under COBRA or Cal-COBRA had remained in force. For the employee or spouse, continuation coverage following the end of COBRA or Cal-COBRA is subject to payment of premiums to the health care service plan. Individuals ineligible for COBRA or Cal-COBRA, or who are eligible but have not elected or exhausted continuation coverage under federal COBRA or Cal-COBRA, are not entitled to continuation coverage under this section. Premiums for continuation coverage under this section shall be billed by, and remitted to, the health care service plan in accordance with subdivision (d). Failure to pay the requisite premiums may result in termination of the continuation coverage in accordance with the applicable provisions in the plan's group subscriber agreement with the former employer.

(2) The employer shall notify the former employee or spouse or both, or the former spouse of the employee or former employee, of the availability of the continuation benefits under this section in accordance with Section 2800.2 of the Labor Code. To continue health care coverage pursuant to this section, the individual shall elect to do so by notifying the plan in writing within 30 calendar days prior to the date continuation coverage under COBRA or Cal-COBRA is scheduled to end. Every health care service plan and specialized health care service plan shall provide to the employer replacing a health care service plan contract issued by the plan, or to the employer's agent or broker representative, within 15 days of any written request, information in possession of the plan reasonably required to administer the requirements of Section 2800.2 of the Labor Code.

(3) The continuation coverage shall end automatically on the earlier of (A) the date the individual reaches age 65, (B) the date the individual is covered under any group health plan not maintained by the employer or any other health plan, regardless of whether that coverage is less valuable, (C) the date the individual becomes entitled to Medicare under Title XVIII of the Social Security Act, (D) for a spouse, five years from the date on which continuation coverage under COBRA or Cal-COBRA was scheduled to end for the spouse, or (E) the date on which the employer terminates its group subscriber agreement with the health care service plan and ceases to provide coverage for any active employees through that plan, in which case the health care service plan shall notify the former employee or spouse or both of the right to a conversion plan in accordance with Section 1373.6.

(c)(1) If a former spouse of an employee or former employee was covered as a qualified beneficiary under COBRA or Cal-COBRA, the former spouse may further continue benefits beyond the date coverage under COBRA or Cal-COBRA ends, as set forth in paragraph (2) of subdivision (b). Except as otherwise specified in this section, continuation coverage shall be under the same benefit terms and conditions as if the continuation coverage under COBRA or Cal-COBRA had remained in force. Continuation coverage following the end of COBRA or Cal-COBRA is subject to payment of premiums to the health care service plan. Premiums for continuation coverage under this section shall be billed by, and remitted to, the health care

service plan in accordance with subdivision (d). Failure to pay the requisite premiums may result in termination of the continuation coverage in accordance with the applicable provisions in the plan's group subscriber agreement with the employer or former employer.

(2) The continuation coverage for the former spouse shall end automatically on the earlier of (A) the date the individual reaches 65 years of age, (B) the date the individual is covered under any group health plan not maintained by the employer or any other health plan, regardless of whether that coverage is less valuable, (C) the date the individual becomes entitled to Medicare under Title XVIII of the Social Security Act, (D) five years from the date on which continuation coverage under COBRA or Cal-COBRA was scheduled to end for the former spouse, or (E) the date on which the employer or former employer terminates its group subscriber agreement with the health care service plan and ceases to provide coverage for any active employees through that plan, in which case the health care service plan shall notify the former spouse of the right to a conversion plan in accordance with Section 1373.6.

(d)(1) If the premium charged to the employer for a specific employee or dependent eligible under this section is adjusted for the age of the specific employee, or eligible dependent, on other than a composite basis, the rate for continuation coverage under this section shall not exceed 102 percent of the premium charged by the plan to the employer for an employee of the same age as the former employee electing continuation coverage in the case of an individual who was eligible for COBRA, and 110 percent in the case of an individual who was eligible for Cal-COBRA. If the coverage continued is that of a former spouse, the premium charged shall not exceed 102 percent of the premium charged by the plan to the employer for an employee of the same age as the former spouse selecting continuation coverage in the case of an individual who was eligible for COBRA, and 110 percent in the case of an individual who was eligible for Cal-COBRA.

(2) If the premium charged to the employer for a specific employee or dependent eligible under this section is not adjusted for age of the specific employee, or eligible dependent, then the rate for continuation coverage under this section shall not exceed 213 percent of the applicable current group rate. For purposes of this section, the "applicable current group rate" means the total premiums charged by the health care service plan for coverage for the group, divided by the relevant number of covered persons.

(3) However, in computing the premiums charged to the specific employer group, the health care service plan shall not include consideration of the specific medical care expenditures for beneficiaries receiving continuation coverage pursuant to this section.

(e) For purposes of this section, "COBRA" means Section 4980B of Title 26 of the United States Code, Section 1161 et seq. of Title 29 of the United States Code, and Section 300bb of Title 42 of the United States Code, as added by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), and as amended.

(f) For purposes of this section, "Cal-COBRA" means the continuation coverage that must be offered pursuant to Article 4.5 (commencing with Section 1366.20), or Article 1.7 (commencing with Section 10128.50) of Chapter 1 of Part 2 of Division 2 of the Insurance Code.

(g) For the purposes of this section, "former spouse" means either an individual who is divorced

from an employee or former employee or an individual who was married to an employee or former employee at the time of the death of the employee or former employee.

(h) Every plan evidence of coverage that is issued, amended, or renewed after July 1, 1999, shall contain a description of the provisions and eligibility requirements for the continuation coverage offered pursuant to this section.

(i) This section shall take effect on January 1, 1999.

(j) This section does not apply to any individual who is not eligible for its continuation coverage prior to January 1, 2005.

Limited - HIPAA Premium Requirements

California Health & Safety Code § 1399.11. Premium requirements

Premiums for contracts offered, delivered, amended, or renewed by plans on or after January 1, 2001, shall be subject to the following requirements:

(a) The premium for new business for a federally eligible defined individual shall not exceed the following amounts:

(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64 years, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64 years, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(b) The premium for in force business for a federally eligible defined individual shall not exceed the following amounts:

(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64 years, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance

Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64 years, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The premium effective on January 1, 2001, shall apply to in force business at the earlier of either the time of renewal or July 1, 2001.

(c) The premium applied to a federally eligible defined individual may not increase by more than the following amounts:

(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average increase in the premiums charged to a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual.

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, the increase in premiums charged to a non-federally qualified individual who is of the same age and resides in the same geographic area as the federally defined eligible individual. The premium for an eligible individual may not be modified more frequently than every 12 months.

(3) For a contract that a plan has discontinued offering, the premium applied to the first rating period of the new contract that the federally eligible defined individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued contract.

2) Statutes and Regulations Applicable to the Department of Insurance

Guaranteed Renewability

California Insurance Code Section 10273.3. Guaranteed renewable policy

The term "guaranteed renewable policy" as used in this chapter (commencing with Section 10270) means a policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (a) until at least age 50, or (b) in the case of a policy issued after age 44, for at least five years from its date of issue during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may, in accordance with the provisions of the policy, make changes in premium rates as to all insureds who were placed in the same class for purposes of rate determination in the process of issuance of the policy or making it guaranteed renewable. Such a policy may use any of the provisions in Section 10291.6, 10350.2, 10350.4 or 10369.7, which may be used in noncancelable policies.

California Insurance Code Section 10273.6 . Eligibility for renewal of individual health benefit plans

All individual health benefit plans, except for short-term limited duration insurance, shall be renewable with respect to all eligible individuals or dependents at the option of the individual except as follows:

(a) For nonpayment of the required premiums or contributions by the individual in accordance with the terms of the health insurance coverage or the timeliness of the payments.

(b) For fraud or intentional misrepresentation of material fact under the terms of the coverage by the individual.

(c) Movement of the individual contractholder outside the service area but only if coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(d) If the disability insurer ceases to provide or arrange for the provision of health care services for new individual health benefit plans in this state; provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease new or existing individual health benefit plans in this state is provided to the commissioner and to the individual policy or contractholder at least 180 days prior to discontinuation of that coverage.

(2) Individual health benefit plans shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a disability insurer that remains in force, any disability insurer that ceases to offer for sale new individual health benefit plans shall continue to be governed by this section with respect to business conducted under this section.

(3) A disability insurer that ceases to write new individual health benefit plans in this state after the effective date of this section shall be prohibited from offering for sale individual health benefit plans in this state for a period of five years from the date of notice to the commissioner.

(e) If the disability insurer withdraws an individual health benefit plan from the market; provided, that the disability insurer notifies all affected individuals and the commissioner at least 90 days prior to the discontinuation of these plans, and that the disability insurer makes available to the individual all health benefit plans that it makes available to new individual businesses without regard to a health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.

Rate filing. Disapproval.

California Insurance Code Section 10290. Filing and approval of policy

A disability policy shall not be issued or delivered to any person in this State until:

(a) A copy of the form thereof and, if more than one class of risks is written, of the classification of risks, and the premium rates pertaining thereto are filed with the commissioner.

(b) Either:

(1) Thirty days expire without notice from the commissioner after such copy is filed, or,

(2) The commissioner gives his written approval prior to that time.

California Insurance Code Section 10291. Notice of disapproval

If the commissioner notifies the insurer in writing, that the filed form does not comply with the requirements of law, specifying the reasons for his opinion, it is unlawful thereafter for any such insurer to issue any policy in such form..

Individual Health Insurance: Regulation of Loss Ratio

California Insurance Code Section 10293. Withdrawal of approval

(a) The commissioner shall, after notice and hearing, withdraw approval of an individual or mass-marketed policy of disability insurance if after consideration of all relevant factors the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged. The commissioner shall, from time to time as conditions warrant, after notice and hearing, promulgate such reasonable rules and regulations, and amendments and additions thereto, as are necessary to establish the standard or standards by which the commissioner shall withdraw approval of any such policy. Any such rule or regulation shall be promulgated in accordance with the procedure provided in Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and shall be effective 90 days after adoption by the commissioner.

(b) Unless the commissioner specifies otherwise in writing in the withdrawals, or subsequent thereto, grants an extension, any such withdrawal shall be effective prospectively and not retroactively on the 91st day following the mailing or delivery of the withdrawal.

(c) As used in this section:

(1) "Mass-marketed policy" means any group or blanket disability insurance policy which is offered by means of direct response solicitation through a sponsoring organization, or through the mails or other mass communications media and under which a person insured pays all or substantially all of the cost of his or her insurance.

(2) "Direct response solicitation" means any offer by an insurer to persons in this state, either directly or through a third party, to effect health insurance coverage which enables the individual to apply or enroll for the insurance on the basis of the offer. It shall not include solicitation for insurance through an employer benefit plan which is defined in Public Law 93-406, nor shall it

include such a solicitation through the individual's creditor with respect to credit health insurance.

Small Employer Health Insurance

California Insurance Code 10700 Definitions

As used in this chapter:

(a) "Agent or broker" means a person or entity licensed under Chapter 5 (commencing with Section 1621) of Part 2 of Division 1.

(b) "Benefit plan design" means a specific health coverage product issued by a carrier to small employers, to trustees of associations that include small employers, or to individuals if the coverage is offered through employment or sponsored by an employer. It includes services covered and the levels of copayment and deductibles, and it may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality health care services which has significant incentives for the covered individuals to use the system.

(c) "Board" means the Major Risk Medical Insurance Board.

(d) "Carrier" means any disability insurance company or any other entity that writes, issues, or administers health benefit plans that cover the employees of small employers, regardless of the situs of the contract or master policyholder. For the purposes of Articles 3 (commencing with Section 10719) and 4 (commencing with Section 10730), "carrier" also includes health care service plans.

(e) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (z).

(f) "Eligible employee" means either of the following:

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of at least 30 hours, in the small employer's regular place of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer's business, and they are included as employees under a health benefit plan of a small employer, but does not include employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee as defined in this paragraph who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. A permanent employee who works at least 20 hours but not more than 29 hours is

deemed to be an eligible employee if all four of the following apply:

(A) The employee otherwise meets the definition of an eligible employee except for the number of hours worked.

(B) The employer offers the employee health coverage under a health benefit plan.

(C) All similarly situated individuals are offered coverage under the health benefit plan.

(D) The employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The insurer may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

(2) Any member of a guaranteed association as defined in subdivision (z).

(g) "Enrollee" means an eligible employee or dependent who receives health coverage through the program from a participating carrier.

(h) "Financially impaired" means, for the purposes of this chapter, a carrier that, on or after the effective date of this chapter, is not insolvent and is either:

(1) Deemed by the commissioner to be potentially unable to fulfill its contractual obligations.

(2) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(i) "Fund" means the California Small Group Reinsurance Fund.

(j) "Health benefit plan" means a policy or contract written or administered by a carrier that arranges or provides health care benefits for the covered eligible employees of a small employer and their dependents. The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(k) "In force business" means an existing health benefit plan issued by the carrier to a small employer.

(l) "Late enrollee" means an eligible employee or dependent who has declined health coverage under a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period

provided under the terms of the guaranteed association's health benefit plan and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, another person eligible for coverage through a guaranteed association pursuant to subdivision (z), or an eligible dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) He or she was covered under another employer health benefit plan, the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, or the Medi-Cal program at the time the individual was eligible to enroll.

(B) He or she certified at the time of the initial enrollment that coverage under another employer health benefit plan, the Healthy Families Program, the AIM Program, or the Medi-Cal program was the reason for declining enrollment provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) He or she has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual, or of a person through whom the individual was covered as a dependent, the termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of the person through whom the individual was covered as a dependent, legal separation, divorce, loss of coverage under the Healthy Families Program, the AIM Program, or the Medi-Cal program.

(D) He or she requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan, or requests enrollment within 60 days after termination of Medi-Cal program coverage, AIM Program coverage, or Healthy Families Program coverage.

(2) The individual is employed by an employer who offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

(3) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan.

(4)(A) In the case of an eligible employee as defined in paragraph (1) of subdivision (f), the carrier cannot produce a written statement from the employer stating that the individual or the person through whom an individual was eligible to be covered as a dependent, prior to declining coverage, was provided with, and signed acknowledgment of, an explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the carrier to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the individual meets the criteria specified in paragraph (1), (2), or (3).

(B) In the case of an eligible employee who is a guaranteed association member, the plan cannot produce a written statement from the guaranteed association stating that the association sent a written notice in boldface type to all potentially eligible association members at their last known address prior to the initial enrollment period informing members that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the member's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the member can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) or meets the requirements of paragraph (2) or (3).

(C) In the case of an employer or person who is not a member of an association, was eligible to purchase coverage through a guaranteed association, and did not do so, and would not be eligible to purchase guaranteed coverage unless purchased through a guaranteed association, the employer or person can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1), or meets the requirements of paragraph (2) or (3), or that he or she recently had a change in status that would make him or her eligible and that application for coverage was made within 30 days of the change.

(5) The individual is an employee or dependent who meets the criteria described in paragraph (1) and was under a COBRA continuation provision and the coverage under that provision has been exhausted. For purposes of this section, the definition of "COBRA" set forth in subdivision (e) of Section 1373.62 shall apply.

(6) The individual is a dependent of an enrolled eligible employee who has lost or will lose his or her coverage under the Healthy Families Program, the AIM Program, or the Medi-Cal program and requests enrollment within 60 days after termination of that coverage.

(7) The individual is an eligible employee who previously declined coverage under an employer health benefit plan and who has subsequently acquired a dependent who would be eligible for coverage as a dependent of the employee through marriage, birth, adoption, or placement for adoption, and who enrolls for coverage under that employer health benefit plan on his or her behalf, and on behalf of his or her dependent within 30 days following the date of marriage, birth, adoption, or placement for adoption, in which case the effective date of coverage shall be the first day of the month following the date the completed request for enrollment is received in the case of marriage, or the date of birth, or the date of adoption or placement for adoption, whichever applies. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(8) The individual is an eligible employee who has declined coverage for himself or herself or his or her dependents during a previous enrollment period because his or her dependents were covered by another employer health benefit plan at the time of the previous enrollment period. That individual may enroll himself or herself or his or her dependents for plan coverage during a special open enrollment opportunity if his or her dependents have lost or will lose coverage under that other employer health benefit plan. The special open enrollment opportunity shall be requested by the employee not more than 30 days after the date that the other health coverage is

exhausted or terminated. Upon enrollment, coverage shall be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(m) "New business" means a health benefit plan issued to a small employer that is not the carrier's in force business.

(n) "Participating carrier" means a carrier that has entered into a contract with the program to provide health benefits coverage under this part.

(o) "Plan of operation" means the plan of operation of the fund, including articles, bylaws and operating rules adopted by the fund pursuant to Article 3 (commencing with Section 10719).

(p) "Program" means the Health Insurance Plan of California.

(q) "Preexisting condition provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(r) "Creditable coverage" means:

(1) Any individual or group policy, contract, or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(5) 10 U.S.C. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Sec. 2504(e)).

(11) Any other creditable coverage as defined by subdivision (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

(s) "Rating period" means the period for which premium rates established by a carrier are in effect and shall be no less than six months.

(t) "Risk adjusted employee risk rate" means the rate determined for an eligible employee of a small employer in a particular risk category after applying the risk adjustment factor.

(u) "Risk adjustment factor" means the percent adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard claims. This factor may not be more than 120 percent or less than 80 percent until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent.

(v) "Risk category" means the following characteristics of an eligible employee: age, geographic region, and family size of the employee, plus the benefit plan design selected by the small employer.

(1) No more than the following age categories may be used in determining premium rates:

Under 30

30-39

40-49

50-54

55-59

60-64

65 and over

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the health benefit plan will be primary or secondary to benefits provided by the federal Medicare program pursuant to Title XVIII of the federal Social Security Act.

(2) Small employer carriers shall base rates to small employers using no more than the following family size categories:

(A) Single.

(B) Married couple.

(C) One adult and child or children.

(D) Married couple and child or children.

(3)(A) In determining rates for small employers, a carrier that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and shall divide no county into more than two regions. Carriers shall be deemed to be operating statewide if their coverage area includes 90 percent or more of the state's population. Geographic regions established pursuant to this section shall, as a group, cover the entire state, and the area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.

(B) In determining rates for small employers, a carrier that does not operate statewide shall use no more than the number of geographic regions in the state than is determined by the following formula: the population, as determined in the last federal census, of all counties which are included in their entirety in a carrier's service area divided by the total population of the state, as determined in the last federal census, multiplied by nine. The resulting number shall be rounded to the nearest whole integer. No region may be smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and no county may be divided into more than two regions. The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous. No carrier shall have less than one geographic area.

(w) "Small employer" means either of the following:

(1) Any person, proprietary or nonprofit firm, corporation, partnership, public agency, or association that is actively engaged in business or service that, on at least 50 percent of its working days during the preceding calendar quarter, or preceding calendar year, employed at least two, but not more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, the insurer shall use the test that ensures eligibility if only one test would establish eligibility. However, for purposes of subdivisions (b) and (h) of Section 10705, the definition shall include employers with at least three eligible employees until July 1, 1997,

and two eligible employees thereafter. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined income tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer pursuant to this chapter, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this chapter that apply to a small employer shall continue to apply until the health benefit plan anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this paragraph who purchases coverage through a guaranteed association, and any employer purchasing coverage for employees through a guaranteed association.

(2) Any guaranteed association, as defined in subdivision (y), that purchases health coverage for members of the association.

(x) "Standard employee risk rate" means the rate applicable to an eligible employee in a particular risk category in a small employer group.

(y) "Guaranteed association" means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria which (1) includes one or more small employers as defined in paragraph (1) of subdivision (w), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has been offering health insurance to its members for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any benefit plan design that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the benefit plan design offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the carrier with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

This subdivision applies regardless of whether a master policy by an admitted insurer is delivered directly to the association or a trust formed for or sponsored by an association to administer benefits for association members.

For purposes of this subdivision, an association formed by a merger of two or more associations after January 1, 1992, and otherwise meeting the criteria of this subdivision shall be deemed to have been in active existence on January 1, 1992, if its predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and otherwise met the criteria of this subdivision.

(z) "Members of a guaranteed association" means any individual or employer meeting the association's membership criteria if that person is a member of the association and chooses to purchase health coverage through the association. At the association's discretion, it may also include employees of association members, association staff, retired members, retired employees of members, and surviving spouses and dependents of deceased members. However, if an association chooses to include those persons as members of the guaranteed association, the association must so elect in advance of purchasing coverage from a plan. Health plans may require an association to adhere to the membership composition it selects for up to 12 months.

(aa) "Affiliation period" means a period that, under the terms of the health benefit plan, must expire before health care services under the plan become effective.

Public Access to Rate Filings

California Insurance Code Section 12956. Public inspection of policy forms

Forms of policies filed with the commissioner and writings in respect thereto shall be open to public inspection except where, in his judgment, the public welfare or the welfare of any insurer demands that any portion thereof be not made public. In such cases he may withhold such information from public inspection for such time as in his judgment is necessary or advisable.

Regulations Pertaining to Medical Loss Ratio

10 California Code of Regulations Section 2222.10 et seq:

Section 2222.10. Applicability

This article is adopted pursuant to and in implementation of Section 10293(a) of the Insurance Code, is applicable to individual disability policies providing hospital, medical or surgical insurance coverages, as defined in Section 2222.11 herein, and mass-marketed policies as defined in Insurance Code section 10293(c)(1), that are either (1) delivered or issued for delivery to any person in this State on or after July 1, 2007, or (2) delivered or issued for delivery to any person in this State on or after July 1, 1962 and subject to any rate revision effective on or after July 1, 2007, and relates to standards by which the Insurance Commissioner shall withdraw approval of policy forms the benefits of which are unreasonable in relation to the premiums charged.

Section 2222.11. Definitions

(a) The term "hospital, medical or surgical policy" as used in this article means any disability insurance contract (whether composed solely of a policy or of a policy and one or more riders, endorsements, or amendments attached thereto) designed, constructed, advertised or sold as having as its dominant purpose the provision of benefits contingent upon the rendition of hospital, medical or surgical services. This definition includes a "mass-marketed policy," as described in Insurance Code section 10293. This definition also includes a policy of "health insurance" as described in Insurance Code section 106(b), but does not include supplemental policies of individual health insurance that provide coverage for vision care expenses only,

dental care expenses only, or short-term limited duration health insurance with coverage durations of 6 months or less.

For purposes of this article, the phrase "dominant purpose" means any disability insurance contract (whether composed solely of a policy, or of a policy and one or more riders, endorsements, or amendments attached thereto) upon which at least 50 percent of the initial premium or of any renewal premium is or may be, under the underwriting rules or practices of the insurer, allocated or apportioned or should reasonably be allocated or apportioned to the hospital, medical or surgical benefits provided therein. In case of a "hospital, medical or surgical policy" which contains, in addition to benefits contingent upon the rendition of hospital, medical or surgical services, other benefits which are not subject to this article, the insurer may segregate the earned premiums and the incurred losses for those benefits which are subject to the provision of this article, and the commissioner may require such segregation if substantial benefits not subject to this article are provided. If there is no such segregation, the experience of the policy will be considered as a unit. This definition shall not be construed to include: (1) policies which provide a benefit expressed as an increase of a loss of time benefit during hospital confinement, which is not advertised or sold as a hospital benefit, or (2) a single premium nonrenewable transportation ticket policy having as its dominant feature the protection of the insured from a transportation hazard.

(b) The term "individual" policy as used in this article means a disability policy purporting to insure only one person, except that included within this definition shall be a family policy or family expense policy defined in Section 10320(c) of the Insurance Code.

(c) Policies "issued on a mass underwriting basis" as used in this article shall mean individual hospital, medical, or surgical policies (1) conforming to all of the underwriting and renewal conditions set forth in Section 10270.97 of the Insurance Code, relating to selected group disability insurance; or (2) issued without individual underwriting pursuant to the exercise of a conversion privilege in a group policy; or (3) issued at lower than the individual policy rates otherwise charged predicated on the expectation of substantial savings in operating expenses to members of a group of individuals (such as members of a professional association), under a plan or arrangement entered into between the insurer and the association; or issued on a mass enrollment basis to members of a defined group of individuals (such as residents over age 65 in one state) under a plan whereby the insurer will not discontinue, or modify rates of, any policy, unless it simultaneously discontinues or similarly modifies all other policies in the same group; or (4) at the discretion of the commissioner, any similar policy predicated upon substantial savings in operating expense arising from mass enrollment.

(d) The terms "premiums earned" and "losses incurred" as used in this article shall be developed by a method consistent with that method used for developing such items in Schedule H of the life and accident and health annual statement blank, unless otherwise specifically indicated in this article.

(e) References to specified portions of annual statement blanks shall apply to all amendments and additions or successor provisions hereafter made.

(f) "Rate revision" means a change in premium rates that applies to existing policies.

(g) "Lifetime anticipated loss ratio" means the ratio of (i) divided by (ii), where (i) is equal to the sum of the accumulated value of past incurred claims since the inception of the policy and the present value of future anticipated claims, and (ii) is the sum of the accumulated value of past earned premiums and the present value of future anticipated premiums earnings.

(h) "Disease management expenses" means expenses incurred by an insurer for services administered to patients in order to improve their overall health and to prevent clinical exacerbations and complications utilizing cost-effective, evidence-based guidelines and patient self-management strategies.

(i) "Lifetime anticipated disease management ratio" means the ratio of (i) divided by (ii), where (i) is equal to the sum of the accumulated value of past incurred disease management expenses since the inception of the policy and the present value of future anticipated disease management expenses, and (ii) is the sum of the accumulated value of past earned premiums and the present value of future anticipated premium earnings.

Section 2222.12. Standards of Reasonability

The authority of the commissioner under Insurance Code Section 10293 being to withdraw approval of policy forms the benefits of which are not reasonable in relation to the premium charged, whether the approval of any form of an insurer should be withdrawn pursuant to said section shall be determined by an analysis of actual loss experience, giving due consideration to all factors relevant to the determination of how the past loss experience may be used to reasonably indicate the average loss experience which should develop. Some of such factors which will be considered by the commissioner are hereinafter in this article set forth, but their listing does not preclude an insurer from urging any other factors which it considers relevant to the issue involved.

(a) Benefits provided by a hospital, medical or surgical policy shall be deemed to be reasonable in relation to premiums if either (1) the lifetime anticipated loss ratio is not less than 70%, and (2) in the case of a rate revision, the anticipated loss ratio over the future period for which the revised rates are computed to provide coverage is also not less than 70%, or, if the insurer chooses to include disease management expenses in determining compliance with these standards, (3) the sum of the lifetime anticipated less ratio and the lifetime anticipated disease management ratio is not less than 70%, and (4) in the case of a rate revision, the sum of the anticipated less ratio over the future period for which the revised rates are computed to provide coverage and the anticipated disease management ratio over the future period for which revised rates are computed to provide coverage is also not less than 70%.

(b) Benefits provided by a hospital, medical, or surgical policy delivered or issued for delivery to any person in this State prior to July 1, 2007 and not subject to any rate revision effective on or after July 1, 2007 shall be deemed to be reasonable in relation to premiums if the lifetime anticipated loss ratio is not less than 50%.

(c) Benefits provided by supplemental policies of individual health insurance that provide coverage for vision care expenses only, dental care expenses only, or short-term limited duration

health insurance with coverage durations of 6 months or less shall be deemed to be reasonable in relation to premiums if the lifetime anticipated loss ratio is not less than 50%.

(d) Benefits provided by a hospital, medical or surgical policy designed to supplement Medicare, as defined in subdivision (l) of Insurance Code section 10192.4, must meet the loss ratio standards established in Subdivision (a)(1)(A) of Section 10192.14 of the Insurance Code.

Section 2222.14. Credibility Factors

The commissioner may consider the use of credibility factors consistent with sound actuarial principles in the review of experience to recognize deviations from the loss ratio standard that may be due to chance variation.

Section 2222.15. Communication to Insurer

Prior to taking any action under Section 2222.17, the commissioner will communicate with the insurer in writing, identifying those policies for which any preliminary review does not establish an inference that the benefits provided therein are reasonable in relation to the premium charged. Such communication shall be deemed confidential, and shall advise the insurer that it should inform the commissioner as to any factors applicable to the consideration of the policy under review which it considers relevant to the reasonableness of the relationship of benefits to premiums. The insurer may, from time to time, submit supplementary material which it deems to be relevant to the study of the loss ratios generated by a specific policy; and the commissioner may request such additional information as he may deem necessary to complete his consideration of such policy.

Section 2222.16. Consideration of Relevant Factors

In reviewing any specific policy the commissioner shall consider all factors as are relevant to a determination as to whether the benefits are unreasonable in relation to the premium charged therefor. Relevant factors and the weight to be given thereto depend upon the attributes of such particular policy, as determined by the commissioner in accordance with the provisions of this article. The following is a list of relevant factors which are generally applicable to policies subject to this statute:

(a) Policy experience generated over the period of the one preceding calendar year (ending with the beginning of the year of review) in addition to the year of review may be considered as relevant in case of any policy form. Experience generated over a still longer period (ending with the year of review) may be considered in case of any policy as to which there are substantial reasons to believe, insofar as loss experience is relevant to the issue to be determined, that the experience statistics for the shorter period do not give a fair indication of the actual loss experience of the policy under review. Experience over such extended periods can be considered only if relevant experience figures are made available to the commissioner.

(b) Adjustment of experience statistics to conform to assumption of payment of premiums annually in advance. The adjustment will be that the annual premium shall be deemed to be an amount which is:

(1) 96 percent of the sum of semiannual premiums;

(2) 94 percent of the sum of quarterly premiums; or

(3) 92 1/2 percent of the sum of monthly premiums.

If the insurer desires consideration of the increase in handling expenses arising from fractional premium payments, the insurer must furnish for the experience period (i) the distribution of earned premiums according to mode of premium payment during the year, and (ii) adjusted experience statistics based upon conforming earned premiums related to premiums collected semiannually, quarterly, monthly, and upon a weekly and monthly debit basis to the earned premiums developed from the corresponding pro rata annual premium.

(c) Effect of any premium rate changes made during the experience period under review. In order that the commissioner may properly evaluate this factor, the insurer must furnish complete data thereon, including adjusted experience statistics in which earned premiums are adjusted to conform with the current rate basis.

(d) The effect of any experience refunds or dividends paid to policyholders. Insurers desiring consideration of this factor should furnish particulars with respect to such amount accrued for the period of review together with adjusted experience statistics in which such refunds or dividends are considered as a reduction of premiums earned.

(e) With respect to a policy not subject to the reserve requirements of Insurance Code Section 997(b), the loss ratio experienced and reasonably anticipated by policy year; and, where appropriate, the aggregate loss ratio excluding the first policy year. In order that the commissioner may properly evaluate these factors, the insurer must furnish in conjunction therewith data as to the persistency experienced and reasonably anticipated on the policy under review, together with a weighted average loss ratio computed over a reasonable period of time giving effect to these factors. Such weighted average should be based on the experience reasonably to be anticipated in the light of persistency actually experienced and other circumstances likely to affect future persistency. The insurer may also furnish other data relating to actuarial assumptions relevant to the experience to be expected on the policy.

(f) With respect to a policy subject to the reserve requirements of Insurance Code Section 997(b), the insurer should submit for consideration an adjusted loss ratio for the experience period based on the formula given in the footnote to Schedule H in the Life and Accident and Health Annual Statement blank relating to the development of a supplemental loss ratio for individual noncancelable accident and health policies which takes into account the reserves held pursuant to Section 997. If such adjusted loss ratio, after giving effect to such other factors as may be relevant, does not; establish the reasonableness of benefits to premiums, the insurer must furnish an analysis of the relation of actuarial net annual premium rates for the policy to the corresponding gross annual premium rates established by the insurer. Such net premiums may be determined on a basis consistent with the minimum valuation standards set forth in Section 997(b) or on an appropriate alternate basis permitted by Section 997 provided details of the actuarial assumptions used are furnished the commissioner. In order that the commissioner may

properly evaluate this factor, the insurer may also be required to submit an actuarial analysis of the relation of the actual morbidity experience under the policy to the assumptions used in determining the net premium rates, with an estimate of the extent of the change in the net premium rates indicated by such actual experience, with due allowance for reserves held pursuant to Section 997.

(g) Experience in any areas where different rate levels were in effect as compared with the countrywide experience on such policy of the insurer in any case in which it can be shown that such experience differs significantly from such countrywide experience.

(h) The likelihood of fluctuation in experience under the policy because of infrequency of loss occurrence or catastrophic nature of hazard covered. Insurers requesting consideration of this factor should furnish appropriate data as requested.

(i) Establishment of credibility of loss ratio experienced on policy under review, based upon available data to be furnished by the insurer for the experience period as to volume of premiums earned, average premium paid per person insured for one year's coverage, average amount of loss per claim incurred, and distribution of claims incurred by size of claim.

(j) With respect to any policy under review the commissioner may on his own initiative or at the request of the insurer consider experience and other factors on other policy forms to the extent they are relevant to determination of the reasonableness of benefits to premium; in particular, such aggregate or averages as may serve to show the reasonableness of benefits to premiums on a class of business as a whole of which the policy under review is a part.

(k) When in connection with the consideration of any policy it is established that there is a trend upward or downward in the loss experience for the type of benefits provided therein, consideration may be given to the probable effect of such trend factor on the loss experience reasonably to be anticipated under such policy.

§ 2222.17. Notice to Insurer

If after consideration of all relevant factors the commissioner believes that the benefits provided under an individual hospital, medical or surgical policy are not reasonable in relation to the premium charged, the commissioner shall so inform the insurer in writing. Such notification shall be deemed a confidential communication. The commissioner shall also advise the insurer that the commissioner will, at the commissioner's discretion, commence proceedings for withdrawal of authorization of the form after notice and hearing as provided by law unless, within 31 days from the date of the notification, the insurer commits itself in writing to the commissioner that it will, within 90 days, voluntarily either (1) cease further issuance of the policy form or (2) increase benefits under the policy in relation to the premiums charged in an amount sufficient to bring the policy into compliance with the standards of reasonability provided for in section 2222.12. If the insurer does not commit itself, within 31 days from the date of the notification, to discontinue issuing the policy or increase benefits under the policy in relation to premiums charged, the commissioner may commence proceedings at any time as provided by law for withdrawal of the authorization of the policy form.

§ 2222.18. When Resubmission Deemed to Be Same as Withdrawn Policy

The commissioner may consider two or more forms of the policy contracts as prepared by any one insurer or two or more affiliated insurers as one policy form for the purpose of determining under the provisions of this article whether benefits are reasonable in relation to premiums if the benefits and premiums or premium rates of such policy forms are alike in substance. Any policy form submitted by an insurer to replace a form of itself or its affiliates, the approval of which has been withdrawn under the provisions of this article, shall not be considered to be a new form or a form different from that of the form the approval of which was withdrawn, unless the benefits of the new form are sufficiently more favorable to the insured, or the premium or premium rates are sufficiently lower so as to indicate that the new form will meet the tests of this article.

Section 2222.19. Statement of Compliance

Unless requested by the commissioner to provide more specific information on policy forms subject to the standards of reasonability in Section 2222.12, a company shall, by April 1 of each year, provide a statement from a qualified actuary that lists the policy forms to which the standards apply, the lifetime anticipated loss ratio and, if applicable, the lifetime anticipated disease management ratio for each form, and a statement that the standards of reasonability have been met, for each policy form for the preceding calendar year. For policy forms to which Section 2222.12(a) applies, a company shall also submit by April 1 of each year a schedule detailing disease management expenses for the preceding calendar year, if applicable.

Appendix 2:
Health Rate Reductions,
California Department of Insurance
2007-2010

Date Closed, Market share (total), *Policyholders*	**Rate change(s) requested**	**Final rate after CDI intervention**	**Date Closed**	**Rate change(s) requested**	**Final rate after CDI intervention**
1/11/07 <.01, *10*	+39%	+13.2%	1/18/07 0.02 *463*	+15%	+5%
2/5/07 0.88 *126*	+50%	+20%	3/6/07 0.01 *289*	+50%	+25%
4/18/07	+25%	+15%	4/18/07	+23.2%, +17.6%, +12.0%, 0.0%	+15.0%, +15.0% +12.0% 0.0%
4/26/07 <.01 *5*	+200%	+100%	5/17/07 0.02 *463*	+25%	+15%
5/22/07 0.03 *712*	+25.4%	Withdrawn by company after CDI review	7/6/07 0.01 *34*	+20%	+10%
7/13/07 0.02 *463*	+30%	+20%	8/1/07 0.04 *988*	+35%	+12.0%
8/2/07	+30.5%	+12.0%	8/2/07	+30.5%	+12.0%
8/2/07	+12.0%	+6.0%	9/18/07 0.19 *3,676*	+16.2%	+10%
9/24/07 <.01 *29*	+10%	Withdrawn by company after CDI review	9/24/07 <.01 *29*	+10%	Withdrawn by company after CDI review
9/26/07 <.01 *26*	+15%	Withdrawn by company after CDI review	10/17/07 <.01 34	+20%	+10%
11/26/07 <.01 5	+25%	+10%	12/27/07	+15%	Withdrawn by company after CDI review
1/18/08 0.02	+25.0%	+18.0%	1/18/08 0.02	+25.0%	+18.0%

453			*453*		
1/18/08 47.79% *611,278*	+17.0%	Withdrawn by company after CDI review	2/15/08 0.21 *5,047*	+40.0% and +26.8%	+6.7% and+16.2%
2/26/08 0.02 *536*	+15.0%	+10.0%	4/8/08	8.0%	Withdrawn by company after CDI review
5/12/08 0.02 *453*	+10.0%	Withdrawn by company after CDI review	7/21/08 47.79% *611,278*	An average of +15.3%	An average of +14.9%
8/21/08	+10.0%	Withdrawn by company after CDI review	9/2/08 <.01 *5*	+100.0% for a Rider	+20.0% for a Rider
9/3/08 0.02 *536*	+20.0%	+13.0%	9/8/2008	+30.0%	Withdrawn by company after CDI review
9/17/08	+30.0%	Withdrawn by company after CDI review	9/17/08	+19.0%	+5.7%
9/17/08 <.01 *5*	+19.0%	+5.7%	9/17/08 <.01 *34*	+20.0%	+10.0%
11/5/08	+25.0%	+5.0%	11/20/08	+20.0%	+5.0%
1/12/09	+25.0%	Withdrawn by company after CDI review	2/5/2009 0.01 *130*	+15.0%	+12.0%
5/21/09 <.01 *10*	+39.0%	+23.3%	8/7/09 0.02 *536*	+15.0%	+10.0%
8/21/09 0.02 *536*	+15.0%	+10.0%	10/30/09 <.01 *34*	+22.0%	Withdrawn by company after CDI review
10/30/09 <.01 *34*	+9.0%	Withdrawn by company after CDI review	11/19/09 <.01 *34*	+15.0%	+10.0%
12/3/09 <.01 *34*	+10.0%	Withdrawn by company after CDI review	1/21/10 3.35 *81,348*	An average of +14.0%	An average of +12.0%
4/29/10 47.79% *611,278*	+29.1%	Withdrawn by company after CDI review	4/29/10 47.79% *611,278*	+16.3%	Withdrawn by company after CDI review
4/29/10 47.79%	+16.6%	Withdrawn by company after	4/29/10 47.79%	Plans that Exclude	Withdrawn by company after

611,278		CDI review	*611,278*	maternity coverage: +12.3%; Plans that Include maternity coverage: +32.7%;	CDI review
4/29/10 47.79% *611,278*	+22.8%	Withdrawn by company after CDI review	4/29/10 47.79% *611,278*	+29.5	Withdrawn by company after CDI review
4/29/10 47.79% *611,278*	+32.0%	Withdrawn by company after CDI review	5/11/10 0.88 *126*	+30.0%	+15.0
5/11/10 0.05 *1.160*	+15.0%	+10.0			

Appendix 3:
California Department of Insurance Budget Breakdown
For Health Rate Review Activities

Position	% time involved in rate review	Budget allocation attributable to rate review %, $
Supervising Actuary	50%	$79,712
Senior Actuary	100%	157,196
Senior Actuarial Statistician	50%	$44,619
Senior Staff Counsel (3)	3 x 20%	90,082
Senior Legal Typist	30%	16,707
Total		$388,316

Appendix 4:
California Department of Insurance
Education and Professional Background
Of Staff Responsible for Rate Review

• **Perry Kupferman, Supervising Life Actuary.** B.S., M.A., Mathematics, California Polytechnic University, San Luis Obispo. Fellow of the Society of Actuaries (1980), Member of the American Academy of Actuaries (1979).Actuary at Occidental Life 1970-1974, SVP and Chief Life Actuary at Balboa Insurance Group 1974-1987, SVP Risk Management and Chief Actuary at Lyndon Insurance Group 1987-2004, SVP, Chief Actuary and Chief Underwriter at Resource Life/Virginia Surety 2004-2006, Supervising Life Actuary at California Department of Insurance 2007-present

• **Ali A. Zaker-Shahrak, Senior Life Actuary**. B.Sc., M.Sc., Ph.D. (Economics), The London School of Economics, London, England. Fellow of the Society of Actuaries (2000), Member of the American Academy of Actuaries (1999), Chartered Financial Analyst (2001). Actuarial experience: Delta Dental Plan of California, San Francisco, CA – (July – December 1993), Allstate Research and Planning Center, Menlo Park, CA – (July – October 1994), Metropolitan Life Insurance Company, New York, NY – (November 1996 – June 2002), Manager, Horizon Blue Cross Blue Shield of New Jersey, NJ – (August 2003 – May 2004), , Senior Life Actuary, California Department of Insurance, 2005-present.. Academic positions: New York Institute of Finance, New York, NY – (September 1996 – June 2001), Pace University, New York, NY - (September – December 1996), Stanford University – Stanford, CA – (September – December 1992 and January – March 1994), University of California, Santa Cruz, CA - (September – December 1996), Santa Clara University, Santa Clara, CA – (June 1998 – August 1992), The London School of Economics, University of London, London, England – Academic Year 1972/73.

• **Marsha Seeley, Senior Staff Counsel**. B.A., Southern Illinois University (Carbondale), 1976, J.D., Golden Gate University, 1980. Member, State Bar of California. Legal Division, California Dept. of Insurance, 1990-present.

• **Kim Morimoto, Senior Staff Counsel**. AB, University of California, Berkeley, JD, University of the Pacific, McGeorge School of Law. Member, State Bar of California. 9 years of insurance regulatory law practice at private law firms, 5 years with the Legal Division, California Department of Insurance.

• **Bruce Hinze, Senior Staff Counsel**. AB (Botany), University of California, Berkeley, BS (Nursing), University of California, San Francisco, JD, University of San Francisco. Member, State Bar of California. 14 years of private practice, specializing in defense of medical malpractice actions, 10 years of California state service at the Department of Corporations, Department of Managed Health Care, Commission on Judicial Performance, and the Legal Division, California Department of Insurance (4 years).

Appendix 5:
Department of Managed Health Care
Duty Statements for Staff Responsible for Current Rate Review

Duty Statement

Department of Managed Health Care

CLASSIFICATION: Health Program Specialist I
WORKING TITLE: Health Program Specialist I

POSITION: *111-8338-010*

DIVISION: *Licensing*

SECTION A: *General Description*

Under the direction of the Health Program Manager II the incumbent performs extremely high profile, sensitive and complex specialized assignments involving broad policy issues, which have significant statewide impact on the Department's licensing program pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Act), the California Code of Regulations, Title 28 (Regulations), and program policies and procedures. The incumbent is responsible for monitoring and ensuring that full service commercial and specialized health care service plans comply with the licensing requirements of the Act and Regulations. The incumbent performs research, analyzes and compiles data independently, and drafts written material involving complex policy matters. Additionally, the incumbent conducts studies and formulates recommendations to counsel, including OLS, on the drafting of new regulations. The incumbent leads complex project management matters that require inter-divisional workgroups, meetings with outside stakeholders, development of goals with timeframes and production of progress reports to monitor the projects to ensure completion; and prepares written material for the Director that may be used in the Director's testimony in legislative oversight hearings and/or at presentations given by the Director. Duties and responsibilities include, but are not limited to the following:

SECTION B: *Essential Functions*

Candidates must be able to perform the following functions with or without reasonable accommodations.

55% Research, analyze and evaluate extremely high profile, sensitive and complex specialized assignments involving broad policy issues to determine the impact on full service commercial and specialized health care service plans. These duties include being the

project liaison on complex inter-divisional matters, such as developing and monitoring the implementation of new legislation and/or regulations that impact the Department on a regular basis. As the project liaison, the incumbent must determine the Department requirements under the statute and/or regulations, identify Plan filings required, identify and lead inter-divisional workgroups, meet with and inform stakeholders, identify and develop checklists to streamline the filing process, develop and monitor timeframes to meet goals, and update Executive Management regarding progress of any issues until completion of the project. In addition to having project management responsibility on complex matters, the incumbent will provide consultation to Executive Management and will exercise decision-making responsibilities on matters such as; making recommendations to the Director regarding whether or not the Director should employ discretion in issuing statutory exemptions and/or regulatory waivers when issuing an Order or License to maintain regulatory compliance with the Act. The incumbent must possess in-dept knowledge of the Act, an understanding of managed care practice and trends and Department policies in order to represent the DOL at intra and inter-departmental meetings; and must be able to serve as a resource to DOL and the Department, including Executive Management, on strategic planning and DOL program expertise relating to complex health plan policies. In serving as a resource, the incumbent must be able to make recommendations for development of legislative and/or regulatory changes, including making recommendations to counsel and OLS on the drafting of new regulations. The incumbent provides leadership and assistance in preparing written material for the Director that may be used in the Director's testimony in legislative oversight hearings; and also in preparing material such as power point presentation(s), which the Director utilizes when making presentations. The incumbent makes recommendations to the Division Chief and managers on technical, legislative and policy matters affecting the licensing program.

25% Conduct review of complex license applications, amendments and notices of material modifications filed by full service commercial health plans licensed pursuant to the Act including; coordinating reviews with other divisions on complex and high-profile filings such as premium rate charges pursuant to statutory requirements, for HIPAA-GI PPO products. The filing reviews require communication with Plans and reporting the results to Executive Management. Incumbent serves as a mentor and as a resource, including training and developing improved training materials for new DOL staff. Provides leadership and assistance in developing and implementing new policies and procedures for the licensing program.

15% Prepare program performance reports for approval by senior management and make periodic presentations to management teams. Coordinate special studies to identify new program opportunities and approaches. Provide task force leadership to formulate guidelines for broad application in monitoring adverse trends in managed health care programs.

SECTION C: Non-Essential or Marginal Functions

5% Attend meetings, training courses, seminars, travel, and perform other job-related duties as needed.

Duty Statement

Department of Managed Health Care

CLASSIFICATION: Health Program Manager II
WORKING TITLE: Same As Above

POSITION: *111-8428-001*

DIVISION: *Licensing*

SECTION A: *General Description*

Under the direction of the Assistant Chief Counsel, Division of Licensing (DOL), the incumbent directs and manages program activities pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Act), the California Code of Regulations, Title 28 (Regulations), and program policies and procedures. Because health plan filings include review and analysis by both DOL and the DFO (Division of Financial Oversight), the incumbent is responsible for crossing program lines within Health Plan Oversight (HPO) to ensure consistency, monitor and report on performance metrics in accordance with the Department's goals and objectives to streamline filings. The incumbent is responsible for coordinating special projects that are cross-divisional and also coordinates special projects/workgroups that involve other health care departments (e.g. DHCS, MRMIB, etc.) and major commercial health plans and stakeholders. The incumbent provides recommendations on assigned projects that include matters related to highly visible issues both within and outside the Department. These issues include health care reform, difficult and complex health care program matters, health care transparency, risk-based review of health plan filings, and program efficiency. The incumbent serves as the HPO contact person for data compilation and Ad Hoc reports, including analyzing monthly efiling statistics to prepare reports and spreadsheets to synthesize trends. The incumbent develops training materials, including employee online information system and DOL website, and is responsible for scheduling and coordinating all new DOL staff training. The incumbent provides direction and leadership in all phases of the program operations, policy decision and direct oversight of the statewide activities, development projects, and pilot projects. Supervision Received: Under the general supervision from the Assistant Chief Counsel. Supervision Exercised: The incumbent manages 11 staff, directly supervises one Health Program Manager I, two Health Program Specialist I positions, and one Staff Services Manager I. The incumbent allocates resources to achieve designated objectives in the most effective and efficient manner and monitors conformity with policies. Duties and responsibilities include, but are not limited to the following:

SECTION B: Essential Functions

Candidates must be able to perform the following functions with or without reasonable accommodations.

45% Manage the workflow redesign of the Health Plan Oversight (HPO), including overseeing filing review processes and performance metrics for both DFO and DOL. Review and make recommendations for streamlining filing review processes to promote consistency and efficiencies for both DFO and DOL. Meets regularly with DFO and DOL staff to assist with establishing priorities for risk-based review of filings. Analyze HPO data and develop spreadsheets to trend filing data and performance metrics to compare to Department goals and objectives. Responsible for creating and preparing monthly reports on HPO statistics for filings and performance metrics. Responsible for various HPO reports, including preparing the HPO Annual Report with goals/objectives, including monitoring and reporting on quarterly updates.

25% Serves as the primary liaison for the HPO for data compilation, including assisting the Press Information Office and Executive management, by accurately responding to various inquires related to health plan information and financial data. Prepares various Ad Hoc reports for Executive management.

10% Manage and supervise the work of a team of analysts responsible for the review of license applications, amendments and notices of material modifications filed by health plans licensed pursuant to the Act and related functions. Perform personnel matters for assigned staff, including assigning duties and monitoring work performance. Provide leadership and direction to staff by working with HPO staff and outside health organizations (e.g. DHCS, MRMIB, etc.) on joint filing workgroups to coordinate new strategies for streamlining filing processes.

10% Develops training materials and responsible for conducting initial training for all new hires in DOL. Coordinates bi-weekly trainings for DOL staff. Responsible for developing recruitment material, participates in exam panels, interviews, and preparing performance evaluations of subordinate staff within personnel guidelines. Develop HPO policies and procedures, including ensuring these are revised/updated as necessary. Works with staff to develop and/or update Technical Assistance Guides (TAGs) and Checklists as necessary. Serves as the primary contact person for developing and updating the DOL website to ensure accuracy.

5% Make recommendations to the Division Chief and managers on technical, legislative and policy matters affecting the licensing program. Make recommendations for development of statutory changes and new regulations.

SECTION C: Non-Essential or Marginal Functions

5% Establish and maintain cooperative relations with a variety of governmental, educational, and provider entities. Attend management and team meetings as well as other state and Ad Hoc meetings, work groups, training courses, seminars, travel and perform other job-related duties as needed.

SECTION D: ADA Requirement

Alternatives may be provided for incumbents who are unable to perform the non-essential functions of the job due to a disability covered under the Americans with Disabilities Act.

Duty Statement

Department of Managed Health Care

CLASSIFICATION: *Corporations Examiner*
WORKING TITLE: Examiner

POSITION: 121-4443-XXX

DIVISION: Financial Oversight

SECTION A: General Description

Under the supervision of the Supervising Examiner, the Examiner will perform field examinations of the financial and administrative affairs of full service and specialized Health Care Service Plans (i.e., HMOs, dental, vision, behavioral and chiropractic).

SECTION B: Essential Functions

Candidates must be able to perform the following functions with or without reasonable accommodation.

30% Perform field examination of the financial and administrative affairs of Knox-Keene licensed organizations on a routine and non-routine basis.

30% Perform financial and administrative reviews of applications for license notices of material modifications and amendments to application files of Knox-Keene licensees.

30% Perform review and evaluation of financial statements routinely filed with the Department by Knox-Keene licensees.

SECTION C: Non-Essential or Marginal Functions

10% Perform other compliance/miscellaneous duties, as assigned, including financial and related compliance/research matters, data gathering and compilation activities, legislation, monthly activity reports, special projects and training.

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** Budget Narrative.DOC

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

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

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

Budget Narrative for California

This grant proposal is for $1,000,000 to be used by the California Department of Managed Health Care (DMHC), which is the lead agency for this proposal, and the California Department of Insurance (CDI). The grant money will be used for information technology purposes, as well as obtaining actuarial services. Currently, the DMHC has limited rate review authority and spends approximately $45,561 annually reviewing those limited filings. CDI reviews rates as part of its broader authority to regulate medical loss ratios for individual products, expending approximately $388,316 on these reviews.

Estimated funding requirements:

CDI and DMHC Jointly ($18,808) to improve the NAIC's System for Electronic Form Filing (SERFF) for the aggregation, analysis, and reporting of rate trending data to HHS.

DMHC TOTAL $589,190

DMHC - IT ($55,688) *1. Premium Rate Information on the Web.* ($8,799). Personnel and benefits for an estimated 160 hours of time.

2. Establish database to warehouse SERFF data on DMHC. ($8,799). Cost is based on personnel and benefits for an estimated 160 hours of time.

3. Equipment Cost needed to review information from SERFF. ($3,000) 4 work stations.

4. SERFF Training costs. ($3,090). Transportation, food, lodging for 2 NAIC trainers.

5. IT infrastructure to collect, analyze and report premium trends to HHS. ($32,000). Based on an estimated 400 hours of contracted time.

Any grant funds allocated for IT expenses that are not needed for IT purposes will be spent on Actuarial Services.

DMHC – Actuarial ($533,502) The DMHC proposes to use grant funds to develop premium rate review procedures and to review premium rate filings submitted by health plans, estimating review time to range from 10 hours to 80 hours depending on complexity. The DMHC regulates 53 full service health plans and the frequency of submissions will likely range from one to several per health plan. The DMHC estimates total premium review time of 4240

hours, which, at the rate of 1784 hours per year, equates to 2.4 FTE. The DMHC estimates that it will need to obtain outside contracted actuarial services, or hire 2 Senior Actuaries at a total cost of $157,146 per actuary, and an Actuary Statistician to assist the actuaries at a total annual cost of $94,486. The DMHC estimates that it will also need approximately 300 hours of contract actuarial services. This would equate to approximately $124,724, at a rate ranging from $300 – $475 per hour.

Alternative. If, because of the industry demand for actuaries, the DMHC is unable to use the grant to hire actuaries, it will use the entire amount allocated for actuarial services for purchase of contracted actuarial services.

CDI TOTAL $392,002

CDI – IT ($81,025) *1. Equipment Cost to Expand Rate Review Capability on SERFF:* ($2,225) 2 workstations: $1,550. Additional Software: $250. Monitor and video card: $425

2. IT infrastructure to collect, analyze and report premium trends to HHS. ($32,000). Based on an estimated 400 hours of staff time for IT modification..

3. Premium Rate Information on the Web. ($46,800) CDI currently posts rate information to its website manually. Funds will develop an IT process to retrieve SERFF rate data to the CDI website, to optimize transparency in the rate filing process.

CDI –Actuarial ($310,977) CDI currently evaluates approximately 240 individual health rate filings per year, averaging approximately 10 person-hours of review time per filing. Recent reviews found errors in company calculations. The grant funds would be used for (1) retention of outside actuaries, and/or the hiring of a Senior Actuary for the duration of this grant (at an annualized cost of $157,146), to provide expanded intensive analysis of rate filings, and (2) to provide consultation for the development of processes to obtain needed information from current individual filings, and for the forthcoming group filings that will be submitted pursuant to PPACA, for the purpose of regulatory oversight, rate trend analysis, and reporting to the Secretary.

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. Support the improvement of NAIC's System for Electronic Form Filing.	93.511	$ 0.00	$ 0.00	$ 18,808.00	$ 0.00	$ 18,808.00
2. Enhance IT infrastructure to support SERFF data collection and public disclosure of rates.	93.511	0.00	0.00	136,713.00	0.00	136,713.00
3. Hire state actuaries to develop premium rate review process and review rate filings	93.511	0.00	0.00	565,924.00	0.00	565,924.00
4. Obtain contractual actuarial services to develop premium rate review process and review rate filings				278,555.00		278,555.00
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)
	Support the improvement of NAIC's System for Electronic Form Filing.	Enhance IT infrastructure to support SERFF data collection and public disclosure of rates.	Hire state actuaries to develop premium rate review process and review rate filings	Obtain contractual actuarial services to develop premium rate review process and review rate filings	
a. Personnel	$ 0.00	$ 13,297.57	$ 427,628.83	$ 0.00	$ 440,926.40
b. Fringe Benefits	0.00	4,300.43	138,295.17	0.00	142,595.60
c. Travel	0.00	0.00	0.00	0.00	
d. Equipment	0.00	5,225.00	0.00	0.00	5,225.00
e. Supplies	0.00	0.00	0.00	0.00	
f. Contractual	18,808.00	110,800.00	0.00	278,555.00	408,163.00
g. Construction	0.00	0.00	0.00	0.00	
h. Other	0.00	3,090.00	0.00	0.00	3,090.00
i. Total Direct Charges (sum of 6a-6h)	18,808.00	136,713.00	565,924.00	278,555.00	$ 1,000,000.00
j. Indirect Charges	0.00	0.00	0.00	0.00	$
k. TOTALS (sum of 6i and 6j)	$ 18,808.00	$ 136,713.00	$ 565,924.00	$ 278,555.00	$ 1,000,000.00
7. Program Income	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. Not Applicable	$	$	$	$
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	$ 366,640.75	$ 211,119.75	$ 211,119.75	$ 211,119.75
14. Non-Federal	$	0.00	0.00	0.00	0.00
15. TOTAL (sum of lines 13 and 14)	$ 1,000,000.00	$ 366,640.75	$ 211,119.75	$ 211,119.75	$ 211,119.75

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. Support the improvement of NAIC's System for Electronic Form Filing.	$ 18,808.00	$ 0.00	$ 0.00	$ 0.00
17. Enhance IT infrastructure to support SERFF data collection and public disclosure of rates.	136,713.00	0.00	0.00	0.00
18. Hire state actuaries to develop premium rate review process and review rate filings	565,924.00	0.00	0.00	0.00
19. Obtain contractual actuarial services to develop premium rate review process and review rate filings	278,555.00			
20. TOTAL (sum of lines 16 - 19)	$ 1,000,000.00	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks: This budget summary reflects total costs for the Department of Managed Health Care AND the California Department of Insurance. Separate budget summaries for DMHC and CDI activities have been included as attachments.

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Completed on submission to Grants.gov	Director, DMHC
* APPLICANT ORGANIZATION	* DATE SUBMITTED
Department of Managed Health Care	Completed on submission to Grants.gov

DISCLOSURE OF LOBBYING ACTIVITIES

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

Approved by OMB
0348-0046

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

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

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

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

** Name:* Department of Managed Health Care

** Street 1:* 980 9th Street, Suite 500 *Street 2:*

** City:* Sacramento *State:* CA: California *Zip:* 95814

Congressional District, if known: CA-005

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

6. * Federal Department/Agency:
Ofc of Consumer Information & Insurance

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

CFDA Number, *if applicable:* 93.511

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*
$ 1,000,000.00

10. a. Name and Address of Lobbying Registrant:

Prefix: ** First Name:* NA *Middle Name:*

** Last Name:* NA *Suffix:*

** Street 1:* *Street 2:*

** City:* *State:* *Zip:*

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

Prefix: ** First Name:* NA *Middle Name:*

** Last Name:* NA *Suffix:*

** Street 1:* *Street 2:*

** City:* *State:* *Zip:*

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

*** Signature:** Completed on submission to Grants.gov

***Name:** *Prefix:* ** First Name:* Lucinda *Middle Name:*

** Last Name:* Ehnes *Suffix:*

Title: Director **Telephone No.:** 916-322-2012 **Date:** Completed on submission to Grants.gov

Federal Use Only:

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**

Department of Managed Health Care

*** Length of Proposed Project**

Application Control No.

Federal Share Requested (for each year)

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

Non-Federal Share Requested (for each year)

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

*** Project Title**

Premium Review Grant

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

Project Abstract Summary

*** Project Summary**

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

Other Attachment File(s)

*** Mandatory Other Attachment Filename:**

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

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

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