Department of Health and Human Services

Grants to States for Health Insurance Premium Review-Cycle I

Initial Announcement
Invitation to Apply for FY 2010

CFDA: 93.511

Date: June 7, 2010

Applicable Dates:

Electronic Grant Application Due Date: July 7, 2010 by 11:59 p.m. Eastern Daylight Time
Issuance of Notice of Awards: August 9, 2010
Grant Period of Performance/Budget Period: August 9, 2010 through September 30, 2011

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I. FUNDING OPPORTUNITY DESCRPTION

A. Funding Description Overview

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act of 2010 (PPACA). On March 30th, 2010, the Health Care and Education Reconciliation Act of 2010 was also signed into law. The two laws are collectively referred to as the Affordable Care Act. The Affordable Care Act includes a wide variety of provisions designed to promote a high quality, high value, health care system. These include significant grant funding to assist States in working with the Federal Government to implement comprehensive health reform.

One of the first grant programs to be launched is established under Section 2794 of the Public Health Service Act (PPACA Section 1003) entitled, "Ensuring That Consumers Get Value for Their Dollars". Section 2794, together with several other provisions that take effect this year, are designed to help make private health insurance more accessible and affordable and increase the transparency of the health insurance system by providing new oversight of health insurance companies. Section 1003 of the Affordable Care Act requires the Secretary of the Department of Health and Human Services (HHS), in conjunction with the States, to establish a process for the annual review of health insurance premiums[1] to protect consumers from unreasonable, unjustified and/or excessive rate increases. This requirement takes effect beginning with the 2010 plan year.

Key components of this oversight require insurers to report certain health insurance rate information to both the Secretary and the States in which they operate, including:

1. All increases in rates for health insurance over the prior year that meet the established unreasonable threshold (currently under development);
2. Justifications for unreasonable increases in rates prior to their implementation.

The Secretary will ensure public disclosure of this information and insurers will be required to prominently post the information on their respective Internet websites.

Section 2794 also provides for a program of grants to states to help them improve the health insurance rate review and reporting process. Congress has appropriated $250 million for this grant program for the federal fiscal years (FFYs) of 2010-2014. HHS is authorized to award this money during multiple award cycles to eligible States beginning in FFY 2010.

Federal regulatory guidance is currently under development to establish the statutorily mandated process of annual rate review for health insurance. This will include factors to be used in determining whether or not a proposed rate increase is "unreasonable" and the criteria for evaluating if an unreasonable rate is

[1] The Affordable Care Act uses the term "premium"; however, the National Association of Insurance Commissioners uses the term, "rate" for purposes of industry review. To remain aligned with industry terminology, hereafter "rate" will be used in lieu of "premium" in this grant announcement.

"excessive or unjustified." These regulations also will establish criteria for future grant awards to support States' development and implementation of the review process.

HHS has requested state input through a Request for Information (RFI) in the Federal Register (FR Doc. 2010-8600 Filed 4-12-10) and is working with state insurance commissioners through the National Association of Insurance Commissioners (NAIC).

All States are eligible for the first rate review grants (Cycle I), which is being made prior to the release of the Federal regulatory guidance. In order to receive a grant, an applicant must propose a prospective plan to use grant funds to develop or enhance the state process for health insurance rate review in FFYs 2010 and 2011, including a plan for disclosing rates to the public and the Secretary.

All successful Cycle I grant awardees will receive $1 million awards.

The release of the second grant cycle (Cycle II) solicitation will occur after the release of the Federal regulatory rate review guidance in the fourth quarter of calendar year 2010 and grant awards will be made prior to January 1, 2011. Grant awardees will be required to implement the rate review requirements detailed in regulatory guidance.

B. Priority for Award of Grants

The primary goal of the Cycle I grants is to provide awards to states to enhance their current rate review process for health insurance premiums. This may include developing new or enhancing existing health insurance rate review processes that will promote immediate improvements in private health insurance consumer protections. Successful applicants are required to demonstrate that they will use grant funds to create and/or augment rate review and approval processes and/or data based systems used to support these activities.

The Cycle I grants will be awarded with the objective of achieving the following goals:

- Increases in health insurance premiums and rate filings are thoroughly evaluated and, to the extent permitted by law, approved or disapproved through a comprehensive rate review process that is meaningful and transparent to the public, enrollees, policyholders and the HHS Secretary.

- States develop the infrastructure to collect, analyze, and report to the Secretary critical information about rate filings and the review and, to the extent permitted by law, the approval and disapproval process.

As described in Section 2794 of the Public Health Service Act, States must use grant funds to support the following three activities:

- **Develop or Enhance rate review activities (*required*):** States will be required to use grant funds to either develop or enhance their current capacity to review and, to the extent permitted by state law, approve or deny rate increases in the individual and group markets. States that do not currently review rate filings will need to demonstrate in their application how they plan to develop a process to conduct meaningful rate reviews or otherwise enhance their oversight over insurers' rating practices,

including plans to share rate data with the Secretary. Examples of rate review enhancements are provided in Section V, *Application Review Criteria and Information*.

- **Reporting to the Secretary on Rate Increase Patterns (*required*):** States will be required to provide the Secretary with information about rate trends in health insurance coverage as well as meet other reporting guidelines as outlined in this grant announcement. To the extent that states do not currently have the capacity to report these data, they may utilize grant funds to develop procedures and/or the infrastructure to enable them to report in the future.

  In addition, States may use up to five percent of grant funds, or $50,000 during Cycle I, to establish data centers that compile and publish fee schedule information.

This solicitation provides detailed information on the Cycle I grant requirements related to these activities and instructions for application submission.

II. AWARD INFORMATION

A. Total Funding:

The total funding available to each State during Cycle I (date of award through FFY 2011) of the Health Insurance Premium Review Grant program is $1 million. Grants will be awarded in FFY 2010 and can be used for activities during FFY 2010 and FFY 2011. States who do not apply for this grant announcement are encouraged to apply for consideration in subsequent grant cycles.

B. Award Amount:

Each state is only eligible for one grant award during Cycle I and each grantee award will be $1 million. Grant requests that exceed the duration of Cycle I (FFYs 2010-2011) or exceed $1 million will not be considered. States are permitted to discuss long-term plans for rate review processes; however additional funding will be tied to future grant cycles. Any remaining grant funds that are not expended during this grant cycle, are permitted to be rolled-over to subsequent grant cycles, however; the use of funding must be in compliance with the terms and conditions dictating the subsequent grant cycle, including compliance with and adherence to Federal regulatory guidance.

C. Anticipated Award Date:

August 9, 2010.

D. Period of Performance:

This period of performance for Cycle 1 will be August 9, 2010 through FFY 2011, which ends September 30, 2011.

E. Number of Awards:

No more than fifty-one awards

F. Eligibility for subsequent awards:

HHS will publish subsequent Affordable Care Act Health Insurance Rate Review Grant solicitations on http://www.grants.gov. HHS will provide additional guidance in FY 2011 after Cycle I grants are awarded.

III. ELIGIBLITY INFORMATION

A. Eligible Applicants:

This grant opportunity is open to states Departments of Insurance (DOI) or the state entity with the primary statutory and regulatory authority for the regulation of private health insurance. Only one application per State is permitted.

Additionally, each applicant must submit a letter from the Governor officially endorsing the grant application and the proposed health insurance rate review activities or enhancements.

B. Cost Sharing/Matching and Maintenance of Effort:

Awardees are not required to provide matching contributions. However, the state share of funds expended for rate review activities under the state's proposed plan for rate review shall not be less than the funds expended in the fiscal year proceeding the fiscal year for which the grant is awarded. All applicants must provide assurances that grant funds will only be used to enhance the state's existing rate review efforts, and not as a substitute for existing funding for such efforts.

C. One Application Requirement:

Only one application may be submitted by a single eligible state for funding in Cycle I.

IV. APPLICATION AND SUBMISSION INFORMATION

A. Application Submission Information:

This solicitation serves as the application package for this grant and contains all the instructions that a potential applicant requires to apply for grant funding. The application should be written primarily as a narrative with the addition of standard forms required by the Federal government for all grants. Application materials will be available for download at http://www.grants.gov. Please note that the Office of Consumer Information and Insurance Oversight is requiring applications for all announcements to be submitted electronically through http://www.grants.gov. For assistance with http://www.grants.gov, contact support@grants.gov or 1-800-518-4726 between 7 a.m. and 9 p.m. Eastern Daylight Time. At http://www.grants.gov, applicants will be able to download a copy of the application packet, complete it off-line, and the upload and submit the application via the grants.gov website. The solicitation can also be viewed on the Department of Health and Human Services website at www.hhs.gov/OCIIO.

Specific instructions for applications submitted via http://www.grants.gov :

- You can access the electronic application for this program on http://www.grants.gov. You must search the downloadable application page by the CFDA number 93.511.
- At the http://www.grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. The Office of Consumer Information and Insurance Oversight strongly recommends that you do not wait until the application due date to begin the application process through http://www.grants.gov because of the time delay.
- All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number. The DUNS number is a nine-digit identification number that uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the following Website: www.dunandbradstreet.com or call 1-866-705-5711. This number should be entered in the block with the applicant's name and address on the cover page of the application (Item 8c on the Form SF-424, Application for Federal Assistance). The name and address in the application should be exactly as given for the DUNS number.
- The applicant must also register in the Central Contractor Registration (CCR) database in order to be able to submit the application. You should allow a minimum of five days to complete the CCR registration. Information about CCR is available at http://www.ccr.gov. The central contractor registration process is a separate process from submitting an application. Applicants are encouraged to register early. In some cases, the registration process can take approximately two weeks to be completed. Therefore, registration should be completed in sufficient time to ensure that it does not impair your ability to meet required submission deadlines.
- Authorized Organization Representative: The Authorized Organization Representative (AOR) who will officially submit applications on behalf of the organization must register with Grants.gov for a username and password. Potential AOR's must wait 1 business day after registration in CCR before entering their profiles in Grants.gov. AOR's must complete a profile with Grants.gov using their organization's DUNS Number to obtain their username and password. http://apply07.grants.gov/apply.OrcRegister.
- When an AOR registers with Grants.gov, the EBIZ POC will receive an email notification. The EBIZ-POC must login to Grants.gov (using your organization's DUNS number for a username and the "M-PIN" password obtained in Step 2) and approve the AOR, thereby giving him or her permission to submit applications.
- When the E-BIZ POC approves the AOR, Grants.gov will send the AOR an email confirmation using the email address submitted in the profile. The AOR can then login to Grants.gov using their username and password to verify that they have been approved at https:00apply07.grants.gov/app;y/loginhome.jsp.pdf.
- You must submit all documents electronically, including all information included on the SF 424 and all necessary assurances and certifications.
- Prior to application submission, Microsoft Vista and Office 2007 users should review the Grants.gov compatibility information and submission instructions provided at http://www.grants.gov (click on "Vista and Microsoft Office 2007 Compatibility Information").
- Your application must comply with any page limitation requirements described in this Program Announcement.
- After you electronically submit your application, you will receive an automatic acknowledgement from http://www.grants.gov that contains a Grants.gov tracking number. OCIIO will retrieve your application form from Grants.gov.

- After OCIIO retrieves your application form from Grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by Grants.gov.
- Each year organizations and entities registered to apply for Federal grants through http://www.grants.gov will need to renew their registration with the Central Contractor Registry (CCR). You can register with the CCR online and it will take about 30 minutes (http://www.ccr.gov).

Applications cannot be accepted through any email address. Full applications cannot be accepted through any website other than http://www.grants.gov. Full applications cannot be received via paper mail, courier, or delivery service.

All grant applications must be submitted electronically and be received through http://www.grants.gov by 11:59 p.m. Eastern Daylight time on July 7, 2010 to be considered "on time." All applications will receive an automatic time stamp upon submission and applicants will receive an automatic e-mail reply acknowledging the application's receipt.

B. Format, Standard Form (SF) and Content Requirements:

Each application must include all contents described below, in the order indicated, and in conformance with the following specifications:

Double-space all narrative pages. The project abstract may be single-spaced.

All applications must meet the requirements outlined in Section III, *Eligibility Information* and Section IV, *Application and Submission Information.* Applicants are strongly encouraged to thoroughly review information provided in Section V, *Application Review Criteria and Information*.

The application Project Narrative will not exceed 15 pages in length, and the Budget Narrative will not exceed 2 additional pages (a total of 17 pages in length). The additional supporting documentation listed below is excluded from the page limitation.

The following documents are required for a complete application:

1. Cover Sheet and Standard Forms:

a) Application Check-off Cover Sheet: Complete the check-off cover sheet as indicated; refer to Attachment A.

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

i. SF 424: Official Application for Federal Assistance (see note below
ii. SF 424A: Budget Information Non-Construction
iii. SF 424B: Assurances—Non-Construction Programs
iv. SF LLL: Disclosure of Lobbying Activities
v. Additional Assurance Certifications: http://apply.grants.gov/forms/sample/SSA_AdditionalAssurances-V1.0.pdf
List of Key Contacts including the Project Officer and Financial Officer who is responsible for completing the Financial Status Report (SF-269a) and the Federal Cash Transactions Report (PSC 272)

Note: On SF 424 "Application for Federal Assistance":

- Item 15 “Descriptive Title of Applicant’s Project.” Please indicate in this section the name of this grant: Premium Review Grant.
- Check box “C” to item 19, as Review by State Executive Order 12372 does not apply to these grants.
- Assure that the total Federal grant funding requested is for the period of the grant.

2. Required Letters of Support and Memorandum of Agreement

All applicants must submit a letter of support from the Governor’s office that outlines support for the grant application and the proposed health insurance rate review enhancements.

3. Applicant’s Application Cover Letter:

A letter from the applicant must identify the:

Eligible entity (e.g., Department of Insurance);
Title of the project; and
Principal Investigator/Project Director of the grant project with contact information.
The letter should indicate that the submitting agency or Lead Agency has existing authority to oversee and coordinate the proposed activities or can demonstrate a plausible plan for obtaining such authority and is capable of convening a suitable working group of all relevant members.

4. Project Abstract:
A one-page abstract should serve as a succinct description of the proposed project and should include the goals of the project, the total budget, a description of how the grant will be used to enhance health insurance rate review in the State.

5. Project Narrative (as outlined in Section V. A. 1., *Project Narrative Instructions*)

6. Work Plan and Time Line (as outlined in Section V. A. 2., *Work Plan and Time Line*)

7. Proposed Budget (as outlined below and in Section V. A. 3., *Budget Narrative*)
The applicant is required to provide a detailed budget for the grant period. The budget presentation must include the following:

- Estimated Budget Total.
- Current state funding for health insurance rate review efforts, if the state currently devotes funding to such reviews. The amount that was spent in the preceding fiscal year on rate review activities for the Maintenance of Effort requirement (MOE).
- Total estimated funding requirements for each of the following line items, and a break down for each line item by grant year:
    - Personnel
    - Fringe benefits
    - Contractual costs, including subcontract contracts
    - Equipment
    - Supplies
    - Travel
    - Indirect charges, in compliance with the appropriate OMB Circulars. If requesting indirect costs in the budget, a copy of the indirect cost rate agreement is required.

- Other costs
- Completion of the Budget Form 424A remains a requirement for consideration of your application. This Estimated Budget Presentation is an important part of your proposal and will be reviewed carefully by HHS staff. Remember all quarters of the budget must be included on this form.
- Provide budget notes for major expenditures and notes on personnel costs and major contractual costs.

8. Appendices

- Required Attachments as indicated in this solicitation (and as referenced in Section V. A. 4., *Required Supporting Documentation)*.
- Resumes/Job Descriptions for Project Director and Assistant Director and the percentage of time that each person will be working on this project and the percentage of time that each will spend on duties outside of the grant activities.

C. Intergovernmental Review:

Applications for these grants are not subject to review by States under Executive Order 12372, "Intergovernmental Review of Federal Programs" (45 CFR 100). Please check box "C" to item 19 of the SF-424 (Application for Federal Assistance) as Review by State Executive Order 12372 does not apply to these grants.

D. Funding Restrictions:

1. Indirect Costs

Applicable cost principles are as follows:

- **OMB Circular A-87**, Cost Principles for State, Local and Indian Tribal Governments, which establishes the cost principles for allowable costs incurred by State, local and Federally-recognized Indian tribal governments under Federally-sponsored agreements.
  The application must include a copy of the approved Indirect Cost Rate Agreement used in calculating the budget, if applicable.

2. Reimbursement of Pre-Award Costs

No grant funds awarded under this solicitation may be used to reimburse pre-award costs (e.g. consultant fees associated with preparing the Rate Review Grant application).

3. Prohibited Uses of Grant Funds

No grant funds awarded under this solicitation may be used for any item listed in the Prohibited Uses of Grant Funds as detailed in Attachment 2. Additionally, in Cycle I, grant funding permitted for the use of data centers is limited to five percent of the total grant award. Cycle I grants are limited to $1 million; therefore up to $50,000 may be used to fund data centers.

V. APPLICATION REVIEW CRITERIA AND INFORMATION

A. Description of Review Criteria:

In order to receive a grant award, States must submit a proposal to develop or enhance the process for health insurance rate review, including a plan for disclosing rates to the public and the Secretary as described in this section. As part of the application, the State must describe the extent of their current authority, if any, to review and modify rates and provide a plan to strengthen and enhance this process. Specific application requirements are outlined below.

As indicated in Section IV (*Application and Submission Information*), all applicants must submit a project narrative, a work plan, a timeline and budget as part of their grant application. A complete description of each of the grant application requirements is provided below:

1. Project narrative instructions:

The project narrative (which includes the *Documentation of Grant Eligibility*; *Current Rate Review Process*; *Proposed Rate Review Enhancements*; *Plan for Reporting to the Secretary on Rate Increase Patterns*; and *Optional Data Center Funding*) may be no more than 15 pages in length and may include attachments and tables for the data requests indicated in the application requirements below (attachments will not be subject to the page limit).

a) Current health insurance rate review capacity and process

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

- General health insurance rate regulation information:
    - Which health insurance products (HMO, PPO etc) are licensed and regulated by the States' DOI or the relevant state agency by market segment (e.g. small group, large group, individual markets, not for profit as applicable).
    - Rating rules (e.g. adjusted commuting rating, rating bands, and actuarial justification) and case characteristics used (e.g. geographic location and age) for rate regulation by market segment together with a description of the rating rules in the narrative and including copies of any relevant statutory and regulatory authority as an appendix to the application.
- Health Insurance rate review and filing requirements including:
    - A description of the types of data included in insurers' rate filings. If there is a standardized filing format, if permitted under State Law, provide a sample health insurance rate filing as an appendix to the application, a redacted version is acceptable.

- A comprehensive description of the rate review process, including rates subject to review, resources and a breakdown of State staff and private sector consultants, if any employed in the review process.
- The criteria for implementing legal authority for rate review and how rates are evaluated.
- The grounds for rate approval, modification and rejection. Discuss the factors that are considered in rate review, for example, medical loss ratios, the costs of medical care, the financial history of the company and previous rate changes.
- An explanation as to whether rates are approved, modified or rejected prospectively (i.e. before implementation) or retrospectively (after implementation).
- An explanation of the factors that trigger retrospective review, whether or not rebates provided to consumers if rates are determined to be unjustified and, if so, how rebates are calculated and disbursed.
- If the applicant lacks explicit statutory or regulatory approval authority, evidence of instances where requested rate modification and/or negotiation resulted in demonstrably lower rate/s. Discussion of rate modification should include additional contextual information such as the market share of the insurance product and the number of affected policyholders.

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

- An explanation of current level of resources and capacity for reviewing health insurance rates: Budget and Staffing
    - A description of annual overall total budget and revenue for the Insurance Department.
    - The budgetary breakdown for resources allocated to rate review for health insurance coverage in the individual and/or group markets.
    - A description of the qualifications (education and professional background) of the Insurance Department staff responsible for rate review. To the extent that actuarial services are contracted, please provide the name of the company and description of the nature of the contract service.
    - If available, provide the total number of health insurance rate filings that are received for the individual and/or group markets (annually and/or monthly), and the average amount of time that is required to complete the review process.

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

- Are summaries of rate changes offered in plain language for consumers? Please provide an example.
- How much advanced notice is given to consumers prior to proposed rate changes? Are consumers provided with official comment periods to review and comment on proposed rate changes?
- What processes exist for public meetings and/or hearings on rate filings?
- Provide the number and summarize the nature of consumer inquiries and complaints related to health insurance rates that have been received for the past two plan years.

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

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

b) Proposed rate review enhancements for health insurance

Applicants must provide assurances that grant awards will be used to develop or make improvements to their existing rate review and approval practices. States currently reviewing rate filings must propose enhancements that will further strengthen their existing authorities and process. States that do not currently review rate filings must describe their plans to conduct reviews or otherwise enhance their oversight over insurers' rating practices. Examples of acceptable uses of grant funds are included below. States are encouraged to submit rate review plans beyond those characterized below:

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

- **Improving rate filing requirements:** States may use grant funds to develop and implement more rigorous rate filing requirements that better document the underlying factors that influence proposed rate increases. For example, States may require more comprehensive supporting documentation and actuarial attestations such as exhibits that describe the underlying assumptions and factors used to derive medical trend estimates, require companies to separately report and justify administrative expenses (salaries, advertising, etc.) and take into consideration an insurance company's overall finances (profits/investment income) when making rate change determinations. States without current rate review and approval authority may propose to use grant funds to require the submission

of actuarially certified rate filings and other reporting requirements that expand the scope of current review.

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

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

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

Applicants must detail the enhancements that they intend to make and explain how these enhancements differ from and improve upon current practices. Applicants are encouraged to submit additional information as available that will serve as context to the proposed rate review changes, including a discussion of projected medical trends, market share, market dynamics and reforms and the influence of other statewide health reform initiatives. States are also encouraged to discuss any predicted challenges in establishing an enhanced rate review process. Applicants can propose rate review enhancements in all or some of the categories listed above.

The description of proposed enhancements must include:

- Detailed description of all proposed rate review enhancements (with budget and timeline)
- Clearly articulate the goals, *measurable* objectives and milestones for each change
- Description of required additional resources (systems, staff, etc.)

c) Reporting to the Secretary on Trend Data

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

For Cycle I, each grant awardee will be required to provide certain rate filing data to the Secretary for the individual, small and large group market segments for which the Insurance Commissioner has jurisdiction

or review and approval authority. States that have reviewed rates prior to 2010 should report trend data for plan years 2009 through 2011 to the extent available. All states awarded a grant under Cycle I will be provided a uniform reporting template for data reporting purposes that will be part of the Special Terms and Conditions (STCs) provided to all States who have been awarded a grant. The data points described below highlight the nature of the reporting requirements that may be required (final reporting requirements will be outlined in the STCs). Again, States that are not currently collecting health insurance rate filing data are permitted to use Cycle 1 grant funds to develop a plan to enhance capacity for data collection.

1) Required data for ***each*** rate filing in the individual, small group and large group markets:

Company Name and contact information

Number of policy forms covered by the filing

Policy form number(s) covered by the filing

Product types (HMO; PPO; etc.)

Market segment (individual; small group; large group)

Type of insurer (for-profit, non profit)

Whether the products are opened or closed

Enrollment in each policy and rating form

Member months in each policy form

Annual rate

Total earned premiums in each policy form

Total incurred claims in each policy form

Average rate increase initially requested

Rate review category (approved as originally submitted; initially rejected and resubmitted with modifications; initially rejected and not resubmitted; initially rejected and challenged)

Average rate increase approved

Effective date of rate increase

Number of policyholders or members affected by each policy form

Overall annual medical trend factor assumptions in each rate filing for *all benefits* and disaggregated by *benefit category* to include (hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services-laboratory and radiology)

For annual insurance trends by benefit category (hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services-laboratory and radiology) provide the amount of the projected trend attributable to the use of services (claims), price inflation or fees and risk. Discuss comparison of claims cost and rate changes overtime.

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

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

2) Required ***aggregate*** data for rate filings in the individual, small group and large group markets:

- Number and percentage of rate filings reviewed by;
  - Plan Year
  - Segment type (individual market; small group; large group)
  - Product type (PPO, HMO, etc.)
  - Number of Policyholders
  - Number of covered lives affected
- Report on the average rate increase by;
  - Plan Year
  - Segment type (individual market; small group; large group)
  - Product type (PPO, HMO, etc.)

Applicants and Awardees are encouraged to submit other relevant data on their processes related to health insurance rate review.

d) Optional Data Center Funding

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

- Institution requirements: data centers must be academic or other nonprofit research institutions. Data centers shall adopt by-laws that the center and all governing board members are independent and free of all conflicts of interest.
- Research functions of data center: data centers must collect and analyze medical reimbursement data from insurers. As part of their research, the centers must develop fee schedule databases and

regularly update them to reflect rate changes. Applicants must assure that data centers will demonstrate use of appropriate analytic methods and must describe how the proposed research will add to the existing body of available fee schedule research (i.e., ensuring that data center efforts are not duplicative).

- Public disclosure requirements: The data centers must make data and research findings (and statistical methodologies) publically available to issuers, health care providers, health researchers, health policymakers and the public. Additionally, the centers must make cost information available to the general public that allows consumers to evaluate service costs in their area.

An applicant requesting funds for data centers must identify their plans for establishing a relationship with an eligible non-profit or institution, and for assuring each entity meets the requirements listed above, clearly outline the function and scope of work for the data center, and describe how the data center will contribute to the states rate review process and improve quality in the private insurance market. An applicant proposing to use grant funds for a data center should also discuss any planned enhancements to the state insurance department IT infrastructure in order to share information for enhanced data analysis and reporting.

2) Work Plan and Timeline:

A timeline is required with the project goals and objectives consistent with those outlined in the project narrative. The work plan submitted with the application should document reasonable milestones with associated timeframes, and identify by name and title of the individual responsible for accomplishing the goals of the project.

3) Budget Narrative:

A budget with appropriate budget line items and a narrative that identifies the funding needed to accomplish the grant's goals is required. For the budget recorded on form SF 424 A, provide a breakdown of the aggregate numbers detailing their allocation to each major set of activities. The budget narrative must separately report on technical assistance activities. The proposed budget for the program should distinguish the proportion of grant funding designated for each grant activity. The budget must separate out funding that is administered directly by the lead agency from funding that will be subcontracted to other partners.

4) Required Supporting Documentation:

The following supporting documentation should accompany the application. This information is excluded from the page limit for applications.

a) Letter of Support from State:
   - State certification of maintenance of effort verifying that the grant funds will not supplant existing state expenditures or explaining state fiscal constraints.
   - A letter from the Governor stating support for grant activities including enhancement of statewide rate review activities.

b) The state must provide a clear delineation of the roles and responsibilities of project staff and how they will contribute to achieving the project's objectives including:
   i. The State's capacity to implement the proposed project and manage grant funds, including a reasonable and cost-efficient budget; and
   ii. An organizational chart and job descriptions of staff who will be dedicated to the project indicating the time that staff will spend on grant activities (this will also be reflected in the budget). The number and role of current state actuaries as well as any budgeted plans to hire additional actuaries must be highlighted.

B. Review and Selection Process

A team consisting of qualified staff from HHS will review all applications. The team will meet as necessary on an ongoing basis as applications are received. The review process will include the following:

- Applications will be screened to determine eligibility for further review using the criteria detailed in the Section III. *Eligibility Information* of this solicitation. Applications that are received late or fail to meet the eligibility requirements as detailed in this solicitation or do not include the required forms will not be reviewed.

- The results of the objective review of applications by HHS staff will be used to advise the approving HHS official.

- Successful applicants will receive one grant award based on this solicitation.

C. Anticipated Announcement and Award Dates

The anticipated award date is August 9, 2010

VI. AWARD ADMINISTRATION INFORMATION

A. Award Notices:

Successful applicants will receive a Notice of Award (NOA) signed and dated by the HHS Grants Management Officer. The NOA is the document authorizing the grant award and will be sent through the U.S. Postal Service to the state as listed on its SF-424. Any communication between HHS and applicants prior to issuance of the NOA is not an authorization to begin performance of a project. Unsuccessful applicants will be notified by letter, sent through the U.S. Postal Service to the applicant organization as listed on its SF 424, after August 9, 2010.

B. Administrative and National Policy Requirements:

The following standard requirements apply to applications under this solicitation:

- Specific administrative and policy requirements of applicants as outlined in 45 CFR 74 and 45 CFR 92 apply to this grant opportunity.

- All states receiving awards under these grant programs must meet the requirements of:

  a. Title VI of the Civil Rights Act of 1964,

b. Section 504 of the Rehabilitation Act of 1973,
c. The Age Discrimination Act of 1975,
d. Hill-Burton Community Service nondiscrimination provisions, and
e. Title II Subtitle A of the Americans with Disabilities Act of 1990.

- All equipment, staff, and other budgeted resources and expenses must be used exclusively for the projects identified in the applicant's original grant application or agreed upon subsequently with HHS, and may not be used for any prohibited uses.

- Consumers and other stakeholders must have meaningful input into the planning, implementation, and evaluation of the project. All grant budgets must include some funding to facilitate participation on the part of individuals who have a disability or long-term illness and their families.

C. Terms and Conditions

A funding opportunity award with HHS will include the *Health and Human Services (HHS) Grants Policy Statement* at http://www.hhs.gov/grantsnet/adminis/gpd/index.htm and will also include additional specific grant "special" terms and conditions. Potential applicants should be aware that special requirements could apply to grant awards based on the particular circumstances of the effort to be supported and/or deficiencies identified in the application by the HHS review panel.

D. Reporting

For each cycle, the awardees are expected to complete quarterly and annual progress reports that include progress with respect to the required milestones and to complete a final report for HHS. The progress reports will be due 30 days after the end of each quarter and the annual report is due 30 days after the end of the 12th month of each year of the grant award. The final report will be due 30 days after the conclusion of the project period.

Awardees must agree to cooperate with any Federal evaluation of the program and provide reports at the intervals listed in the terms and conditions of the award, and a final report at the end of the grant period in a form prescribed by HHS. Until such time as HHS has migrated to the SF 425 FFR, award recipients will utilize the SF 269 FSR. Progress reports may be submitted electronically. These reports will outline how grant funds were used, describe program progress, and describe any barriers and measurable outcomes. HHS will provide a format for reporting and technical assistance necessary to complete required report forms. Awardees must also agree to respond to requests and provide data on rate review activities as needed by the Secretary. An original and two copies of the interim SF-269a must be mailed to the HHS Grants Management Specialist as identified in the terms and conditions. The frequency of the SF-269a report will be identified in the terms and conditions of the grant award. The final SF-269a submitted to this office must agree with the final expenditures reported on the PSC-272 to the Payment Management System. Before final FSR submission all obligations must be liquidated. An original and two copies are due no later than 90 days after the project period end date. Use Standard Form 269a, which is available online at: http://www.whitehouse.gov/omb/grants/sf269a.pdf. Please note that interim SF-269a reports should not be marked as final. If awarded a grant, please be prepared to provide the contact information of the person or office that will complete the Financial Status Reports.

VII. AGENCY CONTACTS

Programmatic Content and Administrative Questions
Programmatic and administrative questions about the Grants to States for Health Insurance Premium Review can be directed to:

Jacqueline Roche
(202) 260 6094
Jacqueline.Roche@hhs.gov
The Office of Consumer Information and Insurance Oversight

List of Attachments

A. Prohibited Use of Grant Funds
B. Definitions
C. Application Cover Sheet and Check List

ATTACHMENT A

Prohibited Uses of Grants Funds

The Department of Health and Human Services Grants for Rate Review Cycle I for FY 2010-2011 funds may not be used for any of the following:

1. To cover the costs to provide direct services to individuals.

2. To match any other Federal funds.

3. To provide services, equipment, or supports that are the legal responsibility of another party under Federal or State law (e.g.; vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.

4. To supplant existing State, local, or private funding of infrastructure or services such as staff salaries, etc.

ATTACHMENT B

Définitions

Actuarial justification — The demonstration by an insurer, as certified by a licensed actuary that the rates collected are justified, relative to the benefits provided under the plan and/or that the allocation of *premiums* among policyholders is proportional to the distribution of their expected benefits, subject to limitations of state and federal law.

Adjusted community rating — A method of pricing insurance where *rates* are not based upon a policyholder's health status, but may be based upon other factors, such as age and geographic location.

Calendar Year — Earned rates and loss transactions occurring with a twelve-month period beginning January 1 through December 31.

Community rating — A method of pricing insurance, where each policyholder pays the same rate, regardless of health status, age or other factors.

Conflicts of Interest—A circumstance where the private or financial interests of an individual or entity conflict or appear to conflict with official or fiduciary responsibilities, drive, or guide actions of.

Group health plan, group health insurance coverage, and health insurance coverage— have the meanings given such terms in section 2791 of the Public Health Service Act, 42 U.S.C. §300 gg-91.

Guaranteed issue — Guaranteed issue is a requirement by State government that a health plan must allow enrollment regardless of health, age, gender or other factors, such as pre-existing condition, that might predict use of health services.

Guaranteed renewability — A requirement that health insurers renew coverage under a health plan except for failure to pay premiums or for fraud.

Federal fiscal year— A twelve-month period beginning on the first day of October and ending on the last day of the following September.

File and Use—A State requirement that an insurance company must file a proposed rate increase with the insurance commissioner before implementation, but need not first obtain the commissioner's affirmative approval. The commissioner may or may not have the authority to disapprove the rate after it takes effect.

Health insurance coverage— Benefits providing payment for medical services under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

Health insurance issuer— Defined by regulation at 45 C.F.R. 144.103.

HIPAA (Health Insurance Portability and Accountability Act of 1996) Public Law No. 104-191, 110 Stat. 1936 (1996).—

Individual market — The market segment for health insurance coverage offered to individuals rather than in connection with a *group health plan*.

Informational filing — A rate filing pursuant to State statue or regulation that allows a health insurer to increase its rates at will as long as the insurer files the rate increase contemporaneously with or soon after the effective date of the increase whether or not the State Insurance Commissioner has the authority to disapprove the rate after it takes effect.

Lead Agency – Designated state agency authorized to supervise administration of the grant.

Loss Ratio – relationship of incurred losses plus loss adjustment expense to premiums received.

Medical loss ratio — The percentage of health insurance *premiums* that are spent by the insurance company on health care services clinical services and activities that improve health care quality as defined in the Affordable Care Act.

No file— A State statutory or regulator provision pursuant to which an insurer is not required to file rates with the State Insurance Commissioner.

Patient Protection and Affordable Care Act (PPACA) — Public Law 111-148 (March 23, 2010)

Preferred Provider Organization (PPO) — A type of managed care organization (health plan) that provides health care coverage through a network of providers. Typically the PPO requires the policyholder to pay a co-payment and/or deductable for care from an *out-of-network provider*.

Premium — The periodic payment by a consumer required to keep a policy in force.

Premium rating area— Health insurance coverage with rates based on a geographic methodology.

Prior approval — A State statutory or regulatory requirement that an insurance company must obtain the affirmative approval of the insurance commissioner before implementing any rate increase

Prospective premium rating authority —State statutory or regulatory authority, requiring prior approval, or, premium rates associated with health insurance policies.

Retrospective rating authority—The authority under state law to review and approve or disapprove premium rates based on actual loss experience.

Rate Review—A State or Federal review of proposed health insurance premiums and premium increases.

Self-insured — A plan is self-insured (or self-funded), when an entity engaged in a business, trade, or profession, a plan of a non-profit organization such as a social, fraternal, labor, educational, religious, or professional organization carries its own risk instead of taking out insurance with a carrier. This term includes a plan of an individual or other entity engaged in a business, trade, or profession, a plan of a non-profit organization such as a social, fraternal, labor, educational, religious, or professional organization.

Small group market — The market segment for health insurance coverage offered to small businesses – those with between 2 and 50 employees in most states. PPACA will broaden the market to those with between 1 and 100 employees.

Solvency — The ability of a health insurer to meet all of its financial obligations.

Use and file—A State statute or regulation that allows an insurer to increase its rates at will. Under this scheme although the insurer must file its rates with the State Insurance commissioner, the commissioner has no authority to disapprove the rate.

ATTACHMENT C

APPLICATION COVER SHEET AND CHECK-OFF LIST

Indentifying Information:

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

DUNS #:_____ Grant Award: $1 million_____

Applicant:_____

Primary Contact Person, Name:_____

Telephone Number:_____Fax number:_____

Email address:_____

APPLICATION COVER SHEET AND CHECK-OFF LIST

REQUIRED CONTENTS

A complete proposal consists of the following material organized in the sequence below: Please ensure that the project narrative is page-numbered. The sequence is:

- ☐ Cover Sheet
- ☐ Forms/Mandatory Documents (Grants.gov).

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

- ☐ SF-424: Application for Federal Assistance
- ☐ SF-424A: Budget Information
- ☐ SF-424B: Assurances-Non-Construction Programs
- ☐ SF-LLL: Disclosure of Lobbying Activities
- ☐ Additional Assurance Certifications
- ☐ Required Letter of support and Memorandum of Agreement
- ☐ Applicant's Application Cover Letter
- ☐ Project Abstract
- ☐ Project Narrative
- ☐ Work plan and Time Line
- ☐ Proposed Budget (Narrative/Justifications)
- ☐ Required Appendices
- ☐ Resume/Job Description for Project Director and Assistant Director