1 BALDWIN STREET,
MONTPELIER, VT 05633-5701

PHONE: (802) 828-2295
FAX: (802) 828-2483

STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: James Reardon, Commissioner of Finance & Management

From: Nathan Lavery, Fiscal Analyst

Date: October 14, 2010

Subject: JFO #2463

No Joint Fiscal Committee member has requested that the following item be held for review, and the remainder of the 30 day review period has been waived:

JFO #2463 — $1,000,000 grant from the U.S. Department of Health and Human Services to the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). These funds will help Vermont enhance the health insurance rate review process and assist in the implementation of federal health care reform legislation. This request includes the establishment of six limited service positions.
[*JFO received 9/28/10*]

The Governor's approval may now be considered final. We ask that you inform the Secretary of Administration and your staff of this action.

cc: Michael Bertrand, Commissioner

1 BALDWIN STREET,
MONTPELIER, VT 05633-5701

PHONE: (802) 828-2295
FAX: (802) 828-2483

STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: Joint Fiscal Committee Members

From: Nathan Lavery, Fiscal Analyst

Date: September 30, 2010

Subject: Grant Request

Enclosed please find one (1) request that the Joint Fiscal Office has received from the administration. This request includes the establishment of six (6) limited service positions.

JFO #2463 — $1,000,000 grant from the U.S. Department of Health and Human Services to the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). These funds will help Vermont enhance the health insurance rate review process and assist in the implementation of federal health care reform legislation. This request includes the establishment of six limited service positions. **Expedited review of this item has been request by BISHCA. Joint Fiscal Committee members will be contacted by October 12 with a request to waive the statutory review period and accept this item.**
[*JFO received 9/28/10*]

In accordance with the procedures for processing such requests, we ask you to review the enclosed and notify the Joint Fiscal Office (Nathan Lavery at 802-828-1488; nlavery@leg.state.vt.us) if you have questions or would like an item held for Joint Fiscal Committee review.

cc: James Reardon, Commissioner
Michael Bertrand, Commissioner

1 BALDWIN STREET
MONTPELIER, VT 05633-5701

PHONE: (802) 828-2295
FAX: (802) 828-2483

STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: Representative Steven Maier

From: Nathan Lavery, Fiscal Analyst

Date: September 30, 2010

Subject: JFO #2463

Representative Michael Obuchowski asked that I forward to you a copy of the enclosed grant materials and cover memo. He requests your observations regarding the enclosed item.

cc: Rep. Michael Obuchowski

VERMONT

JFO 2463

State of Vermont
Department of Finance & Management
109 State Street, Pavilion Building
Montpelier, VT 05620-0401

[phone] 802-828-2376
[fax] 802-828-2428

Agency of Administration

STATE OF VERMONT
FINANCE & MANAGEMENT GRANT REVIEW FORM

Grant Summary:	This grant is to help Vermont enhance its health insurance rate review process and is awarded under the Affordable Care Act (ACA). BISHCA has five initiatives under this grant. Under this grant BISHCA has included 6 one-year limited service position requests to do work related to this grant.				
Date:	9/13/2010				
Department:	Department of Banking, Insurance, Securities and Health Care Administration				
Legal Title of Grant:	2010 Grants to States for Health Insurance Premium Review--Cycle 1				
Federal Catalog #:	93.511				
Grant/Donor Name and Address:	Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, Grants, 7501 Wisconsin Ave. West Tower, Room 10-15, Bethesda Maryland 20814-6519				
Grant Period: From:	8/9/2010	**To:**	9/30/2011		
Grant/Donation	$1,000,000				

	SFY 1	SFY 2	SFY 3	Total	Comments
Grant Amount:	$756,484	$243,516	$	$1,000,000	

	# Positions	Explanation/Comments
Position Information:	6	See attached position request form. One year limited service positions needed to do the work required for this grant.

Additional Comments:	In addition there will be contract for one half of the needed actuarial services.	
Department of Finance & Management	9/27/10	(Initial)
Secretary of Administration	TP 9/24/10	(Initial)
Sent To Joint Fiscal Office	9/28/10	**Date**

RECEIVED
SEP 28 2010
JOINT FISCAL OFFICE

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

BASIC GRANT INFORMATION	
1. Agency:	
2. Department:	Department of Banking, Insurance, Securities and Health Care Administration
3. Program:	Rates and Forms (Health Care Administration)
4. Legal Title of Grant:	2010 Grants to States for Health Insurance Premium Review-Cycle 1
5. Federal Catalog #:	CFDA: 93.511

6. Grant/Donor Name and Address:
Department of Health & Human Services, Office of Consumer Information & Insurance Oversight, Grants, 7501 Wisconsin Ave West Tower, Room 10-15, Bethesda, MD 20814-6519

7. Grant Period:	**From:**	8/9/2010	**To:**	09/30/2011

8. Purpose of Grant:
To enhance Vermont's rate review process for health insurance in 2010 and 2011.

9. Impact on existing program if grant is not Accepted:
Department's ability to implement health care reform as mandated by ACA will be compromised.

10. BUDGET INFORMATION

	SFY 1	SFY 2	SFY 3	Comments
Expenditures:	FY 2011	FY 2012	FY	
Personal Services	$715,551	$238,516	$	
Operating Expenses	$40,933	$5,000	$	
Grants	$	$	$	
Total	$756,484	$243,516	$	
Revenues:				
State Funds:	$	$	$	
Cash	$	$	$	
In-Kind	$	$	$	
Federal Funds:	$	$	$	
(Direct Costs)	$756,484	$243,516	$	
(Statewide Indirect)	$	$	$	
(Departmental Indirect)	$	$	$	
Other Funds:	$	$	$	
Grant (source)	$	$	$	
Total	$756,484	$243,516	$	

Appropriation No:	2210040000	**Amount:**	$1,000,000
			$
			$
			$
			$
			$
			$
		Total	$1,000,000

REC'D SEP 0 3 2010

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

PERSONAL SERVICE INFORMATION

11. Will monies from this grant be used to fund one or more Personal Service Contracts? ☒ Yes ☐ No

If "Yes", appointing authority must initial here to indicate intent to follow current competitive bidding process/policy.

Appointing Authority Name: Michael Bertrand Agreed by: MSB (initial)

12. Limited Service Position Information:	**# Positions**	**Title**
	2	Rate Analysts
	1	Administrative Assistant
	1	Claims analyst
	2	1 Grant Program Administrator and 1 Rates and Forms Actuary
Total Positions	6	

12a. Equipment and space for these positions: ☐ Is presently available. ☐ Can be obtained with available funds.

13. AUTHORIZATION AGENCY/DEPARTMENT

I/we certify that no funds beyond basic application preparation and filing costs have been expended or committed in anticipation of Joint Fiscal Committee approval of this grant, unless previous notification was made on Form AA-1PN (if applicable):

Signature:	Date: 8/31/2010
Title: Commissioner	
Signature:	Date:
Title:	

14. SECRETARY OF ADMINISTRATION

☑ Approved: 2R	(Secretary or designee signature)	Date: 9/2/10

15. ACTION BY GOVERNOR

☑ Check One Box: Accepted		9/27/10
☐ Rejected	(Governor's signature)	Date:

16. DOCUMENTATION REQUIRED

Required GRANT Documentation

☐ Request Memo	☐ Notice of Donation (if any)
☐ Dept. project approval (if applicable)	☐ Grant (Project) Timeline (if applicable)
☐ Notice of Award	☐ Request for Extension (if applicable)
☐ Grant Agreement	☐ Form AA-1PN attached (if applicable)
☐ Grant Budget	

End Form AA-1

STATE OF VERMONT
Joint Fiscal Committee Review
Limited Service - Grant Funded
Position Request Form

This form is to be used by agencies and departments when additional grant funded positions are being requested. Review and approval by the Department of Human Resources must be obtained prior to review by the Department of Finance and Management. The Department of Finance will forward requests to the Joint Fiscal Office for JFC review. A Request for Classification Review Form (RFR) and an updated organizational chart showing to whom the new position(s) would report **must** be attached to this form. Please attach additional pages as necessary to provide enough detail.

Agency/Department: BISHCA Date: 8/26/2010

Name and Phone (of the person completing this request): Sandy Barton, 828-2379

Request is for:
- ☑ Positions funded and attached to a new grant.
- ☐ Positions funded and attached to an existing grant approved by JFO #_____

1. Name of Granting Agency, Title of Grant, Grant Funding Detail (attach grant documents):
   Department of Health and Human Services, 2010 Grants to States for Health Insurance Premium Review, Cycle I

2. List below titles, number of positions in each title, program area, and limited service end date (information should be based on grant award and should match information provided on the RFR) position(s) will be established only after JFC final approval:

Title* of Position(s) Requested	# of Positions	Division/Program	Grant Funding Period/Anticipated End Date
Insurance Rates and Forms Analyst	2	Health Care Administration	8/9/2010-9/30/2011
Administrative Assistant A	1	Health Care Administration	8/9/2010-9/30/2011
Grants Program Specialist II	1	Health Care Administration	8/9/2010-9/30/2011
Rates and Forms Actuary	1	Health Care Administration	8/9/2010-9/30/2011

*Final determination of title and pay grade to be made by the Department of Human Resources Classification Division upon submission and review of Request for Classification Review.

3. Justification for this request as an essential grant program need:

Position request continued:

BISHCA Claims Analyst	1	Health Care Administration	8/9/2010-9/30/2011

Justification: See Attached

I certify that this information is correct and that necessary funding, space and equipment for the above position(s) are available (required by 32 VSA Sec. 5(b).

Signature of Agency or Department Head — Date: 8.31.2010

Approved/Denied by Department of Human Resources (Molly Paul) — Date: 9/1/10

Approved/Denied by Finance and Management — Date: 9/2/10

Approved/Denied by Secretary of Administration — Date: 9/2/10

Comments: DHR approval is contingent upon F&M approval of funding source / timeframe.

DHR – 11/7/05

RECD SEP 03 2010

Justification for Limited Service Positions

Without the limited service, grant funded positions listed in the attached request, Vermont will be unable to enhance its rate review process or implement any of the initiatives proposed in the grant. As such, the positions identified are essential if the Department is to successfully enhance the rate review process to accomplish the overall goal of providing consistent, complete and effective regulation necessary to ensure that health insurance rates are not unjust, unfair, inequitable, excessive, inadequate or unfairly discriminatory. Furthermore, if the Department's request for limited service positions is denied, the State's ability to implement comprehensive health care reform as mandated by the Affordable Care Act (ACA), will be severely compromised. For the reasons stated above, the limited service positions requested are an essential grant program need.

State of Vermont
Department of Banking, Insurance,
Securities and Health Care Administration
89 Main Street
Montpelier, VT 05620-3101
www.bishca.state.vt.us

Consumer Assistance Only:
Insurance: 1-800-964-1784
Health Care Admin.: 1-800-631-7788
Securities: 1-877-550-3907

To: James Reardon, Commissioner, Finance & Management

From: Michael Bertrand, Commissioner, BISHCA MB

Date: August 31, 2010

Re: Grant Acceptance
2010 Grants to States for Health Insurance Premium Review – Cycle 1

The Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) applied for federal funds under the new federal health care legislation for the purpose of enhancing Vermont's health insurance rate review process. Under the grant proposal ("2010 Grants to States for Health Insurance Premium Review-Cycle 1"), all States were eligible for funding. Funding was made available to assist with the implementation of comprehensive health care reform as mandated by the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation. The two laws, both passed in 2010, are collectively referred to as the Affordable Care Act (ACA).

Successful grant applicants were required to demonstrate that grant funds would be used to either develop or enhance their current rate capacity for rate review in the individual and group markets. On the August 16th of 2010, BISHCA received official notification that our application had been accepted. At this time, BISHCA is requesting State acceptance of the federal grant.

Vermont, like all grantee awardees, will receive a grant amount of $1 million. While the federal legislation authorizes the award of additional grants in future fiscal years, this specific award is for federal fiscal year 2011 only.

BISHCA has proposed five initiatives to enhance the Vermont's rate review process for health insurance premiums. Each initiative will require professional resources beyond current Department levels. The initiatives that can be funded through acceptance of the grant are as follows:

1. Expand the scope of current review and approval activities by conducting reviews of large group rates and rate review of minor lines of health insurance such as student policies. By September 30, 2011 the Department will establish procedures for annual rate reviews of the large group market, with reviews beginning for calendar year 2012. Resources needed: allocate time of existing staff and hire and/or contract for additional actuarial and professional resources. Estimated cost: $166,221.00.

2. Improve rate filing requirements by developing rate filing standards, and by collecting informational data for plans administered by Third Party Administrators. By July 1, 2011 the Department will establish and publish standards for carrier rate filings, including a requirement of a layperson summary of the rate increase request. Also, by September 30, 2011, the Department will establish and publish standards for annual informational filings to be made by third party administrators. Resources needed: allocate time of existing staff and hire and/or contract for additional actuarial and professional resources. Estimated cost: $166,221.00.

3. Enhance the rate review process by verifying claims experience and by analyzing public program migration. By July 1, 2011 the Department will collect claims data for validation and conduct targeted examinations to validate or change the assumptions used by carriers in their rate filings. Resources needed: allocate time of existing staff and hire and/or contract for additional actuarial and professional resources. Estimated cost: $266,579

4. Enhance the rate review process with a significant upgrade in Vermont's IT capacity. IT enhancements will include: updating the National Association of Insurance Commissioners' (NAIC) System for Electronic Rate and Form Filer (SERFF) program to include federal reporting elements, collecting and integrating historical rate filing data with current filed data, customizing Vermont's all payer claims utilization and reporting system to support rate review, consolidating carrier "carve-out" data, providing claims reporting by product type, and providing claims reporting by provider. By September 30, 2011 the Department will increase its rate analysis and reporting capacity with respect to rate review; collect and integrate historical; and current rate information and will contract for enhancements to its VTCURES and SERFF IT capabilities. Resources needed include: hiring or contracting for increased professional services; and contract for VHCURES enhancements and increased contractual resources. Estimated cost: $379,025.00.

5. Enhance consumer protection standards by posting readable, layperson summaries of rate increase requests on the Department's website, and by adding a ratepayer comment functionality to the Department's website. By July 1, 2011, the

Department will establish requirements for carriers to file layperson summaries of rate filings; and design a website to offer a ratepayer comment forum opportunity for rate carrier increase requests. Resources needed: allocate time of existing staff and hire and/or contract for additional professional resources. Estimated cost: $21,954.00.

The proposed enhancements in the scope and depth of Department's rate review for health insurance premiums will require professional resources in addition to current staffing and contracting resources. If the grant is accepted by the State, BISHCA will increase its professional resources for enhanced rate review. BISHCA is proposing to implement the initiatives previously described above through a combination of contract authority and the hiring of limited service positions. Our current proposal is to:

1. Contract for one half (0.5) of the additional actuarial services needed for the work proposed in initiatives #1-3.

2. Hire limited service positions for:
   a. One (1) actuary to perform the additional actuarial services needed for the work proposed of initiatives #1 through #3, including (but not limited to): analyze statistical data; construct probability tables to forecast risk and liability for payment of future benefits; ascertain premium rates required to ensure payment of future benefits.

   b. Two (2) rate analysts to carry out the professional services required for initiatives #1 through #3 and #5. Including (but not limited to): expand the scope of Department review of all filings; develop new rate filing standards; collect and integrate various types data.

   c. One (1) data entry and support staff position for the additional professional services required for initiatives #1 through #5. Including (but not limited to): assist with data collection and integration efforts; provide technical support to staff; perform other duties as needed.

   d. One (1) claims analyst for professional services required for initiatives #4 & #5. Including (but not limited to): review claims data to verify and describe the nature of claims experience in Vermont's health insurance market.

   e. One (1) grant administrator to perform multiple grant administration functions, including (but not limited to): ensuring accurate and timely preparation of grant billings and reports; ongoing monitoring of grant budgets and expenditures; communication of relevant grant information with Department and grantor.

The Grant Budget has been included as required.

Acceptance of the grant funds will assist the Department in the implementation of federal health care reform. Additionally, acceptance will enable Vermont to enhance its rate review process to accomplish the overall goal of offering consistent, comprehensive and effective regulation of health insurance rates for all carriers and all markets in order to ensure that health insurance rates are not unjust, unfair, inequitable, excessive, inadequate or unfairly discriminatory. Without acceptance of the funds, the State's ability to implement comprehensive health care reform, including enhanced rate review of health insurance rates, will be compromised.

Please let me know if you have any questions regarding this submission.

MB/sl
Enclosures

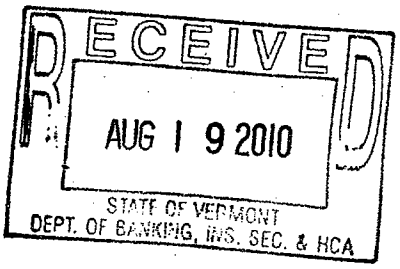
DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Consumer Information and Insurance Oversight

200 Independence Avenue SW
Washington, DC 20201

AUG 16 2010

Mike Bertrand
Commissioner
Vermont Insurance Division
Department of Banking, Insurance, Securities and Health Care
89 Main Street
Montpelier, VT 05620



Dear Commissioner Bertrand:

The Office of Consumer Information and Insurance Oversight (OCIIO) is pleased to inform you that you have been awarded a grant under the funding opportunity announcement entitled Grants to States for Health Insurance Premium Review Grants-Cycle 1. Congratulations on your successful application. The Notice of Grant Award is included in the attachments to this Award Letter.

Pursuant to the HHS Grants Policy Statement there are terms and conditions associated with the receipt of this grant, and these are also attached to this Award Letter. These include the Standard and Special Terms and Conditions (STCs). Also attached are the templates for quarterly programmatic reporting and the required data collection and instructions on how to obtain disbursement of grant funds.

OCIIO requests affirmation that the Maintenance of Effort requirement as outlined on page 7 of the Funding Opportunity Announcement is in place. Please confirm that grant funds will not be used to fund costs relating to existing state activities, including salaries of employees performing these activities.

Please carefully review all the standard and special terms and conditions of the grant award and provide OCIIO with a written letter of acceptance of these terms and conditions by September 13, 2010. The letter of acceptance may be submitted electronically to Jacqueline Roche at Jacqueline.Roche@hhs.gov and Gladys Bohler at Gladys.Bohler@hhs.gov.

We at OCIIO thank you for your commitment to this program and we look forward to continued collaboration with Vermont as you embark upon an ambitious program to enhance the premium review process in your state and take important strides to help protect consumers from unjustified and/or excessive premium increases.

Sincerely,

Jay Angoff
Director

Enclosures

Department of Health and Human Services

Office of the Secretary

Office of Consumer Information and Insurance Oversight

Grants, Contracts and Integrity Division
7501 Wisconsin Ave West Tower
Room 10-15
Bethesda, MD 20814-6519

NOTICE OF GRANT AWARD

AUTHORIZATION (Legislation/Regulations)
Section 2794 of the Public Health Service Act (Section 1003 of the Affordable Care Act)

1. DATE ISSUED (Mo./Day/Yr.) 08/03/2010	**2. CFDA NO.** 93.511
3. SUPERCEDES AWARD NOTICE dated except that any additions or restrictions previously imposed remain in effect unless specifically rescinded	
4. GRANT NO. 1 IPRPR100027-01-00 **Formerly:**	**5. ADMINISTRATIVE CODES** IPR
6. PROJECT PERIOD Mo./Day/Yr. **From** 08/09/2010	Mo./Day/Yr. **Through** 09/30/2011
7. BUDGET PERIOD Mo./Day/Yr. **From** 08/09/2010	Mo./Day/Yr. **Through** 09/30/2011

8. TITLE OF PROJECT (OR PROGRAM) *(Limit to 56 spaces)*
2010 Grants to States for Health Insurance Premium Review-Cycle I

9. GRANTEE NAME AND ADDRESS
a. Vermont Department of Banking, Insurance, Securities and Hea
b. 89 Main St
c.
d. Montpelier e. VT f. 05602-3168

10. DIRECTOR OF PROJECT (PROGRAM DIRECTOR/PRINCIPLE INVESTIGATOR)
(LAST NAME FIRST AND ADDRESS)
Christine Oliver
89 Main St
Montpelier, VT 05602
Phone: 802-828-2900

11. APPROVED BUDGET (Excludes HHS Direct Assistance)
I HHS Grant Funds Only
II Total project costs including grant funds and all other financial participation **II**
(Select one and place NUMERAL in box)

a.	Salaries and Wages	299,300	
b.	Fringe Benefits	92,783	
c.	Total Personnel Costs		392,083
d.	Consultants Costs		0
e.	Equipment		17,500
f.	Supplies		7,500
g.	Travel		2,000
h.	Patient Care – Inpatient		0
i.	Patient Care – Outpatient		0
j.	Alterations and Renovations		0
k.	Other		20,000
l.	Consortium/Contractual Costs		560,917
m.	Trainee Related Expenses		0
n.	Trainee Stipends		0
o.	Trainee Tuition and Fees		0
p.	Trainee Travel		0
q.	TOTAL DIRECT COSTS		1,000,000
r.	INDIRECT COSTS (rate of)		0
s.	**TOTAL APPROVED BUDGET**		$ 1,000,000
t.	SBIR Fee		
u.	Federal Share		$ 1,000,000
v.	Non-Federal Share		$ 0

12. AWARD COMPUTATION FOR GRANT

a. Amount of HHS Financial Assistance *(from item 11.u)*	1,000,000
b. Less Unobligated Balance From Prior Budget Periods	0
c. Less Cumulative Prior Award(s) This Budget Period	0
d. **AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION**	1,000,000

13. RECOMMENDED FUTURE SUPPORT
(Subject to the availability of funds and satisfactory progress of the project):

YEAR	TOTAL DIRECT COSTS	YEAR	TOTAL DIRECT COSTS
a. 2		d. 5	
b. 3		e. 6	
c. 4		f. 7	

14. APPROVED DIRECT ASSISTANCE BUDGET *(IN LIEU OF CASH):*

a. AMOUNT OF HHS Direct Assistance	0
b. Less Unobligated Balance From Prior Budget Periods	
c. Less Cumulative Prior Award(s) This Budget Period	
d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION	0

15. PROGRAM INCOME SUBJECT TO 45 CFR PART 74, SUBPART F, OR 45 CFR 92.25, SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:
(Select one and place LETTER in box.)
a. DEDUCTION
b. ADDITIONAL COSTS
c. MATCHING
d. OTHER RESEARCH (Add / Deduct Option)
e. OTHER *(See REMARKS)*

b

16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, HHS ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:
a. The grant program legislations cited above.
b. The grant program regulation cited above.
c. This award notice including terms and conditions, if any, noted below under REMARKS.
d. HHS Grants Policy Statement including addenda in effect as of the beginning date of the budget period.
e. 45 CFR Part 74 or 45 CFR Part 92 as applicable.
In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS: (Other Terms and Conditions Attached - ☐ Yes ☒ No)

Refer to the following Award Attachments: 1) The Standard and Special Terms and Conditions 2) Grants to States for Health Insurance Premium Review-Cycle I Quarterly Report Template 3) Data Dictionary for the Policy Rate Filing Record-Data Collection for the Rate Review Grants.

GRANTS MANAGEMENT OFFICER: *(Signature)* *(Name – Typed/Print)* Gladys Bohler *(Title)* Senior Grants Management Specialist

17. OBJ CLASS 4121	18. CRS - EIN 1036000264D8		19. LIST NO.	CONG. DIST.: 00
FY-CAN	DOCUMENT NO.	ADMINISTRATIVE CODE	AMT ACTION FIN ASST	AMT ACTION DR ASST
20. a. 0-199RE19	b. IPRPR0027A	c. IPR	d. 1,000,000	e. 0
21. a	b.	c.	d.	e.
22. a	b.	c.	d.	e.

AWARD ATTACHMENTS

Vermont Department of Banking, Insurance, Securities and Health Care — 1 IPRPR100027-01-00

1. Standard and Special Terms and Conditions
2. Grants to States for Health Insurance Premium Review-Cycle I Quarterly Report Template
3. Data Dictionary for the Policy Rate Filing Record-Data Collection for the Rate Review Grants

STANDARD GRANT CONDITIONS

1. **The HHS/Office of Consumer Information and Insurance Oversight (OCIIO) Program Official,** assigned with responsibility for technical and programmatic questions from the grantee is: Jacqueline Roche, Jacqueline.Roche@hhs.gov at OCIIO.

2. **The HHS/OCIIO Grants Management Specialist,** assigned by the GMO, with responsibility for the financial and administrative aspects (non-programmatic areas) of grants administration questions from the grantee is Gladys Bohler at Gladys.Bohler@hhs.gov at OCIIO.

3. **HHS Grants Policy Statement.** This award is subject to the requirements of the HHS Grants Policy Statement (HHS GPS). The HHS Grants Policy Statement is available at http://www.hhs.gov/grantsnet/adminis/gpd/index.htm. Please read carefully the following: (1) fraud, waste, and abuse (toll free number 800-424-5454), page I-7; (2) lobbying, page I-15; (3) costs, pages II-30 to II-44; (4) financial management systems and procedures, page II-61; (5) re-budgeting/prior approval, pages II-50 to II-57; and (6) publications, page II-73.

4. **Code of Federal Regulations:**
This grant is subject to the requirements as set forth in 45 CFR Part 92 (for State, local, and federally recognized tribal government) available at http://www.hhs.gov/opa/grants/toolsdocs/45cfr92.html.

5. **Cost Principles for State, Local and Indian Tribal Governments (OMB Circular A-87):**
This grant is subject to the requirements as set forth in Title 2 Part 225, State, Local, and Indian Tribal Governments (previously A-87)

6. **Public Reporting:** When issuing statements, press releases, requests for proposals, bid solicitations, and documents describing this project, clearly state: (1) the percentage of the total cost of the project financed with Federal money, (2) the dollar amount of Federal Funds for the project, and (3) the percentage and dollar amount of the total costs of the project that is financed by nongovernmental sources.

7. **Policy Requirements:** Debarment and Suspension as well as Drug Free Workplace are now standard terms and conditions of the award. These requirements no longer require separate certifications; however, by signing the application (either electronic signature credentials or face page of the SF-424A) the applicant certifies they are meeting the requirements of 45 CFR Part 76 (Debarment and Suspension) and 45 CFR Part 82 (Drug-Free Workplace).

Special Terms of Award (STC) - Programmatic

1. **Acceptance Letter and Assurance:** The grant award is subject to the recipient providing OCIIO a letter as acknowledgement of the award and the acceptance of all Standard and Special Terms and Conditions (STCs) within 30 days of the date of issuance of the award package. With the acceptance of this grant award, the Grantee agrees to ensure that the project is administered in accordance with the grant requirements as indicated in these STCs and that the Grantee is in compliance with the requirements of the grant funding opportunity announcement.

2. **Budget and Project Period:** The project and budget period for Premium Review Grants - Cycle 1 is from August 9, 2010 through September 30, 2011. The start date for the grants is on or after August 9, 2010. No grant funds can be used for expenses incurred prior to August 9, 2010.

3. **Revised Budget:** When the Notice of Grant Award requires the Grantee to submit a revised budget (e.g., a revised timeline, budget narrative and SF-424A section b only), these documents must be submitted within 60 days of the start of the grant period, (August 9, 2010). OCIIO will advise states of the approval of such documents within 60 days from the date the revised draft documents are received by the OCIIO.

4. **Collaborative Responsibilities:** At the request of the OCIIO, Grantees may be required to participate in scheduled activities and communications to identify and share "best practices" for health insurance premium review, including discussion of state proposals and sharing of information via public websites. The OCIIO will post general summaries of the state proposals on the OCIIO website. Quarterly and Final reports may also be posted on the OCIIO website. The Grantee is required to participate in all required communications (e.g., monitoring calls, guidance calls) as requested by the OCIIO.

5. **Required Financial Reports:** A Financial Status Report (FSR) (SF 269A – Short Form) is required from the recipient within 90 days after the end of the project period. Records of expenditures and any program income generated must be maintained in accordance with the provisions of 45 CFR 74.53 or 92.42. In addition, an Interim SF 269 report must be submitted after the first 12 months of grant activity. The Grantee will submit the FSR to the OCIIO Grant Specialist listed on this Notice of Grant Award with a copy to the OCIIO Project Officer. (The SF-269A may be accessed at the following site: http://www.whitehouse.gov/omb/grants/sf269a.pdf).

   Effective January 1, 2010, grantees are to report cash transaction data via the Payment Management System (PMS) using the Federal Financial Report (FFR or Standard Form 425) cash transaction data elements. The FFR must be filed within 30 days of the end of the quarter (instead of the 45 days allowed for filing the PSC 272). Reporting cash transaction data using the FFR replaces the use of the Federal Cash Transaction Report (SF-272/SF272A). Additional information and training are available on the Division of Payment Management website: **http://www.dpm.psc.gov/**.

A Quick Reference Guide for completing the FFR in the PMS is at http://www.dpm.psc.gov/grant_recipient/guides_forms/ffr_quick_reference.aspx

6. **Required Grant Reporting**

A. Requirement to Report Data to the Secretary. For Cycle I, each grant awardee is required to provide certain rate filing data to the Secretary of Health and Human Services. Included as Attachment C is the template for providing the required premium data to HHS. Operational processing and data exchange with the State awardees using the enclosed data format will begin in December 2010 to support required reporting for Cycle I grants. States unable to provide the rate filing data as required under these terms and conditions of award and as outlined in the template must provide an explanation of their inability to do so. As stated in the FOA, States are permitted to use grant funds to enhance their authority and capacity to collect and report the required data. The Office of Oversight will provide technical assistance to all state awardees over the course of the grant period to fulfill the data reporting requirements.

B. Quarterly and Final (Progress) Reports

1. The Grantee is required to submit three quarterly progress reports and one final report to the OCIIO Grant Specialist and to the OCIIO Project Officer. Quarterly progress reports are due within 30 days after the end of the quarter (see STC #7 for dates). These reports must comply with the format in Attachment B: ***Grants to States for Health Insurance Premium Review-Cycle I Template for Quarterly Progress Reports.***

2. The Grantee is required to submit a Final Report to the OCIIO Grant Specialist, with a copy to the OCIIO Project Officer, within 90 days after the project period ending date (December 31, 2011). A template for the final report will be forthcoming.

3. In each progress report (quarterly and final), the Grantee will describe the progress, and provide data on, the Grantee's impact on enhancing the rate review process for health insurance premiums in the state and efforts to report data on health insurance premiums to the HHS Secretary. The Grantee will describe each activity performed in the quarter/year and how that activity was linked to enhanced rate review practices.

4. All quarterly and final (progress) reports must be submitted electronically.

7. Data Center Requirements: As outlined in the FOA, up to $50,000 in grant funds are permitted to be used to fund an optional data center as described in Section 2794 of the Public Health Service Act. All states choosing to use grants funds to support a data center must provide the following information by October 31, 2010.

   a) Name, location and governance of Data Center. Please make certain that the data center meets the requirements as outlined in the Affordable Care Act.
   b) Full Description of Data Centers current mission;
   c) Described function and scope of work for data center;

d) Describe how proposed research will add to existing body of available fee schedule data;
e) Plans for public disclosure of data; and
f) Full and/or modified budget for the data center with a line-item breakout.

The Office of Oversight will be working with each state applicant on an individual basis to make certain the proposed data center is aligned with the requirements under the Affordable Care Act and advances the directives of this grant program.

8. The Grantee is required to notify the OCIIO Project Officer and the OCIIO Grant Specialist within thirty (30) days of any personnel changes affecting the grant's Project Director, Assistant Project Director, or the Financial Officer who is responsible for completing the Financial Status Report (SF-269A) and the Federal Cash Transactions Report (PSC-272).

9. All funds provided under this grant will be used by the Grantee exclusively for the Grants to States for Health Insurance Premium Review as defined in Section 1003 of the Affordable Care Act and as described in the grant funding opportunity announcement. If the Grantee uses these funds for any purpose other than those awarded through the OCIIO Premium Review Grants – Cycle I (or those modifications that have the prior written approval of the OCIIO Project Officer), then all funds provided under this grant may be required to be returned to the United States Treasury.

ATTACHMENT A:

Grants to States for Health Insurance Premium Review – Cycle I

TIMELINE
August 9, 2010– September 30, 2011

ACTIVITY	TIMELINE
Grant award	August 9, 2010
Grant period begins	August 9, 2010
Accept award package	September 9, 2010
Notify OCIIO of Fiscal Agent/Officer Responsible for completing the SF-269A and PSC-272	September 30, 2010
Revised Budget and SF-424A (when applicable)	Due within 60 days of award
Financial Status Report	Due 30 days after the first 12 months
Required Data Center Information	October 31, 2010
Quarterly Progress Reports	Due 30 days after the end of each Federal fiscal quarter (e.g., January 31, April 30, July 31, and October 31, 2011)
Awardees must respond to requests necessary for the evaluation of the Health Insurance Premium Review Grants as requested	As required by the OCIIO
Guidance Call for Preparation of the Final Report	To be scheduled by the OCIIO Project Officer approximately 60 days before end of grant year (e.g. July 31, 2011)
Final Report	Due 90 days after the conclusion of the grant project period (December 31, 2011)
Liquidation of all Obligations	Due 90 days after the grant period end date and prior to filing of the final Fiscal Status Report

Final Financial Status Report (FSR)	Due 30 days after the first 12 months of grant activity and 90 days after the grant period end date (December 31, 2011)
No Cost Extension Request	Should the State need a no cost extension, a written request to the Project Officer must be received no later than September 30, 2011.

ATTACHMENT B:

Grants to States for Health Insurance Premium Review – Cycle I
Quarterly Report Template

Date:

State:

Project Title:

Project Quarter Reporting Period:
Example:
Quarter 1 (08/09/2010-12/31/2010)

Grant Contact (name and title):

Email:

Phone:

Date submitted to OCIIO:

Grants to States for Health Insurance Premium Review – Cycle I
Quarterly Report Template

Reporting Period:

Grant Performance Period:	August 9, 2010 to September 30, 2011
Reporting Period:	Award Date to December 31, 2010 January 1, 2011 to March 31, 2011 April 1, 2011 to June 30, 2011 July 1, 2011 to September 30, 2011
Deadline for Delivery:	January 31, 2011 April 30, 2011 July 31, 2011 October 31, 2011

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 to protect consumers from unreasonable, unjustified and/or excessive rate increases. Section 2974 of the Public Health Service Act (PPACA Section 1003) provides for a program of grants that enable states to improve the health insurance rate review and reporting processes.

States are required to submit quarterly progress reports to OCIIO. The quarterly progress report describes significant advancements towards the State's goal of improving its current health insurance rate review and reporting process beginning from the time of approval through completion of the grant period.

The reports are due to OCIIO 30 days after the end of each quarter and must be submitted electronically.

The following report guidelines are intended as framework and can be modified when agreed upon by the OCIIO grant project officer and the State. A complete quarterly progress report must detail how grants funds were utilized, describe program progress and barriers in addition to providing an updated on all the measurable objectives of the grant program.

NARRATIVE REPORT FORMAT:

Introduction

Provide a brief overview of the project describing the proposed rate review enhancements and clearly articulating the goals, measurable objectives and milestones for each proposed enhancement.

Program Implementation Status As relevant to your project, include a discussion and update on progress towards:

1. Accomplishments to Date: implementation milestones, early outcomes, etc, include progress toward stated goals, objectives and milestones.
2. Challenges and Responses: provide a detailed description of any encountered challenges in implementing your program, the response and the outcome
3. Describe any required variations from the original timeline

Significant Activities – Undertaken and Planned
Discuss events occurring during the quarter or anticipated to occur in the new future that affect the progression of comprehensive rate review for your state. For States proposing legislative enhancements to expand their scope of rate review activities, please provide a detailed status update on the progress of all proposed grant activities undertaken in support of new legislation.

Operational/Policy Developments/Issues
Identify all significant program developments/issues/problems that have occurred in the current quarter, including legislative activity and proposed ways to rectify the barriers.

Please complete the following table that outlines all rate review activity under the grant program. The State should indicate "N/A" where appropriate. If there was no activity under a review category, the State should indicate that by "0."

A. Quarterly Rate Review - Progress

State	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Number of submitted rate filings					
Number of policy rate filings requesting increase in premiums					
Number of filings reviewed for approval/denial, etc.					
Number of filings approved					
Number of filings denied					
Number of filings deferred					

B. Number and Percentage of Rate Failings Reviewed – Individual Group

State	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Plan Year					
Product Type (PPO, HMO, etc.)					
Number of Policy Holders					
Number of covered lives affected					

C. Number and Percentage of Rate Failings Reviewed – Small Group

State	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Plan Year					
Product Type (PPO, HMO, etc.)					
Number of Policy Holders					
Number of covered lives affected					

D. Number and Percentage of Rate Failings Reviewed – Large Group

State	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Plan Year					
Product Type (PPO, HMO, etc.)					
Number of Policy Holders					
Number of covered lives affected					

E. Rate Filing Data

Provide data for **each rate filing** in the individual, small group and large group markets as defined in Attachment C

Public Access Activities

Summarize activities and/or promising practices for the current quarter working toward increased public access to rate review information for your state. Identify all barriers associated with increasing public access to rates and rate filing information and proposed ways to rectify the barriers.

Collaborative efforts

Describe any collaborative efforts in place that that are advancing the objectives of the Rate Review Program in your state.

Lessons Learned

Provide additional information on lessons learned and any initial promising practices

Updated Budget

Provide a detailed account of expenditures spent to date and describe whether the current allocation of funds follows the progression of the detailed budget provided in your original application. Also provide any unforeseen expenses and a brief description of the event that led its occurrence. Attach an updated detailed budget with the State's quarterly report submission.

Updated Work Plan and Timeline

Provide an updated work plan and timeline to reflect the events of the previous quarter. Highlight any additional time frames or items that were not included on the State's original submission as well as completion of milestones.

Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is ***0938-1092****. The time required to complete this information collection is estimated to average 24 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

Data Dictionary for the Policy Rate Filing Record-Data Collection for the Rate Review Grants

Data Element	Mandatory Y/N	Definition
State Abbreviation	Yes	The two digit State abbreviation as recognized by the US Postal Service
Reviewed by State Y/N	Yes	A yes/no flag used to identify whether the rate change was reviewed by the State. This value will be "no" for States that collect information but do not currently review rates and for States that "deem" rates approved.
State Review Includes Actuary Y/N	Reviewed by State is yes, otherwise, No	A yes/no flag that demonstrates if the State review process includes a review by an actuary.
Insurance Company Name	Yes	The name of the insurance company
Insurance Product Name	Yes	The name of the insurance product as sold by the insurance company
Issuer ID	Yes	The unique identifier as assigned by the HHS HIOS system.
Policy Form ID	Yes	The policy form ID of the insurance product as sold by the insurance company (NAIC policy or other ID)
Rate Filing ID	Yes	The rate filing ID of the insurance product as sold by the insurance company (NAIC policy or other ID)
New Policy Y/N	Yes	A yes/no flag that demonstrates if the policy is a New issue that has never been issued before.
Market Segment	Yes	Allowable values for market segment are: Large group, Small group, Individual, Conversion
Comprehensive Medical Coverage Type	Yes	Allowable values for comprehensive medical coverage type are: HMO, PPO, POS, FFS, EPO, Other - (please note details)
Block Status	Yes	Demonstrates if the rate for the policy is "open", "closed"
Rate Effective Date	Yes	Date that the rate is effective for the policyholders.
% Change Requested	Yes	The percentage of change approved can be a positive or negative number.
% Change Approved	No	The percentage of change requested can be a positive or negative number.
Change Period	Yes	Demonstrates the time for which the premium change is effective. Allowable values are: Annual, Semi-annual, Quarterly, Other - (Please note details)
Number Affected Insured's	Yes - unless Number Affected Policy Holders is the only data collected by the State	Total number of enrolled individuals affected by the rate change. This may be null for States that only collect policy holder counts.
Number Affected Policy Holders	Yes - unless Number Affected Insured's is the only data collected by the State	Total number of policy holders affected by the rate change. This may be null for States that only collect the number of enrolled individuals.
Member Months	Yes	The member months used for the purpose of the rate development.
Annual $ for New Rate	Yes	The dollar amount of the New Annual Rate.
Annual $ for Prior Rate	Yes	The dollar amount of the Prior Annual Rate.
SERFF Tracking Number	No	The tracking number assigned by the NAIC SERFF system assigned to the rate filing?
SERFF Rate Filing Type	No	The rate filing type as used in the NAIC SERFF system.
NAIC Company ID Number	No	The company identifier assigned by the NAIC system to identify the insurer.
Description of trend factors	No	Text description of trend factors and rating factors used in developing the rate
Benefit Adjusted Y/N	Yes	A yes/no flag used to identify if the benefits were adjusted or changed for the period.
Deductible Increase Y/N	Yes	A yes/no flag used to identify if the deductible amount was increased.
Benefit Increase Y/N	Yes	A yes/no flag used to identify if the services bevefits were increased.
Benefit Decrease Y/N	Yes	A yes/no flag used to identify if the services bevefits were decreased.
Cost Sharing Y/N	Yes	A yes/no flag used to identify if there are cost sharing requirements for the rate.
Coinsurance Y/N	Yes	A yes/no flag used to identify if there are coinsurance requirements for the rate.
Primary Care Copayment Amount	Yes	The copayment required at the primary care doctors office that coincides with the rate
Specialist Care Copayment Amount	Yes	The copayment required at specialty care doctors office that coincides with the rate
Inpatient Hospital Copayment Amount	Yes	The copayment required for inpatient hospitalization that coincides with the rate

Data Dictionary for the Policy Rate Filing Record-Data Collection for the Rate Review Grants

Data Element	Mandatory Y/N	Definition
Outpatient Hospital Copayment Amount	Yes	The copayment required for outpatient hospitalization that coincides with the rate
Generic Pharmacy Copayment Amount	Yes	The copayment required for generic drugs at the pharmacy that coincides with the rate
Brand Pharmacy Copayment Amount	Yes	The copayment required for brand name drugs at the pharmacy that coincides with the rate
Total Earned Premium Amount - Prior year	Yes	The total dollar amount collected for the purpose of premium payments.
Total Incurred Claims Amount - Prior year	Yes	The total dollar amount paid for services incurred.
Disposition of Rate Review	No	The disposition of the rate review, e.g. "approved," denied", "deferred",
Prospective Rate % Attributed to Claims and Capitation	Yes	The prospective percent of the rate increase attibuted to historical Claims and Capitation
Prospective Rate % Attributed to Admin	Yes	The prospective percent of the rate increase attibuted to historical Admin increase
Prospective Rate % Attributed to Broker Commissions	Yes	The prospective percent of the rate increase attibuted to historical Claims and Capitation increase
Prospective Rate % Attributed to Premium Taxes	Yes	The prospective percent of the rate increase attibuted to historical Premium tax increase
Prospective Rate % Attributed to Assessment Fees	Yes	The prospective percent of the rate increase attibuted to historical assessment fee increase
Prospective Rate % Attributed to Federal Taxes	Yes	The prospective percent of the rate increase attibuted to historical Federal tax increase
Prospective Rate % Attributed to Reserves	Yes	The prospective percent of the rate increase attibuted to historical reserves increase
Medical Price % Change	Yes	The medical price percentage of change used to develop the rate
Medical Utilization % Change	Yes	The medical utilization percentage of change used to develop the rate
Medical Trend % Insufficient Prior Rate	Yes	The percentage of historical insufficient prior rate used as a factor to develop the current rate
Overall Medical Trend % Increase	Yes	Derived data - The prospective total of the Medical Price % Change, Medical Utilization % Change, and the Medical Trend % Insufficient Prior Rate

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1092. The time required to complete this information collection is estimated to average (24 hours) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Payment Management System information for Recipients of the Department of Health and Human Services

The Payment Management System (PMS) is a centralized grants payment and cash management system, operated by the HHS Program Support Center (PSC), Division of Payment Management (DPM). The Payment Management System accomplishes all payment-related activities for HHS grants from the time of award through closeout of a grant. In addition, the Payment Management System provides these same services for several major Federal agencies outside of HHS. DPM, in operating the PMS, acts as the intermediary between awarding agencies and grant recipients.

The recipient registration process differs depending on whether the grant award is from an agency within the Department of Health and Human Services **(HHS)** or one from a **non-HHS** Federal agency or department. The information that follows is for HHS recipients.

The issuance of grant awards and other financial assistance is the responsibility of the awarding agencies. The Division of Payment Management does not award grants. Once an award is made by the HHS agency, the funds are posted in recipient accounts established in the Payment Management System (PMS). Grantees may then access their funds by using the Smartlink funds request process.

The SMARTLINK funds request process enables grantees to request funds using a Personal Computer with an Internet connection. The funds are then delivered to the recipient via Electronic Funds Transfer (EFT).

The Forms found on the Division of Payment Management website are the required forms for submitting data for input into the Payment Management System (PMS).

While these forms are similar to *Standard Forms* (SF) used throughout federal and state governments, the forms or the completion instructions have been modified for use in PMS.

Click on the form name for a direct link to:

Smartlink Instructions.doc

If you cannot submit your funds request via SMARTLINK, please contact your PMS Account Liaison.

Information We Need From the Recipient: 1199A Form and DPM Payment Management System Access Form:

- An 1199A Direct Deposit Form must be submitted to DPM by the recipient before processing any requests for funds.

  If recipients have already submitted an 1199A, and the information previously provided changes, a new 1199A form must be submitted reflecting the changes.

- **Grantee Banking Information - SF 1199A (English)**
- **Grantee Banking Information - SF 1199A (Espanol)**

The DPM Payment Management System Access Form is attached. This form must accompany the original SF1199A.

Division of Payment Management PMS Ac

IMPORTANT NOTE: All completed SF1199A forms (i.e. Direct Deposit Sign Up forms) must bear ORIGINAL SIGNATURES in Sections 1 and 3 ("Payee/Joint Payee Certification" and "Financial Institution Certification").

ALL "**original**" documents should be forwarded to the following address.

Division of Payment Management
Regular Mail Only – Post Office Box 6021, Rockville, MD 20852
Express Mail Only – 5600 Fishers Lane – Parklawn Bldg Room 11-33, Rockville, MD 20857

Information You Need From PMS: User Name and Password

The recipient must obtain a User Identification Name and Password prior to attempting to access funds PMS. However, the necessary forms as noted above must be submitted to PMS before the recipient is provided a User Name and Password.

If you need help with your User Identification Name and Password, please contact **PMSsupport@psc.hhs.gov** or (877) 614-5533 for assistance. If you have any questions or require any assistance, please contact your PMS Account Liaison.

PMS Reporting Requirements: FFR User Form

The Federal Financial Report (FFR) Federal Cash Transaction Report (FCTR) formerly known as the PSC 272 Electronic Report is one component of the Federal Financial Report (FFR)-425. The FFR has replaced the PSC-272. The new FFR form and the FFR Attachment for reporting disbursements for multiple Contracts must be filed.

The FFR cash transaction reports must be filed within **30 days** of the end of the quarter (instead of the 45 days allowed for filing the PSC-272).

PMS Training

Training on the payment management process through PMS is available. To submit your training request please send an e-mail to **PMS_Training@psc.hhs.gov** and place the phrase "Request for GRT Class" in the subject line of your email message.

Vermont Rate Review Enhancement Project
Project Abstract

Overall goal. Vermont law requires the prior approval of health insurance rates by the Vermont Department of Banking, Insurance, Securities and Health Care Administration (Department). The Department proposes to enhance its rate review process to accomplish the overall goal of offering consistent, comprehensive and effective regulation of health insurance rates for all carriers and all markets, in order to ensure that health insurance rates are neither unjust, unfair, inequitable, excessive, inadequate or unfairly discriminatory.

Rate Review Enhancements. The following initiatives will be undertaken to achieve Vermont's overall goal during the Cycle 1 time period:

A. Expand the scope of current review and approval activities by conducting reviews of large group rates; and rate review of minor lines of health insurance such as student blanket policies.

B. Improve rate filing requirements by developing rate filing standards; and by collecting informational data for plans administered by Third Party Administrators.

C. Enhance the rate review process by verifying claims experience and by analyzing public program mitigation.

D. Enhance the rate review process with a significant upgrade in Vermont's IT capacity. IT enhancements will include: updating the NAIC's SERFF program to include federal reporting elements; collecting and integrating historical rate filing data with current filed data; customizing Vermont's all payer claims utilization and reporting system to support rate review; consolidating carrier "carve-out" data; providing claims reporting by product type; and providing claims reporting by provider.

E. Enhance consumer protection standards by posting readable, layperson summaries of rate increase requests on the Department's website; and by adding a ratepayer comment functionality to the Department's website.

Project Budget. The total budget for the Vermont Rate Review Enhancement Project for the Cycle 1 time period is one million ($1,000,000.00) dollars. The Department intends to use these grant funds to employ or contract with additional actuaries; rate analysts; a data entry clerk; a claims analyst; and a grant administrator. The Department will support the Project through the allocation of time by existing staff, but does not intend to use grant funds for existing staff.

Vermont . . .

Department of Banking, Insurance, Securities and Health Care Administration

July 7, 2010

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

Re: Grants to States for Health Insurance Premium Review - Cycle I
CFDA: 93.511
Opportunity No. RFA-FD-10-999

Dear Secretary Sebelius:

The Vermont Department of Banking, Insurance, Securities and Health Care Administration (hereinafter "the Department"), on behalf of the State of Vermont, hereby makes Application for the above-referenced grant.

The over-all project to be funded by the grant will be called "The Vermont Rate Review Enhancement Project."

The Project Leader will be: Christine Oliver, Deputy Commissioner
Division of Health Care Administration
89 Main Street, Montpelier, VT 05620-3101;
802-828-2900; christine.oliver@state.vt.us

The Department has existing authority under Vermont law to oversee, coordinate and implement the rate review enhancement activities described in the Project Narrative. Title 8, Vermont Statutes Annotated, Sections 12 and 4062; Title 18 Vermont Statutes Annotated, Sections 9403 and 9410(h).

The Department further certifies, subject to the Department's annual appropriation enacted by the Vermont General Assembly, that the state share of funds expended for rate review activities under this Application will not be less than the funds expended during State fiscal Year 2011, and that the grant funds will not supplant existing state appropriations.

Please let me or Deputy Commissioner Oliver know if there are any questions concerning this application.

Yours truly,

Michael S. Bertrand, Commissioner

Vermont Department of Banking, Insurance, Securities and Health Care Administration
89 Main Street, Drawer 20
Montpelier, VT 05620-3101
802-828-3301

Federal Rate Review Grant

Project number →				I	II	III	V	VI
			Total Budget	25%	25%	35%	10%	5%
Personnel	$	149,650	$ 299,300	$ 74,825	$ 74,825	$ 104,755	$ 29,930	$ 14,965
Fringe benefits	$	46,392	$ 92,783	$ 23,196	$ 23,196	$ 32,474	$ 9,278	$ 4,639
Travel	$	1,000	$ 2,000	$ 500	$ 500	$ 700	$ 200	$ 100
Equipment	$	8,750	$ 17,500	$ 4,375	$ 4,375	$ 6,125	$ 1,750	$ 875
Supplies	$	3,750	$ 7,500	$ 1,875	$ 1,875	$ 2,625	$ 750	$ 375
Space/rental	$	10,000	$ 20,000	$ 5,000	$ 5,000	$ 7,000	$ 2,000	$ 1,000
Contracts/sub-contractors	$	-						
Actuarial services	$	112,900	$ 225,800	$ 56,450	$ 56,450	$ 112,900		
Update SERF	$	-	$ 18,808				$ 18,808	
Enhance IT	$	-	$ 316,309				$ 316,309	
Construction	$	-	$ -					
Other	$	-	$ -					
Total direct	$	332,442	$ 1,000,000	$ 166,221	$ 166,221	$ 266,579	$ 379,025	$ 21,954
Indirect staff time*								
Grand Totals			$ 1,000,000	$ 166,221	$ 166,221	$ 266,579	$ 379,025	$ 21,954

*Department staff will support activities above but no funds have been requested in the grant.

Personnel detail

2 Rate analysts	$ 145,000	Travel, equip, & supplies based on number of people employed
1 Data entry & support staff	$ 40,000	Fringe budgeted at 31% of salary.
1 Claims analyst	$ 62,300	
1 Grant Adminstrator	$ 52,000	
	$ 299,300	

Project Narrative – The Vermont Rate Review Enhancement Project

Section 1. Current health insurance rate review capacity and process

A. General health insurance rate regulation in Vermont

The rates and rate increases of all group and health insurance product lines are reviewed and approved before use by the Vermont Department of Banking, Insurance, Securities and Health Care Administration ("the Department"). The actual premium to be charged subscribers in large groups for large group comprehensive insurance is not reviewed; however the trend and rating methodology used to produce the premium must be approved by the Department.

Vermont's rating rules have been established in statute and regulation. Vermont's general authority to review health insurance rates is pursuant to 8 V.S.A §§ 4062 and 4515a.[1] In the small group market, a small group carrier must offer a small group plan rate structure which at least differentiates between single person, two person and family rates, must use a community rating method, acceptable to the Commissioner, to determine premiums, is prohibited from using medical underwriting and screening, and must guarantee rates on a small group plan for a minimum of six months. 8 V.S.A § 4080a.

Similar rules apply to the non-group market. 8 V.S.A § 4080b. In addition, the Commissioner must disprove any nongroup rates unless the anticipated loss ratios for the entire period for which rates are computed are at least 70 percent. 8 V.S.A § 4080b(m).

The Department has adopted the following regulations relating to the rate review process: Regulation 91-4b, Minimum Regulation for Compliance with 8 V.S.A. § 4080a; Regulation 93-5, Minimum Regulation for compliance with 8 V.S.A. § 4080b; and Regulation H-99-4 Community Rating & Approval of Community Rating Formulas.

B. Health insurance rate review and filing requirements in Vermont

[1] See Appendix 1 for copies of Vermont's health insurance rate review statutes and regulations.

All rates for health insurance products are subject to review and must be approved prior to use. For health insurance rate filings submitted to the Department, health insurers must provide: an actuarial memorandum, signed and dated by a qualified actuary and supporting documentation (e.g., claims experience, historical loss ratios). The specific exhibits and documents are submitted directly to the Department via the System for Electronic Rates and Form Filings ("SERFF") program administered by the National Association of Insurance Commissioners ("NAIC").

Generally, in reviewing a rate filing, Vermont examines the past history of rate changes; past Vermont experience; past nationwide experience; projected Vermont experience; projected nationwide experience; Vermont lifetime loss ratios; nationwide lifetime loss ratios; the credibility of Vermont experience; the health insurer's administrative costs, rating manuals, loss ratios, adequacy of reserves, and profitability or surplus. Also, if necessary, the Department will examine regional past experience, regional projected experience and regional lifetime loss ratios. A rate analyst and the Director of Rates & Forms review all health product line rate filings.

The rate filings of insurers representing the largest market share of comprehensive medical coverages are reviewed by the Department's contracted actuarial firm. The Department's contracted actuaries review medical trends submitted by an insurer, and calculate an independent range for the trends using their own proprietary software. Contracted actuaries compare the medical trends used in the insurer's rate filing to their independent calculations. For a rate filing to be approved the health insurer's proposed medical trends must be within the actuary's acceptable range. If the rate filing is found deficient during review, the filing is declined. When a rate filing is declined the carrier may respond and correct the deficiencies. If the carrier is unable to correct the deficiencies, the filing is closed and no rate increase is allowed.

C. An explanation of the current level of resources and capacity for reviewing health insurance rates: information technology (IT) and system capacity

All rate filings are required to be made electronically and via SERFF. The Department does not have any additional IT resources available to support its rate review capacity. The State of Vermont has established the Vermont Healthcare Claims Uniform Reporting and Evaluation System ("VHCURES"), "to continuously review health care utilization, expenditures, and performance in Vermont." 18 V.S.A. § 9410. VHCURES is administered by the Department, and includes de-identified eligibility records and medical and pharmacy claims for over 330,000 privately insured Vermonters or about 80 percent of the privately insured population. The paid claims data includes diagnosis codes, procedures codes, facility codes, billing and service provider information, charges, and amount paid including insurer payments and member payments (deductible, copayments, coinsurance).[2] In its current form, VHCURES cannot be utilized to support Vermont's rate review process, but there is substantial potential for enhancing the rate review process by integrating the review process with VHCURES.

D. An explanation of the current level of resources and capacity for reviewing health insurance rates: budget and staffing

The annual overall total budget for the Division of Health Care Administration for State fiscal Year 2011 is $4,741,907. This funding supports a number of programs in addition to the rate review program, including: hospital budget approval; the Certificate of Need program; quality assurance; consumer services; public service outreach; data analysis, market conduct; and enforcement.

The Division's annual budget allocated for rate review is $501,580. Of this amount, approximately $401,264 is allocated for review of health insurance rates in the individual and small group/association markets.

Vermont currently has a full time person reviewing all rate increase requests. The one rate reviewer closed 516 filings in the past year ending May 12, 2010. The number of closed rate

[2] The VHCURES report on expenditures and utilization published in January 2010 is attached as Appendix 2.

filings does not take into account that each rate filing averages three reviews by the analyst, because the initial carrier filings can be insufficient or cannot be approved. Thus, on average, the 516 closed rate filings represent 1,548 actual reviews. The Department's rate analyst has approximately twenty-two years of experience in the insurance field, including work as senior actuarial analyst and Director of Rates and Forms (Life & PC). The rate analyst has a Bachelor of Science (BS) degree in Mathematics and Management. $87,000 is budgeted to support the rate analyst.

The Director of Rates and Forms supervises and manages the rate review process, along with other duties, and provides legal support. The Director of Rates and Forms has a law degree, a MPH degree, and a BS degree. In addition to the present position, the Director of Rates and Forms has served as staff attorney at Vermont Legal Aid and had a supervisory position for two community based epidemiology studies while on staff at the University of Minnesota's School of Public Health. $14,580 is budgeted from the Department's Administration Division (General Counsel's Office) to support the rate review functions of the Director of Rates and Form.

The Department also contracts with Oliver Wyman for actuarial services. The principal contracted actuary has over twenty-five years of experience and has earned both a FCA and MAAA. $400,000 is budgeted to support this contract.

E. Consumer Protections

All rate filings made with the Department are open to the public pursuant to the Vermont Public Records Law (1 V.S.A. Chapter 5, Subchapter 3). A carrier may request the Department to keep portions of the rate filing confidential, upon a proper showing that the material is a trade secret. 1 V.S.A. § 317(c)(9). Rate filings can be reviewed on the Department's public computer, via a read-only access to SERFF system. The Department also produces a **Consumer Tips**

publication, which contains small-group and individual rates for specific companies and specific plans.[3]

Layperson summaries of rate changes are currently not offered for consumers, but the Department anticipates this can be accomplished as part of the Vermont Rate Review Enhancement Project.

F. Examination and oversight

The State of Vermont requires prior approval before any proposed rate increase can take effect. Over the past two years, there have been multiple instances when the Department has denied a health insurer's request for a rate increase. In most of these instances, the health insurer has voluntarily lowered the proposed rate increase. The Department is unable to quantify the exact number of policyholders affected, however, it is safe to conclude that a significant number of Vermont policyholders have been impacted by these proactive determinations.

On occasion, a health insurer has appealed the Department's determination to deny a rate increase, pursuant to 8 V.S.A § 4062. Over the past two years, carrier appeals have led to two formal hearings, following which the Commissioner issued written decisions denying the appeals. One such decision included a Supplemental Order, pursuant to the Commissioner's authority under 8 V.S.A. § 4513(c), directing the carrier to engage in additional cost containment activities, and ordering a ratepayer refund of excessive executive compensation amounts.[4]

Section 2. Proposed rate review enhancements for health insurance

Introduction

As described in Section 1, above, the Department administers a comprehensive, rigorous health insurance rate review process. Nevertheless, the Department can enhance its current rate review process by means of the following initiatives.

A. Expanding the scope of current review and approval activities.

[3] See Appendix 3
[4] See Appendix 4.

The Department proposes an appropriate level of rate review for all carriers, in all markets.

Large group market rates are not filed for review and approval; rather, the Department reviews and approves a rating formula included within the carrier's "rate manual", and the Department reviews and approves a medical trend factor and other factors that are incorporated into the carrier's rate manual. For minor lines of health insurance such as student health insurance policies, which are filed as "blanket" health insurance, the Department's rate review process is an abbreviated one.

Ratepayers in the large group market and in minor lines markets would benefit from a more thorough rate review approval process.

Proposed enhancements:

1. Goal: Effective rate review in all insurance markets. Measurable objective, timeline, and milestone for change: By September 30, 2011 the Department will establish procedures for annual rate reviews of rates in the large group market. The Department anticipates review of large group rates beginning for calendar year 2012 rates. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $83,111.[5]
2. Goal: Rate review of minor lines of insurance. Measurable objective, timeline and milestone for change: By July 1, 2011 the Department will establish procedures for rate reviews of minor lines of insurance such as student health insurance. The Department anticipates review of rates for minor lines insurance beginning with rate filings made after October 1, 2011. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $83,110.

B. Improving rate filing requirements.

[5] All cost estimates are for the Cycle 1 time period.

The Department proposes to standardize rate filing requirements, in order to strengthen the rate review process, and to improve communications with ratepayers. The Department also proposes to collect rate and benefit plan information for all Vermont markets, in order to increase the Department's capacity to analyze market trends, and thereby strengthen the rate review process.

Carriers include different information, in different formats, when filing rate requests with the Department. As a result, comparison between rate filings of each carrier is difficult. Some filings do not include information concerning the benefit plan (cost sharing, network limitations and coverage) for which a specific rate increase is sought. In addition, carriers' rate filings are written in technical language, and therefore are difficult for the layperson ratepayer to understand.

The Department also proposes to require Third Party Administrators to make information-only filings relating to benefits, coverages, enrollment and costs so that the Department will have a better understanding of the Vermont health insurance market as a whole, and thus be better able to review and analyze rates in the regulated health insurance markets.

Proposed enhancements:

1. Goal: Adopt standards for carrier rate filings. Measurable objectives, timeline and milestone for change: By July 1, 2011, the Department will establish and publish standards for carrier rate filings, including a requirement that a description of each benefit plan be linked with the rate request for that plan, and a requirement of narrative, layperson summary of the rate increase request. The Department anticipates that its filing standards will be applicable to rate filings beginning for calendar year 2012. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $83,110.
2. Goal: Informational filings by Third Party Administrators. Measurable objectives, timeline and milestone for change: By September 30, 2011, the Department will establish

and publish standards for annual, informational filings by Third Party Administrators of benefits, coverages, enrollment and costs for each benefit plan administered. The Department anticipates that its TPA filing standards will be effective on and after January 1, 2012. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $83,111.

C. Enhanced review process – verification of filed rate information.

The Department proposes to enhance the accuracy and credibility of the rate review process by conducting periodic examinations of carriers' claims experience. This capacity is particularly important with respect to Vermont's Catamount Health premium subsidy program for the uninsured, and with respect to benefit and coverage changes required by the Patient Protection and Affordable Care Act ("PPACA"). Anecdotal observations have suggested that considerable migration takes place between Catamount Health[6] and VHAP[7] because of differences in eligibility and pre-existing condition limitations of the two programs. Carriers will be making assumptions about the cost of implementing the benefit and coverage requirements of the PPACA without significant experience upon which to base those assumptions.

Proposed enhancements:

1. Goal: Examine claims experience based on new federal requirements. Measurable objectives, timeline and milestone for change: By July 1, 2011 the Department will collect early claims experience in order to validate or change the estimated rate increments which have been included by carriers to account for changes in benefits and coverages required by federal law. Resources needed: allocate time of existing staff, and

[6] Catamount Health is a premium subsidy program for the uninsured with household income between 150-300% FPL, with a policy issued by a private carrier. It is funded by state and federal funds in accordance with a Section 115 Medicaid waiver.
[7] VHAP is a Medicaid-administered Section 115 waiver program for Vermont residents with household income under 150% FPL.

hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $98,213.

2. Goal: Migration analysis. Measurable objectives, timeline and milestone for change: By July 1, 2011, the Department will collect information on the relationship between the Catamount Health program and the VHAP, in order to validate or change the estimated claims costs assumed by carriers for Catamount Health insureds. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $98,214.
3. Goal: Targeted data verification examinations. Measurable objectives, timeline and milestone for change: By July 1, 2011, the Department will begin to conduct targeted examinations to validate or change the assumptions used by carriers in their rate filings. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $70,152.

D. Enhance rate review process – staffing.

The Department proposes to increase its professional staffing and/or contracted resources allocated to the health insurance rate review process.

The enhancements in the scope and depth of rate review and analysis contemplated by the Department and described in this Application will require professional resources in addition to current staffing and contracting resources.

Proposed enhancements:

Goal: Increase professional resources for rate review. Measurable objectives, timeline and milestone for change: Throughout the course of the Cycle 1 time period, beginning in September, 2010, the Department proposes to increase its professional resources for health insurance rate review functions, as set forth below, and as described further in Section 2 (A), (B), (C), (E) and

(F). The options for increasing professional resources will be either by hiring Department employees, or by contracting for professional services, or both. Staff may be hired to either temporary or permanent positions. The options chosen will be based in part on whether the Department will be authorized to hire for new positions and what type of positions will be authorized, and in part on the Department's judgment as to the availability of funds to support these additional resources in future years. It is anticipated that acquisition of additional actuarial resources will be accomplished by contract.

1. Two (2) professional actuaries. Estimated cost: $225,800.
2. Two (2) rate analysts with actuarial experience. Estimated cost: $180,000.
3. One (1) data entry clerks. Estimated cost: $50,000.
4. One (1) claims analyst. Estimated cost: $90,000.
5. One (1) grant administrator. Estimated cost: $68,500.

E. Enhanced rate review process – IT capacity.

(a) Rate filings.

The Department proposes to enhance its rating filing IT infrastructure (1) to report on current rate filing components in Vermont in accordance with the information required to be reported to the Secretary of HHS (see Section 3 below), and (2) to integrate the reporting of current data with the collection and reporting on historical rate filing components. Both current and historical data is critical for the Department's understanding and analysis of trends in health insurance markets and health insurance rates, as well as for the Department's ability to communicate with essential constituencies, including but not limited to the HHS Secretary, the Vermont Legislative and Executive Branches, business and individual ratepayers, carriers, hospitals, physicians, and other health care providers.

(b) Rate review supported by claims data.

The Department proposes to customize use of claims data to provide a powerful tool for rate review, in order to improve information symmetry between the regulator and regulated entities, and to enhance the Department's flexibility and effectiveness in analyzing insurance markets, and in reviewing carrier rate requests.

The State of Vermont has established VHCURES; an all payer claims database intended "to continuously review health care utilization, expenditures, and performance" in Vermont. 18 V.S.A. § 9410. Vermont is one of a very few states in the country to have established such an all payer claims database.

VHCURES can make available to the rate review process actual eligibility, product, provider and claims data, which will allow the Department to critically analyze assumptions used by insurers to set proposed rates, including demographics and health status ("My members are older and/or sicker"); reimbursement ("My members use more expensive facilities and providers"); and cost drivers ("My members use more services and/or more expensive services"). The Department proposes to utilize the VHCURES IT program in a manner specifically customized to support the rate review process.

Strengthening of the Department's rate view process through enhanced IT capacity and resources will be accomplished by means of four VHCURES IT initiatives, as follows:

First: the Department proposes to customize VHCURES reporting to support rate review. In reviewing trends in health insurance utilization and expenditures, actuaries use regional and national averages and benchmarks for specified categories of expenditures such as hospital inpatient, hospital outpatient, physician office visits including primary and specialty care consultation, prescription drugs, durable medical equipment, etc. VHCURES reporting currently categorizes utilization and expenditures in close alignment with the National Health Expenditures categories published by the Centers for Medicare and Medicaid Services (CMS) as applicable to commercial health insurance. This first IT initiative will enable the rate review process to

compare the VHCURES categorization to the categorization used traditionally by actuaries, resulting in greater accuracy in assessing carrier utilization and expenditures, and in identifying cost drivers.

Second, the Department proposes to consolidate carrier "carve-out" data to permit better analysis of filed rate information. Most major insurers with carve-outs submit a consolidated file for medical members, including a single eligibility file for medical, mental health, and pharmacy claims. Benefits covered by one major carrier are also carved-out, but three separate companies submit eligibility and claims records to VHCURES. This VHCURES IT enhancement will consolidate expenditure and utilization reports, thereby strengthening the rate review process for the plans issued by this carrier.

Third, the Department proposes to increase the depth of rate analysis by providing claims reporting by product type. VHCURES currently reports expenditures and utilization at the major insurer level, accounting for over 90 percent of the privately insured market including the insured market and self-insured employer market for comprehensive health benefits. The data is also reported at the hospital service area level to support population-based comparison of rates. Within the VHCURES data set for every insurer, every member eligibility record and claim is coded with Insurance Product Type that for comprehensive major medical benefits includes HMO, PPO, POS, EPO, and indemnity. After the appropriate categories are developed for reporting expenditures and utilization as discussed above, reports by insurance product type would be generated by major insurer to aid in rate review of products by insurance type.

Fourth, the Department proposes to identify claims by provider, thereby creating the capacity to identify and analyze cost drivers, and to compare carrier effectiveness in addressing those cost drivers. Health services and actuarial research and literature have identified cost drivers in health care with robust trends in increased utilization and contribution to rising cost with potentially marginal health benefits. Insurers, payers, purchasers, and providers are interested in

understanding trends in utilization of cost drivers such as advanced imaging, potentially avoidable hospital admissions, readmissions, and emergency department use, and use of prescription drugs. The capability to drill down on cost drivers and identify facilities and providers associated with significant expenditures and utilization would bring a valuable perspective and refinement to the rate review process. To develop this capability requires development and maintenance of an accurate Master Provider Index ("MPI") of both facility claims and professional claims.

Proposed enhancements:

1. Goal: Enhanced rate data collection and reporting. Measurable objectives, timeline and milestone for change: Within three months (initial enhancement), and within eight months (additional enhancement) following the receipt of HHS reporting requirements, the Department will collaborate with other states through the NAIC and its SERFF program in order to improve the IT, analysis and reporting capacity of the Department with respect to rate review. Vermont already requires carriers to file their proposed rates with SERFF.[8] Estimated cost: $18,808.[9]
2. Goal. Integration of historical and current rate data. Measurable objectives, timeline and milestone for change: By September 30, 2011 the Department will collect and integrate historical rate information with the current information reported through SERFF, in order to better understand rate and market trends over time, and to better communicate with consumers and other stakeholders. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services. Estimated cost: $20,000.
3. Goal: Customize VHCURES reporting to support rate review. Measurable objectives, timeline and milestone for change: By September 30, 2011, the Department will establish

[8] The SERFF proposal is submitted as Appendix 5.
[9] The cost to the Department to duplicate the IT functions and reporting capability of SERFF have not been estimated, but are anticipated to be many multiples of the estimated cost utilizing the SERFF program.

a collaborative relationship between VHCURES staff and the Department's actuarial consultant and rate analysts to identify alternative claims data categorizations, and thereby support enhanced evaluation of carrier filing data, trends and cost drivers. Resources needed: contract for VHCURES enhancements. Estimated cost: $99,372.

4. Goal: Consolidate carrier "carve-out" data. Measurable objectives, timeline and milestone for change: By September 30, 2011 the Department will contract for changes to the VHCURES system in order to support the consolidation of carrier "carve-out" data. Resources needed: contract for VHCURES enhancements. Estimated cost: $10,000.
5. Goal: Claims reporting by product type. By September 30, 2011 the Department will contract for a VHCURES IT enhancement to permit a review of rate filings in collaboration with the Rate and Form Unit's consultants by product type. Resources needed: allocation of current staff time, hiring or contracting for a claims analyst, and increased VHCURES contractual resources. Estimated cost: $145,845.
6. Goal. Claims reporting by provider. Measurable objectives, timeline and milestone for change: By September 30, 2011, the Department will contract for a VHCURES IT enhancement to permit a linkage between claims and providers, thereby enhancing the rate review process by identifying cost drivers in the health care system. Resources needed: develop and maintain an accurate Master Provider Index ("MPI") for both facility claims and professional claims. Estimated cost: $85,000.

F. Enhancing consumer protection standards.

Under Vermont law, the rate review process is a public, open process. Carrier rate filings are public records subject to disclosure to consumers (other than proprietary, trade secret information), and Vermont law requires 45 days advance notice to ratepayers before the proposed effective date of a rate. The Department proposes additional measures to enhance its existing consumer protection standards.

Proposed enhancements:

1. Goal. Layperson summaries of rate filings. Measurable objectives, timeline and milestone for change: By July 1, 2011 the Department will establish requirements for carriers to file layperson-friendly summaries of rate filings. Beginning for calendar year 2012 rate requests, the Department will post these summaries on the Department's website. Resources needed: allocation of existing staff time. Estimated cost: $9,440.
2. Goal. Ratepayer comment opportunity. Measurable objectives, timeline and milestone for change: By July 1, 2011 the Department will design its website to offer a ratepayer comment and/or forum opportunity for carrier rate increase requests. Beginning for calendar year 2012 rate requests, the Department proposes to incorporate these website functionalities on the health insurance rate portion of its website. Resources needed: allocation of existing staff time. Estimated cost: $12,514.

Section 3. Reporting to the Secretary on rate increase patterns

The Department attests that it will comply with the requirements of the PPACA with respect to required reporting to the Secretary of HHS. As described in Section 3(E), above, the Department intends to collaborate with other states through the NAIC and its SERFF program in order to improve the IT, analysis and reporting capacity of the Department with respect to rate review.

Section 4. Optional data center funding

The Department does not intend to request optional data center funding for compiling and publishing fee schedule information, as described in the grant Announcement.

VERMONT

JFO 2463

State of Vermont
Department of Finance & Management
109 State Street, Pavilion Building
Montpelier, VT 05620-0401

[phone] 802-828-2376
[fax] 802-828-2428

Agency of Administration

STATE OF VERMONT
FINANCE & MANAGEMENT GRANT REVIEW FORM

Grant Summary:	This grant is to help Vermont enhance its health insurance rate review process and is awarded under the Affordable Care Act (ACA). BISHCA has five initiatives under this grant. Under this grant BISHCA has included 6 one-year limited service position requests to do work related to this grant.				
Date:	9/13/2010				
Department:	Department of Banking, Insurance, Securities and Health Care Administration				
Legal Title of Grant:	2010 Grants to States for Health Insurance Premium Review--Cycle 1				
Federal Catalog #:	93.511				
Grant/Donor Name and Address:	Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, Grants, 7501 Wisconsin Ave. West Tower, Room 10-15, Bethesda Maryland 20814-6519				
Grant Period: From:	8/9/2010	**To:**	9/30/2011		
Grant/Donation	$1,000,000				

	SFY 1	SFY 2	SFY 3	Total	Comments
Grant Amount:	$756,484	$243,516	$	$1,000,000	

	# Positions	Explanation/Comments
Position Information:	6	See attached position request form. One year limited service positions needed to do the work required for this grant.

Additional Comments:	In addition there will be contract for one half of the needed actuarial services.

Department of Finance & Management	9/27/10	(Initial)
Secretary of Administration	TP 9/24/10	(Initial)
Sent To Joint Fiscal Office	9/28/10	**Date**

RECEIVED
SEP 28 2010
JOINT FISCAL OFFICE

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

PERSONAL SERVICE INFORMATION

11. Will monies from this grant be used to fund one or more Personal Service Contracts? ☒ Yes ☐ No
If "Yes", appointing authority must initial here to indicate intent to follow current competitive bidding process/policy.

Appointing Authority Name: Michael Bertrand Agreed by: MSB (initial)

12. Limited Service Position Information:	**# Positions**	**Title**
	2	Rate Analysts
	1	Administrative Assistant
	1	Claims analyst
	2	1 Grant Program Administrator and 1 Rates and Forms Actuary
Total Positions	6	

12a. Equipment and space for these positions: ☐ Is presently available. ☐ Can be obtained with available funds.

13. AUTHORIZATION AGENCY/DEPARTMENT

I/we certify that no funds beyond basic application preparation and filing costs have been expended or committed in anticipation of Joint Fiscal Committee approval of this grant, unless previous notification was made on Form AA-1PN (if applicable):	Signature: [signature]	Date: 8/31/2010
	Title: Commissioner	
	Signature:	Date:
	Title:	

14. SECRETARY OF ADMINISTRATION

☑ Approved:	(Secretary or designee signature) [signature]	Date: 9/2/10

15. ACTION BY GOVERNOR

☑ Check One Box: Accepted	[signature]	9/27/10
☐ Rejected	(Governor's signature)	Date:

16. DOCUMENTATION REQUIRED

Required GRANT Documentation

☐ Request Memo	☐ Notice of Donation (if any)
☐ Dept. project approval (if applicable)	☐ Grant (Project) Timeline (if applicable)
☐ Notice of Award	☐ Request for Extension (if applicable)
☐ Grant Agreement	☐ Form AA-1PN attached (if applicable)
☐ Grant Budget	

End Form AA-1

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

BASIC GRANT INFORMATION	
1. Agency:	
2. Department:	Department of Banking, Insurance, Securities and Health Care Administration
3. Program:	Rates and Forms (Health Care Administration)
4. Legal Title of Grant:	2010 Grants to States for Health Insurance Premium Review-Cycle 1
5. Federal Catalog #:	CFDA: 93.511

6. Grant/Donor Name and Address:
Department of Health & Human Services, Office of Consumer Information & Insurance Oversight, Grants, 7501 Wisconsin Ave West Tower, Room 10-15, Bethesda, MD 20814-6519

7. Grant Period:	**From:**	8/9/2010	**To:**	09/30/2011

8. Purpose of Grant:
To enhance Vermont's rate review process for health insurance in 2010 and 2011.

9. Impact on existing program if grant is not Accepted:
Department's ability to implement health care reform as mandated by ACA will be compromised.

10. BUDGET INFORMATION

	SFY 1	SFY 2	SFY 3	Comments
Expenditures:	**FY** 2011	**FY** 2012	**FY**	
Personal Services	$715,551	$238,516	$	
Operating Expenses	$40,933	$5,000	$	
Grants	$	$	$	
Total	$756,484	$243,516	$	
Revenues:				
State Funds:	$	$	$	
Cash	$	$	$	
In-Kind	$	$	$	
Federal Funds:	$	$	$	
(Direct Costs)	$756,484	$243,516	$	
(Statewide Indirect)	$	$	$	
(Departmental Indirect)	$	$	$	
Other Funds:	$	$	$	
Grant (source)	$	$	$	
Total	$756,484	$243,516	$	

Appropriation No:	2210040000	**Amount:**	$1,000,000
			$
			$
			$
			$
			$
			$
		Total	$1,000,000

RECD SEP 0 3 2010

STATE OF VERMONT
Joint Fiscal Committee Review
Limited Service - Grant Funded
Position Request Form

This form is to be used by agencies and departments when additional grant funded positions are being requested. Review and approval by the Department of Human Resources must be obtained prior to review by the Department of Finance and Management. The Department of Finance will forward requests to the Joint Fiscal Office for JFC review. A Request for Classification Review Form (RFR) and an updated organizational chart showing to whom the new position(s) would report **must** be attached to this form. Please attach additional pages as necessary to provide enough detail.

Agency/Department: BISHCA Date: 8/26/2010

Name and Phone (of the person completing this request): Sandy Barton, 828-2379

Request is for:
- ☑ Positions funded and attached to a new grant.
- ☐ Positions funded and attached to an existing grant approved by JFO #_____

1. Name of Granting Agency, Title of Grant, Grant Funding Detail (attach grant documents):

   Department of Health and Human Services, 2010 Grants to States for Health Insurance Premium Review, Cycle I

2. List below titles, number of positions in each title, program area, and limited service end date (information should be based on grant award and should match information provided on the RFR) position(s) will be established only after JFC final approval:

Title* of Position(s) Requested	# of Positions	Division/Program	Grant Funding Period/Anticipated End Date
Insurance Rates and Forms Analyst	2	Health Care Administration	8/9/2010-9/30/2011
Administrative Assistant A	1	Health Care Administration	8/9/2010-9/30/2011
Grants Program Specialist II	1	Health Care Administration	8/9/2010-9/30/2011
Rates and Forms Actuary	1	Health Care Administration	8/9/2010-9/30/2011

*Final determination of title and pay grade to be made by the Department of Human Resources Classification Division upon submission and review of Request for Classification Review.

3. Justification for this request as an essential grant program need:

Position request continued:			
BISHCA Claims Analyst	1	Health Care Administration	8/9/2010-9/30/2011

Justification: See Attached

I certify that this information is correct and that necessary funding, space and equipment for the above position(s) are available (required by 32 VSA Sec. 5(b).

Signature of Agency or Department Head — Date: 8.31.2010

Approved/Denied by Department of Human Resources — Date: 9/1/10

Approved/Denied by Finance and Management — Date: 9/2/10

Approved/Denied by Secretary of Administration — Date: 9/2/10

Comments: DHR approval is contingent upon F&M approval of funding source/timeframe.

DHR – 11/7/05

RECD SEP 03 2010

Justification for Limited Service Positions

Without the limited service, grant funded positions listed in the attached request, Vermont will be unable to enhance its rate review process or implement any of the initiatives proposed in the grant. As such, the positions identified are essential if the Department is to successfully enhance the rate review process to accomplish the overall goal of providing consistent, complete and effective regulation necessary to ensure that health insurance rates are not unjust, unfair, inequitable, excessive, inadequate or unfairly discriminatory. Furthermore, if the Department's request for limited service positions is denied, the State's ability to implement comprehensive health care reform as mandated by the Affordable Care Act (ACA), will be severely compromised. For the reasons stated above, the limited service positions requested are an essential grant program need.

State of Vermont
Department of Banking, Insurance,
Securities and Health Care Administration
89 Main Street
Montpelier, VT 05620-3101
www.bishca.state.vt.us

Consumer Assistance Only:
Insurance: 1-800-964-1784
Health Care Admin.: 1-800-631-7788
Securities: 1-877-550-3907

To: James Reardon, Commissioner, Finance & Management

From: Michael Bertrand, Commissioner, BISHCA MB

Date: August 31, 2010

Re: Grant Acceptance
2010 Grants to States for Health Insurance Premium Review – Cycle 1

The Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) applied for federal funds under the new federal health care legislation for the purpose of enhancing Vermont's health insurance rate review process. Under the grant proposal ("2010 Grants to States for Health Insurance Premium Review-Cycle 1"), all States were eligible for funding. Funding was made available to assist with the implementation of comprehensive health care reform as mandated by the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation. The two laws, both passed in 2010, are collectively referred to as the Affordable Care Act (ACA).

Successful grant applicants were required to demonstrate that grant funds would be used to either develop or enhance their current rate capacity for rate review in the individual and group markets. On the August 16th of 2010, BISHCA received official notification that our application had been accepted. At this time, BISHCA is requesting State acceptance of the federal grant.

Vermont, like all grantee awardees, will receive a grant amount of $1 million. While the federal legislation authorizes the award of additional grants in future fiscal years, this specific award is for federal fiscal year 2011 only.

BISHCA has proposed five initiatives to enhance the Vermont's rate review process for health insurance premiums. Each initiative will require professional resources beyond current Department levels. The initiatives that can be funded through acceptance of the grant are as follows:

SEP 08 2010

1. Expand the scope of current review and approval activities by conducting reviews of large group rates and rate review of minor lines of health insurance such as student policies. By September 30, 2011 the Department will establish procedures for annual rate reviews of the large group market, with reviews beginning for calendar year 2012. Resources needed: allocate time of existing staff and hire and/or contract for additional actuarial and professional resources. Estimated cost: $166,221.00.

2. Improve rate filing requirements by developing rate filing standards, and by collecting informational data for plans administered by Third Party Administrators. By July 1, 2011 the Department will establish and publish standards for carrier rate filings, including a requirement of a layperson summary of the rate increase request. Also, by September 30, 2011, the Department will establish and publish standards for annual informational filings to be made by third party administrators. Resources needed: allocate time of existing staff and hire and/or contract for additional actuarial and professional resources. Estimated cost: $166,221.00.

3. Enhance the rate review process by verifying claims experience and by analyzing public program migration. By July 1, 2011 the Department will collect claims data for validation and conduct targeted examinations to validate or change the assumptions used by carriers in their rate filings. Resources needed: allocate time of existing staff and hire and/or contract for additional actuarial and professional resources. Estimated cost: $266,579

4. Enhance the rate review process with a significant upgrade in Vermont's IT capacity. IT enhancements will include: updating the National Association of Insurance Commissioners' (NAIC) System for Electronic Rate and Form Filer (SERFF) program to include federal reporting elements, collecting and integrating historical rate filing data with current filed data, customizing Vermont's all payer claims utilization and reporting system to support rate review, consolidating carrier "carve-out" data, providing claims reporting by product type, and providing claims reporting by provider. By September 30, 2011 the Department will increase its rate analysis and reporting capacity with respect to rate review; collect and integrate historical; and current rate information and will contract for enhancements to its VTCURES and SERFF IT capabilities. Resources needed include: hiring or contracting for increased professional services; and contract for VHCURES enhancements and increased contractual resources. Estimated cost: $379,025.00.

5. Enhance consumer protection standards by posting readable, layperson summaries of rate increase requests on the Department's website, and by adding a ratepayer comment functionality to the Department's website. By July 1, 2011, the

Department will establish requirements for carriers to file layperson summaries of rate filings; and design a website to offer a ratepayer comment forum opportunity for rate carrier increase requests. Resources needed: allocate time of existing staff and hire and/or contract for additional professional resources. Estimated cost: $21,954.00.

The proposed enhancements in the scope and depth of Department's rate review for health insurance premiums will require professional resources in addition to current staffing and contracting resources. If the grant is accepted by the State, BISHCA will increase its professional resources for enhanced rate review. BISHCA is proposing to implement the initiatives previously described above through a combination of contract authority and the hiring of limited service positions. Our current proposal is to:

1. Contract for one half (0.5) of the additional actuarial services needed for the work proposed in initiatives #1-3.

2. Hire limited service positions for:
   a. One (1) actuary to perform the additional actuarial services needed for the work proposed of initiatives #1 through #3, including (but not limited to): analyze statistical data; construct probability tables to forecast risk and liability for payment of future benefits; ascertain premium rates required to ensure payment of future benefits.

   b. Two (2) rate analysts to carry out the professional services required for initiatives #1 through #3 and #5. Including (but not limited to): expand the scope of Department review of all filings; develop new rate filing standards; collect and integrate various types data.

   c. One (1) data entry and support staff position for the additional professional services required for initiatives #1 through #5. Including (but not limited to): assist with data collection and integration efforts; provide technical support to staff; perform other duties as needed.

   d. One (1) claims analyst for professional services required for initiatives #4 & #5. Including (but not limited to): review claims data to verify and describe the nature of claims experience in Vermont's health insurance market.

   e. One (1) grant administrator to perform multiple grant administration functions, including (but not limited to): ensuring accurate and timely preparation of grant billings and reports; ongoing monitoring of grant budgets and expenditures; communication of relevant grant information with Department and grantor.

The Grant Budget has been included as required.

Acceptance of the grant funds will assist the Department in the implementation of federal health care reform. Additionally, acceptance will enable Vermont to enhance its rate review process to accomplish the overall goal of offering consistent, comprehensive and effective regulation of health insurance rates for all carriers and all markets in order to ensure that health insurance rates are not unjust, unfair, inequitable, excessive, inadequate or unfairly discriminatory. Without acceptance of the funds, the State's ability to implement comprehensive health care reform, including enhanced rate review of health insurance rates, will be compromised.

Please let me know if you have any questions regarding this submission.

MB/sl
Enclosures

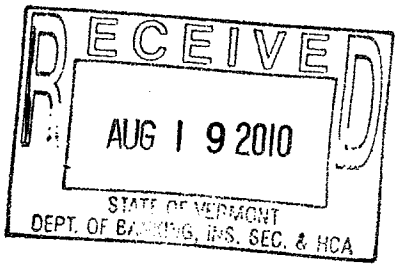
DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Consumer Information and Insurance Oversight

200 Independence Avenue SW
Washington, DC 20201

AUG 16 2010

Mike Bertrand
Commissioner
Vermont Insurance Division
Department of Banking, Insurance, Securities and Health Care
89 Main Street
Montpelier, VT 05620



Dear Commissioner Bertrand:

The Office of Consumer Information and Insurance Oversight (OCIIO) is pleased to inform you that you have been awarded a grant under the funding opportunity announcement entitled Grants to States for Health Insurance Premium Review Grants-Cycle 1. Congratulations on your successful application. The Notice of Grant Award is included in the attachments to this Award Letter.

Pursuant to the HHS Grants Policy Statement there are terms and conditions associated with the receipt of this grant, and these are also attached to this Award Letter. These include the Standard and Special Terms and Conditions (STCs). Also attached are the templates for quarterly programmatic reporting and the required data collection and instructions on how to obtain disbursement of grant funds.

OCIIO requests affirmation that the Maintenance of Effort requirement as outlined on page 7 of the Funding Opportunity Announcement is in place. Please confirm that grant funds will not be used to fund costs relating to existing state activities, including salaries of employees performing these activities.

Please carefully review all the standard and special terms and conditions of the grant award and provide OCIIO with a written letter of acceptance of these terms and conditions by September 13, 2010. The letter of acceptance may be submitted electronically to Jacqueline Roche at Jacqueline.Roche@hhs.gov and Gladys Bohler at Gladys.Bohler@hhs.gov.

We at OCIIO thank you for your commitment to this program and we look forward to continued collaboration with Vermont as you embark upon an ambitious program to enhance the premium review process in your state and take important strides to help protect consumers from unjustified and/or excessive premium increases.

Sincerely,

Jay Angoff
Director

Enclosures

Department of Health and Human Services

Office of the Secretary

Office of Consumer Information and Insurance Oversight

Grants, Contracts and Integrity Division
7501 Wisconsin Ave West Tower
Room 10-15
Bethesda, MD 20814-6519

NOTICE OF GRANT AWARD

AUTHORIZATION (Legislation/Regulations)
Section 2794 of the Public Health Service Act (Section 1003 of the Affordable Care Act)

1. DATE ISSUED (Mo./Day/Yr.)	2. CFDA NO.
08/03/2010	93.511

3. SUPERCEDES AWARD NOTICE dated
except that any additions or restrictions previously imposed remain in effect unless specifically rescinded

4. GRANT NO.	5. ADMINISTRATIVE CODES
1 IPRPR100027-01-00 Formerly:	IPR
6. PROJECT PERIOD Mo./Day/Yr. From 08/09/2010	Through 09/30/2011
7. BUDGET PERIOD Mo./Day/Yr. From 08/09/2010	Through 09/30/2011

8. TITLE OF PROJECT (OR PROGRAM) *(Limit to 56 spaces)*
2010 Grants to States for Health Insurance Premium Review-Cycle I

9. GRANTEE NAME AND ADDRESS
a. Vermont Department of Banking, Insurance, Securities and Hea
b. 89 Main St
c.
d. Montpelier e. VT f. 05602-3168

10. DIRECTOR OF PROJECT (PROGRAM DIRECTOR/PRINCIPLE INVESTIGATOR)
(LAST NAME FIRST AND ADDRESS)
Christine Oliver
89 Main St
Montpelier, VT 05602
Phone: 802-828-2900

11. APPROVED BUDGET (Excludes HHS Direct Assistance)
I HHS Grant Funds Only
II Total project costs including grant funds and all other financial participation [II]
(Select one and place NUMERAL in box)

a.	Salaries and Wages	299,300	
b.	Fringe Benefits	92,783	
c.	Total Personnel Costs		392,083
d.	Consultants Costs		0
e.	Equipment		17,500
f.	Supplies		7,500
g.	Travel		2,000
h.	Patient Care – Inpatient		0
i.	Patient Care – Outpatient		0
j.	Alterations and Renovations		0
k.	Other		20,000
l.	Consortium/Contractual Costs		560,917
m.	Trainee Related Expenses		0
n.	Trainee Stipends		0
o.	Trainee Tuition and Fees		0
p.	Trainee Travel		0
q.	TOTAL DIRECT COSTS		1,000,000
r.	INDIRECT COSTS (rate of)		0
s.	TOTAL APPROVED BUDGET		$ 1,000,000
t.	SBIR Fee		
u.	Federal Share		$ 1,000,000
v.	Non-Federal Share		$ 0

12. AWARD COMPUTATION FOR GRANT

a. Amount of HHS Financial Assistance *(from item 11.u)*	1,000,000
b. Less Unobligated Balance From Prior Budget Periods	0
c. Less Cumulative Prior Award(s) This Budget Period	0
d. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	1,000,000

13. RECOMMENDED FUTURE SUPPORT
(Subject to the availability of funds and satisfactory progress of the project):

YEAR	TOTAL DIRECT COSTS	YEAR	TOTAL DIRECT COSTS
a. 2		d. 5	
b. 3		e. 6	
c. 4		f. 7	

14. APPROVED DIRECT ASSISTANCE BUDGET *(IN LIEU OF CASH):*

a. AMOUNT OF HHS Direct Assistance	0
b. Less Unobligated Balance From Prior Budget Periods	
c. Less Cumulative Prior Award(s) This Budget Period	
d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION	0

15. PROGRAM INCOME SUBJECT TO 45 CFR PART 74, SUBPART F, OR 45 CFR 92.25, SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:
(Select one and place LETTER in box.)
a. DEDUCTION
b. ADDITIONAL COSTS
c. MATCHING
d. OTHER RESEARCH (Add / Deduct Option)
e. OTHER *(See REMARKS)*

[b]

16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, HHS ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:
a. The grant program legislations cited above.
b. The grant program regulation cited above.
c. This award notice including terms and conditions, if any, noted below under REMARKS.
d. HHS Grants Policy Statement including addenda in effect as of the beginning date of the budget period.
e. 45 CFR Part 74 or 45 CFR Part 92 as applicable.
In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS: (Other Terms and Conditions Attached - ☐ Yes ☒ No)

Refer to the following Award Attachments: 1) The Standard and Special Terms and Conditions 2) Grants to States for Health Insurance Premium Review-Cycle I Quarterly Report Template 3) Data Dictionary for the Policy Rate Filing Record-Data Collection for the Rate Review Grants.

GRANTS MANAGEMENT OFFICER: *(Signature)* *(Name – Typed/Print)* *(Title)*
Gladys M. Bohler, Gmd — **Gladys Bohler** — Senior Grants Management Specialist

17. OBJ CLASS 4121	18. CRS - EIN 1036000264D8		19. LIST NO.	CONG. DIST.: 00
FY-CAN	DOCUMENT NO.	ADMINISTRATIVE CODE	AMT ACTION FIN ASST	AMT ACTION DR ASST
20. a. 0-199RE19	b. IPRPR0027A	c. IPR	d. 1,000,000	e. 0
21. a	b.	c.	d.	e.
22. a	b.	c.	d.	e.

AWARD ATTACHMENTS

Vermont Department of Banking, Insurance, Securities and Health Care — 1 IPRPR100027-01-00

1. Standard and Special Terms and Conditions
2. Grants to States for Health Insurance Premium Review-Cycle I Quarterly Report Template
3. Data Dictionary for the Policy Rate Filing Record-Data Collection for the Rate Review Grants

STANDARD GRANT CONDITIONS

1. **The HHS/Office of Consumer Information and Insurance Oversight (OCIIO) Program Official,** assigned with responsibility for technical and programmatic questions from the grantee is: Jacqueline Roche, Jacqueline.Roche@hhs.gov at OCIIO.

2. **The HHS/OCIIO Grants Management Specialist,** assigned by the GMO, with responsibility for the financial and administrative aspects (non-programmatic areas) of grants administration questions from the grantee is Gladys Bohler at Gladys.Bohler@hhs.gov at OCIIO.

3. **HHS Grants Policy Statement.** This award is subject to the requirements of the HHS Grants Policy Statement (HHS GPS). The HHS Grants Policy Statement is available at http://www.hhs.gov/grantsnet/adminis/gpd/index.htm. Please read carefully the following: (1) fraud, waste, and abuse (toll free number 800-424-5454), page I-7; (2) lobbying, page I-15; (3) costs, pages II-30 to II-44; (4) financial management systems and procedures, page II-61; (5) re-budgeting/prior approval, pages II-50 to II-57; and (6) publications, page II-73.

4. **Code of Federal Regulations:**
This grant is subject to the requirements as set forth in 45 CFR Part 92 (for State, local, and federally recognized tribal government) available at http://www.hhs.gov/opa/grants/toolsdocs/45cfr92.html.

5. **Cost Principles for State, Local and Indian Tribal Governments (OMB Circular A-87):**
This grant is subject to the requirements as set forth in Title 2 Part 225, State, Local, and Indian Tribal Governments (previously A-87)

6. **Public Reporting:** When issuing statements, press releases, requests for proposals, bid solicitations, and documents describing this project, clearly state: (1) the percentage of the total cost of the project financed with Federal money, (2) the dollar amount of Federal Funds for the project, and (3) the percentage and dollar amount of the total costs of the project that is financed by nongovernmental sources.

7. **Policy Requirements:** Debarment and Suspension as well as Drug Free Workplace are now standard terms and conditions of the award. These requirements no longer require separate certifications; however, by signing the application (either electronic signature credentials or face page of the SF-424A) the applicant certifies they are meeting the requirements of 45 CFR Part 76 (Debarment and Suspension) and 45 CFR Part 82 (Drug-Free Workplace).

Special Terms of Award (STC) - Programmatic

1. **Acceptance Letter and Assurance:** The grant award is subject to the recipient providing OCIIO a letter as acknowledgement of the award and the acceptance of all Standard and Special Terms and Conditions (STCs) within 30 days of the date of issuance of the award package. With the acceptance of this grant award, the Grantee agrees to ensure that the project is administered in accordance with the grant requirements as indicated in these STCs and that the Grantee is in compliance with the requirements of the grant funding opportunity announcement.

2. **Budget and Project Period:** The project and budget period for Premium Review Grants - Cycle 1 is from August 9, 2010 through September 30, 2011. The start date for the grants is on or after August 9, 2010. No grant funds can be used for expenses incurred prior to August 9, 2010.

3. **Revised Budget:** When the Notice of Grant Award requires the Grantee to submit a revised budget (e.g., a revised timeline, budget narrative and SF-424A section b only), these documents must be submitted within 60 days of the start of the grant period, (August 9, 2010). OCIIO will advise states of the approval of such documents within 60 days from the date the revised draft documents are received by the OCIIO.

4. **Collaborative Responsibilities:** At the request of the OCIIO, Grantees may be required to participate in scheduled activities and communications to identify and share "best practices" for health insurance premium review, including discussion of state proposals and sharing of information via public websites. The OCIIO will post general summaries of the state proposals on the OCIIO website. Quarterly and Final reports may also be posted on the OCIIO website. The Grantee is required to participate in all required communications (e.g., monitoring calls, guidance calls) as requested by the OCIIO.

5. **Required Financial Reports:** A Financial Status Report (FSR) (SF 269A – Short Form) is required from the recipient within 90 days after the end of the project period. Records of expenditures and any program income generated must be maintained in accordance with the provisions of 45 CFR 74.53 or 92.42. In addition, an Interim SF 269 report must be submitted after the first 12 months of grant activity. The Grantee will submit the FSR to the OCIIO Grant Specialist listed on this Notice of Grant Award with a copy to the OCIIO Project Officer. (The SF-269A may be accessed at the following site: http://www.whitehouse.gov/omb/grants/sf269a.pdf).

   Effective January 1, 2010, grantees are to report cash transaction data via the Payment Management System (PMS) using the Federal Financial Report (FFR or Standard Form 425) cash transaction data elements. The FFR must be filed within 30 days of the end of the quarter (instead of the 45 days allowed for filing the PSC 272). Reporting cash transaction data using the FFR replaces the use of the Federal Cash Transaction Report (SF-272/SF272A). Additional information and training are available on the Division of Payment Management website: **http://www.dpm.psc.gov/**.

A Quick Reference Guide for completing the FFR in the PMS is at http://www.dpm.psc.gov/grant_recipient/guides_forms/ffr_quick_reference.aspx

6. Required Grant Reporting

A. Requirement to Report Data to the Secretary. For Cycle I, each grant awardee is required to provide certain rate filing data to the Secretary of Health and Human Services. Included as Attachment C is the template for providing the required premium data to HHS. Operational processing and data exchange with the State awardees using the enclosed data format will begin in December 2010 to support required reporting for Cycle I grants. States unable to provide the rate filing data as required under these terms and conditions of award and as outlined in the template must provide an explanation of their inability to do so. As stated in the FOA, States are permitted to use grant funds to enhance their authority and capacity to collect and report the required data. The Office of Oversight will provide technical assistance to all state awardees over the course of the grant period to fulfill the data reporting requirements.

B. Quarterly and Final (Progress) Reports

1. The Grantee is required to submit three quarterly progress reports and one final report to the OCIIO Grant Specialist and to the OCIIO Project Officer. Quarterly progress reports are due within 30 days after the end of the quarter (see STC #7 for dates). These reports must comply with the format in Attachment B: ***Grants to States for Health Insurance Premium Review-Cycle I Template for Quarterly Progress Reports.***

2. The Grantee is required to submit a Final Report to the OCIIO Grant Specialist, with a copy to the OCIIO Project Officer, within 90 days after the project period ending date (December 31, 2011). A template for the final report will be forthcoming.

3. In each progress report (quarterly and final), the Grantee will describe the progress, and provide data on, the Grantee's impact on enhancing the rate review process for health insurance premiums in the state and efforts to report data on health insurance premiums to the HHS Secretary. The Grantee will describe each activity performed in the quarter/year and how that activity was linked to enhanced rate review practices.

4. All quarterly and final (progress) reports must be submitted electronically.

7. Data Center Requirements: As outlined in the FOA, up to $50,000 in grant funds are permitted to be used to fund an optional data center as described in Section 2794 of the Public Health Service Act. All states choosing to use grants funds to support a data center must provide the following information by October 31, 2010.

   a) Name, location and governance of Data Center. Please make certain that the data center meets the requirements as outlined in the Affordable Care Act.
   b) Full Description of Data Centers current mission;
   c) Described function and scope of work for data center;

d) Describe how proposed research will add to existing body of available fee schedule data;
e) Plans for public disclosure of data; and
f) Full and/or modified budget for the data center with a line-item breakout.

The Office of Oversight will be working with each state applicant on an individual basis to make certain the proposed data center is aligned with the requirements under the Affordable Care Act and advances the directives of this grant program.

8. The Grantee is required to notify the OCIIO Project Officer and the OCIIO Grant Specialist within thirty (30) days of any personnel changes affecting the grant's Project Director, Assistant Project Director, or the Financial Officer who is responsible for completing the Financial Status Report (SF-269A) and the Federal Cash Transactions Report (PSC-272).

9. All funds provided under this grant will be used by the Grantee exclusively for the Grants to States for Health Insurance Premium Review as defined in Section 1003 of the Affordable Care Act and as described in the grant funding opportunity announcement. If the Grantee uses these funds for any purpose other than those awarded through the OCIIO Premium Review Grants – Cycle I (or those modifications that have the prior written approval of the OCIIO Project Officer), then all funds provided under this grant may be required to be returned to the United States Treasury.

ATTACHMENT A:

Grants to States for Health Insurance Premium Review – Cycle I

TIMELINE
August 9, 2010– September 30, 2011

ACTIVITY	TIMELINE
Grant award	August 9, 2010
Grant period begins	August 9, 2010
Accept award package	September 9, 2010
Notify OCIIO of Fiscal Agent/Officer Responsible for completing the SF-269A and PSC-272	September 30, 2010
Revised Budget and SF-424A (when applicable)	Due within 60 days of award
Financial Status Report	Due 30 days after the first 12 months
Required Data Center Information	October 31, 2010
Quarterly Progress Reports	Due 30 days after the end of each Federal fiscal quarter (e.g., January 31, April 30, July 31, and October 31, 2011)
Awardees must respond to requests necessary for the evaluation of the Health Insurance Premium Review Grants as requested	As required by the OCIIO
Guidance Call for Preparation of the Final Report	To be scheduled by the OCIIO Project Officer approximately 60 days before end of grant year (e.g. July 31, 2011)
Final Report	Due 90 days after the conclusion of the grant project period (December 31, 2011)
Liquidation of all Obligations	Due 90 days after the grant period end date and prior to filing of the final Fiscal Status Report

Final Financial Status Report (FSR)	Due 30 days after the first 12 months of grant activity and 90 days after the grant period end date (December 31, 2011)
No Cost Extension Request	Should the State need a no cost extension, a written request to the Project Officer must be received no later than September 30, 2011.

ATTACHMENT B:

Grants to States for Health Insurance Premium Review – Cycle I
Quarterly Report Template

Date:

State:

Project Title:

Project Quarter Reporting Period:
Example:
Quarter 1 (08/09/2010-12/31/2010)

Grant Contact (name and title):

Email:

Phone:

Date submitted to OCIIO:

Grants to States for Health Insurance Premium Review – Cycle I
Quarterly Report Template

Reporting Period:

Grant Performance Period:	August 9, 2010 to September 30, 2011
Reporting Period:	Award Date to December 31, 2010 January 1, 2011 to March 31, 2011 April 1, 2011 to June 30, 2011 July 1, 2011 to September 30, 2011
Deadline for Delivery:	January 31, 2011 April 30, 2011 July 31, 2011 October 31, 2011

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 to protect consumers from unreasonable, unjustified and/or excessive rate increases. Section 2974 of the Public Health Service Act (PPACA Section 1003) provides for a program of grants that enable states to improve the health insurance rate review and reporting processes.

States are required to submit quarterly progress reports to OCIIO. The quarterly progress report describes significant advancements towards the State's goal of improving its current health insurance rate review and reporting process beginning from the time of approval through completion of the grant period.

The reports are due to OCIIO 30 days after the end of each quarter and must be submitted electronically.

The following report guidelines are intended as framework and can be modified when agreed upon by the OCIIO grant project officer and the State. A complete quarterly progress report must detail how grants funds were utilized, describe program progress and barriers in addition to providing an updated on all the measurable objectives of the grant program.

NARRATIVE REPORT FORMAT:

Introduction

Provide a brief overview of the project describing the proposed rate review enhancements and clearly articulating the goals, measurable objectives and milestones for each proposed enhancement.

Program Implementation Status As relevant to your project, include a discussion and update on progress towards:

1. Accomplishments to Date: implementation milestones, early outcomes, etc, include progress toward stated goals, objectives and milestones.
2. Challenges and Responses: provide a detailed description of any encountered challenges in implementing your program, the response and the outcome
3. Describe any required variations from the original timeline

Significant Activities – Undertaken and Planned

Discuss events occurring during the quarter or anticipated to occur in the new future that affect the progression of comprehensive rate review for your state. For States proposing legislative enhancements to expand their scope of rate review activities, please provide a detailed status update on the progress of all proposed grant activities undertaken in support of new legislation.

Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter, including legislative activity and proposed ways to rectify the barriers.

Please complete the following table that outlines all rate review activity under the grant program. The State should indicate "N/A" where appropriate. If there was no activity under a review category, the State should indicate that by "0."

A. Quarterly Rate Review - Progress

State	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Number of submitted rate filings					
Number of policy rate filings requesting increase in premiums					
Number of filings reviewed for approval/denial, etc.					
Number of filings approved					
Number of filings denied					
Number of filings deferred					

B. Number and Percentage of Rate Failings Reviewed – Individual Group

State	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Plan Year					
Product Type (PPO, HMO, etc.)					
Number of Policy Holders					
Number of covered lives affected					

C. Number and Percentage of Rate Failings Reviewed – Small Group

State	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Plan Year					
Product Type (PPO, HMO, etc.)					
Number of Policy Holders					
Number of covered lives affected					

D. Number and Percentage of Rate Failings Reviewed – Large Group

State	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Plan Year					
Product Type (PPO, HMO, etc.)					
Number of Policy Holders					
Number of covered lives affected					

E. Rate Filing Data

Provide data for **each rate filing** in the individual, small group and large group markets as defined in Attachment C

Public Access Activities

Summarize activities and/or promising practices for the current quarter working toward increased public access to rate review information for your state. Identify all barriers associated with increasing public access to rates and rate filing information and proposed ways to rectify the barriers.

Collaborative efforts

Describe any collaborative efforts in place that that are advancing the objectives of the Rate Review Program in your state.

Lessons Learned

Provide additional information on lessons learned and any initial promising practices

Updated Budget

Provide a detailed account of expenditures spent to date and describe whether the current allocation of funds follows the progression of the detailed budget provided in your original application. Also provide any unforeseen expenses and a brief description of the event that led its occurrence. Attach an updated detailed budget with the State's quarterly report submission.

Updated Work Plan and Timeline

Provide an updated work plan and timeline to reflect the events of the previous quarter. Highlight any additional time frames or items that were not included on the State's original submission as well as completion of milestones.

Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is ***0938-1092****. The time required to complete this information collection is estimated to average 24 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

Data Dictionary for the Policy Rate Filing Record-Data Collection for the Rate Review Grants

Data Element	*Mandatory Y/N*	*Definition*
State Abbreviation	Yes	The two digit State abbreviation as recognized by the US Postal Service
Reviewed by State Y/N	Yes	A yes/no flag used to identify whether the rate change was reviewed by the State. This value will be "no" for States that collect information but do not currently review rates and for States that "deem" rates approved.
State Review Includes Actuary Y/N	Reviewed by State is yes, otherwise, No	A yes/no flag that demonstrates if the State review process includes a review by an actuary.
Insurance Company Name	Yes	The name of the insurance company
Insurance Product Name	Yes	The name of the insurance product as sold by the insurance company
Issuer ID	Yes	The unique identifier as assigned by the HHS HIOS system.
Policy Form ID	Yes	The policy form ID of the insurance product as sold by the insurance company (NAIC policy or other ID)
Rate Filing ID	Yes	The rate filing ID of the insurance product as sold by the insurance company (NAIC policy or other ID)
New Policy Y/N	Yes	A yes/no flag that demonstrates if the policy is a New issue that has never been issued before.
Market Segment	Yes	Allowable values for market segment are: Large group, Small group, Individual, Conversion
Comprehensive Medical Coverage Type	Yes	Allowable values for comprehensive medical coverage type are: HMO, PPO, POS, FFS, EPO, Other - (please note details)
Block Status	Yes	Demonstrates if the rate for the policy is "open", "closed"
Rate Effective Date	Yes	Date that the rate is effective for the policyholders.
% Change Requested	Yes	The percentage of change approved can be a positive or negative number.
% Change Approved	No	The percentage of change requested can be a positive or negative number.
Change Period	Yes	Demonstrates the time for which the premium change is effective. Allowable values are: Annual, Semi-annual, Quarterly, Other - (Please note details)
Number Affected Insured's	Yes - unless Number Affected Policy Holders is the only data collected by the State	Total number of enrolled individuals affected by the rate change. This may be null for States that only collect policy holder counts.
Number Affected Policy Holders	Yes - unless Number Affected Insured's is the only data collected by the State	Total number of policy holders affected by the rate change. This may be null for States that only collect the number of enrolled individuals.
Member Months	Yes	The member months used for the purpose of the rate development.
Annual $ for New Rate	Yes	The dollar amount of the New Annual Rate.
Annual $ for Prior Rate	Yes	The dollar amount of the Prior Annual Rate.
SERFF Tracking Number	No	The tracking number assigned by the NAIC SERFF system assigned to the rate filing?
SERFF Rate Filing Type	No	The rate filing type as used in the NAIC SERFF system.
NAIC Company ID Number	No	The company identifier assigned by the NAIC system to identify the insurer.
Description of trend factors	No	Text description of trend factors and rating factors used in developing the rate
Benefit Adjusted Y/N	Yes	A yes/no flag used to identify if the benefits were adjusted or changed for the period.
Deductible Increase Y/N	Yes	A yes/no flag used to identify if the deductible amount was increased.
Benefit Increase Y/N	Yes	A yes/no flag used to identify if the services bevefits were increased.
Benefit Decrease Y/N	Yes	A yes/no flag used to identify if the services bevefits were decreased.
Cost Sharing Y/N	Yes	A yes/no flag used to identify if there are cost sharing requirements for the rate.
Coinsurance Y/N	Yes	A yes/no flag used to identify if there are coinsurance requirements for the rate.
Primary Care Copayment Amount	Yes	The copayment required at the primary care doctors office that coincides with the rate
Specialist Care Copayment Amount	Yes	The copayment required at specialty care doctors office that coincides with the rate
Inpatient Hospital Copayment Amount	Yes	The copayment required for inpatient hospitalization that coincides with the rate

Data Dictionary for the Policy Rate Filing Record-Data Collection for the Rate Review Grants

Data Element	*Mandatory Y/N*	*Definition*
Outpatient Hospital Copayment Amount	Yes	The copayment required for outpatient hospitalization that coincides with the rate
Generic Pharmacy Copayment Amount	Yes	The copayment required for generic drugs at the pharmacy that coincides with the rate
Brand Pharmacy Copayment Amount	Yes	The copayment required for brand name drugs at the pharmacy that coincides with the rate
Total Earned Premium Amount - Prior year	Yes	The total dollar amount collected for the purpose of premium payments.
Total Incurred Claims Amount - Prior year	Yes	The total dollar amount paid for services incurred.
Disposition of Rate Review	No	The disposition of the rate review, e.g. "approved," denied", "deferred",
Prospective Rate % Attributed to Claims and Capitation	Yes	The prospective percent of the rate increase attibuted to historical Claims and Capitation
Prospective Rate % Attributed to Admin	Yes	The prospective percent of the rate increase attibuted to historical Admin increase
Prospective Rate % Attributed to Broker Commissions	Yes	The prospective percent of the rate increase attibuted to historical Claims and Capitation increase
Prospective Rate % Attributed to Premium Taxes	Yes	The prospective percent of the rate increase attibuted to historical Premium tax increase
Prospective Rate % Attributed to Assessment Fees	Yes	The prospective percent of the rate increase attibuted to historical assessment fee increase
Prospective Rate % Attributed to Federal Taxes	Yes	The prospective percent of the rate increase attibuted to historical Federal tax increase
Prospective Rate % Attributed to Reserves	Yes	The prospective percent of the rate increase attibuted to historical reserves increase
Medical Price % Change	Yes	The medical price percentage of change used to develop the rate
Medical Utilization % Change	Yes	The medical utilization percentage of change used to develop the rate
Medical Trend % Insufficient Prior Rate	Yes	The percentage of historical insufficient prior rate used as a factor to develop the current rate
Overall Medical Trend % Increase	Yes	Derived data - The prospective total of the Medical Price % Change, Medical Utilization % Change, and the Medical Trend % Insufficient Prior Rate

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1092. The time required to complete this information collection is estimated to average (24 hours) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Payment Management System information for Recipients of the Department of Health and Human Services

The Payment Management System (PMS) is a centralized grants payment and cash management system, operated by the HHS Program Support Center (PSC), Division of Payment Management (DPM). The Payment Management System accomplishes all payment-related activities for HHS grants from the time of award through closeout of a grant. In addition, the Payment Management System provides these same services for several major Federal agencies outside of HHS. DPM, in operating the PMS, acts as the intermediary between awarding agencies and grant recipients.

The recipient registration process differs depending on whether the grant award is from an agency within the Department of Health and Human Services **(HHS)** or one from a **non-HHS** Federal agency or department. The information that follows is for HHS recipients.

The issuance of grant awards and other financial assistance is the responsibility of the awarding agencies. The Division of Payment Management does not award grants. Once an award is made by the HHS agency, the funds are posted in recipient accounts established in the Payment Management System (PMS). Grantees may then access their funds by using the Smartlink funds request process.

The SMARTLINK funds request process enables grantees to request funds using a Personal Computer with an Internet connection. The funds are then delivered to the recipient via Electronic Funds Transfer (EFT).

The Forms found on the Division of Payment Management website are the required forms for submitting data for input into the Payment Management System (PMS).

While these forms are similar to *Standard Forms* (SF) used throughout federal and state governments, the forms or the completion instructions have been modified for use in PMS.

Click on the form name for a direct link to:

Smartlink Instructions.doc

If you cannot submit your funds request via SMARTLINK, please contact your PMS Account Liaison.

Information We Need From the Recipient: 1199A Form and DPM Payment Management System Access Form:

- An 1199A Direct Deposit Form must be submitted to DPM by the recipient before processing any requests for funds.

  If recipients have already submitted an 1199A, and the information previously provided changes, a new 1199A form must be submitted reflecting the changes.

- **Grantee Banking Information - SF 1199A (English)**
- **Grantee Banking Information - SF 1199A (Espanol)**

The DPM Payment Management System Access Form is attached. This form must accompany the original SF1199A.

Division of Payment Management PMS Acc

IMPORTANT NOTE: All completed SF1199A forms (i.e. Direct Deposit Sign Up forms) must bear ORIGINAL SIGNATURES in Sections 1 and 3 ("Payee/Joint Payee Certification" and "Financial Institution Certification").

ALL "**original**" documents should be forwarded to the following address.

Division of Payment Management
Regular Mail Only – Post Office Box 6021, Rockville, MD 20852
Express Mail Only – 5600 Fishers Lane – Parklawn Bldg Room 11-33, Rockville, MD 20857

Information You Need From PMS: User Name and Password

The recipient must obtain a User Identification Name and Password prior to attempting to access funds PMS. However, the necessary forms as noted above must be submitted to PMS before the recipient is provided a User Name and Password.

If you need help with your User Identification Name and Password, please contact **PMSsupport@psc.hhs.gov** or (877) 614-5533 for assistance. If you have any questions or require any assistance, please contact your PMS Account Liaison.

PMS Reporting Requirements: FFR User Form

The Federal Financial Report (FFR) Federal Cash Transaction Report (FCTR) formerly known as the PSC 272 Electronic Report is one component of the Federal Financial Report (FFR)-425. The FFR has replaced the PSC-272. The new FFR form and the FFR Attachment for reporting disbursements for multiple Contracts must be filed.

The FFR cash transaction reports must be filed within **30 days** of the end of the quarter (instead of the 45 days allowed for filing the PSC-272).

PMS Training

Training on the payment management process through PMS is available. To submit your training request please send an e-mail to **PMS_Training@psc.hhs.gov** and place the phrase "Request for GRT Class" in the subject line of your email message.

Vermont Rate Review Enhancement Project
Project Abstract

Overall goal. Vermont law requires the prior approval of health insurance rates by the Vermont Department of Banking, Insurance, Securities and Health Care Administration (Department). The Department proposes to enhance its rate review process to accomplish the overall goal of offering consistent, comprehensive and effective regulation of health insurance rates for all carriers and all markets, in order to ensure that health insurance rates are neither unjust, unfair, inequitable, excessive, inadequate or unfairly discriminatory.

Rate Review Enhancements. The following initiatives will be undertaken to achieve Vermont's overall goal during the Cycle 1 time period:

A. Expand the scope of current review and approval activities by conducting reviews of large group rates; and rate review of minor lines of health insurance such as student blanket policies.

B. Improve rate filing requirements by developing rate filing standards; and by collecting informational data for plans administered by Third Party Administrators.

C. Enhance the rate review process by verifying claims experience and by analyzing public program mitigation.

D. Enhance the rate review process with a significant upgrade in Vermont's IT capacity. IT enhancements will include: updating the NAIC's SERFF program to include federal reporting elements; collecting and integrating historical rate filing data with current filed data; customizing Vermont's all payer claims utilization and reporting system to support rate review; consolidating carrier "carve-out" data; providing claims reporting by product type; and providing claims reporting by provider.

E. Enhance consumer protection standards by posting readable, layperson summaries of rate increase requests on the Department's website; and by adding a ratepayer comment functionality to the Department's website.

Project Budget. The total budget for the Vermont Rate Review Enhancement Project for the Cycle 1 time period is one million ($1,000,000.00) dollars. The Department intends to use these grant funds to employ or contract with additional actuaries; rate analysts; a data entry clerk; a claims analyst; and a grant administrator. The Department will support the Project through the allocation of time by existing staff, but does not intend to use grant funds for existing staff.

Vermont . . .

Department of Banking, Insurance, Securities and Health Care Administration

July 7, 2010

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

Re: Grants to States for Health Insurance Premium Review - Cycle I
CFDA: 93.511
Opportunity No. RFA-FD-10-999

Dear Secretary Sebelius:

The Vermont Department of Banking, Insurance, Securities and Health Care Administration (hereinafter "the Department"), on behalf of the State of Vermont, hereby makes Application for the above-referenced grant.

The over-all project to be funded by the grant will be called "The Vermont Rate Review Enhancement Project."

The Project Leader will be: Christine Oliver, Deputy Commissioner
Division of Health Care Administration
89 Main Street, Montpelier, VT 05620-3101;
802-828-2900; christine.oliver@state.vt.us

The Department has existing authority under Vermont law to oversee, coordinate and implement the rate review enhancement activities described in the Project Narrative. Title 8, Vermont Statutes Annotated, Sections 12 and 4062; Title 18 Vermont Statutes Annotated, Sections 9403 and 9410(h).

The Department further certifies, subject to the Department's annual appropriation enacted by the Vermont General Assembly, that the state share of funds expended for rate review activities under this Application will not be less than the funds expended during State fiscal Year 2011, and that the grant funds will not supplant existing state appropriations.

Please let me or Deputy Commissioner Oliver know if there are any questions concerning this application.

Yours truly,

Michael S. Bertrand, Commissioner

Federal Rate Review Grant

Project number →				I	II	III	V	VI
			Total Budget	25%	25%	35%	10%	5%
Personnel	$	149,650	$ 299,300	$ 74,825	$ 74,825	$ 104,755	$ 29,930	$ 14,965
Fringe benefits	$	46,392	$ 92,783	$ 23,196	$ 23,196	$ 32,474	$ 9,278	$ 4,639
Travel	$	1,000	$ 2,000	$ 500	$ 500	$ 700	$ 200	$ 100
Equipment	$	8,750	$ 17,500	$ 4,375	$ 4,375	$ 6,125	$ 1,750	$ 875
Supplies	$	3,750	$ 7,500	$ 1,875	$ 1,875	$ 2,625	$ 750	$ 375
Space/rental	$	10,000	$ 20,000	$ 5,000	$ 5,000	$ 7,000	$ 2,000	$ 1,000
Contracts/sub-contractors	$	-						
Actuarial services	$	112,900	$ 225,800	$ 56,450	$ 56,450	$ 112,900		
Update SERF	$	-	$ 18,808				$ 18,808	
Enhance IT	$	-	$ 316,309				$ 316,309	
Construction	$	-	$ -					
Other	$	-	$ -					
Total direct	$	332,442	$ 1,000,000	$ 166,221	$ 166,221	$ 266,579	$ 379,025	$ 21,954
Indirect staff time*								
Grand Totals			$ 1,000,000	$ 166,221	$ 166,221	$ 266,579	$ 379,025	$ 21,954

*Department staff will support activities above but no funds have been requested in the grant.

Personnel detail

2 Rate analysts	$ 145,000	Travel, equip, & supplies based on number of people employed
1 Data entry & support staff	$ 40,000	Fringe budgeted at 31% of salary.
1 Claims analyst	$ 62,300	
1 Grant Administrator	$ 52,000	
	$ 299,300	

Project Narrative – The Vermont Rate Review Enhancement Project

Section 1. Current health insurance rate review capacity and process

A. General health insurance rate regulation in Vermont

The rates and rate increases of all group and health insurance product lines are reviewed and approved before use by the Vermont Department of Banking, Insurance, Securities and Health Care Administration ("the Department"). The actual premium to be charged subscribers in large groups for large group comprehensive insurance is not reviewed; however the trend and rating methodology used to produce the premium must be approved by the Department.

Vermont's rating rules have been established in statute and regulation. Vermont's general authority to review health insurance rates is pursuant to 8 V.S.A §§ 4062 and 4515a.[1] In the small group market, a small group carrier must offer a small group plan rate structure which at least differentiates between single person, two person and family rates, must use a community rating method, acceptable to the Commissioner, to determine premiums, is prohibited from using medical underwriting and screening, and must guarantee rates on a small group plan for a minimum of six months. 8 V.S.A § 4080a.

Similar rules apply to the non-group market. 8 V.S.A § 4080b. In addition, the Commissioner must disprove any nongroup rates unless the anticipated loss ratios for the entire period for which rates are computed are at least 70 percent. 8 V.S.A § 4080b(m).

The Department has adopted the following regulations relating to the rate review process: Regulation 91-4b, Minimum Regulation for Compliance with 8 V.S.A. § 4080a; Regulation 93-5, Minimum Regulation for compliance with 8 V.S.A. § 4080b; and Regulation H-99-4 Community Rating & Approval of Community Rating Formulas.

B. Health insurance rate review and filing requirements in Vermont

[1] See Appendix 1 for copies of Vermont's health insurance rate review statutes and regulations.

All rates for health insurance products are subject to review and must be approved prior to use. For health insurance rate filings submitted to the Department, health insurers must provide: an actuarial memorandum, signed and dated by a qualified actuary and supporting documentation (e.g., claims experience, historical loss ratios). The specific exhibits and documents are submitted directly to the Department via the System for Electronic Rates and Form Filings ("SERFF") program administered by the National Association of Insurance Commissioners ("NAIC").

Generally, in reviewing a rate filing, Vermont examines the past history of rate changes; past Vermont experience; past nationwide experience; projected Vermont experience; projected nationwide experience; Vermont lifetime loss ratios; nationwide lifetime loss ratios; the credibility of Vermont experience; the health insurer's administrative costs, rating manuals, loss ratios, adequacy of reserves, and profitability or surplus. Also, if necessary, the Department will examine regional past experience, regional projected experience and regional lifetime loss ratios. A rate analyst and the Director of Rates & Forms review all health product line rate filings.

The rate filings of insurers representing the largest market share of comprehensive medical coverages are reviewed by the Department's contracted actuarial firm. The Department's contracted actuaries review medical trends submitted by an insurer, and calculate an independent range for the trends using their own proprietary software. Contracted actuaries compare the medical trends used in the insurer's rate filing to their independent calculations. For a rate filing to be approved the health insurer's proposed medical trends must be within the actuary's acceptable range. If the rate filing is found deficient during review, the filing is declined. When a rate filing is declined the carrier may respond and correct the deficiencies. If the carrier is unable to correct the deficiencies, the filing is closed and no rate increase is allowed.

C. An explanation of the current level of resources and capacity for reviewing health insurance rates: information technology (IT) and system capacity

All rate filings are required to be made electronically and via SERFF. The Department does not have any additional IT resources available to support its rate review capacity. The State of Vermont has established the Vermont Healthcare Claims Uniform Reporting and Evaluation System ("VHCURES"), "to continuously review health care utilization, expenditures, and performance in Vermont." 18 V.S.A. § 9410. VHCURES is administered by the Department, and includes de-identified eligibility records and medical and pharmacy claims for over 330,000 privately insured Vermonters or about 80 percent of the privately insured population. The paid claims data includes diagnosis codes, procedures codes, facility codes, billing and service provider information, charges, and amount paid including insurer payments and member payments (deductible, copayments, coinsurance).[2] In its current form, VHCURES cannot be utilized to support Vermont's rate review process, but there is substantial potential for enhancing the rate review process by integrating the review process with VHCURES.

D. An explanation of the current level of resources and capacity for reviewing health insurance rates: budget and staffing

The annual overall total budget for the Division of Health Care Administration for State fiscal Year 2011 is $4,741,907. This funding supports a number of programs in addition to the rate review program, including: hospital budget approval; the Certificate of Need program; quality assurance; consumer services; public service outreach; data analysis, market conduct; and enforcement.

The Division's annual budget allocated for rate review is $501,580. Of this amount, approximately $401,264 is allocated for review of health insurance rates in the individual and small group/association markets.

Vermont currently has a full time person reviewing all rate increase requests. The one rate reviewer closed 516 filings in the past year ending May 12, 2010. The number of closed rate

[2] The VHCURES report on expenditures and utilization published in January 2010 is attached as Appendix 2.

filings does not take into account that each rate filing averages three reviews by the analyst, because the initial carrier filings can be insufficient or cannot be approved. Thus, on average, the 516 closed rate filings represent 1,548 actual reviews. The Department's rate analyst has approximately twenty-two years of experience in the insurance field, including work as senior actuarial analyst and Director of Rates and Forms (Life & PC). The rate analyst has a Bachelor of Science (BS) degree in Mathematics and Management. $87,000 is budgeted to support the rate analyst.

The Director of Rates and Forms supervises and manages the rate review process, along with other duties, and provides legal support. The Director of Rates and Forms has a law degree, a MPH degree, and a BS degree. In addition to the present position, the Director of Rates and Forms has served as staff attorney at Vermont Legal Aid and had a supervisory position for two community based epidemiology studies while on staff at the University of Minnesota's School of Public Health. $14,580 is budgeted from the Department's Administration Division (General Counsel's Office) to support the rate review functions of the Director of Rates and Form.

The Department also contracts with Oliver Wyman for actuarial services. The principal contracted actuary has over twenty-five years of experience and has earned both a FCA and MAAA. $400,000 is budgeted to support this contract.

E. Consumer Protections

All rate filings made with the Department are open to the public pursuant to the Vermont Public Records Law (1 V.S.A. Chapter 5, Subchapter 3). A carrier may request the Department to keep portions of the rate filing confidential, upon a proper showing that the material is a trade secret. 1 V.S.A. § 317(c)(9). Rate filings can be reviewed on the Department's public computer, via a read-only access to SERFF system. The Department also produces a **Consumer Tips**

publication, which contains small-group and individual rates for specific companies and specific plans.[3]

Layperson summaries of rate changes are currently not offered for consumers, but the Department anticipates this can be accomplished as part of the Vermont Rate Review Enhancement Project.

F. Examination and oversight

The State of Vermont requires prior approval before any proposed rate increase can take effect. Over the past two years, there have been multiple instances when the Department has denied a health insurer's request for a rate increase. In most of these instances, the health insurer has voluntarily lowered the proposed rate increase. The Department is unable to quantify the exact number of policyholders affected, however, it is safe to conclude that a significant number of Vermont policyholders have been impacted by these proactive determinations.

On occasion, a health insurer has appealed the Department's determination to deny a rate increase, pursuant to 8 V.S.A § 4062. Over the past two years, carrier appeals have led to two formal hearings, following which the Commissioner issued written decisions denying the appeals. One such decision included a Supplemental Order, pursuant to the Commissioner's authority under 8 V.S.A. § 4513(c), directing the carrier to engage in additional cost containment activities, and ordering a ratepayer refund of excessive executive compensation amounts.[4]

Section 2. Proposed rate review enhancements for health insurance

Introduction

As described in Section 1, above, the Department administers a comprehensive, rigorous health insurance rate review process. Nevertheless, the Department can enhance its current rate review process by means of the following initiatives.

A. Expanding the scope of current review and approval activities.

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[3] See Appendix 3
[4] See Appendix 4.

The Department proposes an appropriate level of rate review for all carriers, in all markets.

Large group market rates are not filed for review and approval; rather, the Department reviews and approves a rating formula included within the carrier's "rate manual", and the Department reviews and approves a medical trend factor and other factors that are incorporated into the carrier's rate manual. For minor lines of health insurance such as student health insurance policies, which are filed as "blanket" health insurance, the Department's rate review process is an abbreviated one.

Ratepayers in the large group market and in minor lines markets would benefit from a more thorough rate review approval process.

Proposed enhancements:

1. Goal: Effective rate review in all insurance markets. Measurable objective, timeline, and milestone for change: By September 30, 2011 the Department will establish procedures for annual rate reviews of rates in the large group market. The Department anticipates review of large group rates beginning for calendar year 2012 rates. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $83,111.[5]
2. Goal: Rate review of minor lines of insurance. Measurable objective, timeline and milestone for change: By July 1, 2011 the Department will establish procedures for rate reviews of minor lines of insurance such as student health insurance. The Department anticipates review of rates for minor lines insurance beginning with rate filings made after October 1, 2011. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $83,110.

B. Improving rate filing requirements.

[5] All cost estimates are for the Cycle 1 time period.

The Department proposes to standardize rate filing requirements, in order to strengthen the rate review process, and to improve communications with ratepayers. The Department also proposes to collect rate and benefit plan information for all Vermont markets, in order to increase the Department's capacity to analyze market trends, and thereby strengthen the rate review process.

Carriers include different information, in different formats, when filing rate requests with the Department. As a result, comparison between rate filings of each carrier is difficult. Some filings do not include information concerning the benefit plan (cost sharing, network limitations and coverage) for which a specific rate increase is sought. In addition, carriers' rate filings are written in technical language, and therefore are difficult for the layperson ratepayer to understand.

The Department also proposes to require Third Party Administrators to make information-only filings relating to benefits, coverages, enrollment and costs so that the Department will have a better understanding of the Vermont health insurance market as a whole, and thus be better able to review and analyze rates in the regulated health insurance markets.

Proposed enhancements:

1. Goal: Adopt standards for carrier rate filings. Measurable objectives, timeline and milestone for change: By July 1, 2011, the Department will establish and publish standards for carrier rate filings, including a requirement that a description of each benefit plan be linked with the rate request for that plan, and a requirement of narrative, layperson summary of the rate increase request. The Department anticipates that its filing standards will be applicable to rate filings beginning for calendar year 2012. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $83,110.
2. Goal: Informational filings by Third Party Administrators. Measurable objectives, timeline and milestone for change: By September 30, 2011, the Department will establish

and publish standards for annual, informational filings by Third Party Administrators of benefits, coverages, enrollment and costs for each benefit plan administered. The Department anticipates that its TPA filing standards will be effective on and after January 1, 2012. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $83,111.

C. Enhanced review process – verification of filed rate information.

The Department proposes to enhance the accuracy and credibility of the rate review process by conducting periodic examinations of carriers' claims experience. This capacity is particularly important with respect to Vermont's Catamount Health premium subsidy program for the uninsured, and with respect to benefit and coverage changes required by the Patient Protection and Affordable Care Act ("PPACA"). Anecdotal observations have suggested that considerable migration takes place between Catamount Health[6] and VHAP[7] because of differences in eligibility and pre-existing condition limitations of the two programs. Carriers will be making assumptions about the cost of implementing the benefit and coverage requirements of the PPACA without significant experience upon which to base those assumptions.

Proposed enhancements:

1. Goal: Examine claims experience based on new federal requirements. Measurable objectives, timeline and milestone for change: By July 1, 2011 the Department will collect early claims experience in order to validate or change the estimated rate increments which have been included by carriers to account for changes in benefits and coverages required by federal law. Resources needed: allocate time of existing staff, and

[6] Catamount Health is a premium subsidy program for the uninsured with household income between 150-300% FPL, with a policy issued by a private carrier. It is funded by state and federal funds in accordance with a Section 115 Medicaid waiver.
[7] VHAP is a Medicaid-administered Section 115 waiver program for Vermont residents with household income under 150% FPL.

hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $98,213.

2. Goal: Migration analysis. Measurable objectives, timeline and milestone for change: By July 1, 2011, the Department will collect information on the relationship between the Catamount Health program and the VHAP, in order to validate or change the estimated claims costs assumed by carriers for Catamount Health insureds. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $98,214.
3. Goal: Targeted data verification examinations. Measurable objectives, timeline and milestone for change: By July 1, 2011, the Department will begin to conduct targeted examinations to validate or change the assumptions used by carriers in their rate filings. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services, as further described in Section 2 (D). Estimated cost: $70,152.

D. Enhance rate review process – staffing.

The Department proposes to increase its professional staffing and/or contracted resources allocated to the health insurance rate review process.

The enhancements in the scope and depth of rate review and analysis contemplated by the Department and described in this Application will require professional resources in addition to current staffing and contracting resources.

Proposed enhancements:

Goal: Increase professional resources for rate review. Measurable objectives, timeline and milestone for change: Throughout the course of the Cycle 1 time period, beginning in September, 2010, the Department proposes to increase its professional resources for health insurance rate review functions, as set forth below, and as described further in Section 2 (A), (B), (C), (E) and

(F). The options for increasing professional resources will be either by hiring Department employees, or by contracting for professional services, or both. Staff may be hired to either temporary or permanent positions. The options chosen will be based in part on whether the Department will be authorized to hire for new positions and what type of positions will be authorized, and in part on the Department's judgment as to the availability of funds to support these additional resources in future years. It is anticipated that acquisition of additional actuarial resources will be accomplished by contract.

1. Two (2) professional actuaries. Estimated cost: $225,800.
2. Two (2) rate analysts with actuarial experience. Estimated cost: $180,000.
3. One (1) data entry clerks. Estimated cost: $50,000.
4. One (1) claims analyst. Estimated cost: $90,000.
5. One (1) grant administrator. Estimated cost: $68,500.

E. Enhanced rate review process – IT capacity.

(a) Rate filings.

The Department proposes to enhance its rating filing IT infrastructure (1) to report on current rate filing components in Vermont in accordance with the information required to be reported to the Secretary of HHS (see Section 3 below), and (2) to integrate the reporting of current data with the collection and reporting on historical rate filing components. Both current and historical data is critical for the Department's understanding and analysis of trends in health insurance markets and health insurance rates, as well as for the Department's ability to communicate with essential constituencies, including but not limited to the HHS Secretary, the Vermont Legislative and Executive Branches, business and individual ratepayers, carriers, hospitals, physicians, and other health care providers.

(b) Rate review supported by claims data.

The Department proposes to customize use of claims data to provide a powerful tool for rate review, in order to improve information symmetry between the regulator and regulated entities, and to enhance the Department's flexibility and effectiveness in analyzing insurance markets, and in reviewing carrier rate requests.

The State of Vermont has established VHCURES, an all payer claims database intended "to continuously review health care utilization, expenditures, and performance" in Vermont. 18 V.S.A. § 9410. Vermont is one of a very few states in the country to have established such an all payer claims database.

VHCURES can make available to the rate review process actual eligibility, product, provider and claims data, which will allow the Department to critically analyze assumptions used by insurers to set proposed rates, including demographics and health status ("My members are older and/or sicker"); reimbursement ("My members use more expensive facilities and providers"); and cost drivers ("My members use more services and/or more expensive services"). The Department proposes to utilize the VHCURES IT program in a manner specifically customized to support the rate review process.

Strengthening of the Department's rate view process through enhanced IT capacity and resources will be accomplished by means of four VHCURES IT initiatives, as follows:

First: the Department proposes to customize VHCURES reporting to support rate review. In reviewing trends in health insurance utilization and expenditures, actuaries use regional and national averages and benchmarks for specified categories of expenditures such as hospital inpatient, hospital outpatient, physician office visits including primary and specialty care consultation, prescription drugs, durable medical equipment, etc. VHCURES reporting currently categorizes utilization and expenditures in close alignment with the National Health Expenditures categories published by the Centers for Medicare and Medicaid Services (CMS) as applicable to commercial health insurance. This first IT initiative will enable the rate review process to

compare the VHCURES categorization to the categorization used traditionally by actuaries, resulting in greater accuracy in assessing carrier utilization and expenditures, and in identifying cost drivers.

Second, the Department proposes to consolidate carrier "carve-out" data to permit better analysis of filed rate information. Most major insurers with carve-outs submit a consolidated file for medical members, including a single eligibility file for medical, mental health, and pharmacy claims. Benefits covered by one major carrier are also carved-out, but three separate companies submit eligibility and claims records to VHCURES. This VHCURES IT enhancement will consolidate expenditure and utilization reports, thereby strengthening the rate review process for the plans issued by this carrier.

Third, the Department proposes to increase the depth of rate analysis by providing claims reporting by product type. VHCURES currently reports expenditures and utilization at the major insurer level, accounting for over 90 percent of the privately insured market including the insured market and self-insured employer market for comprehensive health benefits. The data is also reported at the hospital service area level to support population-based comparison of rates. Within the VHCURES data set for every insurer, every member eligibility record and claim is coded with Insurance Product Type that for comprehensive major medical benefits includes HMO, PPO, POS, EPO, and indemnity. After the appropriate categories are developed for reporting expenditures and utilization as discussed above, reports by insurance product type would be generated by major insurer to aid in rate review of products by insurance type.

Fourth, the Department proposes to identify claims by provider, thereby creating the capacity to identify and analyze cost drivers, and to compare carrier effectiveness in addressing those cost drivers. Health services and actuarial research and literature have identified cost drivers in health care with robust trends in increased utilization and contribution to rising cost with potentially marginal health benefits. Insurers, payers, purchasers, and providers are interested in

understanding trends in utilization of cost drivers such as advanced imaging, potentially avoidable hospital admissions, readmissions, and emergency department use, and use of prescription drugs. The capability to drill down on cost drivers and identify facilities and providers associated with significant expenditures and utilization would bring a valuable perspective and refinement to the rate review process. To develop this capability requires development and maintenance of an accurate Master Provider Index ("MPI") of both facility claims and professional claims.

Proposed enhancements:

1. Goal: Enhanced rate data collection and reporting. Measurable objectives, timeline and milestone for change: Within three months (initial enhancement), and within eight months (additional enhancement) following the receipt of HHS reporting requirements, the Department will collaborate with other states through the NAIC and its SERFF program in order to improve the IT, analysis and reporting capacity of the Department with respect to rate review. Vermont already requires carriers to file their proposed rates with SERFF.[8] Estimated cost: $18,808.[9]
2. Goal. Integration of historical and current rate data. Measurable objectives, timeline and milestone for change: By September 30, 2011 the Department will collect and integrate historical rate information with the current information reported through SERFF, in order to better understand rate and market trends over time, and to better communicate with consumers and other stakeholders. Resources needed: allocate time of existing staff, and hire and/or contract for additional professional and clerical services. Estimated cost: $20,000.
3. Goal: Customize VHCURES reporting to support rate review. Measurable objectives, timeline and milestone for change: By September 30, 2011, the Department will establish

[8] The SERFF proposal is submitted as Appendix 5.
[9] The cost to the Department to duplicate the IT functions and reporting capability of SERFF have not been estimated, but are anticipated to be many multiples of the estimated cost utilizing the SERFF program.

a collaborative relationship between VHCURES staff and the Department's actuarial consultant and rate analysts to identify alternative claims data categorizations, and thereby support enhanced evaluation of carrier filing data, trends and cost drivers. Resources needed: contract for VHCURES enhancements. Estimated cost: $99,372.

4. Goal: Consolidate carrier "carve-out" data. Measurable objectives, timeline and milestone for change: By September 30, 2011 the Department will contract for changes to the VHCURES system in order to support the consolidation of carrier "carve-out" data. Resources needed: contract for VHCURES enhancements. Estimated cost: $10,000.
5. Goal: Claims reporting by product type. By September 30, 2011 the Department will contract for a VHCURES IT enhancement to permit a review of rate filings in collaboration with the Rate and Form Unit's consultants by product type. Resources needed: allocation of current staff time, hiring or contracting for a claims analyst, and increased VHCURES contractual resources. Estimated cost: $145,845.
6. Goal. Claims reporting by provider. Measurable objectives, timeline and milestone for change: By September 30, 2011, the Department will contract for a VHCURES IT enhancement to permit a linkage between claims and providers, thereby enhancing the rate review process by identifying cost drivers in the health care system. Resources needed: develop and maintain an accurate Master Provider Index ("MPI") for both facility claims and professional claims. Estimated cost: $85,000.

F. Enhancing consumer protection standards.

Under Vermont law, the rate review process is a public, open process. Carrier rate filings are public records subject to disclosure to consumers (other than proprietary, trade secret information), and Vermont law requires 45 days advance notice to ratepayers before the proposed effective date of a rate. The Department proposes additional measures to enhance its existing consumer protection standards.

Proposed enhancements:

1. Goal. Layperson summaries of rate filings. Measurable objectives, timeline and milestone for change: By July 1, 2011 the Department will establish requirements for carriers to file layperson-friendly summaries of rate filings. Beginning for calendar year 2012 rate requests, the Department will post these summaries on the Department's website. Resources needed: allocation of existing staff time. Estimated cost: $9,440.
2. Goal. Ratepayer comment opportunity. Measurable objectives, timeline and milestone for change: By July 1, 2011 the Department will design its website to offer a ratepayer comment and/or forum opportunity for carrier rate increase requests. Beginning for calendar year 2012 rate requests, the Department proposes to incorporate these website functionalities on the health insurance rate portion of its website. Resources needed: allocation of existing staff time. Estimated cost: $12,514.

Section 3. Reporting to the Secretary on rate increase patterns

The Department attests that it will comply with the requirements of the PPACA with respect to required reporting to the Secretary of HHS. As described in Section 3(E), above, the Department intends to collaborate with other states through the NAIC and its SERFF program in order to improve the IT, analysis and reporting capacity of the Department with respect to rate review.

Section 4. Optional data center funding

The Department does not intend to request optional data center funding for compiling and publishing fee schedule information, as described in the grant Announcement.

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

BASIC GRANT INFORMATION	
1. Agency:	
2. Department:	Department of Banking, Insurance, Securities and Health Care Administration
3. Program:	Rates and Forms (Health Care Administration)
4. Legal Title of Grant:	2010 Grants to States for Health Insurance Premium Review-Cycle 1
5. Federal Catalog #:	CFDA: 93.511

6. Grant/Donor Name and Address:
Department of Health & Human Services, Office of Consumer Information & Insurance Oversight, Grants, 7501 Wisconsin Ave West Tower, Room 10-15, Bethesda, MD 20814-6519

7. Grant Period:	**From:**	8/9/2010	**To:**	09/30/2011

8. Purpose of Grant:
To enhance Vermont's rate review process for health insurance in 2010 and 2011.

9. Impact on existing program if grant is not Accepted:
Department's ability to implement health care reform as mandated by ACA will be compromised.

10. BUDGET INFORMATION

	SFY 1	SFY 2	SFY 3	Comments
Expenditures:	**FY** 2011	**FY** 2012	**FY**	
Personal Services	$715,551	$238,516	$	
Operating Expenses	$40,933	$5,000	$	
Grants	$	$	$	
Total	$756,484	$243,516	$	
Revenues:				
State Funds:	$	$	$	
Cash	$	$	$	
In-Kind	$	$	$	
Federal Funds:	$	$	$	
(Direct Costs)	$756,484	$243,516	$	
(Statewide Indirect)	$	$	$	
(Departmental Indirect)	$	$	$	
Other Funds:	$	$	$	
Grant (source)	$	$	$	
Total	$756,484	$243,516	$	

Appropriation No:	2210040000	**Amount:**	$1,000,000
			$
			$
			$
			$
			$
			$
		Total	$1,000,000

REC'D SEP 03 2010

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

PERSONAL SERVICE INFORMATION

11. Will monies from this grant be used to fund one or more Personal Service Contracts? ☒ Yes ☐ No
If "Yes", appointing authority must initial here to indicate intent to follow current competitive bidding process/policy.

Appointing Authority Name: Michael Bertrand Agreed by: MSB (initial)

12. Limited Service Position Information:	**# Positions**	**Title**
	2	Rate Analysts
	1	Administrative Assistant
	1	Claims analyst
	2	1 Grant Program Administrator and 1 Rates and Forms Actuary
Total Positions	6	

12a. Equipment and space for these positions: ☐ Is presently available. ☐ Can be obtained with available funds.

13. AUTHORIZATION AGENCY/DEPARTMENT

I/we certify that no funds beyond basic application preparation and filing costs have been expended or committed in anticipation of Joint Fiscal Committee approval of this grant, unless previous notification was made on Form AA-1PN (if applicable):

Signature:	Date: 8/31/2010
Title: Commissioner	
Signature:	Date:
Title:	

14. SECRETARY OF ADMINISTRATION

☐ Approved: 2A (Secretary or designee signature) Date: 9/2/10

15. ACTION BY GOVERNOR

☑ Check One Box: Accepted (Governor's signature) Date: 9/27/10

☐ Rejected

16. DOCUMENTATION REQUIRED

Required GRANT Documentation

☐ Request Memo	☐ Notice of Donation (if any)
☐ Dept. project approval (if applicable)	☐ Grant (Project) Timeline (if applicable)
☐ Notice of Award	☐ Request for Extension (if applicable)
☐ Grant Agreement	☐ Form AA-1PN attached (if applicable)
☐ Grant Budget	

End Form AA-1

STATE OF VERMONT
Joint Fiscal Committee Review
Limited Service - Grant Funded
Position Request Form

This form is to be used by agencies and departments when additional grant funded positions are being requested. Review and approval by the Department of Human Resources must be obtained prior to review by the Department of Finance and Management. The Department of Finance will forward requests to the Joint Fiscal Office for JFC review. A Request for Classification Review Form (RFR) and an updated organizational chart showing to whom the new position(s) would report **must** be attached to this form. Please attach additional pages as necessary to provide enough detail.

Agency/Department: BISHCA Date: 8/26/2010

Name and Phone (of the person completing this request): Sandy Barton, 828-2379

Request is for:

☑ Positions funded and attached to a new grant.

☐ Positions funded and attached to an existing grant approved by JFO #_____

1. Name of Granting Agency, Title of Grant, Grant Funding Detail (attach grant documents):

   Department of Health and Human Services, 2010 Grants to States for Health Insurance Premium Review, Cycle I

2. List below titles, number of positions in each title, program area, and limited service end date (information should be based on grant award and should match information provided on the RFR) position(s) will be established only after JFC final approval:

Title* of Position(s) Requested	# of Positions	Division/Program	Grant Funding Period/Anticipated End Date
Insurance Rates and Forms Analyst	2	Health Care Administration	8/9/2010-9/30/2011
Administrative Assistant A	1	Health Care Administration	8/9/2010-9/30/2011
Grants Program Specialist II	1	Health Care Administration	8/9/2010-9/30/2011
Rates and Forms Actuary	1	Health Care Administration	8/9/2010-9/30/2011

*Final determination of title and pay grade to be made by the Department of Human Resources Classification Division upon submission and review of Request for Classification Review.

3. Justification for this request as an essential grant program need:

   Position request continued:

BISHCA Claims Analyst	1	Health Care Administration	8/9/2010-9/30/2011

   Justification: See Attached

I certify that this information is correct and that necessary funding, space and equipment for the above position(s) are available (required by 32 VSA Sec. 5(b).

Signature of Agency or Department Head — Date: 8.31.2010

Approved/Denied by Department of Human Resources — Molly Paul — Date: 9/1/10

Approved/Denied by Finance and Management — Date: 9/21/10

Approved/Denied by Secretary of Administration — Date: 9/21/10

Comments: DHR approval is contingent upon F&M approval of funding source / timeframe.

DHR – 11/7/05

RECD SEP 03 2010

Justification for Limited Service Positions

Without the limited service, grant funded positions listed in the attached request, Vermont will be unable to enhance its rate review process or implement any of the initiatives proposed in the grant. As such, the positions identified are essential if the Department is to successfully enhance the rate review process to accomplish the overall goal of providing consistent, complete and effective regulation necessary to ensure that health insurance rates are not unjust, unfair, inequitable, excessive, inadequate or unfairly discriminatory. Furthermore, if the Department's request for limited service positions is denied, the State's ability to implement comprehensive health care reform as mandated by the Affordable Care Act (ACA), will be severely compromised. For the reasons stated above, the limited service positions requested are an essential grant program need.

State of Vermont
Department of Banking, Insurance,
Securities and Health Care Administration
89 Main Street
Montpelier, VT 05620-3101
www.bishca.state.vt.us

Consumer Assistance Only:
Insurance: 1-800-964-1784
Health Care Admin.: 1-800-631-7788
Securities: 1-877-550-3907

To: James Reardon, Commissioner, Finance & Management

From: Michael Bertrand, Commissioner, BISHCA MB

Date: August 31, 2010

Re: Grant Acceptance
2010 Grants to States for Health Insurance Premium Review – Cycle 1

The Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) applied for federal funds under the new federal health care legislation for the purpose of enhancing Vermont's health insurance rate review process. Under the grant proposal ("2010 Grants to States for Health Insurance Premium Review-Cycle 1"), all States were eligible for funding. Funding was made available to assist with the implementation of comprehensive health care reform as mandated by the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation. The two laws, both passed in 2010, are collectively referred to as the Affordable Care Act (ACA).

Successful grant applicants were required to demonstrate that grant funds would be used to either develop or enhance their current rate capacity for rate review in the individual and group markets. On the August 16th of 2010, BISHCA received official notification that our application had been accepted. At this time, BISHCA is requesting State acceptance of the federal grant.

Vermont, like all grantee awardees, will receive a grant amount of $1 million. While the federal legislation authorizes the award of additional grants in future fiscal years, this specific award is for federal fiscal year 2011 only.

BISHCA has proposed five initiatives to enhance the Vermont's rate review process for health insurance premiums. Each initiative will require professional resources beyond current Department levels. The initiatives that can be funded through acceptance of the grant are as follows:

1. Expand the scope of current review and approval activities by conducting reviews of large group rates and rate review of minor lines of health insurance such as student policies. By September 30, 2011 the Department will establish procedures for annual rate reviews of the large group market, with reviews beginning for calendar year 2012. Resources needed: allocate time of existing staff and hire and/or contract for additional actuarial and professional resources. Estimated cost: $166,221.00.

2. Improve rate filing requirements by developing rate filing standards, and by collecting informational data for plans administered by Third Party Administrators. By July 1, 2011 the Department will establish and publish standards for carrier rate filings, including a requirement of a layperson summary of the rate increase request. Also, by September 30, 2011, the Department will establish and publish standards for annual informational filings to be made by third party administrators. Resources needed: allocate time of existing staff and hire and/or contract for additional actuarial and professional resources. Estimated cost: $166,221.00.

3. Enhance the rate review process by verifying claims experience and by analyzing public program migration. By July 1, 2011 the Department will collect claims data for validation and conduct targeted examinations to validate or change the assumptions used by carriers in their rate filings. Resources needed: allocate time of existing staff and hire and/or contract for additional actuarial and professional resources. Estimated cost: $266,579

4. Enhance the rate review process with a significant upgrade in Vermont's IT capacity. IT enhancements will include: updating the National Association of Insurance Commissioners' (NAIC) System for Electronic Rate and Form Filer (SERFF) program to include federal reporting elements, collecting and integrating historical rate filing data with current filed data, customizing Vermont's all payer claims utilization and reporting system to support rate review, consolidating carrier "carve-out" data, providing claims reporting by product type, and providing claims reporting by provider. By September 30, 2011 the Department will increase its rate analysis and reporting capacity with respect to rate review; collect and integrate historical; and current rate information and will contract for enhancements to its VTCURES and SERFF IT capabilities. Resources needed include: hiring or contracting for increased professional services; and contract for VHCURES enhancements and increased contractual resources. Estimated cost: $379,025.00.

5. Enhance consumer protection standards by posting readable, layperson summaries of rate increase requests on the Department's website, and by adding a ratepayer comment functionality to the Department's website. By July 1, 2011, the

Department will establish requirements for carriers to file layperson summaries of rate filings; and design a website to offer a ratepayer comment forum opportunity for rate carrier increase requests. Resources needed: allocate time of existing staff and hire and/or contract for additional professional resources. Estimated cost: $21,954.00.

The proposed enhancements in the scope and depth of Department's rate review for health insurance premiums will require professional resources in addition to current staffing and contracting resources. If the grant is accepted by the State, BISHCA will increase its professional resources for enhanced rate review. BISHCA is proposing to implement the initiatives previously described above through a combination of contract authority and the hiring of limited service positions. Our current proposal is to:

1. Contract for one half (0.5) of the additional actuarial services needed for the work proposed in initiatives #1-3.

2. Hire limited service positions for:
   a. One (1) actuary to perform the additional actuarial services needed for the work proposed of initiatives #1 through #3, including (but not limited to): analyze statistical data; construct probability tables to forecast risk and liability for payment of future benefits; ascertain premium rates required to ensure payment of future benefits.

   b. Two (2) rate analysts to carry out the professional services required for initiatives #1 through #3 and #5. Including (but not limited to): expand the scope of Department review of all filings; develop new rate filing standards; collect and integrate various types data.

   c. One (1) data entry and support staff position for the additional professional services required for initiatives #1 through #5. Including (but not limited to): assist with data collection and integration efforts; provide technical support to staff; perform other duties as needed.

   d. One (1) claims analyst for professional services required for initiatives #4 & #5. Including (but not limited to): review claims data to verify and describe the nature of claims experience in Vermont's health insurance market.

   e. One (1) grant administrator to perform multiple grant administration functions, including (but not limited to): ensuring accurate and timely preparation of grant billings and reports; ongoing monitoring of grant budgets and expenditures; communication of relevant grant information with Department and grantor.

The Grant Budget has been included as required.

Acceptance of the grant funds will assist the Department in the implementation of federal health care reform. Additionally, acceptance will enable Vermont to enhance its rate review process to accomplish the overall goal of offering consistent, comprehensive and effective regulation of health insurance rates for all carriers and all markets in order to ensure that health insurance rates are not unjust, unfair, inequitable, excessive, inadequate or unfairly discriminatory. Without acceptance of the funds, the State's ability to implement comprehensive health care reform, including enhanced rate review of health insurance rates, will be compromised.

Please let me know if you have any questions regarding this submission.

MB/sl
Enclosures

State of Vermont
Department of Banking, Insurance,
Securities and Health Care Administration
89 Main Street
Montpelier, VT 05620-3101
www.bishca.state.vt.us

Consumer Assistance Only:
Insurance: 1-800-964-1784
Health Care Admin.: 1-800-631-7788
Securities: 1-877-550-3907

To: Molly Paulger, Director, HR Services and Operations

From: Sandy Barton, Director, Administrative Services

Date: September 1, 2010

Re: Limited Service Grant Funded Position Request
2010 Grants to States for Health Insurance Premium Review

Molly, as discussed a few days ago, please find attached a request from BISHCA for limited service grant funded positions.

Please let me know if you need any further information regarding this request.

It is my understanding that you will forward this package of material to Toni Hartrich in the Budget Office after the HR review.

Thank you for your assistance in this process.

Toni,
I have a copy -
Thank you
Molly

SB/attachments

1. Limited Service Grant Funded Position Request form
2. Memo from Michael Bertrand to James Reardon
3. AA-1 Grant Acceptance Form
4. Grant Award package from Federal Department of Health & Human Services
5. BISHCA Grant Application


RECEIVED
SEP - 1 2010
State of Vermont
Dept. of Human Resources
Classification & Compensation Division