Rate Review Grant Cycle I Project Abstract

Applicant: Oregon Department of Consumer and Business Services, Oregon Insurance Division
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The Oregon Insurance Division, Department of Consumer and Business Services (department), is requesting $1,000,000 in federal funds for proposed enhancements to our rate review process for grant cycle 1. Oregon has recently made changes to bring additional transparency and stronger standards to our rate review process. However, it is our goal to use grant funding to further scrutinize actuarial data, and work to give consumers a better understanding of the costs of medical care and how premium dollars are spent. Further, we will use the grant award to seek out additional consumer comments on rate filings and study how we might use the rate review process to possibly control the growth of health care costs. Finally, it is our goal to use this money to grow our IT capacity, allowing the department to collect, organize, and report in-depth information to HHS and consumers.

Below are the major projects that the department is proposing for the use of the grant funds:

Activity 1: Expand the Scope of Rate Review and Data Collection. Grant funds will be used to expand the rate review process to include review of unreasonable large group rates, as well as collect new data on the large group market.

Activity2: Improve rate filing requirements. The department plans to work with various stakeholder groups to develop administrative rules and exhibits regarding the public disclosure of medical loss ratio details as a part of each rate filing.

Activity 3: Bolster Consumer Input. Provide grant funds to support a consumer advocacy organization that would regularly provide meaningful comments to the department on rate filings.

Activity 4: Study regarding provider costs. Grant funds will be used to hire a consulting firm to conduct a study to explore whether there are opportunities within the rate review process to control the growth of health care costs or improve the delivery system (i.e., payment reform).

Activity5: Transparency and Efficiency Enhancements. Grant funds will be used to develop and implement various changes to our rate review systems capacity. This activity includes support for IT staff development and system upgrades, based on estimates provided to the OID for similar initiatives.

In order to carry out the increased workload, the department will use funds to hire four additional employees, whose work will focus on expanded actuarial scrutiny, communication efforts, and consumer outreach. The department plans to hire an additional health actuary to provide a second tier of rate filing review, with a specific focus on the rate of impact the rate filing has on the entire block of business. We will hire a project coordinator, responsible for coordinating department responses to all inquiries and requests for information about health insurance rates, as well as drafting expanded plain language summaries for consumers after a rate decision has been made. Additionally, we will hire a market analyst to audit companies to verify that data submitted is supported by company records using established audit techniques and, finally, we will hire a rate filing intake coordinator to assist in all transparency initiatives and improve our intake efficiency.

In total, the department plans on using $451,951 of grant funds on new personnel, including all related direct/indirect costs. The remaining, $548,049 will be spent on subcontracts and other activity costs. In total, the Cycle I grants will use $1,000,000 in federal funds.

The department will systematically evaluate our rate review enhancements over the course of a year. Much of our success will be based on getting greater information out to consumers to ensure they understand all elements of the rate review process. With grant funds, we expect to grow our transparency efforts, while gaining a better understanding of how the rate review process itself can be used to control health care costs. Our enhancements will allow us to utilize new data, providing for greater review, as well as provide greater information to HHS and consumers.

Health Insurance Premium Rate Review Grant Cycle I
Oregon Department of Consumer and Business Services, Insurance Division

Project Narrative

a) CURRENT HEALTH INSURANCE RATE REVIEW CAPACITY AND PROCESS

General Health Insurance Rate Regulation Information:

The Oregon Department of Consumer and Business Services, through its Insurance Division (department), must approve all rates for individual, small employer and portability health insurance before they can be used in this state. The department currently does not review or regulate rates in the large group health insurance market.

In Oregon, we are among a handful of states that use modified community rating in the individual and small group markets. In the individual market, rates must not vary from the individual geographic average rate except that rates can be adjusted based on age, family composition, and benefit design. The rates can't vary based on an individual's health or claims history, or any other characteristics of the individual (i.e., gender). (ORS 743.767 and OAR 836-053-0465). In the small group market, rates can vary from the geographic average rate by 50 percent (a three-to-one rate band) based only on one or more of the following factors: the age of employees and their covered dependents, family composition, benefit design, employer contributions, participation rates, employee and dependent tobacco use, participation in wellness programs, customer loyalty, and expected claims experience not to exceed 5 percent. (ORS 743.737 and OAR 836-053-0065). Portability plan rates are reviewed to ensure the insurer followed the statutory formula for developing portability rates, which are based on the insurer's small and large group rates. (ORS 743.760 and OAR 836-053-0780).

Health Insurance Rate Review and Filing Requirements:

As evidenced in appendix A, the department requires all rate filings for individual and small group health plans to include: a filing description, rate filing summary, actuarial memorandum,

rate tables and factors, plan relativities, developments of rate change or base rate, trend information and projections, premium retention, worksheet for individual health benefit plan rates, covered benefit or plan design changes, cost containment and quality improvement efforts, insurer's financial position, certification of compliance, third-party authorization, and a statement of administrative expenses.

All individual, small-employer, and portability health rates are subject to approval by the department before they can be used in this state. Our review process begins after the department receives a rate filing submission, at which point, a rates and forms staff member reviews the filing to ensure the filing contains the required documentation to be considered complete. The rate filing is then sent to our health insurance actuarial staff, who scrutinize data and communicate follow-up questions with insurers to ensure the data received is accurate and justifies the proposed rate change.

Concurrent with this effort, administrative staff post the completed rate filing on our web site and send e-mail notification to those subscribed to our rate review tracking system. Once the entire filing is posted, a 30-day public comment period begins and all comments received are also posted to the website. After the public comment period ends, the insurance administrator convenes the rate review committee, consisting of five staff members. Those staff include: the insurance administrator, deputy administrator, operations manager, and two health actuaries. After committee review and discussion of the filing, the insurance administrator makes a final decision on rate approval, modification, or disapproval. Once a determination has been made, the department publishes a rate decision summary explaining in plain language the reasons for the department's decision. Finally, administrative support staff post the final decision and summary on our website and e-mail subscribers that a new decision has been posted.

Oregon rate review statutes require the department to ensure that the proposed rates are reasonable and not excessive, inadequate, or unfairly discriminatory, as authorized by ORS

742.005 and 743.018. Department actuaries ask two fundamental questions about each rate filing: Is the aggregate rate request justified? Is the request fairly allocated among rate payers? The department has explicit authority to consider: historical and projected loss ratios, historical and projected trend, historical and projected administrative costs, net income targets, as well as an insurer's investment income, surplus, and cost containment and quality improvement efforts. The department considers an insurer's overall profitability rather than just the profitability of a particular line of insurance. Additionally, the department separately reviews changes in administrative expenses by line of business.

In addition to the factors explicitly listed in the statute, the department also considers whether the request is for a closed block of business, previous rate changes and anticipated changes in the number of enrollees. For example, in order to lessen the financial burden on consumers, the department has denied rate requests for very small closed blocks of business and modified (reduced) requests for significant rate increases when those requests came on the heels of previous large rate increases to lessen the financial burden on consumers.

All individual health, portability, and small employer rates are reviewed prospectively. We do not retrospectively review rates or require rebates.

As we have increased the transparency of our rate review process and worked to provide more consumer-friendly information on each rate filing, one of the challenges we have encountered is the difficulty in ensuring that the data initially submitted by carriers (and posted on our website) is accurate and consistent throughout the rate filing. The other major challenge we face is translating technical rate filing information into language easy for consumers to understand and further explaining the necessity of rate increases as well as the resulting impact of a given rate filing on consumers.

As we have made more information available through our rate review process, the demand for an even more detailed explanation of the filing is growing. For example, consumers are

expecting that as part of the information we make available regarding each rate filing, we discuss not only the general rate impact of each rate filing but also changes in benefit design and changes in the application of rate factors that may impact consumers in different ways. For example, recently a few Oregon carriers changed the way they rate families with children, resulting in families with more than one child receiving higher-than-average increases in rates and families with only one child receiving lower-than-average increases (or even decreases) in rates. Understandably, consumers receiving a larger than average rate increase wanted an explanation.

Resources: Information and Technology and Systems Capacity:

Oregon receives a majority of its rate filings through SERFF (System for Electronic Rate and Form Filing), although the department does accept paper filings as well. Once a rate filing is submitted via SERFF, department staff download the filing on a per-case basis to an Oracle system. In addition, staff manually enter data to the Oracle system that is specifically designed to display pertinent information to consumers on our website. With our current system capacity, downloaded information must be maintained in both SERFF and Oracle, causing a duplication of work. Future enhancements to our IT infrastructure include plans to reduce the duplication of data entry by staff and provide more efficient methods to display data to consumers. For example, we do not currently have the systems capacity to post rate schedules (charts of approved rates) to allow rate comparison between carriers in one common place on our website. Additionally, we want to enhance our capacity to extract data from our system to ensure we are able to respond to particular inquiries about our rate review process or approval of rate requests.

Resources: Budget and Staffing Capacity:

The Department of Consumer and Business Services regulates commercial health insurance in Oregon, through its Insurance Division (OID). OID has an annual budget of $9,461,444, to support all administrative, financial regulation, and market regulation activities. The OID has an annual projected revenue of $11,455,822 and is financed from other funds,

primarily fees and assessments paid by insurance companies and producers as follows: Insurance premium assessments; license fees and charges for services; company examination fees; investment income and workers' compensation premium assessment. Of the annual budget, the department spends approximately $474,958 each year on rate review. Included in this allocation are salaries and benefits for two full time actuaries and a portion of an administrative specialist. The insurance administrator and deputy administrator each dedicate a quarter of their time to rate review related activities, and the operations manager currently spends half of her time on the rate review process. In total, $349,566 is spent on salaries, $111,384 is spent on Other Payroll Expenses (fringe benefits), $1,600 is spent on equipment, $462.50 is spent on supplies, and $11,945.50 is spent on travel.

Currently, five staff members are responsible for the department's rate review process. *Administrator*: Teresa Miller has a strong background in legislative and policy issues, serving as legislative director, a lobbyist for several businesses and organizations, and an attorney for the Oregon Department of Justice. Ms. Miller has a law degree from Willamette University College of Law and a bachelor's degree in political science and psychology from Pacific Lutheran University. Ms. Miller has been leading the 90-employee OID as administrator since July 8, 2009. Ms. Miller has helped move rate review to the forefront here in Oregon and plays a leadership role in each rate request.

Deputy Administrator: Triz delaRosa has more than 15 years of human resources experience. Ms. delaRosa's focus as deputy administrator has allowed her to use her expertise in dealing with budgets and other internal operational issues that arise in the division. Since joining the OID in November 2008, Ms. delaRosa has worked closely with the Rates and Forms unit, as well with the division's policy analyst team to implement Oregon's health reform bill, including rate review reforms (House Bill 2009).

Operations Manager: Gayle Woods has more than 35 years of insurance experience. Prior to joining the insurance division in 1995, Ms. Woods served as assistant vice president of administration for Pacific Northwest Life Insurance Company; her primary focus was on life and health insurance. Ms. Woods has been serving as the operations manager for the division since 2008, while previously managing the market conduct, market surveillance, and rates and forms units.

Actuary, David Ball is a member of the American Academy of Actuaries, with more than 30 years of experience as an actuary in both the private and public sectors. Mr. Ball received his Bachelor of Arts in Economics from Princeton University. Prior to joining the department in 2001, Mr. Ball spent 14 years with Financial Data Planning Corporation (FDP), consulting with insurance company clients in the US, Britain and the Netherlands. He also worked with several other insurance carriers throughout the United States before landing with the division. Mr. Ball is the lead actuary on health rates, often presenting to the review committee.

Actuary, Scott Fitzpatrick has been a fellow with the Society of Actuaries since 1998, with a Bachelor of Science Degree in Physics from the United States Naval Academy. Prior to joining the department in 2001, Mr. Fitzpatrick spent almost 16 years as an actuary with Standard Insurance, in Portland, Oregon. Upon joining the department, Mr. Fitzpatrick worked with other division staff to aggressively address a backlog of health rate filings.

Administrative Specialist (Support Staff: Mary Ellen Hayes has been with the OID since 1988 and holds an Associate of Arts degree in Business Administration. She has held numerous clerical roles with the department; however, over the course of the last several years, Ms. Hayes' focus has been specifically addressing issues around rate requests and transparency. Ms. Hayes initially receives the rate requests and begins the rate review process, assigning requests or filings to the actuaries. She often provides guidance to those filing requests to ensure the correct information is provided to the department.

Over the last year, the department has reviewed 69 rate filings in the portability, individual and small group markets. Of the 69 total filings, 14 were portability filings, 35 individual filings, and 20 small group filings. The average amount of time it takes to complete a review is 12 hours.

Consumer Protections:

As authorized by ORS 743.018(3) and OAR 836-053-0471 (See appendix A), the department posts rate filings for individual, portability, and small employer health benefit plans on its website once they are deemed complete. All information submitted as part of an insurance company's rate request is posted (no rate filing information is kept confidential). Consumers can sign up on the department's website to receive an e-mail when an insurer files a rate request and again when the department makes a decision. Additionally, a dedicated public workstation is available to consumers who wish to visit the department's office to review rate filing information.

Once a determination has been made, the department posts the decision along with a rate filing decision summary that describes in plain language the key factors underlying each rate filing action.

Once rate filing information is posted on our website, a 30-day public comment period begins and all comments received are also posted to the website.

The department has the authority to convene a public meeting or a public hearing regarding a particular rate filing if warranted.

The department's Consumer Advocacy Unit staffs a free hotline to answer consumer questions and take complaints. Over the past two years, this unit has received approximately 1,600 phone calls about rate increases. These inquiries typically relate to concerns about the affordability of coverage, particular rate increases, and changes to plan benefits.

Examination and Oversight:

No formal enforcement action has been taken against insurance companies over the past two plan years regarding health insurance rates.

In July, 2008, a consumer made a formal request for a hearing challenging a particular health rate filing decision. Following a two-day administrative hearing, the Oregon Office of Administrative Hearings recommended upholding the department's decision. This case is currently being appealed.

b) PROPOSED RATE REVIEW ENHANCEMENTS FOR HEALTH INSURANCE

Oregon has recently made changes to bring additional transparency and stronger standards to our rate review process. However, there is still work to be done to improve and expand consumer representation within the rate review process, further scrutinize actuarial data, and work to give consumers a better understanding of the costs of medical care and how premium dollars are spent. The State of Oregon will not use grant funds to supplant existing state expenditures; all grant funds will be utilized for rate review enhancements. The department has the capacity to implement the proposed enhancements, as well as manage funds according to our corresponding budget narrative.

Expanding Scope of Review and the Collection of Data:

Currently, the department does not review large group rates. As part of federal reforms, it is expected that the department will begin review of unreasonable large group rates as well as collect information on the large group market to report to HHS. We propose using grant funds to develop a process to implement review of large group markets and set up the required database infrastructure. Upon completion, staff will focus on the actual data collection required by HHS. Dedicated staff will be responsible for displaying new information we collect on the website in an organized and easy-to-understand format for consumers. Information gathered will be published in future reports and on our website. As a result of the work produced by this undertaking, the department can efficiently produce required information for HHS, as well as

present relevant information to the public, increasing our transparency efforts. The department estimates that the new systems can be in place within nine months of receiving grant money, with a total budget of $98,400.

Improving Rate Filing Requirements:

In order to improve consumers' understanding of premium increases, we plan to expand the information available to consumers by detailing how premium dollars are spent on medical procedures and services (disclose medical loss ratio detail). In Oregon insurers are not currently required to categorize claims costs. Rather, insurers provide information about how much money is spent paying claims in total. In comparison, we do require insurers to provide detailed information about how the portion of premium allocated to administrative expenses breaks down (i.e., salaries, commissions, marketing, advertising, etc). The department plans to work with various stakeholder groups, including consumers, insurers and other state agencies to develop administrative rules and exhibits regarding the public disclosure of medical loss ratio details as a part of each rate filing. The goal of this process is to create an easy-to-read chart that allows consumers to see how insurers spend a majority of their premium dollar. Potential medical loss ratio categories include: hospital inpatient care, hospital outpatient care, prescription drugs, physician services, laboratory tests, as well as other ancillary services. By further identifying how premium dollars are spent on medical procedures, both the department and consumers will have a better understanding of health care costs and the effectiveness of insurers' cost containment efforts. The department estimates that administrative rules and transparency efforts could be complete in 12 months, with a total project budget of $91,649.

Bolster Consumer Input:

As part of new health care reforms, Oregon has implemented a 30-day public comment period for all individual, portability, and small employer rate filings. However, since implementation of this process began in October 2009, the department has only received 62

public comments on 35 filings. In order to bolster consumer input in the rate review process, we propose to support a consumer advocacy organization with funding to enable the organization to regularly provide meaningful comments to the department on rate filings. To ensure proper consumer representation, we propose to support a consumer advocacy group with a membership base of at least 5,000 members, representing geographic areas from around the state. In addition to providing consumer input, the funding would enable the selected consumer advocacy group to work with the department's consumer liaison to create long-term strategies for the solicitation of individual public comments. Over a period of three to nine months, the department will identify a consumer group to support, with a total budget of $100,000. The department will conduct a review of all submitted comments on a regular basis to ensure the consumer group is providing in depth comments for rate filings posted on the department's website.

Study Regarding Provider Costs within the Rate Review Process:

We propose engaging a consulting firm to conduct a study to assist the division in identifying ways in which commercial health insurers could potentially facilitate delivery system improvement. As we work to increase the awareness and discussion of the drivers of health insurance premiums, this study will allow the department to explore whether there are opportunities within the rate review process to control the growth of health care costs or improve the delivery system (i.e., payment reform). The department estimates that a consulting firm could be hired in four months, with a total project budget of $150,000. The study could be complete in one year and will be used to determine enhancement proposals for other grant cycles.

Transparency and Efficiency Enhancements – IT Capacity:

Equally important to soliciting consumer input is the need to provide accessible and relevant information to consumers. Currently our rate review web page offers access to searchable pdf versions of rate filings where consumers can search for information under

individual filings. However, consumers often find this process difficult to navigate. We propose using grant funds to organize data formats so that consumers can search tables of key rate filing information, such as administrative and medical loss ratio data, through exportable data fields that a consumer may manipulate to fulfill their specific interest. Further, we plan to connect the rate filing page with the federal portal website, as well as improve the rate information posted to allow consumers to easily compare rates. Through the enhancements made to our consumer web page, the department should receive a reduced number of phone calls from consumers and media. As a result, staff will be able to spend more time allocated to the rate review process. The department estimates web design changes could be complete within one year of implementation, with a total budget of $54,000.

The Insurance Division currently manages the rate review process primarily through the combined use of the SERFF system and an internal data system, Oracle. Grant funds will be used to eliminate barriers and inefficiencies in the filing and rate review process, as well as expand access to searchable data fields, making information more readily available to consumers and HHS. Through the development of various changes to our rate review systems capacity, the department can meet our goals of collecting all the required reporting data for HHS, with a focus on the process of collecting previously unsolicited data, work on the automation of complete SERFF downloads to eliminate manual processes and create system enhancements to improve efficiency and reduce processing times in the collection of additional data from insurers. Throughout this process, our goal will be to make data enhancements that organize information in a manner that makes rate review data easier for consumers to understand. The department estimates data systems and web design changes could be complete within one year of implementation, with a total budget of $54,000.

Enhancing Rate Review Process – Staffing

Expanded Actuarial Scrutiny - Actuary: We propose adding an additional health actuary to our staff whose role would be to provide a second tier of rate filing review. Simultaneous to the actuarial review we currently conduct, this additional actuary will review all filings with a goal of performing a more meticulous review and paying special attention to the range of impact of the rate filing on the entire block of business. This will enable the department to furnish to consumers a clear and comprehensive explanation of how the rate filing will affect various categories of policyholders (not just average policyholders). With the addition of a concurrent second-tier review, the department can further achieve our goals of providing additional extensive review of actuarial data, while not lengthening the review time required. The department estimates that an actuary can be hired within 6 months of receiving grant money, with a total salary of $109,116.

Communication and Outreach - Project Coordinator: We propose hiring a project coordinator to be responsible for coordinating department responses to all inquiries and requests for information about health insurance rates. The project coordinator will also be responsible for ensuring we fulfill responsibilities associated with rate review grant funds received, as well as drafting plain language summaries for consumers after a rate decision has been made. While Oregon currently publishes plain language summaries for consumers, the project coordinator will greatly expand the scope of the information presented in the summaries to include a breakdown of medical loss ratio expenses in language appropriate for consumers. The project coordinator will work to identify potential statutory and administrative rule changes that may be needed to implement this legislation. For all rate review rulemaking, the project coordinator will act as a point person, with a focus on recruiting consumer representation for advisory committee meetings. In addition, the project coordinator will work with staff to coordinate preparation of all reports and publications providing information about health insurance rates and ensure information presented on our Web site is timely, accurate and consumer friendly. By hiring a

project coordinator, the department will improve our overall process by coordinating internal procedures, so that consumers have a much needed point of contact for all rate review related questions. The department estimates that the project coordinator can be hired within three months of receiving grant money, with a total salary of $61,812.

Ensuring Accurate Data - Market Analyst (Insurance Examiner): In adding a market analyst position, the rate review process will be greatly enhanced by having a person solely focused on making sure insurers are reporting accurate data in rate filings. Currently, Oregon receives actuarial data from our rate review process, as well as supplemental data from health benefit plan reports, company financial reports, and quarterly enrollment reports. Much of the data collected in a rate review filing should match with data from these other reports, although history has shown that discrepancies often emerge. We propose having a market analyst staff member audit companies by verifying the data submitted is supported by company records using established audit techniques. By hiring a market analyst, the department can achieve its goal of ensuring that insurer's rates are appropriate. This individual will need access to software typically used for this purpose and while we anticipate some of this audit work could be done electronically, travel to insurance company offices throughout the state will be required in order to accomplish this goal. The department estimates that a market analyst can be hired within three months of receiving grant money, with a total salary of $53,940.

Efficiency Improvements – Rate Filing Intake Coordinator: To streamline administrative processes within an expanded rate review system, the intake coordinator will handle all logistical arrangements for rate review staff, including arranging project meetings, contacting workgroup participants, and compiling information for grant progress reports. In addition, the intake coordinator will work to ensure we keep pace with the potential of increased rate filings received as a result of federal reform. Currently, one administrative specialist intakes filings for multiple lines of coverage, confirming whether documents are properly submitted and

labeled before transferring files to the actuaries. The new intake coordinator will handle the intake process for all health rate filings and further scrutinize documents to ensure that a filing not only contains the required documentation to be considered complete, but that the data included in the rate filing is in compliance with required regulations by completing a checklist to be developed. One of the primary goals of the checklist will be to review the filing for inconsistencies and common filing mistakes. In this new role, the intake coordinator will perform much of the compliance work actuaries currently perform, which will free up actuaries to spend more of their time evaluating filings in even greater detail. The department estimates that an intake coordinator can be hired within three months of receiving grant money, with a total salary of $32,340.

c) REPORTING TO SECRETARY ON RATE INCREASE PATTERNS

The State of Oregon will comply with all reporting requirements set forth by Section 2794 of the Patient Protection and Affordable Care Act of 2010. Research services of the department currently generate periodic publications that summarize and analyze a variety of data pertaining to oversight of the insurance industry. This includes a comprehensive annual report on Oregon's commercial health insurance market that incorporates in-depth interpretive analysis by the department. The availability of additional detailed data on health rates will enrich our annual analysis. When appropriate source data becomes available, the research staff will enhance research products to provide added value for the industry and consumers, and prepare a specific, targeted report for the Secretary addressing the required data outlined in the grant. The data will be aggregated and summarized in statistically meaningful ways, with appropriate analysis and qualifications.

As noted previously, the department does not currently retain all source data required to meet the requirements of this grant in electronic form. Notable omissions are enrollment and rate (premium) detail data. This information can be collected and made more readily available

for analysis and reporting by downloading additional information from external data sources such as SERFF and the NAIC, and by enhancing existing online reporting systems such as IREG. The requirements for aggregation of the rate filing data can also be met for individual and small group segments, once the necessary detail data is collected and stored in corporate (internal) data systems. After the data systems are enhanced, the department will be able to submit the required data through the designated uniform reporting template.

Using existing database query, analysis, and reporting tools, additional reports can be developed from these systems that show rate trends by several variables, such as market segment or type of insurer. Other reports could show the trends, if any, in enrollment in different market segments. Research staff may be able to use forecasting and modeling techniques to study the relationship between rates and demographic variables, such as average age, urban/rural distributions, or wages.

With expanded data available on rate filings and other health insurance activities, the department would generate new analyses and either publish a new annual report focused on rate filings, or enhance the existing reports to incorporate the new information. Additional data would also allow more comprehensive and timely responses to requests for information used to assess the impacts of legislation and policy changes.

BUDGET NARRATIVE

The Oregon Insurance Division, Department of Consumer and Business Services (department), is requesting $1,000,000 in federal funds for proposed enhancements to our rate review process for grant cycle 1. The department currently spends approximately $474,958 each year on rate review.

Grant Funded Subcontracts & Other Activity Costs - Total Federal Funds: $548,049, including:

Activity 1: Expanding Scope of Rate Review and Data Collection. Grant funds will be used to expand the rate review process to include review of unreasonable large group rates, as well as collect new data on the large group market. Expanded staff workload and infrastructure developments, as well as IT systems changes are expected to cost $98,400.

Activity 2: Improving rate filing requirements. The department plans to work with various stakeholder groups to develop administrative rules and exhibits regarding the public disclosure of medical loss ratio details as a part of each rate filing. This budget for development of this process includes: $91,649 to establish administrative rules and transparency efforts.

Activity 3: Bolster Consumer Input. Grant funds will support a consumer advocacy organization that would regularly provide meaningful comments to the department on rate filings. Funding to establish a contract will be $100,000**.**

Activity 4: Study regarding provider costs. Grant funds will be used to hire a consulting firm to conduct a

study to explore whether there are opportunities within the rate review process to control the growth of health care costs or improve the delivery system (i.e., payment reform). Funding for the study will be up to $150,000. (Through the procurement process any unused funding would be applied to activity 1.)

Activity 5: Transparency and Efficiency Enhancements. Grant funds will be used to develop and implement various changes to our rate review systems capacity. This activity includes $108,000 to support IT staff development and system upgrades, based on estimates provided to the OID for similar initiatives.

Grant Funded Personnel and Related Direct/Indirect Costs - Total Federal Funds: $451,951, including: **Personnel salaries for four full time employees:** Federal Funds - $257,208

Expanded Actuarial Scrutiny - Actuary*:* This additional actuary will review all filings with a goal of performing a more meticulous review and paying special attention to the range of impact of the rate filing on the entire block of business. **Base salary is $109,116.**

Communication and Outreach - Project Coordinator: The project coordinator will be directly responsible for implementation of the proposed grant activities and coordinating department responses to all inquiries and requests for information about health insurance rates, including expanding the scope of our plain language summaries for consumers after a rate decision has been made. **Base salary is $61,812.**

Ensuring Accurate Data - Market Analyst: The market analyst will determine data collection and information system needs, as well as audit companies by verifying the data submitted is supported by company records using established audit techniques. **Base salary is $53,940.**

Efficiency Improvements – Rate Filing Intake Coordinator*:* The intake coordinator will handle the intake process for all health rate filings and further scrutinize documents to ensure that filings are in compliance with required regulations. **Base salary is $32,340.**

Fringe Benefit Expenses: Federal Funds - $105,891. Payroll taxes are 7.65% of salary. Medical, dental, life and disability insurance are $12,840 per employee. Employment Relation Board and Worker's Compensation is $52.20 per FTE. Retirement is 8.22% of salary, and Mass Transit Tax is 0.6% of salary.

New FTE-related Local Travel: Federal Funds - $4,000. Local travel includes mileage at $0.50 per mile, with an estimated 100 hours of travel per month expected for meetings throughout the state.

New FTE-related Supplies: Federal Funds - $45,001. The supplies estimate includes: Office supplies - $3,348; Telecommunications supplies and services - $6,568; Other miscellaneous office supplies - $6,408; Expendable Property - $3,200; Computers, Printers, & Software - $7,125; Facilities expense - $8,800; Employee Training - $6,000; Office Furniture - $1,352; Training Materials - $2,200.

Other New FTE-related Direct/Indirect Costs: Federal Funds - $39,851. The department uses an indirect cost (assessed against personnel costs only) rate for all grants. The amount is what is considered allowable under approved federal grant cost allocation plans. These costs are for contractual services,

legal fees, budget management services, grants management services, employment related services and financial services.