NEVADA

ATTACHMENT C

APPLICATION COVER SHEET AND CHECK-OFF LIST

Indentifying Information:

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

DUNS #: 093666019 Grant Award: $1 million

Applicant: Division of Insurance - Nevada

Primary Contact Person, Name: Brett Barratt

Telephone Number: (775) 687-4270 Fax number: (775) 687-3937

Email address: bbarratt@doi.state.nv.us

APPLICATION COVER SHEET AND CHECK-OFF LIST

REQUIRED CONTENTS

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

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

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

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

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

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

3. Date Received:	4. Applicant Identifier:

5a. Federal Entity Identifier:	*5b. Federal Award Identifier:

State Use Only:

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

8. APPLICANT INFORMATION:

*a. Legal Name: Division of Insurance (State of Nevada)

*b. Employer/Taxpayer Identification Number (EIN/TIN):	*c. Organizational DUNS:
88-6000022	093666019

d. Address:

*Street 1: 788 Fairview Drive
Street 2:
*City: Carson City
County: Carson City
*State: NV
Province:
*Country: USA
*Zip / Postal Code 89701

e. Organizational Unit:

Department Name:	Division Name:
Department of Business & Industry	Division of Insurance (State of Nevada)

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

Prefix: Mr. *First Name: Brett
Middle Name: J
*Last Name: Barratt
Suffix:

Title: Commissioner of Insurance, State of Nevada

Organizational Affiliation:

*Telephone Number: (775) 687-4270, ext. 277 Fax Number: (775) 687-3937

*Email: bbarratt@doi.state.nv.us

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

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

A.State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**

Department of Health & Human Services, Office of Consumer Information & Insurance Oversight

11. Catalog of Federal Domestic Assistance Number:

93.511

CFDA Title:

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

***12 Funding Opportunity Number:**

RFA-FD-10-999

*Title:

Grants to States for Health Insurance Premium Review - Cycle I

13. Competition Identification Number:

ADOBE-FORMS-B

Title:

Grants to States for Health Insurance Premium Review – Cycle I

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

All citizens in Nevada will benefit from the increased oversight of health insurance rates charged by insurers in Nevada.

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

Preium Review Grant: Enhance the State of Nevada, Division of Insurance's (Division) rate review process of health benefit plans. The Division currently has limited oversight over the filing and approval of rates for health benefit plans. This grant will allow the Division the opportunity to greatly enhance its oversight and prevent the filing and use of "unreasonable" health insurance rates in Nevada.

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: NV-002 *b. Program/Project: NV -all

17. Proposed Project:

*a. Start Date: 08/09/2010 *b. End Date: 09/30/2011

18. Estimated Funding ($):

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

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

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

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

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

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

☐ Yes ☒ No

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

☒ **I AGREE

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

Authorized Representative:

Prefix: Mr. *First Name: Brett

Middle Name: J.

*Last Name: Barratt

Suffix:

*Title: Commissioner of Insurance

*Telephone Number: (775) 687-4270, ext. 277 Fax Number: (775) 687-3937

* Email: bbarratt@doi.state.nv.us

*Signature of Authorized Representative: *Date Signed: June 30, 2010

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Application for Federal Assistance SF-424 Version 02

***Applicant Federal Debt Delinquency Explanation**

The following should contain an explanation if the Applicant organization is delinquent of any Federal Debt.

NOT APPLICABLE

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 0348-0044

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Health Benefit Plan F	93.511	$	$	$ 1,000,000.00	$ 0.00	$ 1,000,000.00
2.						0.00
3.						0.00
4.						0.00
5. Totals		$ 0.00	$ 0.00	$ 1,000,000.00	$ 0.00	$ 1,000,000.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1)	(2)	(3) Health Benefit Plan R	Health Benefit Plan R	(5)
a. Personnel	$	$	$ 459,100.00	$ 0.00	$ 459,100.00
b. Fringe Benefits			137,700.00	0.00	137,700.00
c. Travel			27,804.00	0.00	27,804.00
d. Equipment			69,878.00	0.00	69,878.00
e. Supplies			2,500.00	0.00	2,500.00
f. Contractual			275,000.00	0.00	275,000.00
g. Construction			0.00	0.00	0.00
h. Other			25,000.00	0.00	25,000.00
i. Total Direct Charges *(sum of 6a-6h)*	0.00	0.00	996,982.00	0.00	996,982.00
j. Indirect Charges			0.00	0.00	0.00
k. TOTALS *(sum of 6i and 6j)*	$ 0.00	$ 0.00	$ 996,982.00	$ 0.00	$ 996,982.00
7. Program Income	$	$	$ 0.00	$ 0.00	$ 0.00

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Standard Form 424A (Rev. 7-97)
Prescribed by OMB Circular A-102

Previous Edition Usable

SECTION C - NON-FEDERAL RESOURCES

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

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 1,000,000.00	$ 1,000,000.00	$ 0.00	$ 0.00	$ 0.00
14. Non-Federal	0.00				
15. TOTAL *(sum of lines 13 and 14)*	$ 1,000,000.00	$ 1,000,000.00	$ 0.00	$ 0.00	$ 0.00

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

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. Health Benefit Plan Rate Review	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00
17.				
18.				
19.				
20. TOTAL *(sum of lines 16-19)*	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:
None

22. Indirect Charges:
None

23. Remarks: "Other" category is for the purchase of upgraded Software to allow the upgrade of existing software and purchase of additional software to allow the rate review and tracking of rate filings for health benefit plans.

OMB Approval No. 0348-0040

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

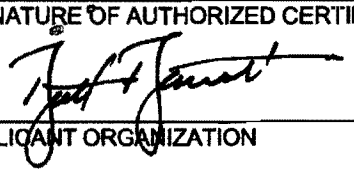
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

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

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

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

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

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
	Commissioner of Insurance
APPLICANT ORGANIZATION	DATE SUBMITTED
Division of Insurance - Nevada	June 30, 2010

Approved by OMB
0348-0046

Disclosure of Lobbying Activities

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. **Type of Federal Action:** a. contract b. b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	2. **Status of Federal Action:** a. bid/offer/application b. b. initial award c. post-award	3. **Report Type:** a. initial filing a. b. material change **For material change only:** Year _____ quarter _____ Date of last report_____

4. **Name and Address of Reporting Entity:** X Prime _____ Subawardee Tier_____, if Known: **Nevada Division of Insurance** **788 Fairview Drive, #300** **Carson City, NV 89701-5491** **Congressional District, *if known*: NV-002**	5. **If Reporting Entity in No. 4 is Subawardee,** Enter Name and Address of Prime: **Congressional District, *if known*:**
6. **Federal Department/Agency:**	7. **Federal Program Name/Description:** CFDA Number, *if applicable*: 93.511
8. **Federal Action Number, *if known:***	9. **Award Amount, *if known:*** **$**
10. a. **Name and Address of Lobbying Registrant** *(if individual, last name, first name, MI):* NONE	b. **Individuals Performing Services** *(including address if different from No. 10a)* *(last name, first name, MI):* NONE
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	**Signature:** /Brett J. Barratt/ **Print Name: Brett J. Barratt** **Title: Nevada Commissioner of Insurance** **Telephone No.: (775) 687-4270 X.277 Date: 06/30/10**
Federal Use Only	**Authorized for Local Reproduction** **Standard Form - LLL (Rev. 7-97)**

Additional Assurance Certifications

NOT APPLICABLE - see SF 424B Assurances Form and the list of key contacts in Applicant's Application cover letter

JIM GIBBONS
GOVERNOR

One Hundred One North Carson Street
Carson City, Nevada 89701
Office: (775) 684-5670
Fax No.: (775) 684-5683

Office of the Governor

June 30, 2010

Secretary Kathleen Sebelius
U.S. Department of Health and Human Services

RE: Grants to States for Health Insurance Premium Review – Cycle I
CFDA: 93.511

Dear Secretary Sebelius:

This letter is my expression of support for the State of Nevada's application for the State Health Insurance Premium Review grant of $1 million to ensure that health insurance premiums charged to Nevada consumers are reasonable. The grant will enhance the health rate review process to better identify unreasonable increases in a manner that is both transparent and more meaningful to the consumer. The grant will not be used to replace or supplant existing state expenditures.

I am designating the State of Nevada, Department of Business and Industry, Division of Insurance ("Division"), as the lead agency to submit Nevada's application for the State Health Insurance Premium Review grant. The Division will also be the lead agency to oversee and coordinate all program activities, as outlined in the grant application, under the authority of:

Brett J. Barratt, Esq.
Acting Commissioner of Insurance
Nevada Division of Insurance
788 Fairview Drive, Suite 300
Carson City, NV 89701-5491
(775) 687-4270, Ext. 277

Thank you.

Sincerely,

JIM GIBBONS
Governor

CC: Brett J. Barratt, Esq.
Acting Commissioner of Insurance

JIM GIBBONS
Governor

DIANNE CORNWALL
Director

STATE OF NEVADA

BRETT J. BARRATT
Acting Commissioner of Insurance

DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE
788 Fairview Drive, Suite 300
Carson City, Nevada 89701-5491
(775) 687-4270 • Fax (775) 687-3937
Website: doi.state.nv.us
E-mail: insinfo@doi.state.nv.us

June 30, 2010

Secretary Kathleen Sebelius
U.S. Department of Health and Human Services

Re: Grants to States for Health Insurance Premium Review – Cycle I

Dear Secretary Sebilius:

Please accept this letter from the Nevada Division of Insurance as our intent to apply for a grant to develop and enhance the rate and premium review process for Nevada consumers. While limited funding and in-house actuarial expertise has constrained the ability of the Division to challenge rate filings, this grant will allow the Division to create a process that is both transparent and meaningful to the consumer.

We are applying for the funds under the following number and funding opportunity title:

Opportunity Title:	Grants to States for Health Insurance Premium Review – Cycle I
CFDA Number:	93.511
CFDA Description:	Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review – Cycle I

The primary Point of Contact is:

Cliff King, Project Director and
Chief Insurance Examiner
Division of Insurance
788 Fairview Drive #300, Carson City, NV 89701
(775) 687-4270, ext. 270
cking@ doi.state.nv.us

Other key personnel include:

Kim Everett, Assistant Project Director and
Assistant Chief Insurance Examiner
(775) 687-4270, ext. 248
keverett@ doi.state.nv.us

Glenn Shippey, Actuary I
(775) 687-4270, ext. 246
gshippey@ doi.state.nv.us

Currently Ms. Everett and Mr. Shippey review all rate filings required to be filed for health benefit plans in Nevada. (Small and large group PPO filings are not currently required to be filed.) While Mr. Shippey will continue in this capacity, we will hire a qualified and credentialed health actuary with at least five years experience in pricing health benefit plans. This is will allow in-depth analysis of the rate filing to ensure that the rates are not excessive, inadequate or unfairly discriminatory as required by Nevada Revised Statute (NRS) 686B.050.

We will also hire an attorney with a specialty in health insurance regulation. This attorney will provide the Division with oversight of the legal process in rate filings and application of the rate approval process. This will include rate hearings for any rate filing that appears to be "unreasonable" or that will potentially have an adverse effect or reaction on consumers.

We will hire a Consumer Advocate to represent, protect and advance the needs of consumers in the analysis of health benefit plan rate filings and hearings. The intent is to bring increased focus on the rate filing process to ensure that health coverage is provided at the lowest possible cost while ensuring that the carriers maintain their solvency.

We will hire a Compliance Investigator who will serve as the front-line person assisting Nevada consumers with health care reform issues. That person will review both formal and informal complaints regarding health insurance coverage related to pricing and claims. This would include questions arising from the rate filing itself so the Investigator must communicate often with the Actuary and other staff. The Attorney will work closely with the Compliance Investigator and Consumer Advocate to prepare and conduct rate hearings as necessary. The Attorney will also assist the Investigator with the handling of consumer complaints regarding claims.

Finally, we will hire a Management Analyst (MA) to assist in the development of systems to capture and report data for HHS and others. The MA will be responsible for posting the rate filing with various media to ensure transparency. He will also be responsible for conducting a variety of studies, research, evaluation or revision of programs, organizations, methods or procedures such as budgeting and financial analysis. He is also responsible for completing the Financial Status Report (SF-269a) and the Federal Cash Transactions Report (PSC 272).

The hiring of these five individuals will create a process of rate review that does not currently exist in the Division. The rate filing will be assigned to Ms. Everett or Mr. Shippey AND the Actuary. Ms. Everett and/or Mr. Shippey will review the forms in conjunction with the Actuary's review of the rates. At the same time, a copy of the entire filing will be provided to the Consumer Advocate for their review and analysis. If the Consumer Advocate has questions or concerns, he will work with the Actuary and Everett/Shippey to gain a full understanding of the filing product. The MA will receive notice of the filing and other data for tracking purposes as well as providing public notice and access to the filing. This will include posting all such filings on the Division web site. The MA will also be responsible for notifying HHS of any concerns with the filing such as it meeting the criteria of being an "unreasonable rate filing."

This process will ensure that the Nevada marketplace will provide a transparent regulatory environment where consumers will have a voice in the regulation of health insurers.

We have presented the idea of creating an optional data center to the University of Nevada, College of Business, in Reno. Professor Jeanne Wendel has worked with the Nevada Department of HHS in the collection of medical claims data for the past few years. She is anxious to expand that operation to meet the needs of the Division to compile and publish fee schedule information. We look forward to pursuing that activity.

Thank you for the opportunity to submit this application for the Rate Review Grant.

Sincerely,

Cliff King, CPCU, ARM
Project Director & Chief Insurance Examiner
Life & Health Section
Division of Insurance

Project Abstract

The Nevada Division of Insurance (Division) is committed to enhancing its health rate review process to better identify potentially unreasonable increases in a manner that is both transparent and more meaningful to the consumer. Limited funding and in-house actuarial expertise has constrained the ability of the Division to challenge rate flings. The Division is further constrained currently by state statutes requiring the Nevada Insurance Commissioner to keep actuarial supporting data within rate filings confidential, limiting public participation in the process.

The Division will propose legislation to obtain prior approval rate review authority for group health benefit plans. The Division anticipates that all group and health benefit plans will be subject to the ratemaking standards and criteria specified within Nevada Revised Statutes 686B. Grant funds will be used to hire additional staff, including a Qualified Health Actuary familiar with the Actuarial Standards of Practice and Guidelines for Professional Conduct, to oversee the regulation of insurance rates for all health benefit plans. The Division will make all health benefit plan rate filings publicly available as soon as they are filed, and plans to post all health benefit plan rate filings on its Web site. Consumers will be encouraged to comment in writing directly to the Division regarding rate proposals. In order to significantly enhance consumer participation in the rate review process, Cycle I grant funds will be used to hire a Consumer Advocate for health insurance customers and an attorney to assist the Advocate. The Commissioner may schedule a public rate hearing shortly after receiving a rate filing determined by the Division and Advocate to be outside reasonable rate filing thresholds, consistent with HHS regulations. Consideration will be given to the magnitude of the request and the market share of the carrier. The Advocate will represent the interests of consumers during the hearing, and may use grant funds to obtain outside actuarial consulting services.

The System for Electronic Rate and Form Filing (SERFF) will be used to collect data and generate required reports to the Secretary of HHS for each health benefit plan rate fling received for the individual, small group and large group markets. The Division will create a database external to SERFF to collect data from rate filings necessary to generate the required aggregate reports for the individual, small group and large group markets. Cycle I grant funds will be used to hire a management analyst who will be responsible for compiling these reports under the direct supervision of the Actuary.

Cycle I allows up to $1 million for enhancing the rate review process. Our budget totals $996,982 to fund the following categories:

Personnel, including office & equipment:	$669,178
Software Enhancements, to allow data collection	25,000
Travel and Training, for enhancing education and community outreach	27,804
Consultants, to grant expertise and independent review	275,000
TOTAL	$996,982

Nevada's primary goal for the use of Cycle I grant funds is to provide a means to enhance our current rate review process for health insurance premiums. This includes developing new processes as well as enhancing/modifying the existing ones to achieve improvements in health insurance consumer protections and transparency.

a) Current health insurance rate review capacity and process

The Nevada Division of Insurance (Division) is committed to enhancing its health rate review process to better identify unreasonable increases in a manner that is both transparent and more meaningful to the consumer. Limited funding and in-house actuarial expertise has constrained the ability of the Division to challenge rate flings. State statutes requiring the Nevada Insurance Commissioner to keep actuarial supporting data within rate filings confidential have limited public participation in the process.

The Division currently has prior approval authority over individual health insurance rates and all HMO rates. There are no rate filing requirements for either small or large group PPO products. Nonprofit medical corporations must also receive prior approval from the Division before implementing rate changes. Initial rates for all new health benefit plan products must be filed with the Division for prior approval.

Individual health benefit plan rating characteristics are age, sex, occupation, geographic area, composition of the family of the individual and health status. The highest rating factor for health status must not exceed the lowest factor by more than 75 percent. A carrier may establish blocks of business for its individual heath benefit plans. After adjustment for rating characteristics and design of benefits, the rate for any block of business must not exceed the rate for any other block of business by more than 50 percent. After adjustment for rating characteristics and design of benefits, the rate change for a single block of business in a 12-month period cannot exceed the rate change for any other block of business by more than 15 percent.

Small employer health benefit plan rating characteristics are age, sex, industry, geographic area, composition of family, size of group and the amount contributed by the employer to the cost of coverage. The highest rating factor associated with any industry classification may not exceed the lowest rating factor associated with any industry classification by more than 20 percent. A small employer carrier may establish no more than nine separate classes of business, and each class must reflect substantial differences in expected claim experience or administrative costs. The index rate, defined to be the arithmetic average of the base rate and the highest premium rate for small employers with similar characteristics within a class, for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20 percent. The premium charged to a small employer with similar characteristics within a class of business may not vary because of health status-related factors from the index rate by more than 30 percent. This effectively allows carriers to rate for health status with a rating factor limit of 85.7 percent within each class of business. The premium rate charged to a small employer for a new rating period may not increase by a percentage greater than the sum of:

1) The percentage of change in the premium rate for new business for the policy under which the small employer is covered, measured from the first day of the previous rating period to the first day of the new rating period;

2) An adjustment, not to exceed 15 percent annually, adjusted pro rata for rating periods of less than one year, on account of the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the carrier's rate manual for the class of business; and

3) Any adjustment on account of change in coverage or change in the characteristics of the small employer as determined from the carrier's rate manual for the class of business.

In addition to the rating restrictions described above, individual health benefit plans are subject to the ratemaking standards and criteria mandated by Nevada Revised Statutes (NRS) Chapter 686B for Rates and Essential Insurance. These statutes require individual health carriers to submit rates to the Division for prior approval. Rates are deemed approved 60 days after the Division determines the filing to be complete if the proposal is not disapproved within that period. Each rate filing is deemed complete unless the Division, within 15 business days after receiving the proposal, determines the proposal is incomplete due to lack of supporting data. A rate filing is generally considered complete if it includes the following:

1) An actuarial memorandum which identifies the carrier's individual blocks of business and demonstrates compliance with the block rating restrictions for health benefit plans;

2) Written and earned premium and paid and incurred claims for each block of business;

3) Earned premium recalculated at current rate level and incurred loss ratios based on premium at current rate level;

4) If Nevada data lacks full credibility, national experience must also be provided. Any credibility weighting of national and Nevada data requires justification using a reasonable credibility model;

5) A minimum of five years of monthly or quarterly state and/or national claim cost and utilization data to support the trend factor used in the filing;

6) A complete rate history; and

7) The number of policies in force.

After the filing is determined to be complete, carrier experience, claim trends and assumptions are analyzed to determine if the proposed rate change is actuarially justified. Statutory standards require that rates must not be inadequate, excessive, or unfairly discriminatory. In determining whether rates for individual health benefit plans comply with these standards, due consideration shall be given to past and prospective loss and expense experience within and outside of this state; catastrophe hazards and contingencies; trends within and outside of this state; loadings for leveling premium rates over time or for dividends or savings to be allowed or returned by insurers to their policyholders, members, or subscribers; and to all other relevant factors, including the judgment of technical personnel. If the analyst determines within 60 days the rate request is unreasonable or is out of compliance with the rating restrictions for individual health benefit plan blocks of business, the filing is disapproved by notifying the carrier in writing of the specific objections. The carrier may modify its proposal or request a hearing to challenge the validity of the determination of the analyst. The hearing must be held within 30 days after the request is submitted. During the hearing, the carrier has the burden of demonstrating compliance with the applicable statutory standards for rates. The rate proposal is deemed approved if the Division fails to issue an order within 45 days after the hearing is held.

During the past two years, few individual health benefit plan rate filings have been disapproved. Most carriers have been submitting rate filings proposing increases at or below medical trend. Generally, the Division has not considered rate requests at trend to be excessive. The rate filing activity during the past two years for carriers actively marketing individual health benefit plans in Nevada is listed below:

Carrier	Submission Date	Request	Amount Approved	Effective Date
Aetna	1/21/2009	15%	15%	8/1/2009
	1/19/2010	17%	pending	
Anthem	10/20/2008	18%	18%	4/1/2009
	11/30/2009	18.5%	12.8%	6/1/2010
Celtic	6/10/2008	12.6%	12.6%	1/1/2009
HPN	6/19/2009	9.5%	9.5%	11/1/2009
Humana	7/25/2008	12.4%	12.4%	10/1/2009
	1/21/2010	5.4%	5.4%	7/1/2010
John Alden	1/12/2009	14.7%	14.7%	3/1/2010
Sierra	6/19/2009	3.8%	3.8%	11/1/2009
Time	1/12/2009	14.7%	14.7%	3/1/2010

An individual health benefit plan rate filing is more likely to be disapproved for failing to comply with the rating restrictions for individual blocks of business. This is particularly the case with carriers that file revised rates for different blocks of business at different points in time. An example of this is the most recent filing from Anthem requesting an 18.5 percent overall increase. This filing was disapproved because its request did not comply with the block rating restriction that limits the rate increase for a block of business in a 12-month period to not more

than 15 percent above the rate increase for any other block of business. The Division earlier this year approved an Anthem rate filing which resulted in a 1 percent decrease to an individual health benefit plan block of business. As a result, the Division reduced Anthem's request to a 12.8 percent overall increase consisting of a 1 percent decrease for one block of business, and a 14 percent increase for all other blocks of business.

Other than HMOs, small employer carriers are not required to file rates with the Division, but many choose to do so. Additionally, each small employer carrier must annually submit an actuarial memorandum certifying and demonstrating compliance with Nevada's small group rating restrictions. Failure to submit this certification or failure to reasonably demonstrate compliance may trigger a retrospective review of a carrier's small group rates. In 2005, this was the case for a major writer of small group business in Nevada. The Division determined that the index rates for several of this carrier's classes of business were more than 20 percent higher than its most preferred class. This carrier was required to reduce its index rates for its least preferred classes to within 20 percent of its index rate of its most preferred class.

The rates for all HMO products are filed for prior approval and are subject to the ratemaking standards NRS Chapter 686B: rates must not be excessive, inadequate, or unfairly discriminatory. Individual and small group HMO products must comply with all individual and small group market rating restrictions in Nevada. Only HMOs are required to file rates for large group products. The large group market in Nevada has been very competitive, and large group HMO rate filings are rarely disapproved.

Most carriers utilize the System for Electronic Rate and Form Filing (SERFF) to submit filings. However, several carriers with significant market share in Nevada continue to submit paper rate filings. On January 1, 2011, all carriers will be required to file rates and forms through SERFF. The Division has not created any databases outside of SERFF to track rates for health benefit plans. This has made it difficult for the Division to analyze health benefit plan rating data for products submitted through paper filings. The Division intends to use funds from this grant to create and maintain a separate database to capture rate filing supporting data for each carrier.

Currently Ms. Kim Everett and Mr. Glenn Shippey review all rate filings required to be filed for health benefit plans in Nevada. Mr. Shippey has academic degrees in mathematics and statistics and is working toward an Associate credential in the Casualty Actuarial Society. He has been reviewing rate filings for the Nevada Division of Insurance for more than six years. Ms. Everett has 16 years experience working for health insurers and ten years experience reviewing rate filings for the Division. The total Division budget for the fiscal year ending June 30, 2010 is $9,197,743 and $89,879 is allocated to fund the salary and benefits for the individual responsible for health benefit plan rates. In 2008, The Division received 26 individual and 40 group health benefit plan rate filings. In 2009, The Division received 41 individual and 56 group health benefit plan rate filings. The average amount of time to complete the rate review process for an individual health benefit plan rate filing has been approximately 16 hours and for a group health benefit plan rate filing has been about 10 hours.

The Division is required to keep supporting actuarial data included in individual and small group rate filings confidential. The public may only inspect filed and approved rates and rating factors,

and a summary of the approved changes. Health carriers are required to provide notice to the insured of any alteration in terms at least 60 days prior to renewal date. A consumer aggrieved by an act of the Commissioner may request a hearing. Such a hearing was granted and held on June 29, 2010, for an Anthem consumer who received notice of a 13.3 percent increase.

The Division receives numerous inquiries from health benefit plan consumers following approval of a rate increase. However, most of these consumers choose not to file written formal complaints. The Division received written formal complaints regarding health benefit plans from 20 consumers in 2008 and 16 consumers in 2009. The Division has not taken any regulatory action against carriers regarding rates for health benefit plans over the past two years.

b) Proposed rate review enhancements for health insurance

During the 2011 session of the Nevada Legislature, the Division will propose legislation to obtain prior approval rate review authority for small and large group health benefit plans. Group health benefit plans will be subject to the ratemaking standards and criteria specified within NRS 686B. Grant funds will be used to hire additional staff, including a Qualified Health Actuary (Actuary) familiar with the Actuarial Standards of Practice and Guidelines for Professional Conduct, to oversee the regulation of insurance rates for all health benefit plans and to help absorb the additional small and large group rate filing workload. Ten percent of the grant funds will be used for outside independent actuarial reviews of unreasonable rate requests.

The Actuary will define an objective process to identify unreasonable rate increases that will be consistent with HHS guidance. Unreasonable rate requests will be based on one or more of the following:

1) Actuarial supporting data provided is inaccurate or incomplete;

2) The overall average rate request exceeds a defined threshold;

3) The rate request for a class of insureds exceeds a defined threshold;

4) The provision for administrative expenses or profit included in the proposed rates is excessive; or

5) Actuarial supporting data does not justify the rate request.

The Actuary will oversee the collection, analysis, and reporting of data used to support rate filings. Ten percent of the initial grant funds will be used for information technology consulting services intended to improve the Division's IT infrastructure.

The Division is committed to enhancing transparency of the rate review process and will seek legislation to make all health benefit plan rate filings publicly available as soon as they are filed, and plans to post all health benefit plan rate filings on its web site. Consumers will be encouraged to comment in writing directly to the Division regarding rate proposals via electronic mail, fax or USPS. In order to significantly enhance consumer participation in the rate review process, approximately 25 percent of the Cycle I grant funds will be used to create a Consumer Advocate for Health Insurance Customers (Advocate) and an attorney to assist the Advocate. The Commissioner may schedule a public rate hearing shortly after receiving a rate filing

determined by the Division and Advocate to be outside reasonable rate filing thresholds consistent with HHS regulations. Consideration will be given to the magnitude of the request and the market share of the carrier. The Advocate will represent the interests of consumers during the hearing, and may use grant funds to obtain outside actuarial consulting services. The Actuary will be the lead witness on behalf of the Division, and the carrier will have the burden of demonstrating compliance with the ratemaking standards and criteria set forth in NRS 686B. The Division may choose to hold hearings in different areas of Nevada depending on the distribution of a carrier's policyholders within the state and the premium impact of the carrier's proposal by geographic area.

Proposed Timeline

8/1/2010	The Division will begin posting a summary of individual health benefit plan rate filings on its web site;
8/1/2010	The Division will begin soliciting public comment on individual health benefit rate filings posted on its web site;
10/1/2010	The Division will hire additional staff including a Qualified Health Actuary, Consumer Advocate, attorney, compliance investigator, and management analyst;
10/1/2010	The Division will report 2009 aggregate market data to HHS;
10/1/2010	The Division will begin reporting data to HHS for each health benefit plan rate filing received;
11/1/2010	The Actuary will finalize the definition of unreasonable rate filing thresholds consistent with HHS regulations;
11/1/2010	The Division will purchase hardware and/or software to improve its IT infrastructure;
11/1/2010	A database external to SERFF will be created to track and analyze actuarial supporting data submitted in rate filings;

11/1/2010	The Advocate will begin reviewing unreasonable individual health benefit plan rate filings;
12/1/2010	The Division will begin the process of holding public hearings requested by the Actuary and Advocate for unreasonable individual health benefit plan rate filings;
1/1/2011	All carriers will be required to submit rate filings using SERFF;
1/1/2011	The Division will report 2010 aggregate market data to HHS;
2/7/2011	The Division will propose legislation permitting the Division to have prior approval rate review authority for all health benefit plans and making these filings available in their entirety open for public inspection;
7/1/2011	If passed, the proposed legislation referenced above permitting the Division prior approval rate review authority for all health benefit plans and making these filings available in their entirety for public inspection becomes effective;
7/1/2011	The Advocate will begin reviewing unreasonable group health benefit plan rate fillings;
7/1/2011	The Division will begin the process of holding public hearings requested by the Actuary and Advocate for unreasonable group health benefit plan rate filings.

c) Reporting to the Secretary on Rate Increase Patterns

The Division will comply with the reporting requirements to the Secretary of HHS outlined in Section 2794 of the Public Health Service Act. SERFF will be used to collect data and generate required reports for each health benefit plan rate fling received for the individual, small group and large group markets. The Division will create a database external to SERFF to collect data from rate filings necessary to generate the required aggregate reports for the individual, small group and large group markets. The Division will use Cycle I grant funds to hire a management analyst who will be responsible for compiling these reports under the direct supervision of the Actuary.

Proposed Timeline

Tasks	Start Date	07/ 2010	08/ 2010	09/ 2010	10/ 2010	11/ 2010	12/ 2010	01/ 2011	02/ 2011	03/ 2011	04/ 2011	05/ 2011	06/ 2011	07/ 2011
Submit grant request:	Jul-10	X												
Website:														
Post summary of individual health benefit plan filings	Aug-10		X											
Solicit public comment on individual health benefit rate filings posted	Aug-10		X											
Hire additional staff:														
Qualified Health Actuary	Oct-10				X									
Consumer Advocate	Oct-10				X									
Attorney	Oct-10				X									
Compliance Investigator	Oct-10				X									
Management Analyst	Oct-10				X									
Reports:														
2009 aggregate market data to HHS	Oct-10				X									
2010 aggregate market data to HHS	Jan-11							X						
Health benefit plan rate received reported to HHS	Oct-10				X									
Equipment:														
Purchase hardware/software, Improve IT Infrastructure	Nov-10					X								
Create a separate database to track and analyze actuarial supporting data	Nov-10					X								
Objectives:														
Advocate to review potentially unreasonable **individual** health benefit plan rate fillings	Nov-10					X								
Advocate to review potentially unreasonable **group** health benefit plan rate fillings	Jul-11													X
Hold public hearings requested by the Actuary and/or Advocate for potentially unreasonable **individual** health benefit plan rate filings	Dec-10						X							
Hold public hearings requested by the Actuary and/or Advocate for potentially unreasonable **group** health benefit plan rate filings	Jul-10	X												
Actuary defines unreasonable rate filing thresholds consistent with HHS regulations	Nov-10					X								
All carriers must submit rate filings using SERFF	Jan-11							X						
Introduce legislation giving the Division prior approval rate review authority for all health benefit plans and making these filings open for public inspection	Feb-11								X					
Prior approval rate review authority for all health benefit plans	Jul-11													X
Health benefit plans rate filings open for public inspection	Jul-11													X

BUDGET NARRATIVE

Object Class Category	Grant Funds
PERSONNEL	$596,800
TRAVEL/TRAINING	$27,804
OFFICE & EQUIPMENT	$72,378
SOFTWARE	$25,000
CONSULTANTS	$275,000
TOTAL	**$996,982**

Object Class Category	Grant Funds	Justification	Narrative
Personnel	$125,000	Qualified Health Actuary	Assumes a Fellow of the Society of Actuaries with at least five years experience in pricing health benefit plans. Salary is typical for this level of required qualifications and responsibility. This position will provide high level of direction and actual oversight on a statewide level.
	$96,000	Attorney -- health insurance specialist	Assumes a Nevada licensed attorney with at least five years experience as an attorney. Preferably experienced in insurance matters related to healthcare; experienced in the administrative hearing process.
	$64,700	Compliance Investigator II	Assumes a bachelors degree from an accredited college or university with major course work in criminal justice, police science, psychology, social work, business administration or closely related field and two years of investigative experience. OR High school graduation and four years experience in investigative work as outlined above. Receives informal and formal complaints by phone or in writing. Conducts interviews with complainants. The position is the front-line person assisting with health care reform issues.
	$92,300	Consumer Advocate	Assumes a bachelors degree from an accredited college or university with a major in public or business administration or other related fields of specialization. This position represents, advances and protects the interests of Nevada consumers including representing consumers in the analysis of health benefit plan rate filings and rate hearings. This also includes the investigation of filings to determine accuracy and adequacy of the information provided by carriers to ensure that rates are not excessive, inadequate or unfairly discriminatory. Understanding the insurance regulatory environment is preferred.
	$81,100	Management Analyst IV	Assumes a bachelors degree from an accredited college or university in public or business administration, finance, social sciences, mathematics or related field, and four years of professional experience in the research, development, evaluation or revision of programs, organizations, methods or procedures. Will conduct a variety of studies, research and analysis of management and administrative areas such as budgeting and financial analysis.
Subtotal	**$459,100**		
Fringe	$37,500 $28,800 $19,400 $27,700 $24,300	Qualified Health Actuary Attorney Compliance Investigator II Consumer Advocate Management Analyst IV	State employee fringe benefits package includes: retirement, workers' compensation, Unemployment Insurance, Medicare, FICA, health insurance and Employee State Assessments.
Subtotal	**$137,700**		
Travel	$7,998	**Out of State Travel** Training Conferences East Coast x 4 nights Airfare: $750; Gnd Trans: $160 Per Diem: $71 x 4 = $284 Total Trip Cost = $2,666 x 3 = $7998	Assumes Project Officer, Consumer Advocate and Actuary will require participation in seminars for specialized training in rate review activities and reporting. Lodging: $250 x 4 = $1,000 Registration: $500 each

		NAIC Meetings - 3 annual meetings	
		East Coast x 4 nights each	Assumes Actuary and/or Management Analyst attends training
		Airfare: $750; Gnd Trans: $160	sessions. NAIC meets 3 times each year -- four days each.
		Per Diem: $71 x 4 = $284	Lodging: $250 x 4 = $1,000
	$6,582	Total Trip Cost = $2,194 x 3 = $6,582	
		In State Travel - rate hearings	
		Rate Hearings	
		Airfare: $300 ea person	Assumes rate hearings in Las Vegas and Elko. Required attendance will include the
		Ground Trans: $120	Consumer Advocate, Actuary, Attorney and Compliance Investigator. Anticipate six
		Parking: $28	rate hearing per year: three in Carson City; three in Las Vegas; and one in Elko.
		Per Diem: $71 x 2 = $142	ground transportation to and from Elko; also from Carson City to Reno.
		Lodging: $118	
		Total Trip Cost= $630 per person;	4 persons = $2520
	$7,560	3 hearings = $7560	
		Consumer Education - Town hall Mtgs	
		Airfare: $300 ea person	Assumes education meetings in Las Vegas, Elko, Winnemucca,
		Ground Tran: $800	Ely, Carson City and Reno. With the exception of Las Vegas, all
		Parking: $14 per day	travel will be by auto. Assumes one annual circuit trip through
		Per Diem: $71 per day	rural Nevada. Three sessions in Las Vegas, two in Reno and two
		Lodging: $118 per night	in Carson City. NOTE: no costs incurred for Carson City; Reno
	$5,664	Total estimated travel: $5,664	costs are limited to auto mileage.
Subtotal	**$27,804**		
Office Space,	$11,050	Computer Equipment	Assumes the addition of five staff members: Actuary, Attorney,
Equipment &	$16,570	Equipment for five people	Management Analyst, Consumer Advocate and Compliance
Supplies	$22,000	Offices for five people	Investigator. Also assumes upgrading current staff computer
	$8,800	Xerox	programs and equipment to enhance existing rate review
	$7,667	Additional printers and scanners	capabilities. Also includes addition of dual monitors for existing
	$3,333	Additional telephone & data lines	and new staff.
	$458	Email and voicemail	
	$2,500	Supplies, postage and printing	
Subtotal	**$72,378**		
Software	$25,000	Estimate for upgraded software to comply with data collection and reporting required under PPACA.	
Subtotal	**$25,000**		
Consultants	$265,000	Actuarial, IT, Legal, Other Consultants	
	$10,000	Legislative Counsel Bureau charges to review proposed legislation	
Subtotal	**$275,000**		
TOTAL	**$996,982**		

NRS 689A.680 Rates for individual health benefit plans to be developed based on rating characteristics: Prohibited characteristics; health status as rating factor.

1. An individual carrier shall develop its rates for its individual health benefit plans pursuant to NRS 689A.470 to 689A.740, inclusive, based on rating characteristics. After any adjustments for rating characteristics and design of benefits, the rate for any block of business for an individual health benefit plan written on or after January 1, 2000, must not exceed the rate for any other block of business for an individual health benefit plan offered by the individual carrier by more than 50 percent. The rate for a block of business is equal to the average rate charged to all the insureds in the block of business. In determining whether the rate of a block of business complies with the provisions of this subsection, any differences in rating factors between blocks of business must be considered.

2. In determining the rating factors to establish premium rates for a health benefit plan, an individual carrier shall not use characteristics other than age, sex, occupation, geographic area, composition of the family of the individual and health status.

3. If an individual carrier uses health status as a rating factor in establishing premium rates, the highest factor associated with any classification for health status may not exceed the lowest factor by more than 75 percent.

4. For the purposes of this section, rating characteristics must not include durational or tier rating, or adverse changes in health status or claim experience after the policy is issued.

5. As used in this section, "characteristics" means demographic or other information concerning individuals that is considered by a carrier in the determination of premium rates for individuals.

(Added to NRS by 1997, 2894; A 1999, 2805)

NRS 689A.685 Amount of change in rate of single block of business; plan with provision for restricted network; involuntary transfer of individual or dependent prohibited; premiums adjusted for block of business.

1. The amount of change in the rate of a single block of business of an individual carrier in any 12-month period because of claims experience or health status-related factors of that block of business, after adjustment for allowed rating characteristics and design of benefits, must not exceed the amount of any similar change in the rate of any other block of business of that individual carrier during the same period by more than 15 percent.

2. For the purposes of NRS 689A.470 to 689A.740, inclusive, a health benefit plan that contains a provision for a restricted network must not be considered to be a similar design of benefits when compared to a health benefit plan that does not contain such a provision if the restriction of benefits to the network providers results in substantial differences in the cost of claims.

3. An individual carrier shall not transfer an individual or his or her dependent covered by an individual health benefit plan issued by the individual carrier involuntarily into or out of a block of business.

4. If an individual carrier adjusts its premiums for a block of business to a level that is higher than permitted by requirements relating to the ratio of losses, as set forth in this Title and the regulations adopted pursuant thereto, to comply with this section and NRS 689A.680, the individual carrier shall make such adjustments on its entire individual health benefit plan business as needed to meet those requirements.

(Added to NRS by 1997, 2895)

NRS 689A.690 Information required to be disclosed as part of solicitation and sales materials; information required to be maintained at place of business; actuarial certification required to be filed with Commissioner.

1. As part of its solicitation and sales materials for an individual health benefit plan, an individual carrier shall disclose, to the extent reasonable:

(a) The extent to which premium rates for an individual and the dependent of the individual are established or adjusted based upon rating characteristics;

(b) The right of the individual carrier to change premium rates and the factors, other than claims experience, that may affect changes in premium rates;

(c) Any provisions in the individual health benefit plan relating to the renewability of the plan; and

(d) Any provisions in the individual health benefit plan relating to an exclusion for a preexisting condition.

2. For the purposes of this section, an individual carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

3. On or before March 1 of each year, an individual carrier shall file with the Commissioner an actuarial certification that the individual carrier is in compliance with NRS 689A.680 to 689A.700, inclusive, and that the rating methods of the individual carrier are actuarially sound. The certification must be in such a form and must contain such information as specified by the Commissioner. A copy of the certification must be retained by the individual carrier at its principal place of business.

4. As used in this section, "actuarial certification" means a written statement signed by a member of the American Academy of Actuaries or any other person acceptable to the Commissioner that an individual carrier is in compliance with the provisions of NRS 689A.680 to 689A.700, inclusive, based upon an examination conducted by the person which included a review of the appropriate records and the actuarial assumptions and methods used by the individual carrier in establishing premium rates for applicable health benefit plans.

(Added to NRS by 1997, 2895)

NRS 689A.695 Information and documents to be made available to Commissioner; proprietary information. An individual carrier shall make the information and documents described in NRS 689A.680 to 689A.700, inclusive, available to the Commissioner upon request. Except in cases of violations of the provisions of this chapter, the information, other than the premium rates charged by the individual carrier, is proprietary, constitutes a trade secret and is not subject to disclosure by the Commissioner to persons outside of the Division except as agreed to by the individual carrier or as ordered by a court of competent jurisdiction.

(Added to NRS by 1997, 2896)

NRS 689A.700 Regulations regarding rates. The Commissioner may adopt regulations to carry out the provisions of NRS 689A.680 to 689A.700, inclusive, and to ensure that the practices used by individual carriers relating to the establishment of rates are consistent with the purposes of NRS 689A.470 to 689A.740, inclusive, including, but not limited to, determining the manner in which geographic areas are designated by all individual carriers.

(Added to NRS by 1997, 2895)

ATTACHMENT B Small Employer Groups

NRS 689C.210 Procedure for increasing premium rates.

1. Except as otherwise provided in subsection 3, a carrier shall not increase the premium rate charged to a small employer for a new rating period by a percentage greater than the sum of:

(a) The percentage of change in the premium rate for new business for the policy under which the small employer is covered, measured from the first day of the previous rating period to the first day of the new rating period;

(b) An adjustment, not to exceed 15 percent annually, adjusted pro rata for rating periods of less than 1 year, on account of the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the carrier's rate manual for the class of business; and

(c) Any adjustment on account of change in coverage or change in the characteristics of the small employer as determined from the carrier's rate manual for the class of business.

2. If the carrier no longer issues new policies for that class of business, the carrier shall use the percentage of change in the premium rate for new business for the class of business which is most similar to the closed class of business and for which the carrier is issuing new policies.

3. In the case of health benefit plans delivered or issued for delivery before January 1, 1996, for groups with not fewer than 2 employees and not more than 25 employees, or before July 1, 1997, for groups with not fewer than 26 employees and not more than 50 employees, a premium rate for a rating period may exceed the ranges set forth in NRS 689C.230 for a period of 3 years following that date. In that case, the percentage of increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

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

(b) Any adjustment on account of change in coverage or change in the characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(Added to NRS by 1995, 983; A 1997, 2946; 1999, 2813)

NRS 689C.220 Adjustment in rates to be applied uniformly. A carrier serving small employers shall not charge adjustments in rates for claim experience, health status and duration of coverage to individual employees or dependents. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of a small employer.

(Added to NRS by 1995, 984)

NRS 689C.230 Determination and application of index rate.

1. The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20 percent.

2. For a class of business, the premium rates charged during a rating period to small employers with similar characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, may not vary, because of health status-related factors, from the index rate by more than 30 percent.

3. As used in this section:

(a) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the carrier to small employers with similar characteristics for health benefit plans subject to regulation by the Commissioner.

(b) "Index rate" means, for each class of business as to a rating period for small employers with similar characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(Added to NRS by 1995, 984; A 1997, 2947)

NRS 689C.240 Use of industry classifications as rating factor. A carrier serving small employers may utilize industry classifications as a rating factor in establishing premium rates, but the highest rate factor associated with any industry classification may not exceed the lowest rate factor associated with any industry classification by more than 20 percent.

(Added to NRS by 1995, 984; A 1995, 989)

NRS 689C.250 Required disclosures to Commissioner; when disclosures constitute trade secret. A carrier serving small employers shall make the information and documents described in NRS 689C.210 to 689C.240, inclusive, available to the Commissioner upon request. Except in cases of violations of NRS 689C.015 to 689C.355, inclusive, the information is proprietary, constitutes a trade secret, and is not subject to disclosure by the Commissioner to persons outside of the Division except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

(Added to NRS by 1995, 984)

NRS 689C.260 Manner in which carrier may establish separate class of business; transferring small employer into or out of class of business.

1. Except as otherwise provided in subsection 2, a carrier serving small employers may establish no more than nine separate classes of business, and each class must reflect substantial differences in expected claim experience or administrative costs related to the following:

(a) The use of more than one type of system for the marketing and sale of health benefit plans to small employers;

(b) The acquisition of a class of business from another carrier serving small employers; or

(c) The provision of coverage to one or more groups that meet the requirements of NRS 689B.026.

2. The Commissioner may approve the establishment of additional classes of business upon application by a carrier and a finding by the Commissioner that this action would enhance the efficiency and fairness of the market for health insurance for small employers.

3. The Commissioner may adopt regulations to provide for a period of transition for a carrier serving small employers to comply with subsection 1 if the carrier acquires an additional class of business from another carrier serving small employers.

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

(Added to NRS by 1995, 984)

ATTACHMENT C HMOs

NRS 695C.180 Schedule of charges.

1. No schedule of charges for enrollee coverage for health care services or amendment thereto may be used in conjunction with any health care plan until a copy of such schedule or amendment thereto has been filed with and approved by the Commissioner.

2. Such charges may be established in accordance with actuarial principles for various categories of enrollees. However the charges shall not be excessive, inadequate nor unfairly discriminatory. A certification by a qualified actuary to the adequacy of the charges shall accompany the filing along with adequate supporting information.

(Added to NRS by 1973, 1251)

ATTACHMENT D Nonprofit Insurers

NRS 695B.170 Acquisition costs and administrative expenses; effect of finding of excess costs. All acquisition costs in connection with the solicitation of subscribers to such hospital, medical or dental service plan shall at all times be subject to the approval of the Commissioner, and the administrative expenses for any calendar year, excluding the first full year of operation, of any such corporation, including acquisition costs, shall be limited to 25 percent of the aggregate amount of rates, dues, fees and other periodic charges actually received during that year. If the Commissioner finds that acquisition costs of any corporation operating under the provisions of this chapter are excessive, or that the administrative expenses exceed the amount above stated, such finding shall be sufficient ground to justify the Commissioner in revoking the consent of the Commissioner to the establishment, maintenance and operation by such corporation of the hospital, medical or dental service plan.

(Added to NRS by 1971, 1869)

ATTACHMENT E Rating Standards

NRS 686B.030 Applicability.

1. Except as otherwise provided in subsection 2, NRS 686B.010 to 686B.1799, inclusive, apply to all kinds and lines of direct insurance written on risks or operations in this State by any insurer authorized to do business in this State, except:

(a) Ocean marine insurance;

(b) Contracts issued by fraternal benefit societies;

(c) Life insurance and credit life insurance;

(d) Variable and fixed annuities;

(e) Group and blanket health insurance and credit health insurance;

(f) Property insurance for business and commercial risks;

(g) Casualty insurance for business and commercial risks other than insurance covering the liability of a practitioner licensed pursuant to chapters 630 to 640, inclusive, of NRS; and

(h) Surety insurance.

2. The exclusions set forth in paragraphs (f) and (g) of subsection 1 extend only to issues related to the determination or approval of premium rates.

(Added to NRS by 1971, 1699; A 1971, 1943; 1985, 1067; 1993, 2397; 1995, 2056; 2003, 3304)

NRS 686B.050 Standards.

1. Rates must not be excessive, inadequate or unfairly discriminatory, nor may an insurer charge any rate which if continued will have or tend to have the effect of destroying competition or creating a monopoly.

2. The Commissioner may disapprove rates if there is not a reasonable degree of price competition at the consumer level with respect to the class of business to which they apply. In determining whether a reasonable degree of price competition exists, the Commissioner shall consider all relevant tests, including:

(a) The number of insurers actively engaged in the class of business and their shares of the market;

(b) The existence of differentials in rates in that class of business;

(c) Whether long-run profitability for insurers generally of the class of business is unreasonably high in relation to its riskiness;

(d) Consumers' knowledge in regard to the market in question; and

(e) Whether price competition is a result of the market or is artificial.

➥ If competition does not exist, rates are excessive if they are likely to produce a long-run profit that is unreasonably high in relation to the riskiness of the class of business, or if expenses are unreasonably high in relation to the services rendered.

3. Rates are inadequate if they are clearly insufficient, together with the income from investments attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

4. One rate is unfairly discriminatory in relation to another in the same class if it clearly fails to reflect equitably the differences in expected losses and expenses. Rates are not unfairly discriminatory because different premiums result for policyholders with similar exposure to loss but different expense factors, or similar expense factors but different exposure to loss, so long as the rates reflect the differences with reasonable accuracy. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, franchise or blanket policy.

(Added to NRS by 1971, 1699; A 1987, 1533)

NRS 686B.060 Determination of whether rates comply with standards. In determining whether rates comply with the standards under NRS 686B.050, the following criteria shall be applied:

1. Due consideration shall be given to past and prospective loss and expense experience within and outside of this state, to catastrophe hazards and contingencies, to trends within and outside of this state, to loadings for leveling premium rates over time or for dividends or savings to be allowed or returned by insurers to their policyholders, members or subscribers, and to all other relevant factors, including the judgment of technical personnel.

2. Risks may be classified in any reasonable way for the establishment of rates and minimum premiums, except that classifications may not be based on race, color, creed or national origin. Rates thus produced may be modified for individual risks in accordance with rating plans or schedules which establish reasonable standards for measuring probable variations in hazards, expenses, or both.

3. The expense provisions included in the rates to be used by an insurer may reflect the operating methods of the insurer and, so far as it is credible, its own expense experience.

4. The rates may contain an allowance permitting a profit that is not unreasonable in relation to the riskiness of the class of business.

(Added to NRS by 1971, 1700)

NEVADA

Cliff King, CPCU, ARM
Project Director - Resume

March 2010 to present:
Nevada Division of Insurance
Chief Insurance Examiner - Life & Health Section
Primary activities: Oversee the implementation of the Patient Protection and Affordable Care Act (PPACA). This includes the enhancement of a system of rate review/oversight of all health benefit plans sold in Nevada. Manage a staff of seven persons reviewing and approving all life, health, annuity, long-term care and other "health-related" insurance products.

July 2007 to March 2010:
Pro Group Management
Director of Group Operations and Group Manager
Pro Group Management is an administrator of self insured group workers' compensation insurance programs in the state of Nevada. Pro Group Captive Management (PGCM) is a captive manager for 45 captive insurers licensed in Nevada. PGCM is also authorized to manage captive insurers in Arizona and Utah.

July 1998 to June 2007:
Nevada Division of Insurance
Chief Administrator of Captive Insurance Programs; Chief Insurance Assistant to the Commissioner; Chief Insurance Examiner - Property & Casualty Section
As Chief Insurance Examiner of the Property and Casualty Section, duties included the oversight of rate and form filings for all personal and commercial lines of business to include auto and homeowners; commercial liability insurance including medical malpractice and workers' compensation; and surety coverage. Reported to the Chief Insurance Assistant.

As Chief Insurance Assistant, duties included supervision of the Life & Health Section, Property & Casualty Section, Self-Insured Workers' Compensation Section, Captive Insurer Section, and Consumer Services Section. Reported directly to the Commissioner.
As Chief Administrator of the Captive Insurance Program Section, reviewed applications, business plans, and other documents related to captive insurance programs for large organization's self-insured programs. Made recommendations to the Commissioner for actions to be taken for regulation of these entities. Reported directly to the Commissioner.

November 1996 to July 1998:
A and H Insurance, Inc., Reno, NV
Account Executive and Underwriting Director
Produced new accounts for the agency as well as acted as liaison to insurers contracted with the agency. Oversaw the placement of business with each insurer and monitored the profitability with each carrier.

April 1995 to November 1996:

MacCready & Guttman Insurance Services of Nevada, Inc., Reno, NV

Director of Underwriting

This was a managing general agency for Republic Western Insurance Company writing small commercial business in seven western states. Was responsible for all policy activities including acceptance, rating/pricing, policy issuance and termination, billing and collections, agency relations including appointment and termination, and other duties required.

February 1993 to March 1995:

CIGNA Property & Casualty Insurance Company

Phoenix, AZ and Rancho Cordova, CA

Vice President and Branch Manager, Phoenix, AZ

Vice President, Community Insurance Group, Rancho Cordova, CA

Vice President, Education Insurance Services, Rancho Cordova, CA

Responsibilities included the overall pricing, production and profitability of commercial business written by our contracted agents and brokers. Responsible for appointing and terminating agents and brokers; supervising employees including marketing representatives, underwriters and clerical staff; achieving and adhering to budget objectives; implement marketing and underwriting strategies.

April 1980 to February 1993

The Hartford Insurance Group

Sacramento, CA

Commercial Underwriting Manager

Manage a staff of underwriters and clerical in the procurement and pricing of commercial business through assigned agents and brokers in California and Nevada.

July1972 to April 1980

USF&G Insurance Company

New Orleans, Sacramento and Phoenix Branch Offices

Management, Marketing and Underwriting Positions

Underwriter and Supervisor of assigned agents and brokers in three branch offices of the company.

Education:

- Bachelor of Science, General Business Administration, Arizona State University, 1971
- Chartered Property & Casualty Underwriter (CPCU) 1997
- Associate in Risk Management (ARM) 2004

Other Experience:

- Instructor in general insurance and Associate in Risk Management (ARM) at Western Nevada Community College 1999 – 2005
- Instructor in ARM in Nevada 2006-2010

Military:

- United States Army Reserve 1971 – 1979 ; Highest rank attained: Captain

KIMBERLY K EVERETT, CPM

Assistant Project Director - Resume

SUMMARY OF QUALIFICATIONS

- 26 years of insurance industry experience.
- 10 years working for the Life and Health Section at the Division of Insurance for the State of Nevada.
- 4.5 years of supervisory experience within the State of Nevada.
- Working knowledge of state and federal laws, current events and trends, issues and discussions.
- Excellent communication skills, experienced in testifying before the Nevada Legislature and workshop/hearings.
- Proficient in analyzing and drafting regulations, proposed statutory language, opinions, bulletins, and complex policy initiatives.
- Effective in balancing the interests of industry with the needs of Nevada consumers.
- Strong leadership skills with emphasis on effective utilization of professional resources.
- Strong organizational and analytical skills.
- Willing to take on additional challenges; resourceful and innovative.

PROFESSIONAL EXPERIENCE

September 2006 to Present
Nevada Division of Insurance, Life & Health Section

September 2006 to present:	Assistant Section Chief
June 2002 to September 2006:	Actuary I
June 2000 to June 2002:	Associate Actuary

July 1997 to June 2000
Sierra Health Services
Policy Compliance Analyst, Legal

February 1996 to June 1997
AMIL International of Nevada
Compliance Coordinator/Operations Support

December 1983 to November 1995
Mutual of Omaha
Various positions held

EDUCATION

Dana College, Blair NE
Iowa Western Community College, Council Bluffs, IA
Bellevue University, Bellevue NE
University of Nevada Las Vegas

Job Descriptions

The Director (King) will be responsible for the overall planning, organizing, staffing, directing and controlling the project. In addition to being the primary point of contact, he will also oversee the budget reporting requirements and other reporting as well as the day-to-day activities of the Life & Health Insurance Section. We anticipate that it will require a minimum of 15% of Mr. King's time to manage this project.

The Assistant Director (Everett) will be the secondary point of contact and also responsible for assisting the Director in the oversight of the project. Ms. Everett will also actively participate in the assignment and review of health benefit plan rate filings. She will handle day-to-day "filing level" activities of assuring that all filings are distributed to the appropriate staff and that each staff member responds in a timely manner to other members in the project. We anticipate that it will require a minimum of 20% of Ms. Everett's time for this project.