GRANTS.GOV™

Grant Application Package

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

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

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

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

*** Application Filing Name:** Illinois Department of Insurance

Mandatory Documents

Move Form to Complete

Move Form to Delete

Mandatory Documents for Submission

- Application for Federal Assistance (SF-424)
- Key Contacts
- Disclosure of Lobbying Activities (SF-LLL)
- Assurances for Non-Construction Programs (SF-42
- Project/Performance Site Location(s)
- Budget Information for Non-Construction Program
- Budget Narrative Attachment Form

Optional Documents

- Project Abstract Summary
- Other Attachments Form
- Basic Work Plan

Move Form to Submission List

Move Form to Delete

Optional Documents for Submission

Instructions

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

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

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

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

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

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

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

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

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

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

Application for Federal Assistance SF-424

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

* 3. Date Received:	4. Applicant Identifier:
07/07/2010	

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: Illinois Department of Insurance

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
03-0452423	1449653600000

d. Address:

* Street1:	320 W. Washington, 4th Floor
Street2:	
* City:	Springfield
County/Parish:	Sangamon
* State:	IL: Illinois
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	62767-001

e. Organizational Unit:

Department Name:	Division Name:
Department of Insurance	Consumer Market Division

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

Prefix:		* First Name:	Melissa
Middle Name:			
* Last Name:	Hansen		
Suffix:			

Title: Director of Legislative Affairs

Organizational Affiliation:
Illinois Department of Insurance

* Telephone Number:	217-524-7949	Fax Number:	217-524-6500

* Email: melissa.hansen@illinois.gov

Application for Federal Assistance SF-424

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

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

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

Ofc of Consumer Information & Insurance Oversight

11. Catalog of Federal Domestic Assistance Number:

93.511

CFDA Title:

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

*** 12. Funding Opportunity Number:**

RFA-FD-10-999

* Title:

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

13. Competition Identification Number:

ADOBE-FORMS-B

Title:

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

Add Attachment

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

Illinois Premium Review Project

Attach supporting documents as specified in agency instructions.

Add Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant 1-19 b. Program/Project 1-19

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment

17. Proposed Project:

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

18. Estimated Funding ($):

* a. Federal	1,000,000.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,000,000.00

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

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

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

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

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

☐ Yes ☒ No

If "Yes", provide explanation and attach

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

☒ ** I AGREE

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

Authorized Representative:

Prefix: * First Name: Michael

Middle Name: T.

* Last Name: McRaith

Suffix:

* Title: Director, Illinois Department of Insurance

* Telephone Number: 217-785-5516 Fax Number: 217-524-6500

* Email: michael.mcraith@illinois.gov

* Signature of Authorized Representative: Melissa Hansen * Date Signed: 07/07/2010

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

Key Contacts Form

*** Applicant Organization Name:**

Illinois Department of Insurance

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

*** Contact 1 Project Role:** Project Manager

Prefix:

* First Name: William

Middle Name:

* Last Name: McAndrew

Suffix:

Title: Deputy Director for Consumer Market

Organizational Affiliation:

* Street1: 320 W Washington, 5th Floor

Street2:

* City: Springfield

County:

* State: IL: Illinois

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 62767-001

* Telephone Number: 217-782-4395

Fax:

* Email: bill.mcandrew@illinois.gov

Delete Entry

Next Person

OMB Number: 4040-0010
Expiration Date: 08/31/2011

Project/Performance Site Location(s)

Project/Performance Site Primary Location ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Illinois Department of Insurance

DUNS Number: 1449653600000

* Street1: 320 W. Washington St.

Street2:

* City: Springfield County: Sangamon

* State: IL: Illinois

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 62767-0001 * Project/ Performance Site Congressional District: IL-all

Project/Performance Site Location 1 ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s)

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	Cover Sheet (Checkoff List).1		Delete Attachment	View Attachment
2) Please attach Attachment 2	Letter of Support (Quinn).pd		Delete Attachment	View Attachment
3) Please attach Attachment 3	Cover Letter (signed).pdf		Delete Attachment	View Attachment
4) Please attach Attachment 4	Project Abstract (final).pdf		Delete Attachment	View Attachment
5) Please attach Attachment 5	Project Narrative (final).pd		Delete Attachment	View Attachment
6) Please attach Attachment 6	Project Workplan (final).pdf		Delete Attachment	View Attachment
7) Please attach Attachment 7	Project Timeline (final).pdf		Delete Attachment	View Attachment
8) Please attach Attachment 8	Budget Narrative (final).pdf		Delete Attachment	View Attachment
9) Please attach Attachment 9	Appendices A through N.pdf		Delete Attachment	View Attachment
10) Please attach Attachment 10	Appendix L_Staff Job Descrip		Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment		
12) Please attach Attachment 12		Add Attachment		
13) Please attach Attachment 13		Add Attachment		
14) Please attach Attachment 14		Add Attachment		
15) Please attach Attachment 15		Add Attachment		

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

Objective Work Plan

Project:

Illinois Premium Review Project

* Year: 1

* Funding Agency Goal: $1,000,000

* Objective:

Expand the scope of current review process,improve rate filing requirements, and increase public disclosure of and accessibility to rates.

* Results or Benefits Expected:

Enhance consumer protection standards.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Improve existing regulations relating to reporting requirements and expand application of reporting requirements to include group market. Notify companies in writing to submit group market rates.	Project Manager	08/16/2010	10/15/2010	50
Increase public disclosure of rates, rate increases, health care expenditures, utilization rates and benefit designs.	Project Manager	08/16/2010	10/15/2010	100
Engage and educate the public and policymakers regarding rate increases, health care costs, utilization rates and benefit designs.	Project Manager	08/16/2010	09/30/2011	100
Improve IT infrastructure to address data collection and reporting needs. The IT modification will include the creation of an interactive tool for consumers to search information regarding health care coverage.	Level II IT consultant	08/16/2010	09/30/2011	2,000

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

Objective Work Plan

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Determine whether rate increases for individual and group markets are actuarially justified. Analyze health care expenditures and evaluate how health care dollars are being spent, whether benefit design results in utilization pattern.	Health actuary, 3 actuarial assistants, and contractual actuaries	08/09/2010	09/30/2011	0
Employ the information compiled from rate review reporting process to educate the public and policymakers regarding premiums and health care costs.	Department Director	08/16/2010	09/30/2011	100
Convene public hearings on rate increases to hear the concerns of Illinois residents with regard to the costs of health insurance coverage.	Assistant Project Manager	08/16/2010	10/15/2010	200

* Criteria for Evaluating Results or Benefits Expected:

Illinois will know how many consumers it reaches by the number of attendees at public hearings, the number of "hits" to the Department's rate review report and related web site materials, and the number of consumer surveys completed.
The number of affected consumers may also include the number of policyholders affected by a proposed rate change reduced as a result of the Department's efforts.

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

Objective Work Plan

You may attach up to 17 additional Objective Work Plan forms here. To extract, fill and attach each additional form, follow these steps:

- Select the "Select to Extract the Objective Work Plan Attachment" button below.

- Save the file using a descriptive name to help you remember the content of the supplemental form that you are creating. When assigning a name to the file, please remember to give it the extension ".pdf" (for example, "Objective_1.pdf"). If you do not name your file with the ".pdf" extension you will be unable to open it later, using Adobe Reader.

- Use the "Open Form" tool on Adobe Reader to open the new form you just saved.

- Enter your additional Objective information in this supplemental form, similar to the Objective Work Plan form that you see in the main body of your application.

- When you have completed entering information in the supplemental form, save and close it.

- Return to this page and attach the saved supplemental form you just filled in, to one of the blocks provided on this "attachments" form.

Important: Attach additional Objective Work Plan forms, using the blocks below. Please remember that the files you attach must be Objective Work Plan PDF forms that were previously extracted using the process outlined above. Attaching any other type of file may result in the inability to submit your application to Grants.gov. Note: It is important to attach completed forms only. Attach ONLY PDF (.pdf) forms where ALL required fields are filled out. Incomplete or missing data will cause your application to be rejected.

Select to extract the Objective Work Plan Attachment

1) Please attach Attachment 1		Add Attachment		
2) Please attach Attachment 2		Add Attachment		
3) Please attach Attachment 3		Add Attachment		
4) Please attach Attachment 4		Add Attachment		
5) Please attach Attachment 5		Add Attachment		
6) Please attach Attachment 6		Add Attachment		
7) Please attach Attachment 7		Add Attachment		
8) Please attach Attachment 8		Add Attachment		
9) Please attach Attachment 9		Add Attachment		
10) Please attach Attachment 10		Add Attachment		
11) Please attach Attachment 11		Add Attachment		
12) Please attach Attachment 12		Add Attachment		
13) Please attach Attachment 13		Add Attachment		
14) Please attach Attachment 14		Add Attachment		
15) Please attach Attachment 15		Add Attachment		
16) Please attach Attachment 16		Add Attachment		
17) Please attach Attachment 17		Add Attachment		

OMB Number: 4040-0003
Expiration Date: 09/30/2011

Project Abstract

The Project Abstract must not exceed one page and must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This Abstract must not include any proprietary/confidential information.

* Please click the add attachment button to complete this entry.

Delete Attachment | View Attachment

Project Abstract (final).pdf

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** Project Narrative (final).pdf

Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

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

Add Optional Project Narrative File

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** Budget Narrative (final).pdf

Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

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

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

BUDGET INFORMATION - Non-Construction Programs

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

SECTION A - BUDGET SUMMARY

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

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1) Premium Review - Cycle I	(2)	(3)	(4)	Total (5)
a. Personnel	$ 351,948.00	$	$	$	$ 351,948.00
b. Fringe Benefits	234,899.00				234,899.00
c. Travel	0.00				
d. Equipment	35,700.00				35,700.00
e. Supplies	0.00				
f. Contractual	336,700.00				336,700.00
g. Construction	0.00				
h. Other	40,753.00				40,753.00
i. Total Direct Charges (sum of 6a-6h)	1,000,000.00				$ 1,000,000.00
j. Indirect Charges					$
k. TOTALS (sum of 6i and 6j)	$ 1,000,000.00	$	$	$	$ 1,000,000.00
7. Program Income	$	$	$	$	$

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8.	$	$	$	$
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

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

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.	$	$	$	$
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks:

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Melissa Hansen	Director, Illinois Department of Insurance
* APPLICANT ORGANIZATION	* DATE SUBMITTED
Illinois Department of Insurance	07/07/2010

DISCLOSURE OF LOBBYING ACTIVITIES

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

Approved by OMB
0348-0046

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

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

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

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

** Name* Illinois Department of Insurance

** Street 1* 320 W Washington *Street 2*

** City* Springfield *State* IL: Illinois *Zip* 62767

Congressional District, if known:

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

6. * Federal Department/Agency:

Department of Health and Human Services

7. * Federal Program Name/Description:

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

CFDA Number, *if applicable:* 93.511

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix ** First Name* N/A *Middle Name*

** Last Name* N/A *Suffix*

** Street 1* *Street 2*

** City* *State* *Zip*

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

Prefix ** First Name* N/A *Middle Name*

** Last Name* N/A *Suffix*

** Street 1* *Street 2*

** City* *State* *Zip*

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

*** Signature:** Melissa Hansen

***Name:** *Prefix* ** First Name* Michael *Middle Name* I

** Last Name* McRaith *Suffix*

Title: Director, Illinois Department of Insurance **Telephone No.:** 217-558-5516 **Date:** 07/07/2010

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OFFICE OF THE GOVERNOR

SPRINGFIELD, ILLINOIS 62706

Pat Quinn
GOVERNOR

July 7, 2010

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: ***Grants to States for Health Insurance Premium Review Cycle I, CFDA: 93.511.***

Dear Secretary Sebelius:

Thank you for the opportunity to apply for $1 million to enhance the State of Illinois' authority to review premium rate increases proposed by health insurers operating in our State.

I strongly support the Illinois proposal entitled the "Premium Review Project." While many states currently have rate review authority, including states as diverse as Maine, Tennessee, North Dakota, Indiana and California, Illinois' Department of Insurance does not have the explicit authority to approve or deny rate increases imposed by health insurers. Review of health insurer premiums is an opportunity for our State to add efficiency to a marketplace that does not provide efficient value in exchange for hard-earned premium dollars.

With an entirely for-profit health insurance marketplace, Illinois' families and businesses of every size are experiencing rate increases of such a punitive magnitude that many are unable to afford meaningful coverage. Small business premiums in Illinois are being raised more than 50 percent, and high deductible plan premiums are being raised more than 30 percent for employers whose employees never actually reach the high deductible threshold.

I strongly support the objective of our proposal with the intention of improving the value of health insurance purchased in Illinois. Our Department of Insurance will maximize the value of the federal grant dollars. The grant funds will be used only to supplement, not supplant, Illinois' existing investment in the rate review process, and we will maintain this existing investment through the balance of the grant cycle.

If you have any further questions, please do not hesitate to contact Michael McRaith, Director of the Illinois Department of Insurance at 312-814-9200.

Sincerely,

Pat Quinn

Pat Quinn
Governor

cc: Michael Gelder

Illinois Department of Insurance

PAT QUINN
Governor

Michael T. McRaith
Director

July 7, 2010

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Grants to States for Health Insurance Premium Review Cycle I, CFDA: 93.511

Dear Secretary Sebelius:

The Illinois Department of Insurance respectfully requests $1,000,000 to fund the Premium Review Project through the *Grants to States for Health Insurance Premium Review Cycle I* grant program, CFDA: 93.511 ("Cycle I grant"). The Illinois Department of Insurance's mission is to protect consumers by providing assistance and information, by efficiently regulating the insurance industry's market behavior and financial solvency, and by fostering a competitive insurance marketplace. The Department carries out its mission through effective administration and enforcement of the Illinois Insurance Code (215 ILCS 5/1 *et seq.*) and related laws and regulations, including Title 50 of the Illinois Administrative Code. The goals and funding provided by the Department of Health and Human Services (HHS) through the Cycle I grant will significantly enhance the ability of the Department to fulfill its consumer protection mission.

The Department's proposed Premium Review Project involves: the establishment of new premium collection and public disclosure processes, enhanced actuarial review of premium rates, and an expansion and updating of the Department's rate review infrastructure. In order to achieve these goals, the Department will hire additional staff and upgrade current data systems, while also working to refine and expand requirements. The Department will then use the compiled rate review information to educate the public and policymakers regarding premiums, health care costs, and the connection between benefit designs and utilization. All such efforts would be public, open, and transparent, with all minutes and deliverables posted prominently on the Department's website.

The Premium Review Project Manager will be Mr. Bill McAndrew, Deputy Director for the Department of Insurance. The Deputy Project Manager will be Kate Gross, Assistant Director for Health Planning within the Department. Their contact information is included below:

William R. McAndrew
Deputy Director
Illinois Department Insurance
320 W. Washington
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Kate Gross MPH
Assistant Director for Health Planning
Illinois Department of Insurance
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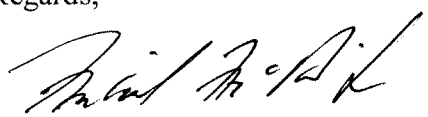
Governor Quinn and the Department enthusiastically support this program. We are eager to launch our rate review effort so that we can better engage, inform and educate consumers and policymakers on the issue of health insurance premium rates and increases. Thank you for your consideration of our request. If you have any questions about this proposal, please contact Kate Gross at 312-814-1236.

Regards,



Michael T. McRaith, Director
Illinois Department of Insurance

PREMIUM REVIEW PROJECT ABSTRACT

One of the primary goals of health care reform, and the vision incorporated into the Affordable Care Act, is to make comprehensive health insurance coverage affordable and accessible to all Americans. The new program launched in Section 2794 of the Public Health Service Act, entitled "Ensuring That Consumers Get Value For Their Dollar," provides new opportunities and invaluable resources for states like Illinois to do just that. For this reason, the Illinois Department of Insurance ("the Department") intends to pursue this grant to fund expanded reporting and review of health insurer premium increases. The people of Illinois, including policymakers, will be educated and informed about Illinois' currently dysfunctional marketplace.

Under the existing framework for health insurance regulation in Illinois, health insurers that offer major medical policies face few statutory reporting requirements and no mandate to deliver affordable options for health coverage. As a result, the health insurance marketplace fails consumers, often pricing Illinois' businesses and families out of health insurance. The goals of the *Premium Review Project* are to expand the scope of the current premium review process in the State and significantly enhance consumer protections, including effective engagement and education of the public and policymakers on the issue of health insurance premium rates. The Department plans to expend the $1,000,000 requested as part of the Cycle I grants to accomplish these goals through: 1) establishment of the infrastructure necessary for premium rate review; and 2) establishment of new processes to collect, publish, and analyze premium information to educate consumers and State policymakers.

More specifically, the Department will increase actuarial staffing and invest in the necessary technological infrastructure to prepare for increased premium rate reporting, analysis, and stakeholder engagement. The current process for collecting rate increase information does not permit the Department's actuaries to analyze and effectively draw conclusions from the information submitted by insurers. Some insurers submit, process, and file information through a strictly paper system. The rate submission process must be updated to facilitate the Department's analysis and understanding of current trends in the State's health insurance marketplace and health care economy.

Using the information gained from improved reporting and analysis of premium rate information, the Department will implement a permanent process to engage and educate consumers and policymakers on health insurer premium rate increases. The Department will conduct public hearings, develop interactive tools on the Department's website allowing consumers to search current health insurance premium rate information and provide feedback on insurance products, and publish reports on rate increases, health care costs, health care utilization and the impact of benefit design on utilization. Additionally, the Department will develop resources for consumers regarding premium rate information to assure such information is in a format that is of value to family and business consumers.

Rate review activities enable the Department to better support a competitive, functioning health insurance marketplace.

Illinois Department of Insurance

Premium Review Project -- Project Narrative

Grant Application for the Health Insurance Premium Review – Cycle I

CFDA: 93.511

July 7, 2010

a) Current health insurance rate review capacity and process

General Health Insurance Information

All insurance companies and all agents/brokers selling insurance products in Illinois are required by State law (215 ILCS 5/1 *et seq.*) to be licensed and regulated by the Department of Insurance (the "Department"). Insurance companies in Illinois sell a variety of major medical health insurance products, including health maintenance organization (HMO) plans, preferred provider organization (PPO) plans, and indemnity plans.[1] These products are available in all markets (individual, small group, and large group). Illinois has an entirely for-profit health insurance industry.

Illinois law does not require that premium rates for individual or group health insurance policies be "actuarially justified." With respect to major medical plans sold in the individual and large group markets (*i.e.*, the market for health insurance sold to employers with more than 50 employees), Illinois law does not restrict the premiums that may be charged by an insurer or HMO.

Plans sold in the small group market are subject to the Small Employer Health Insurance Rating Act (*See* Appendix A, "SEHIRA", 215 ILCS 93 *et seq.*). SEHIRA limits the amount by which premiums charged to small employers can vary due to an employer's health status or claims experience:

- The premium charged to an individual small employer cannot vary from the "index rate" (*i.e.*, the arithmetic mean of the lowest and highest premium rate that is charged or that could be charged to employers with the same or similar "case characteristics" within a class of business) by more than 25 percent; and
- The index rate for a class of business cannot vary by more than +/- 20 percent from the index rate for any other class of business.

[1] For purposes of this application, the terms "health insurance" and "health insurance products" refer to the definitions established under the Patient Protection and Affordable Care Act (P.L. 111-148, the "Affordable Care Act").

SEHIRA *does not* limit premium variation due to "case characteristics" such as gender, age, and geography. SEHIRA nominally limits premium increases, as the premium increase for an individual small employer cannot exceed the sum of the following factors:

1. The percentage change in the new business premium rate;
2. A maximum increase of 15 percent due to changes in health status, claims experience, or duration of coverage; and
3. Any adjustment due to change in case characteristics from the previous year, or to a change in coverage.

Small employer carriers are required to annually submit (on or before May 15) an actuarial certification to the Director of Insurance that certifies the carrier is in compliance with SEHIRA, and that the rating methods are actuarially sound.

Rate Review and Filing Requirements

Individual Market (non-HMO): Insurance companies in Illinois must file premium rates and "classification of risks" with the Director of Insurance before issuing any individual policy of accident and health insurance (*See* Appendix B; 215 ILCS 5/355). Rates are filed with the Department electronically through the System for Electronic Rate Form Filing (SERFF).

Group Market (non-HMO): Non-HMO group plans do not file rates with the Department.

HMO: HMOs must file a schedule of base rates and supporting actuarial documentation for all individual and group plans (*See* Appendix C; 50 Ill. Admin. Code 5421.60). Rates for HMO plans are not filed through SERFF.

Illinois does not have a standardized filing format for rate filings. The filings generally provide only basic data on the base rates for each policy form covered (*i.e.*, the dollar amount of the base rate(s) and perhaps the percentage change from the previous base rate, if applicable).

Rate filings may be accompanied by an actuarial memorandum, which may include information such as:

- The major cost components, experience, assumptions, and procedures used to develop the submitted rates;
- A brief description of the benefits provided by the policies;
- A brief explanation of the new rates and the reason for the rate changes;
- Data on recent experience under the policies (including loss ratios);
- A history of rate changes under the policies going back a certain number of years;
- An anticipated loss ratio; and
- An actuarial certification attesting that the filing complies with the applicable laws of Illinois and the benefits are reasonable in relation to the premiums charged.

Illinois law does not vest the Department with the authority to approve, modify, or deny any proposed rate increase for major medical health insurance policies. As a result, the Department does not currently "review" any rate filings. A filing received by the Department is assigned to an analyst to ensure the filing is complete and properly coded and identified within SERFF. The filing is then forwarded to a supervising analyst for final disposition. Rate filings for HMO plans are kept on file in paper form.

Resources and Staff. One full-time analyst is required to assist with filings.

Information Technology (IT) and Systems Capacity

The absence of any rate review authority means the Department currently devotes few resources to reviewing health insurance rates. As described above, rates for non-HMO plans are filed electronically through the SERFF system. One IT professional within the Department is required to resolve technical difficulties with SERFF. No additional technology is used to file, analyze or publish information related to health insurance rate filings.

As part of the grant application, the Department is requesting not only upgrades to existing technology through SERFF but also funds for planning and implementation to expand electronic filing to HMO carriers and

to manage an increased volume of filings. The Department also seeks new technology to analyze this data for trends and report such findings regularly to stakeholders in a meaningful and consumer-friendly format.

The Department faces a challenge in achieving this goal because the rate information received through SERFF is not easily accessed or analyzed. Currently, data must be extracted manually from SERFF (because data is provided only in PDF format), and entered into another program (*e.g.*, Microsoft Excel) for further analysis and reporting to stakeholders. For example, the most recent report issued by the Department of Insurance in April 2010, the *Individual Major Medical Health Policy Rate Filing Report* (*see* Appendix D), was developed manually over several weeks by 1 of the Department's lead actuaries. Technology exists that could have produced a report such as this in a far more efficient manner. The Department neither has access to such technology nor the resources to procure the necessary upgrades at this time. The ability to efficiently receive, analyze, and move data contained within rate filings is crucial to the Department's goal of enhancing and adding public value to the rate review process in Illinois.

Budget and Staffing Capacity

Annual budget and revenue. The Department's budget for the current fiscal year totals $40,137,400. Projected annual revenue collected in FY10 is $359,200,677 (this amount includes the taxes collected and transferred to the General Revenue Fund).

Resources Allocated for Rate Review. Current budget for resources allocated for rate review (which is limited by law to rate filing review) is $80,481. This includes salary and benefits for an Insurance Analyst II of $75,381 and equipment $5,100. (*See* Appendix E for more detailed information).

Education and Professional Background of Staff Responsible For Rate Review. The education and professional requirements of any individual conducting rate filing and review include the following:

- Requires knowledge, skill and mental development equivalent to completion of four years of high school.

- Requires a working knowledge of the Illinois Insurance Code and related rules and regulations, or of general insurance company methods and procedures, particularly as those methods and procedures relate to life, accident and health policy evaluation.
- Requires a working knowledge of accounting principles and auditing methods.
- Requires a working knowledge of office methods and procedures.
- Requires the ability to analyze facts, data, and information with criteria, and draw reasonable conclusions.
- Requires ability to accurately interpret the Illinois Insurance Code and Department rules and regulations and executive bulletins.
- Requires ability to properly analyze financial statements and/or evaluate contractual provisions of insurance policies.

The Department receives approximately 60 rate filings per year for major medical health insurance policies. Department analysts do not spend more than 1 hour on any given filing because rates are not subject to regulatory approval.

Consumer Protections

The Department discloses rate filings through an Individual Major Medical Health Policy Rate Filing Report (the "Report") made available on the Department's website at www.insurance.illinois.gov.

The Report consists of a table summarizing all rate filings received by the Department since 2005 for major medical policies offered on the individual market. For each filing, the Report lists the company name, filing date, percent change in the filed base rate, name or number of the policies to which the filing applies, and whether such policies are accepting new enrollees. The Report is accompanied by a Rate Filing Guide written in plain language so that a consumer can understand the information contained within the Report and how it relates to the consumer's premium.

In addition, the public has access to rate filings and other information received and maintained by the Department through the Illinois Freedom of Information Act (FOIA). FOIA requires public bodies like the Department to make available certain public records to any individual upon written request. *See* 5 ILCS 140/1 *et seq*. Section 7 of FOIA exempts certain categories of information from this disclosure requirement, including: i) information containing trade secrets or commercial or financial information that is furnished under a claim of confidentiality and that would cause competitive harm to the person or business if disclosed; and ii) information prepared by or for the use of a public body regulator regarding the examination, operating, or condition reports of a regulated entity such as an insurance company. 5 ILCS 140/7. The Department maintains a FOIA section on its website containing general information and a form allowing individuals to submit a FOIA request to the Department.

Summaries of rate changes are not currently offered in plain language for consumers. Illinois law does not require insurers or HMOs to notify policyholders prior to a proposed rate change. With respect to individual health insurance policies only, policyholders must receive written notice of the specific dollar amount of each premium payment 15 – 45 days before the due date (*See* Appendix F, 215 ILCS 5/357.2).

Currently, formal processes do not exist for public hearings on major medical rate filings because of the lack of rate review authority. Legislation drafted by the Department during the last legislative session authorizing the Department to modify or reject unreasonable or excessive rate increases also established a formal process for public hearings (*See* Appendix G).

The Department received a total of 186 complaints regarding rate increases between the years 2008 and 2010 (*See* Appendix H). Eight-seven of these complaints concerned group health plans, while 99 complaints concerned individual health policies.

Group health plan complaints generally consisted of drastic unexpected rate increases irrespective of claims made on the policies, with the insurance company citing vague reasons as to the cause. Due to explosive rate increases and volatility, employers have increased the percentage of the premium charged to employees.

The individual health policy complaints generally consisted of several large rate changes within a short period of time (less than a year). Some noted increases of 80 – 100% per year. Unfortunately, the lack of information required to be reported regarding base rate information, ambiguous actuarial justification, or the percentage of individuals that pay more or less than the insurer's base rate renders the Department uninformed regarding the reasons for the increasing cost of coverage for many individuals and families.

Examination and Oversight

Over the last 2 years, the Department has not taken any formal action related to premium rates due to the absence of authority to approve or deny health insurance rate changes. The Department has not conducted formal hearings regarding health insurance premium increases.

b) Proposed rate review enhancements for health insurance

In order to improve the performance, transparency, and accountability of the private health insurance marketplace, the Department will collect and publicly disclose health insurance rates and rate increases and seek statutory authority to approve or deny premium increases. Health insurance consumers – families and small businesses in particular – will benefit from an additional regulatory tool such as rate regulation for insurers and HMOs. In seeking such additional authority from the Illinois General Assembly, the Department will benefit from an active and informed public. For this reason, the Department will enhance its rate collection and disclosure processes. The Department will engage all stakeholders in a collaborative effort to address the rising cost of health insurance coverage in Illinois, including the underlying health care costs and utilization trends.

Goals of the Grant Application.

Under the leadership of Governor Pat Quinn, Illinois is working towards a more functional, transparent private health insurance marketplace. The Department will collect additional data, obtain the resources and staff to analyze such data, and enhance the ability to provide that data in a meaningful and consumer-friendly format to effectively engage key stakeholders and decision-makers.

For this reason, the *immediate* goals of the Department in applying for the Health Insurance Premium Review Cycle I grants ("Cycle I grants") are to:

1) Expand the current scope of private health insurance premium review activities (as permitted under existing law);
2) Enhance consumer protections and marketplace efficiency; and
3) Enhance statewide understanding of the Illinois health care economy, including where and how premiums pay for health care.

In order to accomplish these goals, the Department estimates $1,000,000 will be necessary to deliver value to families, businesses and policymakers. Funds will be used to implement the Illinois *Premium Review Project* and establish the Department infrastructure to expand rate review activities. Staffing will be increased to

accommodate new demands and technological upgrades will streamline and expand our existing electronic submission and analysis systems (*See* Appendix I and attached budget narrative). *Grant funding will not be used to replace existing State funding dedicated to rate review and reporting. The Department will not reduce its current investment in these activities.*

The Department intends to use these new resources to *improve existing rate filing requirements* by collecting additional information about rates from insurers in the individual, small, and large group markets. Also, the Department will *expand the scope of current review activities* by compiling and publishing proposed rate increases in order to engage and educate the public and policymakers about the cost of health insurance, the cost of health care, utilization of health care, and the impact of benefit design. Finally, the Department intends to significantly invest in *expanding consumer protection standards* through a more open and transparent process for review. This includes conducting public hearings and developing new interactive tools for consumers to navigate health insurance premium information and provide feedback.

In applying for this grant, the *long-term* goal of the Department is to use these new tools and investments to be a more effective regulator of the private health insurance market. With more information and increased public awareness and involvement, the Department will continue to protect the solvency of the insurance industry while improving the performance, transparency, and accountability of the health insurance marketplace. With the approaching and necessary improvements of the Affordable Care Act, rate oversight is especially critical to ensure that less responsible insurers do not abuse customers and patients with unjustified rate increases. This grant will support the inevitable transformation of Illinois' marketplace into one that works not only for insurers but also for families and businesses.

Enhancing the Rate Review Process – Staffing

Due to Illinois' limited statutory premium rate reporting requirements, the Department does not have existing capacity to process or review large amounts of additional rate-related information. Therefore, the Department requests that $217,555 (plus additional costs) be dedicated to immediately hire 2 additional systems

analysts and 1 additional clerk (*See* Appendix J and K). New actuarial staff will enable the Department to process a significantly higher volume of major medical rate filings, manage contracted actuaries, and focus on preparing and submitting information to the Secretary of HHS pursuant to Section 2794 of the Affordable Care Act. As noted above, only 1 staff member currently supports Illinois' limited rate collection processes.

The Department also requests that $369,290 (plus benefits/additional costs) be dedicated to hire 4 additional actuaries: 1 health care actuary and 3 actuarial assistants. The actuary and her assistants will manage increased reporting from individual, small group and large group carriers, including the information regarding health insurance rate trends in premium rating areas required to be reported to the Secretary of HHS pursuant to Section 2794 of the Affordable Care Act. The Department requests an additional $138,700 to supplement permanent staff and assist with collecting, analyzing, and reporting rate information. Actuarial duties will include examination of data, calculation of trends, determination of problems in company reporting, and collaborating with other staff members to communicate this information to key stakeholders. Collaboration may include developing relationships with similarly situated individuals in other states, and involvement with other regulators through the activities of the National Association of Insurance Commissioners (NAIC). As implementation of the Affordable Care Act continues, the information being compiled and analyzed by these new staff members will support efforts to better identify and understand the inevitable changes in the Illinois private health insurance marketplace.

Enhancing the Rate Review Process – IT Capacity

The Department requests that $198,000 be dedicated to contract with a Level II IT consultant to improve the Department's information technology (IT) infrastructure for private health insurance premium rate reporting. This individual will design and build rate review software and convert information into a new web-based system for more efficient and effective consumer use. Specifically, this individual will be responsible for assisting in the planning, development, implementation, updating, and the training of staff on an improved electronic system for:

- Accepting major medical rate information from all private health insurers, including the expanded information required by the Secretary of HHS and the Director of Insurance (this includes developing new technology to leverage SERFF data, as well as staff training on new technology, and support for updated SERFF technology);
- Permitting actuaries to analyze the rate information submitted for advanced trends in rates related to benefit design, administrative costs, enrollment, claims, and other factors that affect premiums;
- Compiling rate information in reports using both narrative and visual graph formats;
- Translating the report information automatically into a format that is consumer-friendly, in coordination with experts in the field of health care communication;
- Allowing consumers to search rate information and compare information from different payers; and
- Integrating functions from existing IT frameworks to allow consumers to electronically provide feedback on private insurance premiums and reports.

The Department plans to continue to leverage SERFF and accompanying state application programming interface services, and will work with the NAIC to incorporate any improvements necessary to meet the new HHS reporting requirements. In order to do so, the Department requests $18,808 to contribute to the process of facilitating and using such updates (*See* Appendix L). This funding is expected to help the Department:

- Meet the data collection and reporting requirements in Section A.1(c)(1) and A. 1(c)(2) of the grant application, as well as necessary staff training;
- Permit insurers to submit the Rate Filing Disclosure and Justification for rates;
- Make non-confidential rate filing information public; and
- Make the uniform template for data reporting available, along with basic trending (assuming HHS will accept reports directly from SERFF).

The Department does not expect that the SERFF updates alone will provide the flexibility necessary to analyze rate data for more advanced trending, electronically report this data in a manner that is both comprehensive and consumer-friendly, and permit the data to be viewed by consumers in a searchable format. For that reason, new software applications (either purchased or developed in-house) will be necessary.

Improve Rate Filing Requirements

The Department intends to expend the resources included in this grant application, as well as the new federal reporting requirements pursuant to Section 1003 of the Affordable Care Act, to add sufficient rigor to existing reporting requirements. This involves expanding rate reporting requirements to include the group market and requiring all insurers to actuarially justify any rate increase. The Department also intends to have HMO plans report rate and actuarial justification information electronically through either SERFF or an alternative system, as defined by the Department. The ability of the Department to implement the previously described IT system upgrades will benefit Illinois consumers.

Enhance Consumer Protection Standards

The Department is committed to employing new investments afforded by the grant to vastly improve consumer protections through increased transparency of premium rates and the rate review process, as well as increased consumer engagement. In order to do so, the Department is proposing the following new initiatives.

The Department requests $5,000 to conduct public hearings on rate increase proposals. The hearings will highlight the many different factors that influence health insurance rates. The hearings will elicit testimony regarding premium rate increases and the impact on individuals, families, and small businesses. The Department will publicize these events through news media, and all information related to the hearings will be posted prominently on the Department's website.

The Department will dedicate a portion of previously described IT funding to develop interactive tools for consumers to search coverage available in Illinois and premium rate information related to that coverage. At a minimum, consumers will have access to:

- Information on the history of an insurer and rate increases charged by the insurer (to the extent the State has this information);
- A function allowing individuals to compare such rates and trends; and
- A means to submit to the Department a standardized survey about experienced rate increases, accompanying benefit reductions, satisfaction with an insurer's rating practices, and any additional information the Director deems necessary.

The Department requests $5,000 to publicize the existence of its rate review web site, the contents of the site, and the opportunities for consumers who visit the site. The Department will engage and educate the public and policymakers regarding health insurance premium increases, health care costs, health care utilization and benefit design.

In addition, the Department requests $11,945 to translate web-based databases, documents, reports and charts to Spanish, Polish and Korean. The Department will also translate documents, reports and charts into other languages identified in the last census (*See* Appendix N).

Premium Rate Review Project Work Plan

I. The goals of the Premium Rate Review Project are to:

1. *Expand the scope of current review processes and improve rate filing requirements.*

a) To improve the infrastructure for health insurance rate filing, review, analysis and publication, the Department of Insurance (the "Department") plans to hire additional staff, update existing technology for collecting and analyzing rate information, and impose reporting requirements on insurers.

b) In addition, the Department plans to engage and educate the public and policymakers. Outreach will be premised upon the information assembled from the rate review reporting (as well as the additional consumer-provided information described below), the analysis of that data, and further reports on consumer impact.

2. *Enhance consumer protection standards.*

a) To increase transparency and enhance both consumer and policymaker engagement, the Department will conduct public hearings on proposed unreasonable rate increases, and the effect of these increases on Illinois families and businesses. All information related to the hearings will be posted prominently on the Department's website.

b) The Department also plans to engage individuals from across the state to inform the Department on the true impact of current health insurance premium rates, to understand the statewide health care economy, utilization trends and benefit designs.

c) The Department will develop interactive tools for consumers, accessible on the Department website, which are dedicated to improving transparency and understanding of premium rate information through the use of consumer-friendly interfaces. This technology will enable individuals and businesses to search a database that will include:

- Information on the history of an insurer and previous rate increases (to the extent the State has this information);
- Functionality to permit individuals to compare rates and trends; and
- A means for a consumer to submit to the Department a standardized survey about experienced rate increases, accompanying benefit reductions, satisfaction with an insurer's rating practices, and any additional information the Director deems necessary.

II. The Department will know how many consumers it reaches by:

a) The number of attendees of the public hearings;

b) The number of "hits" to the website;

c) The number of consumer surveys returned; and

d) The number of policyholders impacted by a proposed rate change.

III. Preliminary actions have taken place for the Premium Rate Review Project.

The Department has publicly and privately engaged the insurance industry and emphasized the need for rate review in Illinois. The Department prepared and published a report of rate increases in the individual market dating from 2005. The Department drafted legislation for the Illinois General Assembly to adopt that would authorize the Department to approve or deny a rate increase. The Department has initiated the formal hiring process to employ necessary personnel.

IV. The Premium Rate Review Project will be conducted by the Department's actuaries and insurance analysts.

Improvement of the rate review process requires the Department to hire 4 additional actuaries (1 health actuary and 3 actuarial assistants) to help manage increased rate reporting and analysis of rates. The Department will hire 2 additional analysts and 1 additional clerk to help process the higher volume of rate filings. Credentials for those employees will include the following:

- The **Health Actuary** performs highly responsible professional actuarial work by providing counsel and advice and conducting technical research in the insurance field of life, accident and health; conducts technical actuarial determinations of insurance firms doing business in the State; develops and prepares reports and recommends appropriate actions to the chief actuary or to the department director and administrators; may supervise lower level actuaries.

- The **Health Actuary** requires knowledge and skill equivalent to completion of four years of college, with courses in higher mathematics, such as calculus, probability and statistics. Requires four years professional experience in actuarial work in the life, accident and health field. Preferably requires the equivalent to the certificate received for the completion of necessary examinations to qualify as an Associate or Fellow of the Society of Actuaries (A.S.A. or F.S.A.) or Casualty Actuarial Society (A.C.A.S. or F.C.A.S.). Preferably requires the type and kind of experience and training necessary for membership in the American Academy of Actuaries.

- **Actuarial Assistants** Under general direction, performs actuarial analysis of statistical insurance data; researches information on various topics to prepare reports for life and/or casualty actuary; analyzes and develops reports on reserve analysis, market surveys and closed claims; reviews documents supporting the licensure of insurance companies, performs profitability studies.

- **Actuarial Assistants** require knowledge and skills equivalent to four years college with a major in actuarial science – **or** – four years college with coursework in mathematics, numerical analysis, calculus, probability and statistics, preferably supplemented by the

equivalent to the certificate received for completion of Part I and any one of Parts 2, 3, or 4 of the examinations administered by the Society of Actuaries.

- **Insurance Analyst II** performs professional duties in specialized areas of insurance: reviewing, analyzing or auditing documents to determine compliance with regulatory and procedural standards; or reviewing or analyzing policy forms, rating plans, filing, license applications, charters and bylaws; or investigating complaints, claims and disputes.

- **Insurance Analyst II** requires knowledge and skill equivalent to completion of four years of high school. Requires one year of professional experience as would have been gained as an Insurance Analyst I. Requires either a working knowledge of either the Illinois Insurance Code, departmental rules, regulations, executive bulletins and general insurance company methods and procedures, particularly as related to life, accident and health or property and liability types of financial regulations; as related to policy evaluation, license and complaint resolution; or requires a working knowledge of the State Employees Group Insurance Act in matters pertaining to benefits, claims, privileges of participants and responsibilities of carrier.

V. The Premium Rate Review Project will take place

August 9, 2010 – September 30, 2011.

PREMIUM REVIEW PROJECT TIMELINE

Should the Premium Review Project proposal be accepted by the Department of Health and Human Services (HHS), the Illinois Department of Insurance ("the Department") will proceed with the following timeline for implementation of stated grant activities to enhance the current rate review process.

First Quarter (August 9, 2010 through December 2010). *This quarter will primarily be composed of going through the formal hiring process, staff training, and planning necessary to effectively execute each of the activities planned in the grant application.*

- August 2010. The Department will initiate the formal process of hiring new staff dedicated to the Rate Review Enhancement Project. Illinois has a structured interview and selection process that includes bargaining contracts, executive orders and court mandates. These procedures may take 12-16 weeks.

- August 2010. The Department will begin the process of preparing for and contracting with a Level II IT consultant and additional actuarial services. The Department will submit a Request for Proposal (RFP) following the statutorily required procurement process, which requires approval from the State Chief Procurement Officer. This is estimated to take approximately 12 weeks.

- August 2010. The Department will develop the administrative plan for the public hearings on proposed rate increases (with the goal of one each quarter in a different region of the state). Planning will consist of location, logistics, potential witnesses, public notification, and administrative processes.

- August 2010. The Department will work with industry, consumer, and community-based organizations to identify partners for the engagement and education of the public and policymakers.

- August/September 2010. The Department anticipates the National Association of Insurance Commissioners (NAIC) will begin work immediately to modify the current System for Electronic Rate and Form Filing (SERFF) to address data collection and reporting requirements in Section A.1(c)(2) and A.1(c)(2) of the grant application. Until the Department is able to hire the Level II IT consultant, the Project Director will be working closely with NAIC over the subsequent 3 months of development to improve this technology.

- July/August 2010. The Department will establish a reporting protocol for major medical insurance products.

- September 2010. The Department will provide written notification to insurers of the Department's rate increase reporting protocol.

- October 2010. Department senior staff will work in concert with the new Level II IT consultant to begin crafting a plan to transition the Department's existing IT infrastructure to meet the needs of improved rate review activities and consumer engagement tools.

- October 2010 – 2012. The Department expects to host public hearings on proposed rate increases.

- November 2010. Appropriate Department staff will commence training on updates to SERFF reporting systems and related API web services, while new technical staff continues to represent the needs of the Department as it relates to additional updates to SERFF and related API services with NAIC.

- December 2010. Using the enhanced SERFF technology and the IT design plan from the consultant, the Department would hire the second IT consultant, or extend the current IT contract, to build the enhanced IT infrastructure to report findings to consumers.

- December 2010. The Department will convene a public forum to address increases in health insurance premiums.

Second Quarter (January 2011 - March 2011). *This quarter will be dedicated to public hearings on rate increases, developing/testing/training staff on the new technological infrastructure necessary, and educating insurers about the IT reporting process.*

- January 2011. The Department will continue to engage and educate the public and policymakers regarding the dysfunction of the Illinois market and the need for extensive rate review authority. The Department professionals will continue to evaluate and analyze data received in the rate review process

- January/February 2011. IT staff will train relevant staff on new rate filling technology. IT staff would work with senior rate filing staff to draft the appropriate notice and directions on the new rate filing system for insurers. New information would be made public, and posted prominently on the Department's website.

- November 2010/December 2010/January 2011**.** As soon as practicable, insurers in every market (individual, small group, large group, HMO) would begin reporting rate information electronically through SERFF and the IT infrastructure developed for this purpose.

- February 2011. The Department will continue to hold public hearings regarding proposed rate increases. The Department will compile and publish analyses regarding rate increases, health care costs, health care utilization and benefit design.

- March 2011. IT staff would launch a beta version consumer interface for the rate review web site and associated tools with simulated information for feedback and refinement.

Third Quarter (April 2011 – June 2011). *This quarter will be dedicated to evaluating implementation of and actual information reported due to the new reporting requirements, more in-depth review of rates, reporting on rates, and communication with key stakeholders during the second half of the state's legislative session.*

- April/May 2011**.** Reports generated from the rate review process will be made publicly available.

- May/June 2011**.** The Department will commence a public campaign to inform individuals and businesses about the information and trends apparent in the rate filing data. This may include only preliminary information, rate trends, and relevant information related to the Medical Loss Ratio data submitted to the state, NAIC, and HHS.

Fourth Quarter (July 2011 – September 30, 2011)

- July/August 2011. Any new legislation granting the Department rate review authority will be incorporated into appropriate regulation, and the Department will evaluate and begin planning for the necessary IT system updates and additional staffing needs related to any potential new authority.

Premium Review Project Budget Narrative

Overall Budget

The Illinois Department of Insurance (DOI) budget for the current fiscal year totals $40,137,400. Projected annual revenue collected in FY10 is $359,200,677 (this amount includes the taxes collected and transferred to the General Revenue Fund).

Current rate review budget for Illinois' FY 2011

The current budget for premium rate review is $80,481. The total includes 1 full-time Insurance Analyst II plus employee benefits which is a cost of $75, 381. Additional employee costs total $5,100. This position does not require travel. (Please see attached spreadsheet for more detail).

Estimated Budget for Premium Review Cycle I

To enhance the current rate review process and to improve consumer protection standards, the Department estimates a total cost of $1,000,000. An itemization of the costs is below.

Personnel

The submitted proposal requires 7 additional staff which includes 1 actuary, 3 actuarial assistants, 2 insurance analysts and 1 support staff. Total estimated cost for salaries is $351,948. Attached at the end of this narrative is an itemization of Personnel and Fringe Benefit costs

Benefits

The cost of benefits for additional staff is $234,899. Additional information is available on budget spreadsheet.

Travel

Not applicable for new staff.

Equipment

Additional average office costs for each employee is $5,100. For 7 new employees the total is $35,700. Attached at the end of this narrative is an itemization of employee costs.

Contractual Services

IT Services
Illinois intends to develop a new analytic data system to report rate increases to consumers. Improvement to the current IT infrastructure requires funding for a Level II IT consultant to design and build rate review software and convert to web-based system for consumer use.

IT development would consist of 2 6-month contracts for web development. Each contract will require the expertise of a Level II IT consultant. The average rate of a Level II IT consultant is currently $99 per hour. Each 6-month contract consists of 1,000 hours of work, for a total of $198,000.

Actuarial Services
Illinois will contract with an actuarial firm to collect, analyze and report rate information. The estimated cost of actuarial services is $138,700.

"Other" Category Spending

IT Upgrades

The Department will upgrade the current SERFF system at a cost of $18,808. The cost estimate covers the expenses associated with modifying SERFF to address data collection and reporting requirements, such as:

- State options to indicate premium review grant participation;
- Company profile changes to incorporate company type;
- State-maintained indicator for rate filing requests meeting the HHS threshold for 'unreasonable';
- Addition of field to indicate product types;
- Company-maintained product information including product name, HHS id, and product status that will allow the companies to track products and apply them to filings;
- A new set of fields added to the Rate/Rule schedule items to provide HIPR data on a policy form basis;
- Changes to the State API to accommodate retrieval of the data elements added above and to allow for updates of appropriate data elements via the State API.

Public Hearings

The Department will conduct public hearings regarding premium rates and increases. The goal is to hear the "real" impact of rate increases on individuals, families and small businesses. The Department estimates the cost of the public hearings to be $5,000. This estimate is based on evaluation of unspecified expenses for print materials, newspaper notices, staff travel, rental of conference

space and miscellaneous expenses (*i.e.*, projectors, screens). *The Department intends to use public meeting space such as public libraries or universities, which may have nominal rental fees.*

Engagement and Education Effort

The Department will engage and educate the public and policymakers regarding health insurance premiums, health care costs, utilization and benefit design. The Department estimates the cost of this effort will be $5,000. The estimate includes travel reimbursement agency staff, printing and postage.

Translation Services

In an effort to provide appropriate services to all Illinois consumers, the Department will translate web-based databases, documents, reports and charts to Spanish, Polish and Korean. In addition, the Department will translate documents, reports and charts into other languages identified in the last census. A detailed description of language services is attached. The Department estimates the cost of these services to be $11,945.

APPENDIX A

(215 ILCS 93/) Small Employer Health Insurance Rating Act.

(215 ILCS 93/1)

Sec. 1. Short title. This Act may be cited as the Small Employer Health Insurance Rating Act.

(Source: P.A. 91-510, eff. 1-1-00.)

(215 ILCS 93/5)

Sec. 5. Purpose. The legislature recognizes that all too often, small employers are forced to increase employee co-pays and deductibles or drop health insurance coverage altogether because of unexpected rate increases as a result of one major medical problem. It is the intent of this Act to improve the efficiency and fairness of the small group health insurance marketplace.

(Source: P.A. 91-510, eff. 1-1-00.)

(215 ILCS 93/10)

Sec. 10. Definitions. For purposes of this Act:

"Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Director that a small employer carrier is in compliance with the provisions of Section 25 of this Act, based upon an examination which includes a review of the appropriate records and of the actuarial assumptions and methods utilized by the small employer carrier in establishing premium rates for the applicable health benefit plans.

"Base premium rate" means for each class of business as to a rating period, the lowest premium rate charged or which could be charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

"Carrier" means any entity which provides health insurance in this State. For the purposes of this Act, carrier includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

"Case characteristics" means demographic, geographic or other objective characteristics of a small employer, that are considered by the small employer carrier, in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage shall not be characteristics for the purposes of the Small Employer Health Insurance Rating Act.

"Class of business" means all or a separate grouping of small employers established pursuant to Section 20.

"Director" means the Director of Insurance.

"Department" means the Department of Insurance.

"Health benefit plan" or "plan" shall mean any hospital or medical expense-incurred policy, hospital or medical service plan contract, or health maintenance organization subscriber contract. Health benefit plan shall not include individual, accident-only, credit, dental, vision, medicare supplement, hospital indemnity, long term care, specific disease, stop loss or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

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

"Late enrollee" has the meaning given that term in the Illinois Health Insurance Portability and Accountability Act.

"New business premium rate" means, for each class of business as to a rating

period, the lowest premium rate charged or offered or which could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

"Objective characteristics" means measurable or observable phenomena. An example of a measurable characteristic would be the number of employees who were late enrollees. Examples of observable characteristics would be geographic location of the employer or gender of the employee.

"Premium" means all monies paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

"Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

"Small employer" has the meaning given that term in the Illinois Health Insurance Portability and Accountability Act.

"Small employer carrier" means a carrier that offers health benefit plans covering employees of one or more small employers in this State.
(Source: P.A. 91-510, eff. 1-1-00.)

(215 ILCS 93/15)

Sec. 15. Applicability and scope. This Act shall apply to each health benefit plan for a small employer that is delivered, issued for delivery, renewed, or continued in this State after July 1, 2000. For purposes of this Section, the date a plan is continued shall be the first rating period which commences after July 1, 2000. The Act shall apply to any such health benefit plan which provides coverage to employees of a small employer, except that the Act shall not apply to individual health insurance policies.
(Source: P.A. 91-510, eff. 1-1-00; 92-16, eff. 6-28-01.)

(215 ILCS 93/20)

Sec. 20. Establishment of Class of Business.

(a) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(1) the small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers;

(2) the small employer carrier has acquired a class of business from another small employer carrier; or

(3) the small employer carrier provides coverage to one or more association groups.

(b) A small employer carrier may establish up to 4 separate classes of business under subsection (a).

(c) The Director may approve the establishment of additional classes of business upon application to the Director and a finding by the Director that such action would enhance the efficiency and fairness of the small employer marketplace.
(Source: P.A. 91-510, eff. 1-1-00.)

(215 ILCS 93/25)

Sec. 25. Premium Rates.

(a) Premium rates for health benefit plans subject to this Act shall be subject to all of the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20%.

(2) For a class of business, the premium rates

charged during a rating period to small employers with similar case 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, shall not vary from the index rate by more than 25% of the index rate.

(3) The percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(A) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate;

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

(C) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

(4) Adjustments in rates for a new rating period due to claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(5) In the case of health benefit plans delivered or issued for delivery prior to the effective date of this Act, a premium rate for a rating period may exceed the ranges set forth in items (1) and (2) of subsection (a) for a period of 3 years following the effective date of this Act. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(A) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; in the case of a class of business into which the small employer carrier is no longer enrolling new small employes, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar class of business into which the small employer carrier is actively enrolling new small employers; and

(B) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(6) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(7) For the purposes of this subsection, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restriction of benefits to network providers results in substantial differences in claim costs.

(b) A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case

characteristics, claim experience, health status or duration of coverage since issue.
(Source: P.A. 91-510, eff. 1-1-00.)

(215 ILCS 93/30)
Sec. 30. Rating and underwriting records.
(a) A small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.
(b) A small employer carrier shall file with the Director annually on or before May 15, an actuarial certification certifying that the carrier is in compliance with this Act, and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the Director. A copy of the certification shall be retained by the small employer carrier at its principal place of business for a period of three years from the date of certification. This shall include any work papers prepared in support of the actuarial certification.
(c) A small employer carrier shall make the information and documentation described in subsection (a) available to the Director upon request. Except in cases of violations of this Act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the Director to persons outside of the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.
(Source: P.A. 91-510, eff. 1-1-00.)

(215 ILCS 93/35)
Sec. 35. Suspension of Rate Requirements. The Director may suspend all or any part of Section 25 as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the Director that either the suspension is reasonable in light of the financial viability of the carrier or the suspension would enhance the efficiency and fairness of the small employer health insurance marketplace.
(Source: P.A. 91-510, eff. 1-1-00.)

(215 ILCS 93/40)
Sec. 40. Director's Regulatory Authority. The Director may adopt and promulgate rules and regulations to carry out the provisions of this Act.
(Source: P.A. 91-510, eff. 1-1-00.)

(215 ILCS 93/99)
Sec. 99. Effective date. This Act takes effect January 1, 2000.
(Source: P.A. 91-510, eff. 1-1-00.)

APPENDIX B

(215 ILCS 5/355) (from Ch. 73, par. 967)

Sec. 355. Accident and health policies-Provisions.)

No policy of insurance against loss or damage from the sickness, or from the bodily injury or death of the insured by accident shall be issued or delivered to any person in this State until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with the Director; nor shall it be so issued or delivered until the Director shall have approved such policy pursuant to the provisions of Section 143. If the Director disapproves the policy form he shall make a written decision stating the respects in which such form does not comply with the requirements of law and shall deliver a copy thereof to the company and it shall be unlawful thereafter for any such company to issue any policy in such form.
(Source: P.A. 79-777.)

APPENDIX C

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
SUBCHAPTER kkk: HEALTH CARE SERVICE PLANS
PART 5421 HEALTH MAINTENANCE ORGANIZATION
SECTION 5421.60 RATES

Section 5421.60 Rates

a) The HMO shall file all schedules of base rates to be used in conjunction with enrollee certificates. The schedules shall be filed with the Director prior to the effective date and will be maintained as a public document by the Division.

b) When the schedules of base rates are filed, percentage change from the previous filing for the schedules of base rates shall be included.

c) Upon the request of the Director, the HMO shall submit actuarial documentation for any submitted rates, which shall be stamped "confidential" by the HMO. Documentation shall include, but not be limited to, the major cost components, experience, assumptions, and procedures used to develop the submitted rates. The actuarial documentation shall be deemed confidential and proprietary by the Division unless specific authorization is given by the HMO.

(Source: Amended at 30 Ill. Reg. 4732, effective March 2, 2006)

Illinois Department of Insurance

PAT QUINN
Governor

MICHAEL T. McRAITH
Director

Guide to the Illinois Department of Insurance
Individual Major Medical Health Policy Rate Filing Report

The Department provides this Report to inform Illinois health insurance consumers seeking to learn more about rate increases to individual major medical health policies. The Department does not receive small or large group health insurance rates or rate changes. The Department continues to improve the clarity and completeness of the information presented in this Report and encourages you to check back frequently for updates.

Illinois law allows for underwriting and rating of individual major medical health insurance policies based on health status as well as several other factors. Illinois law does not limit the amount an insurance company can charge based on health status.

The following columns of information are presented in the Department's Report:

- **Percent Rate Change.** This column reflects the change in the plan's base rate from that plan's most recently filed base rate. The base rate for a plan may be increased by an insurance company based on several reasons, including the claims submitted by every individual enrolled in your plan. A base rate is a starting point for a premium that applies before other factors are taken into account. Some factors, such as your health status, may only affect your premium at the time your policy is issued. Other factors, such as geographic location, may affect your premium both when your policy is issued and when it is renewed. Some of the factors that may affect the actual premium you will pay include:
    - **Health status**. Health status is perhaps the most important factor in determining the amount of premium you pay. Illinois law allows insurance companies to increase your premium based on your past or present medical conditions.
    - **Geographical location**. Your premium will vary depending on where you live in Illinois. For example, consumers living in urban areas like Chicago are typically charged more than consumers living in rural areas.
    - **Policy duration**. Your premium may be increased based on the amount of time you are enrolled in a plan. This factor is typically used by a company to account for the assumption that a policyholder is more likely to file a claim the longer he or she has had the policy.
    - **Gender**. Your premium will be affected by your gender, with women paying significantly more than men for the same policy, even without maternity benefits.
    - **Age**. Your premium will also be affected by your age, with premiums typically rising as you age.

- **Open/Closed.** This column indicates whether the plan listed is accepting (open) or not accepting (closed) new enrollees. Insurance companies routinely create new insurance plans and close new enrollment in existing plans. Pursuant to Illinois law, individuals can be denied major medical health insurance for any reason other than "race, color, religion or national origin." In addition, Illinois law requires that individual policies are guaranteed renewable. As a result, individuals with health care needs who are enrolled in a plan that is closed to new enrollees will remain in

that plan, sometimes for many years. The insurance company will continue to adjust the plan's base and other rates as long as individuals are enrolled in the plan.

NOTE: HMOs do not regularly report whether a plan is open or closed. The Department is in the process of determining whether the listed HMO plans are open or closed and will update the Report accordingly.

- **Company Name**. The names reflected in the Report are the registered business names of the insurance companies offering a plan. HMO plans are distinguished from insurance plans by an "**HMO**" following the insurance company's name. The insurance company name in the Report may not necessarily be the name you see on your policy form or health insurance card. For example, Health Care Service Corporation does business in Illinois as Blue Cross Blue Shield of Illinois. If you do not see the name of your insurance company in the Report you should contact your insurance company or the Department to determine the appropriate registered business name. In the process of compiling this public information, the Department observed that several insurers offering major medical insurance do not appear to have filed rates or rate changes. The Department is investigating.

- **Filing Date.** This column lists the date on which the insurance company rate filing was received by or placed on file with the Department.

- **Policy Name/Number.** This column lists the policy name or number assigned to a plan by the insurance company. This number can be used to track rate changes to your particular plan. The policy name/number should be on your policy but may not be the name by which you know your plan. Please contact your insurance company or the Department for more information on how to find your policy name/number.

More Information

The Department's mission is to protect consumers by providing assistance and information, by efficiently regulating the insurance industry's market behavior and financial solvency, and by fostering a competitive insurance marketplace. The Department assists consumers with all insurance complaints, including health, auto, life, and homeowner. Consumers in need of information or assistance should visit the Department's Web site at insurance.illinois.gov or call our toll-free hotline at (866) 445-5364.

COMPANY NAME	Filing Date	% Rate Change	Policy Name/Number	Open/Closed
CONTINENTAL GENERAL INSURANCE	1/10/2005	+12%	PPQ	Closed
AMERICAN NATIONAL LIFE	1/20/2005	+30%	ANL-KMMT, AML-KMM92, ANL-KM95	Closed
THRIVENT FINANCIAL FOR LUTHERANS	1/21/2005	+70%	BMM, DMM, EMM	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	1/25/2005	+16%	PMED	Closed
THRIVENT FINANCIAL FOR LUTHERANS	1/25/2005	+80%	AMA	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	2/28/2005	+21% for Option A; +11% for Option B	A-3310, A-3326	Open
TRUSTMARK INSURANCE COMPANY	3/25/2005	+17%	TELE-MED IV	Closed
WORLD INSURANCE	3/25/2005	+23%	A3601,A3602,A3603,A3604,A3605, A3606	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	3/29/2005	+20%	HAS	Open
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	4/20/2005	+40%	H-28	Open
AMERICAN NATIONAL INSURANCE	4/20/2005	+30%	POOLED	Closed
GUARANTEE TRUST LIFE	4/20/2005	+49%	6005MM, 6035MM	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	4/25/2005	+18%	640,650,680	Closed
THRIVENT FINANCIAL FOR LUTHERANS	4/25/2005	+35%	H-1	Closed
KNIGHTS OF COLUMBUS	5/2/2005	+25%	KMD,KMM1	Closed
NEW YORK LIFE INSURANCE	5/2/2005	+40%	51-160,5502-1,6170-1,6670-1,6970-1,8280-1,8281-1,8570-1,8580-1,8581-1	Closed
THE TRAVELERS INSURANCE	5/2/2005	+20%	GR1-GR6B , MGR1-MGR7	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/5/2005	+15%	800 94, 880	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/5/2005	+50%	840, 860	Closed
PRUDENTIAL INSURANCE	5/5/2005	+27%	CHIP34500C-B	Closed
ILLINOIS MUTUAL LIFE INSURANCE	5/12/2005	+25%	743,744,745,746,760,775,776,843,885,886	Closed
TRUSTMARK INSURANCE COMPANY	5/16/2005	+35%	OLD FORMS	Closed
GUARANTEE TRUST LIFE	5/26/2005	+20%	841500, 90100	Closed
INVESTORS LIFE INSURANCE COMPANY	5/26/2005	+30%	621,622,623,624,671,672,673,674	Closed
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	DB-22,DB-23,DB-26,DB-40,DB-41	Closed
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	DB-19, DB-20	Closed
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	DB11, DB-12	Closed
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	DB-13,DB-15,DB-18,DB-19,DB-24,DB-25	Closed
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	DB-10	Closed
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	CB-5,CB-6,CB-7,CC-24,CC-26, CC-01.1,CC-0.01	Closed
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	DB-42, DB-43, DB-44, DB-45	Closed
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	DB-42, DB-43, DB-44, DB-45	Open
HEALTH CARE SERVICE CORPORATION	6/3/2005	+2.7%	DB-46, DB-47	Open
HEALTH CARE SERVICE CORPORATION	6/3/2005	+2.7%	DB-48, DB-49	Open
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	DB-18	Closed
HUMANA INSURANCE	6/3/2005	+8%	GN-70129 / IL-70129	Open
CONTINENTAL GENERAL INSURANCE	6/9/2005	+25%	01A,01C,116,12A,12M,19A,544	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	6/15/2005	+31.8%	H-95	Closed
CONTINENTAL GENERAL INSURANCE	6/22/2005	+20%	PPQ	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	7/1/2005	+20%	A-2434,A-2481,A-2484,A-2485, A-2523, A-2718, A-2744, A-2745, A-2927, A-3062, A-3064, A-3065, A-3066, A-3067, A-3166, A-3167,	Open
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	7/6/2005	+21%	H14	Closed
CENTRAL UNITED LIFE INSURANCE	7/11/2005	+15%	MMGR/OR	Closed
GOLDEN RULE INSURANCE COMPANY	7/27/2005	+25%	AS-208, GR-108	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	8/9/2005	+6%	H425	Closed
KANSAS CITY LIFE INSURANCE COMPANY	8/30/2005	+25%	L5333GR,L5337,L5360,L5700	Closed

COMPANY NAME	Filing Date	% Rate Change	Policy Name/Number	Open/Closed
THE PYRAMID LIFE INSURANCE	9/22/2005	+30%	G-91	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	10/5/2005	+25%	CBM	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	10/5/2005	+25%	ACM, CMM	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	10/5/2005	+20%	LMM	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	10/5/2005	+10%	RURL	Closed
TRUSTMARK INSURANCE COMPANY	10/5/2005	+20%	TELE-MED V	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	10/18/2005	+17.5% for Option A; +10% for Option B	A-3310, A-3326	Open
HUMANA INSURANCE	10/18/2005	+8% for $500 deductible; +1% for $1,000 deductible; -1% for $1,000 deductible; -5.1% for $5,000 deductible	GN-70129 / IL-70129	Open
PHYSICIANS MUTUAL INSURANCE	10/18/2005	+45%	P295, P297	Closed
CONTINENTAL GENERAL INSURANCE	12/8/2005	+20%	01A,01C,116,12A,12M,19A,544	Closed
THRIVENT FINANCIAL FOR LUTHERANS	1/17/2006	+60%	AMA	Closed
THRIVENT FINANCIAL FOR LUTHERANS	1/17/2006	+35%	BMM, DMM, EMM	Closed
PRUDENTIAL INSURANCE	1/24/2006	+15%	PRUD-MED 83	Closed
GOLDEN RULE INSURANCE COMPANY	1/30/2006	+14%	GR1-H1, GR1-H8	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	2/10/2006	+25%	A-3310, A-3326	Open
AMERICAN NATIONAL LIFE	2/22/2006	+17%	ANL-KMMT, AML-KMM92, ANL-KM95	Closed
WORLD INSURANCE	3/9/2006	+9%	A3601,A3602,A3603,A3604,A3605, A3606	Closed
CONTINENTAL GENERAL INSURANCE	4/5/2006	+8%	PPQ	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	4/7/2006	+10%	PMED	Closed
HEALTH CARE SERVICE CORPORATION	4/18/2006	+9.3%	DB-22,DB-23,DB-26,DB-40,DB-41	Closed
HEALTH CARE SERVICE CORPORATION	4/18/2006	+9.3%	DB-19, DB-20	Closed
HEALTH CARE SERVICE CORPORATION	4/18/2006	+6.4%	DB-50, DB-51	Open
HEALTH CARE SERVICE CORPORATION	4/18/2006	+9.3%	DB11, DB-12	Closed
HEALTH CARE SERVICE CORPORATION	4/18/2006	+9.3%	DB-13,DB-15,DB-18,DB-19,DB-24,DB-25	Closed
HEALTH CARE SERVICE CORPORATION	4/18/2006	+9.3%	DB-10	Closed
HEALTH CARE SERVICE CORPORATION	4/18/2006	+9.3%	CB-5,CB-6,CB-7,CC-24,CC-26, CC-01.1,CC-0.01	Closed
HEALTH CARE SERVICE CORPORATION	4/18/2006	+6.4%	DB-42, DB-43, DB-44, DB-45	Closed
HEALTH CARE SERVICE CORPORATION	4/18/2006	+9.3%	DB-42, DB-43, DB-44, DB-45	Open
HEALTH CARE SERVICE CORPORATION	4/18/2006	+6.4%	DB-46, DB-47	Open
HEALTH CARE SERVICE CORPORATION	4/18/2006	+6.4%	DB-48, DB-49	Open
HEALTH CARE SERVICE CORPORATION	4/18/2006	+9.3%	DB-18	Closed
WORLD INSURANCE	5/1/2006	+25%	A3570,A3680,A3685,A3690,A3695,A3800,A3810,A3820 ,A3830	Closed
PRUDENTIAL INSURANCE	5/12/2006	+60%	CHIP34500C-B	Closed
AMERICAN NATIONAL INSURANCE	6/12/2006	+17%	POOLED	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	7/6/2006	+15%	640	Closed
ILLINOIS MUTUAL LIFE INSURANCE	7/25/2006	+25%	743,744,745,746,760,775,776,843,885,886	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	8/2/2006	+30%	H-28	Open
GUARANTEE TRUST LIFE	10/11/2006	+25%	6005MM, 6035MM	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	10/12/2006	+17% for H-400; +32% for H-425	H-400, H-425	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	10/12/2006	+39.3%	H-95	Closed
CONTINENTAL GENERAL INSURANCE	10/12/2006	+10%	01A,01C,116,12A,12M,19A,544	Closed

COMPANY NAME	Filing Date	% Rate Change	Policy Name/Number	Open/Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	10/17/2006	+20%	LMM	Closed
THRIVENT FINANCIAL FOR LUTHERANS	10/18/2006	+33%	H-1	Closed
PEKIN LIFE INSURANCE COMPANY	11/16/2006	+20%	H39	Open
PHYSICIANS MUTUAL	11/22/2006	+45%	P295, P297	Closed
TRUSTMARK INSURANCE COMPANY	11/28/2006	+35%	OLD FORMS	Closed
GUARANTEE TRUST LIFE	12/8/2006	+20%	841500, 90100	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	12/19/2006	+30%	A-2434,A-2481,A-2484A-2523, A-2718, A-2744, A-2745, A-2927, A-3062, A-3064, A-3065, A-3066, A-3067, A-3166, A-3167,	Open
AMERICAN REPUBLIC INSURANCE COMPANY	12/21/2006	+30%	A-3310, A-3326	Open
WORLD INSURANCE	12/28/2006	+15%	A3601,A3602,A3603,A3604,A3605, A3606	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	12/29/2006	+7%	ACM, CMM	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	1/4/2007	+30%	A-3393, A-3394	Open
PYRAMID LIFE INSURANCE	1/4/2007	+40%	G-81	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	1/11/2007	+30%	ACM, CMM	Closed
CONTINENTAL GENERAL INSURANCE	1/11/2007	+10%	PPQ	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	1/22/2007	+5%	H-600	Open
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	1/23/2007	+39.3%	H14	Closed
PEKIN LIFE INSURANCE COMPANY	1/23/2007	+20%	H8	Closed
PEKIN LIFE INSURANCE COMPANY	2/10/2007	+10%	H39	Open
PEKIN LIFE INSURANCE COMPANY	2/10/2007	+10%	H38	Open
PEKIN LIFE INSURANCE COMPANY	2/10/2007	+20%	H30	Open
PEKIN LIFE INSURANCE COMPANY	2/10/2007	+20%	H29	Open
PEKIN LIFE INSURANCE COMPANY	2/10/2007	+20%	H1	Closed
PEKIN LIFE INSURANCE COMPANY	2/10/2007	+20%	H21	Closed
PEKIN LIFE INSURANCE COMPANY	2/10/2007	+20%	H17	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	3/5/2007	+50%	840, 860	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	3/7/2007	+12.68%	HSA	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	3/7/2007	+20%	800, 880	Closed
AMERICAN INSURANCE COMPANY OF TEXAS	3/14/2007	+30.5%	K4954,K5115,K5388,MM86	Closed
TRUSTMARK INSURANCE COMPANY	4/12/2007	+17%	TELE-MED IV	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/1/2007	-18%	ICDHP-TIER	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/1/2007	-18%	ICDHP-HSA	Open
THRIVENT FINANCIAL FOR LUTHERANS	5/1/2007	+40%	BMM, DMM, EMM	Closed
THRIVENT FINANCIAL FOR LUTHERANS	5/1/2007	+60%	AMA	Closed
PRUDENTIAL INSURANCE	5/2/2007	+48%	PRUD-MED 83	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/9/2007	+12%	980	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/9/2007	+50%	890	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/9/2007	+12%	880	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	5/23/2007	+22%	A-2434,A-2481,A-2484A-2523, A-2718, A-2744, A-2745, A-3064, A-3065, A-3066, A-3067, A-3167, A-3393, A-3394	Open
AMERICAN REPUBLIC INSURANCE COMPANY	5/23/2007	+20%	A-3310, A-3326	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/29/2007	-18% for new business	PMED	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/29/2007	+20%	PMED	Open
KANSAS CITY LIFE INSURANCE	6/4/2007	+25%	L5333, L5337, L5360, L5700	Closed
KNIGHTS OF COLUMBUS	6/4/2007	+15%	KMD, KMM1, KMP1	Closed
GOLDEN RULE INSURANCE COMPANY	6/8/2007	+12%	AS-208,GR-108	Closed
HEALTH CARE SERVICE CORPORATION	6/26/2007	+10%	CB-5,CB-6,CB-7,CC-0.01,CC-5,CC-6,CC-26,DB-10,DB-11,DB-12,DB-13,DB-15,DB-18,DB-19,DB-24	Closed

COMPANY NAME	Filing Date	% Rate Change	Policy Name/Number	Open/Closed
HEALTH CARE SERVICE CORPORATION	6/26/2007	+8.5%	DB-42, DB-43, DB-44, DB-45	Open
HEALTH CARE SERVICE CORPORATION	6/26/2007	+10.2%	DB-22,DB-23,DB-26,DB-40,DB-41	Closed
HEALTH CARE SERVICE CORPORATION	6/26/2007	+8.5%	DB-50, DB-51	Open
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	6/29/2007	+35%	H-28	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	8/7/2007	+25%	BMM	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	8/8/2007	+40%	H-235	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	8/17/2007	+18% for in-force business; -18% for new business	HSA	Open
GUARANTEE TRUST LIFE	8/17/2007	+25%	6005MM, 6035MM	Closed
THRIVENT FINANCIAL FOR LUTHERANS	8/17/2007	+40%	H-1	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	8/24/2007	+20%	800, 880	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	8/24/2007	+20%	640, 680	Closed
ILLINOIS MUTUAL LIFE INSURANCE	8/24/2007	+25%	743,744,745,746,760,775,776,843,885,886	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	8/27/2007	+25%	840, 860	Closed
CENTRAL UNITED LIFE INSURANCE COMPANY	9/11/2007	+25%	123, 96077,A6308, CGR-61, H220, HMM60,HN200, 0056,TCBS1	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	10/10/2007	+10%	A-3310, A-3326	Open
AXA EQUITABLE LIFE INSURANCE COMPANY	10/29/2007	+30%	ACM, CMM	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	11/5/2007	+30%	A-2523, A-2718, A-2744, A-2745, A-3064, A-3065, A-3066, A-3067, A-3167, A-3393, A-3394	Open
GOLDEN RULE INSURANCE COMPANY	12/19/2007	+12%	GR1-H1, GR1-H8	Closed
GUARANTEE TRUST LIFE	12/27/2007	+10%	841500, 90100	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/28/2007	+10%	RUR	Closed
AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS	1/3/2008	+17%	ANL-KMMT	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	1/15/2008	+33%	H14	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	1/15/2008	+33%	H-95	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	1/25/2008	+25%	CBM	Closed
THE PYRAMID LIFE INSURANCE COMPANY	2/5/2008	+30%	H-71, G-30, G-31, G-50, G-51, G-90, G-91, G-94	Closed
PERSONALCARE INSURANCE COMPANY	2/8/2008	+2.9%	INDPPO	Open
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	3/4/2008	+19.5%	H-400, H-425	Open
THRIVENT FINANCIAL FOR LUTHERANS	3/11/2008	+40%	BMM, DMM, EMM	Closed
THRIVENT FINANCIAL FOR LUTHERANS	3/12/2008	+50%	AMA	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	4/9/2008	+18 for in-force business; -5% for new business	ICDHP-TIER	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	4/9/2008	+18%	ICDHP-HSA	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	4/10/2008	+10%	RUR	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	4/25/2008	+33%	AH-50	Closed
CONTINENTIAL GENERAL INSURANCE	5/6/2008	+50%	FORM01A, FORM01C, FORM116, FORM12A, FORM12M, FORMPPQ	Open
HEALTH ALLIANCE MEDICAL PLANS	5/14/2008	+15% for policies issued more than 3 years prior; +4.9% for policies issued in 3 years prior; -15% for new business	Individual	Open
TRUSTMARK INSURANCE COMPANY	5/14/2008	+17%	TELE-MED IV	Closed
TRUSTMARK INSURANCE COMPANY	5/14/2008	+17%	TELE-MED V	Closed

COMPANY NAME	Filing Date	% Rate Change	Policy Name/Number	Open/Closed
PEKIN LIFE INSURANCE COMPANY	5/27/2008	+15%	H41	Open
PEKIN LIFE INSURANCE COMPANY	5/27/2008	+15%	H39	Open
PEKIN LIFE INSURANCE COMPANY	5/27/2008	+15%	H38	Open
PEKIN LIFE INSURANCE COMPANY	5/27/2008	+15%	H30	Open
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	5/30/2008	+18.2%	H-600	Open
GOLDEN RULE INSURANCE COMPANY	5/30/2008	+15%	GR1-H1, GR1-H8	Closed
HUMANA INSURANCE COMPANY	5/30/2008	+1.1%	GN-70129, IL-70129	Open
AMERICAN NATIONAL INSURANCE COMPANY	6/4/2008	+17%	OLD FORMS	Closed
WORLD INSURANCE COMPANY	6/6/2008	+22%	OLD FORMS	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	6/20/2008	+15%	A-2523, A-2718, A-2744, A-2745, A-3064, A-3065, A-3066, A-3067, A-3167, A-3393, A-3394	Open
AMERICAN REPUBLIC INSURANCE COMPANY	6/20/2008	+20%	A-3310, A-3326	Open
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	6/25/2008	+30%	H-28	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	6/27/2008	+38%	A-1589, A-2288	Closed
WORLD INSURANCE COMPANY	7/14/2008	+30%	A-3601, A-3602, A-3603, A-3604, A-3605, A-3606	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	7/25/2008	+4.7%	ICDHP-TIER	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	7/25/2008	+4.1%	PMEDII	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	7/25/2008	+4.8%	ICDHP-HSA	Open
THE PRUDENTIAL INSURANCE COMPANY OF AMERICA	7/30/2008	+20%	CHIP 34500C-B	Closed
THRIVENT FINANCIAL FOR LUTHERANS	8/21/2008	+35%	H-1	Closed
HEALTH CARE SERVICE CORPORATION	8/26/2008	+18%	CB-5,CB-6,CB-7,CC-0.01,CC-5,CC-6,CC-26,DB-10,DB-11,DB-12,DB-13,DB-15,DB-18,DB-19,DB-24	Closed
HEALTH CARE SERVICE CORPORATION	8/26/2008	+18%	DB-42, DB-43, DB-44, DB-45	Closed
HEALTH CARE SERVICE CORPORATION	8/26/2008	+18%	DB-22,DB-23,DB-26,DB-40,DB-41	Closed
HEALTH CARE SERVICE CORPORATION	8/26/2008	+9%	DB-46,DB-47,DB-48,DB-49	Open
HEALTH CARE SERVICE CORPORATION	8/26/2008	+9%	DB-50, DB-51	Open
HEALTH CARE SERVICE CORPORATION	8/26/2008	+12.6%	DB-42, DB-43, DB-44, DB-45	Open
PERSONALCARE INSURANCE COMPANY	9/3/2008	+2.95%	INDPPO	Open
TRUSTMARK INSURANCE COMPANY	9/17/2008	+25%	GMD-IL, GCA-167, GHC-180	Open
UNITED TEACHER ASSOCIATES INSURANCE COMPANY	10/3/2008	+25%	708, 75.791, 69MG, 1-A1-563, 1708, 63GR01, 67.790, L160, P1-51833	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	10/23/2008	+20%	ICDHP-TIER	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	10/23/2008	+15%	ICDHP-HSA	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	10/23/2008	+20%	840, 860	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	10/23/2008	+20%	800, 880	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	10/23/2008	+18%	HSA	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	10/24/2008	+20% for issues after 1/1/2006; +30% for issues prior to 1/1/2006	PMED	Closed
CENTRAL UNITED LIFE INSURACE COMPANY	12/24/2008	+35%	123, 96077,A6308, CGR-61, H220, HMM60,HN200, 0056,TCBS1	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	12/29/2008	+25%	ACM, CMM	Closed
PERSONALCARE INSURANCE COMPANY	12/29/2008	+3.2%	INDPPO	Open
UNION HEALTH SERVICE INC. (HMO)	1/5/2009	+2.4%	Clinic	-
UNION HEALTH SERVICE INC. (HMO)	1/6/2009	+7.1%	Non-Clinic	-
UNION HEALTH SERVICE INC. (HMO)	1/7/2009	+5.3%	HMO	-
HUMANA HEALTH PLAN, INC. (HMO)	1/9/2009	+3%	Staff Model Network	-

COMPANY NAME	Filing Date	% Rate Change	Policy Name/Number	Open/Closed
PERSONALCARE INSURANCE COMPANY	1/16/2009	+2.9%	INDPPO	Open
TRUSTMARK INSURANCE COMPANY	1/19/2009	+32%	OLD FORMS	Closed
KNIGHTS OF COLUMBUS	1/27/2009	+15%	KMD,KMMI,KMP1	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	1/28/2009	+20%	640, 650, 680	Closed
AMERICAN FAMILY INSURANCE COMPANY	2/25/2009	+40%	H-235	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	2/25/2009	+14%	A-2718,A-2744,A-2745,A-3064,A-3065,A-3066,A-3067,A-2523,A-3167	Open
WORLD INSURANCE COMPANY	2/25/2009	+19.5%	A3601,A3602,A3603,A3604,A3605,A3606	Closed
GUARANTEE TRUST LIFE INSURANCE COMPANY	4/13/2009	+25%	6005-MM, 6035-MM	Closed
AMERICAN NATIONAL LIFE INSURANCE CO OF TEXAS	4/21/2009	+30%	ANL-KMMT	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	4/22/2009	+16%	PMEDII	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	4/22/2009	+16%	ICDHP-TIER	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	4/22/2009	+14%	ICDHP-HSA	Open
HUMANA HEALTH PLAN, INC. (HMO)	5/4/2009	+12%	Michael Reese Personal Plan	Closed
HUMANA HEALTH PLAN, INC. (HMO)	5/4/2009	+14%	Conversion Personal Plan	Closed
HUMANA HEALTH PLAN, INC. (HMO)	5/4/2009	+14%	HHP Direct Payment Plans	Closed
HUMANA INSURANCE COMPANY	5/5/2009	-0.3%	GN-70129, IL-70129	Open
HUMANA INSURANCE COMPANY	5/12/2009	+14.2%	GN-70129, IL-70129	Open
PEKIN LIFE INSURANCE COMPANY	5/14/2009	+15%	H29	Open
HEALTH CARE SERVICE CORPORATION	6/5/2009	+8.4%	DB-43,DB-44,DB-45	Open
HEALTH CARE SERVICE CORPORATION	6/5/2009	+8.4%	DB-46,DB-47,DB-48,DB-49	Open
HEALTH CARE SERVICE CORPORATION	6/5/2009	+8.4%	DB-22,DB-23,DB-26,DB-40,DB-41	Closed
HEALTH CARE SERVICE CORPORATION	6/5/2009	+8.4%	CB-5,CB-6,CB-7,CC-0.01,CC-5,CC-6,CC-26,DB-10,DB-11,DB-12,DB-13,DB-15,DB-18,DB-19,DB-24	Closed
HEALTH CARE SERVICE CORPORATION	6/5/2009	+8.4%	DB-42, DB-43, DB-44, DB-45	Closed
HEALTH CARE SERVICE CORPORATION	6/5/2009	+6.3%	DB-50, DB-51	Open
PERSONALCARE INSURANCE COMPANY	6/10/2009	+3.2%	INDPPO	Open
HEALTH CARE SERVICE CORPORATION (HMO)	7/7/2009	+19.8	Series DB-1 HCSC	-
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	7/13/2009	+40%	890	Closed
PEKIN LIFE INSURANCE COMPANY	7/24/2009	+20%	H41	Open
PEKIN LIFE INSURANCE COMPANY	7/24/2009	+20%	H39	Open
PEKIN LIFE INSURANCE COMPANY	7/24/2009	+20%	H38	Open
PEKIN LIFE INSURANCE COMPANY	7/24/2009	+20%	H30	Open
PEKIN LIFE INSURANCE COMPANY	7/24/2009	+20%	H29	Open
PEKIN LIFE INSURANCE COMPANY	7/24/2009	+20%	H21	Closed
PEKIN LIFE INSURANCE COMPANY	7/24/2009	+20%	H17	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	8/4/2009	+6%	ICDHP-HSA	Open
AMERICAN NATIONAL INSURANCE COMPANY	8/4/2009	+30%	OLD FORMS	Closed
GOLDEN RULE INSURANCE COMPANY	8/4/2009	+13%	GR1-H1, GR1-H8	Closed
HUMANA INSURANCE COMPANY	8/4/2009	+4.3%	GN-70129, IL-70129	Open
THE PRUDENTIAL INSURANCE COMPANY OF AMERICA	8/4/2009	+30%	PRUD-MED 83	Closed
TRUSTMARK INSURANCE COMPANY	8/4/2009	+24%	TELEMED IV	Closed
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/9/2009	+3.7%	GSA High Base Plan	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/10/2009	+5.1	GSA Med Base Plan	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/11/2009	+6.4%	GSA Low Base Plan	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/12/2009	+3.7	94 GSA $5 Plan	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/13/2009	+5.4	94 GSA $10 Plan	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/14/2009	+.5%	94 GSA $10 CoPay Hosp Coins	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/15/2009	+1.7%	94 GSA $15 CoPay Hosp Coins	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/16/2009	+5%	94 GSA $10 CoPay $250	-

COMPANY NAME	Filing Date	% Rate Change	Policy Name/Number	Open/Closed
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/17/2009	+6.1%	94 GSA $15 CoPay $500	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/18/2009	+3.8%	96 GSA low 5/50	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/19/2009	+3.7%	96 GSA low 5/100	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/20/2009	+5.4%	96 GSA low 10/100	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/21/2009	+6.6%	96 GSA low 15/150	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/22/2009	+7.9%	96 GSA low 20/150	-
GUARANTEE TRUST LIFE INSURANCE COMPANY	9/24/2009	+10%	90100	Closed
PERSONALCARE INSURANCE COMPANY	10/2/2009	+3.2%	INDPPO	Open
THRIVENT FINANCIAL FOR LUTHERANS	10/6/2009	+25%	EMM	Closed
THE PRUDENTIAL INSURANCE COMPANY OF AMERICA	11/19/2009	+60%	CHIP34500C-B	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/3/2009	+10%	HSA	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/3/2009	+45%	PMED	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/3/2009	+25%	840, 860	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/3/2009	+10%	800, 880	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/3/2009	+20%	PMEDII	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/3/2009	+35%	ICDHP-TIER	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/3/2009	+10%	ICDHP-TIER	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/3/2009	+10%	ICDHP-HSA	Open
AMERICAN REPUBLIC INSURANCE COMPANY	12/3/2009	+21.6%	A-3562,A-3565,A-A-3566,A-3567,A-3569	Open
PERSONALCARE INSURANCE COMPANY	12/3/2009	+3%	INDPPO - NEW	Open
TRUSTMARK INSURANCE COMPANY	12/3/2009	+24%	TELEMED V	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	12/4/2009	+14%	A-2718,A-2744,A-2745,A-3064,A-3065,A-3066,A-3067,A-2523,A-3167	Open
GUARANTEE TRUST LIFE INSURANCE COMPANY	12/4/2009	+12%	90100	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	12/17/2009	+32.6%	H-600,H-610,H-616	Open
HUMANA INSURANCE COMPANY	12/18/2009	+5.3%	GN-70129, IL-70129	Open
AXA EQUITABLE LIFE INSURANCE COMPANY	12/21/2009	+10%	CBM	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	12/22/2009	+15%	LMM	Closed
PERSONALCARE INSURANCE COMPANY	12/30/2009	+3.2%	INDPPO - 2006 BLOCK	Closed
UNITEDHEALTHCARE OF IL, INC (HMO)	12/30/2009	+13%	GC HMO Choice	-
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	12/31/2009	+30%	H-28	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	12/31/2009	+25%	BMM	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	1/5/2010	+24.5%	H-400,H-425	Open
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	1/5/2010	+20%	AH-50,H-14,H-95	Closed
UNION HEALTH SERVICE INC. (HMO)	1/7/2010	+1.5%	Clinic	-
UNION HEALTH SERVICE INC. (HMO)	1/8/2010	+31.1%	Non-Clinic	-
UNION HEALTH SERVICE INC. (HMO)	1/9/2010	+20.1%	HMO	-
WORLD INSURANCE COMPANY	1/20/2010	+25%	OLD FORMS	Closed
HUMANA HEALTH PLAN, INC. (HMO)	2/16/2010	+3%	Staff Model Network	-
KNIGHT OF COLUMBUS	2/23/2010	+15%	KMD, KMM1, KMP1	Closed

APPENDIX E: FY 2010 Current Rate Review Budget

Title	Monthly Rate	Salary	Retirement	Social Security	Group Insurance	PS& R
Ins. Analyst II	$ 3,679	$ 44,148	$ 13,356	$ 3,377	$ 14,500	$ 75,381

Salaries are based on the Step 4 for AFSCME, and AVG of range for MC

Average Additional Costs/Per Employee

1200-Contractual	$	1,000.00
1290-Travel	$	-
1300-Commodities	$	500.00
1500-Equipment	$	1,000.00
1600-EDP	$	2,000.00
1700-Telecom	$	600.00
	$	5,100.00

TOTAL
$ 80,481.00

APPENDIX F

(215 ILCS 5/357.2) (from Ch. 73, par. 969.2)

Sec. 357.2. "ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions."

(1) Premium Notice Required. No policy of accident and health insurance, as enumerated in class 1(b) or 2(a) of Section 4, shall be declared forfeited or lapsed within 6 months after default in payment of any premium installment or interest or any portion thereof, nor shall any such policy be forfeited or lapsed by reason of nonpayment when due of any premium, installment or interest, or any portion thereof, required by the terms of the policy to be paid, within 6 months from the default in payment of such premium, installment or interest, unless a written or printed notice stating the amount of such premium, installment, interest or portion thereof due on such policy, the place where it shall be paid and the person to whom the same is payable, shall have been duly addressed and mailed with the required postage affixed, to the person insured or to the premium payor if other than the insured at the last known post office address of the insured or premium payor, at least 15 days and not more than 45 days prior to the day when same is due and payable before the beginning of the grace period.

Such notice shall also state that unless such premium or other sum due shall be paid to the company or its agent the policy and all payments thereon will become forfeited and void, except as to any right to a surrender value or paid up policy as provided for by the policy. The affidavit of any officer, clerk or agent of the company or of anyone authorized to mail such notice that the notice required by this Section bearing the required postage has been duly addressed and mailed shall be presumptive evidence that such notice has been duly given.

If the notice is given in a manner other than mailing, then physical proof of the receipt of such notice by the proper recipient shall be maintained by the insurer.

(2) Paragraph (1) of this Section shall not apply to cancellable policies which are renewable at the option of the company nor shall it apply to group policies, industrial policies, or any policies upon which premiums are payable monthly or at shorter intervals.

(Source: P.A. 91-357, eff. 7-29-99.)

(215 ILCS 5/357.3) (from Ch. 73, par. 969.3)

Sec. 357.3. "TIME LIMIT ON CERTAIN DEFENSES: (1) After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 2 year period."

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial 2 year period, nor to limit the application of section 357.15 through section 357.19 in the event of misstatement with respect to age or occupation or other insurance.)

A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least 5 years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the company's option) under the caption "INCONTESTABLE":

"After this policy has been in force for a period of 2 years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application."

(2) "No claim for loss incurred or disability (as defined in the policy) commencing after 2 years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."

(Source: Laws 1967, p. 1735.)

APPENDIX G

AN ACT concerning insurance.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. This Act may be cited as "the Health Insurance Rate Fairness and Affordability Act."

Section 5. The Illinois Insurance Code is amended by adding section 355.01 and by changing sections 355 and 367 as follows:

(215 ILCS 5/355)

Sec. 355. *Accident and health policies – Provisions.* (a) No individual or group policy of insurance against loss or damage from the sickness, or from the bodily injury or death of the insured by accident shall be issued or delivered to any person in this State until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with the Director; nor shall it be so issued or delivered until the Director shall have approved such policy pursuant to the provisions of Section 143 [215 ILCS 5/143]. If the Director disapproves the policy form he shall make a written decision stating the respects in which such form does not comply with the requirements of law and shall deliver a copy thereof to the company and it shall be unlawful thereafter for any such company to issue any policy in such form.

(b) With respect to health insurance coverage offered by a health insurance issuer, a filing of premium rates pursuant to subsection (a) shall not be complete unless it contains all information necessary to justify the premium rate and such other information as the Director may require to determine the rate's compliance with Section 355.01. Each rate filing must also include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment the rate filing is in compliance with the applicable laws and regulations of Illinois and that the benefits are reasonable in relation to premiums.

(c) With respect to premium rate increases, the filing under subsection (a) shall clearly indicate the percentage change from the previously filed rate and the percentage change from the rate that was in effect 12 months prior to the effective date of such rate increase.

(d) In addition to filing premium rates, a company shall notify the Director whenever a policy form subject to this Section has been closed for sale.

(e) As used in subsection (b), the terms "health insurance coverage" and "health insurance issuer" shall have the meaning given those terms in the Illinois Health Insurance Portability and Accountability Act [215 ILCS 97].

(215 ILCS 5/355.01) (new)

Sec. 355.01. Health insurance premium rates – prior approval. (a) With respect to health insurance coverage offered by a health insurance issuer, no such policy, plan, or contract shall be issued or delivered to any person in this State until the classification of risks and the premium rates pertaining thereto have been approved by the Director under this Section. Any subsequent addition to or change in premium rates shall also be subject to the Director's approval under this Section. In all cases the Director shall approve or disapprove a premium rate within 60 days

after submission unless the Director extends by not more than an additional 60 days the period within which he shall approve or disapprove such premium rate by giving written notice to the health insurance issuer of such extension before expiration of the initial 60 day period.

(b) The Director shall disapprove a premium rate under this Section if:

(1) the benefits provided are not reasonable in relation to the premium charged; or

(2) the proposed premium rate is excessive, inadequate, or unfairly discriminatory.

The party proposing a rate has the burden of proving by clear and convincing evidence that the rate does not violate this Section.

(c) The Director shall notify a health insurance issuer in writing of the approval or disapproval of a premium rate under this Section, and such notice shall be posted on the Department's website. If the Director disapproves the premium rate, such written notice shall clearly state the respects in which the premium rate does not comply with the requirements of law and it shall be unlawful thereafter for any such health insurance issuer to use the premium rate. The written notice of disapproval shall also advise the health insurance issuer of the right to a hearing under subsection (e).

(d) With respect to a rate increase approved under this Section, the rate increase shall take effect no sooner than 30 days after the written approval is mailed by the Director. The rate increase shall be stayed if within the 30-day period a written request for a hearing is filed with the Director under subsection (e). A health insurance issuer shall notify in writing all policyholders to which such rate increase applies at least 30 days prior to the effective date of such rate increase. The written notice shall also advise the policyholders of the right to a hearing under subsection (e).

(e) A health insurance issuer may appeal a decision by the Director under this Section by making a written request for a hearing before the Director within 30 days after receiving the written notice under subsection (c) or subsection (f). 1% or 25 (whichever is greater) of the covered lives to which such rate increase applies may appeal a decision by the Director under this Section by submitting a written request to the Department for a hearing before the Director within 30 days after the Department posts public notice under subsection (c).

(f) The Director may request actuarial reasons and data, as well as other information, needed to determine if a previously approved rate continues to satisfy the requirements of this Section. The Director may withdraw approval of any rate that has been previously approved on any of the grounds stated in subsection (b). The Director shall notify a health insurance issuer in writing of the withdrawal of approval. The written notice shall clearly state the respects in which the premium rate ceases to comply with the requirements of law and shall advise the health insurance issuer of the right to a hearing under subsection (e). The written withdrawal of approval shall take effect 30 days from the date of mailing but shall be stayed if within the 30-day period a written request for hearing is filed with the Director under subsection (e).

(g) As used in this Section, the terms "health insurance coverage" and "health insurance issuer" shall have the meaning given those terms in the Illinois Health Insurance Portability and Accountability Act [215 ILCS 97].

(215 ILCS 5/367) (from Ch. 73, par. 979)

Sec. 367. Group accident and health insurance.

(1) Group accident and health insurance is hereby declared to be that form of accident and health insurance covering not less than 2 employees, members, or employees of members, written under a master policy issued to any governmental corporation, unit, agency or department thereof, or to any corporation, copartnership, individual employer, or to any association upon application of an executive officer or trustee of such association having a constitution or bylaws and formed in good faith for purposes other than that of obtaining insurance, where officers, members, employees, employees of members or classes or department thereof, may be insured for their individual benefit. In addition a group accident and health policy may be written to insure any group which may be insured under a group life insurance policy. The term "employees" shall include the officers, managers and employees of subsidiary or affiliated corporations, and the individual proprietors, partners and employees of affiliated individuals and firms, when the business of such subsidiary or affiliated corporations, firms or individuals, is controlled by a common employer through stock ownership, contract or otherwise.

(2) Any insurance company authorized to write accident and health insurance in this State shall have power to issue group accident and health policies. No policy of group accident and health insurance may be issued or delivered in this State unless a copy of the form thereof <u>and of the classification of risks and the premium rates pertaining thereto</u> shall have been filed with the department and approved by it in accordance with Section 355 <u>and Section 355.01</u>, and it contains in substance those provisions contained in Sections 357.1 through 357.30 as may be applicable to group accident and health insurance and the following provisions:

(a) A provision that the policy, the application of the employer, or executive officer or trustee of any association, and the individual applications, if any, of the employees, members or employees of members insured shall constitute the entire contract between the parties, and that all statements made by the employer, or the executive officer or trustee, or by the individual employees, members or employees of members shall (in the absence of fraud) be deemed representations and not warranties, and that no such statement shall be used in defense to a claim under the policy, unless it is contained in a written application.

(b) A provision that the insurer will issue to the employer, or to the executive officer or trustee of the association, for delivery to the employee, member or employee of a member, who is insured under such policy, an individual certificate setting forth a statement as to the insurance protection to which he is entitled and to whom payable.

(c) A provision that to the group or class thereof originally insured shall be added from time to time all new employees of the employer, members of the association or employees of members eligible to and applying for insurance in such group or class.

(3) Anything in this code to the contrary notwithstanding, any group accident and health policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services, may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid. Nothing in this subsection (3) shall prohibit an insurer from providing incentives for insureds to utilize the services of a particular hospital or person.

(4) Special group policies may be issued to school districts providing medical or hospital service, or both, for pupils of the district injured while participating in any athletic activity under the jurisdiction of or sponsored or controlled by the district or the authorities of any school

thereof. The provisions of this Section governing the issuance of group accident and health insurance shall, insofar as applicable, control the issuance of such policies issued to schools.

(5) No policy of group accident and health insurance may be issued or delivered in this State unless it provides that upon the death of the insured employee or group member the dependents' coverage, if any, continues for a period of at least 90 days subject to any other policy provisions relating to termination of dependents' coverage.

(6) No group hospital policy covering miscellaneous hospital expenses issued or delivered in this State shall contain any exception or exclusion from coverage which would preclude the payment of expenses incurred for the processing and administration of blood and its components.

(7) No policy of group accident and health insurance, delivered in this State more than 120 days after the effective day of the Section, which provides inpatient hospital coverage for sicknesses shall exclude from such coverage the treatment of alcoholism. This subsection shall not apply to a policy which covers only specified sicknesses.

(8) No policy of group accident and health insurance, which provides benefits for hospital or medical expenses based upon the actual expenses incurred, issued or delivered in this State shall contain any specific exception to coverage which would preclude the payment of actual expenses incurred in the examination and testing of a victim of an offense defined in Sections 12-13 through 12-16 of the Criminal Code of 1961, or an attempt to commit such offense, to establish that sexual contact did occur or did not occur, and to establish the presence or absence of sexually transmitted disease or infection, and examination and treatment of injuries and trauma sustained by the victim of such offense, arising out of the offense. Every group policy of accident and health insurance which specifically provides benefits for routine physical examinations shall provide full coverage for expenses incurred in the examination and testing of a victim of an offense defined in Sections 12-13 through 12-16 of the Criminal Code of 1961, or an attempt to commit such offense, as set forth in this Section. This subsection shall not apply to a policy which covers hospital and medical expenses for specified illnesses and injuries only.

(9) For purposes of enabling the recovery of State funds, any insurance carrier subject to this Section shall upon reasonable demand by the Department of Public Health disclose the names and identities of its insureds entitled to benefits under this provision to the Department of Public Health whenever the Department of Public Health has determined that it has paid, or is about to pay, hospital or medical expenses for which an insurance carrier is liable under this Section. All information received by the Department of Public Health under this provision shall be held on a confidential basis and shall not be subject to subpoena and shall not be made public by the Department of Public Health or used for any purpose other than that authorized by this Section.

(10) Whenever the Department of Public Health finds that it has paid all or part of any hospital or medical expenses which an insurance carrier is obligated to pay under this Section, the Department of Public Health shall be entitled to receive reimbursement for its payments from such insurance carrier provided that the Department of Public Health has notified the insurance carrier of its claim before the carrier has paid the benefits to its insureds or the insureds' assignees.

(11) (a) No group hospital, medical or surgical expense policy shall contain any provision whereby benefits otherwise payable thereunder are subject to reduction solely on account of the existence of similar benefits provided under other group or group-type accident and sickness insurance policies where such reduction would operate to reduce total benefits payable under

these policies below an amount equal to 100% of total allowable expenses provided under these policies.

(b) When dependents of insureds are covered under 2 policies, both of which contain coordination of benefits provisions, benefits of the policy of the insured whose birthday falls earlier in the year are determined before those of the policy of the insured whose birthday falls later in the year. Birthday, as used herein, refers only to the month and day in a calendar year, not the year in which the person was born. The Department of Insurance shall promulgate rules defining the order of benefit determination pursuant to this paragraph (b).

(12) Every group policy under this Section shall be subject to the provisions of Sections 356g and 356n of this Code.

(13) No accident and health insurer providing coverage for hospital or medical expenses on an expense incurred basis shall deny reimbursement for an otherwise covered expense incurred for any organ transplantation procedure solely on the basis that such procedure is deemed experimental or investigational unless supported by the determination of the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services that such procedure is either experimental or investigational or that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable. If an accident and health insurer has made written request, or had one made on its behalf by a national organization, for determination by the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services as to whether a specific organ transplantation procedure is clinically acceptable and said organization fails to respond to such a request within a period of 90 days, the failure to act may be deemed a determination that the procedure is deemed to be experimental or investigational.

(14) Whenever a claim for benefits by an insured under a dental prepayment program is denied or reduced, based on the review of x-ray films, such review must be performed by a dentist.

Section 10. The Small Employer Health Insurance Rating Act is amended by changing section 25 as follows:

(215 ILCS 93/25)

Sec. 25. Premium Rates.

(a) Premium rates for health benefit plans subject to this Act shall <u>be filed with the Director pursuant to Section 355 of the Illinois Insurance Code [215 ILCS 5/355] or Section 2-11.1 of the Health Maintenance Organization Act [215 ILCS 125/2-11.1] and shall</u> be subject to all of the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than <u>10%</u> ~~20%~~.

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case 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, shall not vary from the index rate by more than <u>10%</u> ~~25%~~ of the index rate.

(3) The percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(A) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business ~~health benefit plan~~ into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate; and

(B) an adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than one year, due to claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business.~~; and~~

~~(C) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.~~

(4) Adjustments in rates for a new rating period due to claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(5) In the case of health benefit plans delivered or issued for delivery prior to the effective date of this Act, a premium rate for a rating period may exceed the ranges set forth in items (1) and (2) of subsection (a) for a period of 3 years following the effective date of this Act. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(A) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; in the case of a class of business into which the small employer carrier is no longer enrolling new small employees, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar class of business into which the small employer carrier is actively enrolling new small employers; and

(B) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(6) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(7) For the purposes of this subsection, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restriction of benefits to network providers results in substantial differences in claim costs.

(b) A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class

of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

(c) Any rate increase under subsection (a)(3)(A), as measured from the effective date of such increase to 12 months prior to the effective date, that is greater than the sum of the prior calendar year's rate of medical inflation plus 6% shall be presumptively disapproved as excessive by the Director under Section 355.01 of the Insurance Code [215 ILCS 5/355.01].

As used in this subsection, the term "rate of medical inflation" shall mean the percentage change in the annual average Medical Care Component of the United States Department of Labor Consumer Price Index for All Urban Consumers.

Section 15. The Health Maintenance Organization Act is amended by adding section 2-11.1 and by changing section 5-3 as follows:

(215 ILCS 125/2-11.1) (new)

Sec. 2-11.1. Premium rates – filing and prior approval. (a) Notwithstanding any other provision of law, no group or individual contract or evidence of coverage shall be issued or delivered in this State until the schedule of base rates to be used in conjunction with the contract or evidence of coverage has been filed with the Director; nor shall it be issued or delivered until the Director shall have approved such base rates pursuant to the provisions of Section 355.01 of the Insurance Code [215 ILCS 5/355.01]. Any subsequent addition to or change in rates are also subject to this Section.

(b) A filing of rates under this Section shall not be complete unless it contains all information necessary to justify the premium rate and such other information as the Director may require to determine the rate's compliance with Section 355.01 of the Insurance Code [215 ILCS 5/355.01]. Each rate filing must also include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment the rate filing is in compliance with the applicable laws and regulations of Illinois and that the benefits are reasonable in relation to premiums.

(c) With respect to rate increases, the filing under this Section shall clearly indicate the percentage change from the previously filed rate and the percentage change from the rate that was in effect 12 months prior to the effective date of such rate increase.

(d) In addition to filing premium rates, a health maintenance organization shall notify the Director whenever a plan subject to this Section has been closed for sale.

(215 ILCS 125/5-3)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 355.01, 355.2, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in

advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(g) Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

Section 99. Effective date. This Act takes effect on January 1, 2011.

APPENDIX H

Consumer Complaints Regarding Health Insurance Premiums (2008-2010)

	2008	2009	2010	Totals
Group Health Plans	18	43	26	87
Individual Health Plans	36	28	35	99
			Total Complaints:	**186**

APPENDIX I: Proposed Total Budget for Premium Review Cycle I

Personnel		
Salaries	$	351,948.00
One Acturary, 3 Actuarial Assistants, 2 Insurance Analysts and 1 Office Coordinator		
Fringe Benefits	$	234,899.00
Social Security, Retirement and Group Insurance		
Equipment	$	35,700.00
Computers, telecom, etc.		
Contractual Services		
Contracts	$	336,700.00
Contracts for IT consulting and acturial services		
"Other"		
IT Upgrades	$	18,808.00
Upgrade to current SERFF system		
Public Hearings	$	5,000.00
Regional public hearings estimated cost includes travel, notification, print materials		
Consumer Education and Outreach	$	5,000.00
Estimated cost includes travel, printing, postage, and telecommunications		
Translation Services	$	11,945.00
Translation of the database, documents, reports and charts		
Total	**$**	**1,000,000.00**

APPENDIX J: Proposed Budget for Additional Staff

Title	Monthly Rate	Salary	Retirement	Social Security	Group Insurance	PS& R Total
			0.30253	0.0765		
Office Associate	$ 3,160	$ 37,920	$ 11,472	$ 2,901	$ 14,500	$ 66,793
Ins. Analyst II	$ 3,679	$ 44,148	$ 13,356	$ 3,377	$ 14,500	$ 75,381
Ins. Analyst II	$ 3,679	$ 44,148	$ 13,356	$ 3,377	$ 14,500	$ 75,381
Actuarial Asst.	$ 4,432	$ 53,184	$ 16,090	$ 4,069	$ 14,500	$ 87,842
Actuarial Asst.	$ 4,432	$ 53,184	$ 16,090	$ 4,069	$ 14,500	$ 87,842
Actuarial Asst.	$ 4,432	$ 53,184	$ 16,090	$ 4,069	$ 14,500	$ 87,842
Actuary I	$ 5,515	$ 66,180	$ 20,021	$ 5,063	$ 14,500	$ 105,764
	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -
7	$ 29,329	**$ 351,948**	**$ 106,475**	**$ 26,924**	**$ 101,500**	**$ 586,847**

Salaries are based on the Step 4 for AFSCME, and AVG of range for MC

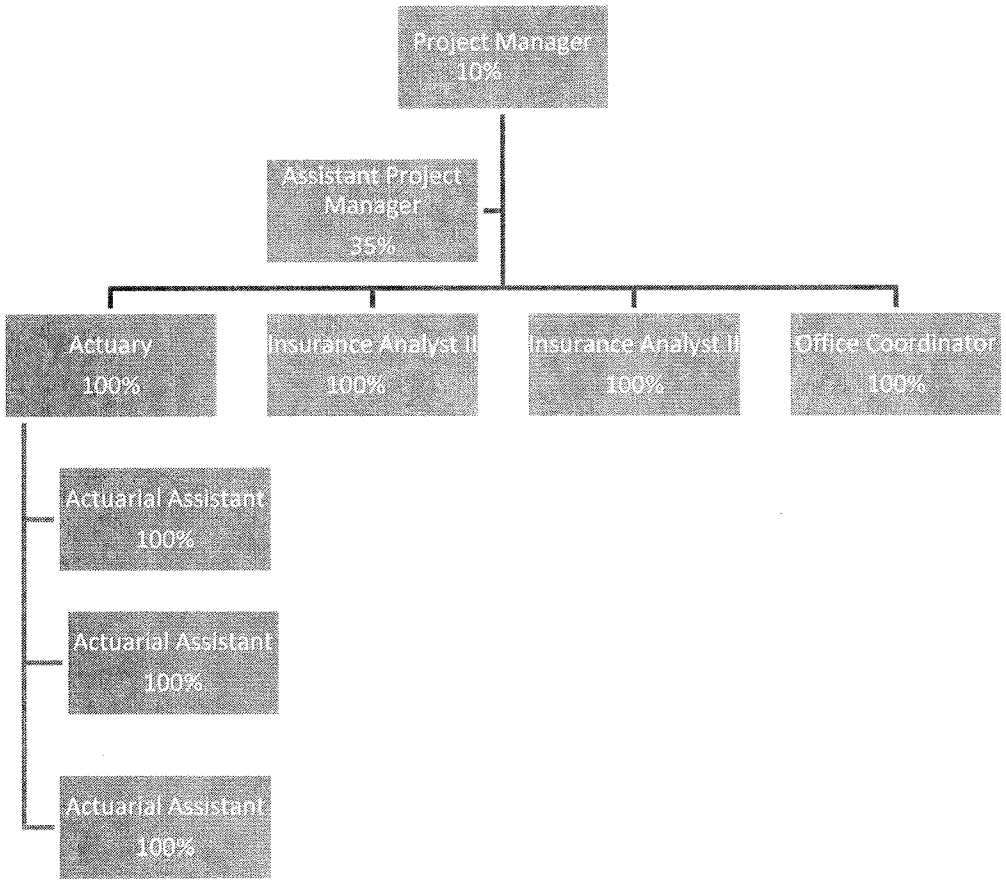
Average Additional Costs/Per Employee

Please note that Travel will be adjusted per title (for example an office associate will have $0.00 for travel.)

		Based on HC	Other	NEW other Ops Total
1200-Contractual	$ 1,000.00	$ 7,000.00		**$ 7,000.00**
1290-Travel	$ -	$ -		**$ -**
1300-Commodities	$ 500.00	$ 3,500.00		**$ 3,500.00**
1500-Equipment	$ 1,000.00	$ 7,000.00		**$ 7,000.00**
1600-EDP	$ 2,000.00	$ 14,000.00		**$ 14,000.00**
1700-Telecom	$ 600.00	$ 4,200.00		**$ 4,200.00**
	$ 5,100.00	$ 35,700.00	$ -	**$ 35,700.00**

Total $
$ 622,547

APPENDIX K: Premium Review Project Organizational Chart



APPENDIX L: Job Descriptions

Job Description for William B. McAndrew, Project Manager

Bill was appointed Deputy Director the Illinois Department of Insurance on January 1, 2009. As head of the Department's Consumer Market Section, Bill oversees all aspects of P&C, LAH and HMO policy filings and approvals, producer licensing, market conduct examinations, consumer complaints and the State of Illinois, Senior Health Insurance Program (SHIP). The Department estimates Bill will spend 90 percent of his time on activities outside of the grant activities.

Job Description for Kate Gross, Assistant Project Manager

Kate Gross serves as the Assistant Director for Health Planning within the Illinois Department of Insurance. Kate's two primary responsibilities are to establish and manage the Health Care Insurance Exchange, and to formulate policy with an emphasis on implementation of statewide health insurance mandates as directed by federal legislation. The latter duty includes compliance with State and Federal laws, mandates and standards, as well as researching, developing, and writing proposals effecting changes in statutes and administrative rules. Additionally, Kate is directed to focus on the long range plans for the Department to ensure progress toward the accomplishment of its goals and objectives. This includes representing the Department and acting as a liaison with the Governor's office, other state departments, citizen groups, Federal government entities, health care providers and insurers, etc. With more than 70 percent of her time dedicated to these activities, the Department estimates Kate will spend 65 percent of her time on activities outside of the grant activities.

APPENDIX M

DATE: June 25, 2010

TO: All Commissioners

FROM: Julienne L. Fritz, Director of Insurance Products and Services

RE: Department of Health and Human Services (HHS) Grants to States for Health Insurance Premium Review-Cycle I – Estimate for leveraging SERFF

Given the NAIC's Speed to Market initiatives and the role SERFF plays in the rate and form filing and review process, it has been considered logical and cost effective to utilize SERFF in meeting many IT requirements as outlined in the grant. Based on the provisions of the grant and at the request of states, the NAIC has estimated the cost of leveraging SERFF. To that end, the NAIC has provided a description of deliverables, timeline and estimated cost, which are outlined below, and may be incorporated into a grant application. It should be noted that the information provided by the NAIC is based on limited knowledge of the HHS reporting requirements and will be refined once the uniform template and definitions for data reporting are provided, which are tentatively scheduled for availability in early August.

The NAIC is comfortable with our ability to meet HHS requirements and has received information that suggests HHS would accept the proposed delivery timelines. It may be valuable to know that, while not required, HHS has indicated interest in being able to collect data/reports through a uniform system implementation, which the NAIC is willing to facilitate and is contemplated below. HHS has also indicated that there is no intention to build any restrictions into a grant acceptance agreement which would limit the states ability to use grant funds for this purpose.

Grant Application Information:

Cost: $18,808

Description of Deliverables:

1) Requirements defined in Section A.1(c)(1) and A.1(c)(2) on pages 15, 16 and 17. Specifically, the estimate covers the expenses associated with modifying SERFF to address data collection and reporting requirements, such as:
    a. State options to indicate premium review grant participation
    b. Company profile changes to incorporate company type
    c. State-maintained indicator for rate filing requests meeting the HHS threshold for 'unreasonable'.
    d. Addition of field to indicate product types
    e. Company-maintained product information including product name, HHS id, and product status that will allow the companies to track products and apply them to filings.
    f. A new set of fields added to the Rate/Rule schedule items to provide HIPR data on a policy form basis.
    g. Changes to the State API to accommodate retrieval of the data elements added above and to allow for updates of appropriate data elements via the State API.
2) Incorporating the submission of a federally mandated Rate Filing Disclosure Form and Justification (currently being reviewed by the B Committee) that is required to be filed under provisions of the Affordable Care Act if a rate request falls under the definition of 'unreasonable'. The estimate provided by the NAIC would also allow the Rate Filing Disclosure Form, or similar document, to be filed regardless of whether the rate request falls under the definition of 'unreasonable' in the event the states wanted to include this in their submission requirements to facilitate meeting the requirement that consumer friendly descriptions of rate filings be made available publicly.
3) Additional SERFF state training that will support the grant requirements.
4) Support for making non-confidential consumer friendly rate disclosures and/or rate filing information available publicly, as required and permitted.
5) Support the ability to satisfy reporting requirements of the uniform template for data reporting within the SERFF system, if HHS will accept reports directly from SERFF, including basic trending reports.

The workflow on a Health filing that requires the enhanced data reporting fields will vary from the existing SERFF workflow. States will set preferences that will indicate the level of data they would like to require. Fields exposed to the industry during the filing creation process are determined by these state preferences. The overall workflow will be changed in that the filer will now be required to tie schedule items (such as rates and policy forms) to a specific product. This will allow for the reporting of data based on the product the consumer will ultimately be offered. A significant portion of the project hours will be devoted to aggregating the collected data into the reports required by HHS. An interface to allow HHS to get reports from SERFF is included within the estimate should that prove a requirement.

Delivery Timeline:

The SERFF enhancements incorporating HHS reporting requirements will be implemented in a phased approach with the first release to occur within 3 months of the receipt of HHS requirements for the uniform template for reporting. The initial release will focus on implementing the means for data collection; subsequent releases will incorporate reporting needs. Releasing functionality in this manner will allow a period of time during which data can then be submitted by insurers prior to any required reporting to HHS, thus avoiding manual data collection processes. Based on the requirements known at this time, the development will occur over an 8 month period beginning when the NAIC receives the reporting template and supporting documentation.

APPENDIX N: Proposed Budget for Translation Services

Document for Translation	Estimated Wordcount
Consumer Database	448
Consumer Report	2000
Q+A Document	1500
Comparison Chart	1000
Other Documents	4000
TOTAL WORD COUNT	8948

Mandatory Languages	Cost Per Word
Spanish	$0.0950
Polish	$0.1050
Korean	$0.1300

Other Available Languages	Cost Per Word
German	$0.0950
Russian	$0.0950
Portuguese	$0.0950
French	$0.0950
Italian	$0.0950
Japanese	$0.1300
Chinese	$0.1300
Vietnamese	$0.1300
Arabic	$0.1400
Other	$0.4000

Language	Estimated Cost of Translation
Spanish	$850.06
Polish	$939.54
Korean	$1,163.24
German	$850.06
Russian	$850.06
Portuguese	$850.06
French	$850.06
Italian	$850.06
Japanese	$1,163.24
Chinese	$1,163.24
Vietnamese	$1,163.24
Arabic	$1,252.72
TOTAL TRANSLATION COST	$11,945.58