



Rate Review Project

Phase II – Rate Review Recommendations

July 8, 2011

## Executive Summary

The Arkansas Insurance Department (AID) applied for and received Cycle I grant funding under the Affordable Care Act of 2010 (ACA) to improve their rate review process. As part of this grant funding, Aon Hewitt has carried out an assessment of the current rate review process (Phase I) and developed recommendations for improving the process (Phase II). A report on Phase I of the project was issued in draft form on May 13 and in final form on June 20.

The following report covers Phase II of this project, with detailed recommendations for process improvements, including some that were already implemented during the course of the project. The activities conducted in Phase II included regulatory enhancements, a comparative analysis of state websites, sample communications strategy documents, a rate review transparency and disclosure analysis, training recommendations, rate review process recommendations, checklists, job aids, and a rate review database. This work is expected to add more rigor and structure to the AID's rate review process, as well as to prepare the AID to meet the requirements of the ACA. However, there is opportunity for the AID to further improve its processes and resources in Cycle 2, and these opportunities are discussed as well.

## Introduction

The recommendations in this report encompass the following areas:

- 1) Regulations
- 2) Communications and website
- 3) Rate review transparency and disclosure
- 4) Training
- 5) Rate review process
- 6) Information technology

## Regulatory Changes After Phase I

### Rate Review Final Rule

At the end of Phase I of this project, the Department of Health and Human Services (HHS) released on May 23, 2011 final regulations for rate increase disclosure and review<sup>1</sup>. These final regulations implemented ACA requirements for health insurers regarding disclosure and review of unreasonable premium increases. The following provisions of the proposed rule issued on December 23, 2010<sup>2</sup> were maintained:

- 1) For states that HHS deems to have an effective rate review process, the states will be allowed to determine whether a rate change request is “unreasonable”. HHS will not be reviewing rate filings for these states.
- 2) An effective rate review process is determined by the following criteria:
  - a. Does the state **receive from the issuer’s data and documentation** that is sufficient to determine if rate increase is unreasonable?
  - b. Does the state effectively **review the data and documentation**?
  - c. Does the state examine the **reasonableness of the assumptions**?
  - d. Does the state apply a **standard set forth in statute or regulation** when making the determination of reasonable vs. unreasonable?
  - e. In the final regulation, HHS also added the requirement that the process must include public input.
- 3) For states that do not have an effective rate review process, HHS will review rate filings using the following two-step process:
  - a. All rate increases at or above a specific threshold will be deemed “**subject to review**”. The initial subject to review threshold will be 10% for all states.
  - b. All rate increases that are “subject to review” will be reviewed by HHS with an assessment as to whether or not the rate increase is unreasonable.

---

<sup>1</sup> Final HHS rule on rate increase disclosure and review: <http://www.federalregister.gov/articles/2011/05/23/2011-12631/rate-increase-disclosure-and-review#p-3> . (May 23, 2011)

<sup>2</sup> Proposed HHS rule on rate increase disclosure and review: <http://www.gpo.gov/fdsys/pkg/FR-2010-12-23/pdf/2010-32143.pdf>. (December 23, 2010)

The major changes since the proposed rule issued on December 23, 2010 were as follows:

- 1) The effective date of the regulations was delayed from July 1, 2011 to September 1, 2011.
- 2) State-specific thresholds will take effect on September 1, 2012
- 3) In order for a rate review process to be deemed effective, the process must include public input (as noted above).
- 4) An "effective state review process" does not need to look at Risk Based Capital (RBC), though states should look at capital and surplus needs if appropriate.
- 5) Large group rate filings will not be subject to the regulations. Association plans may be included, but HHS has requested comment on this issue.

## AID Regulations

### Phase I Observations

In our Phase I report, we made the following observations regarding the AID's rate filing regulations and authority:

- 1) The AID did not have a standard for determining that rates are "unreasonable", and the process has been subject to the discretion of the Commissioner who has been in office at the time.
- 2) Rate filings were not required for non-HMO small group, though annual actuarial certifications were required.
- 3) Non-HMO small group was defined as 2-25 eligible employees.
- 4) For HMO small group rate filings, there were no requirements to submit experience data, a methodology description, or the target medical loss ratio (MLR).
- 5) Individual rate filings had a 30-day deemer period, which means that rate filings could potentially be "deemed" approved without being first reviewed by the state, if the state did not respond within 30 days.

### New AID Individual and Small Group Regulations

On June 29, 2011, the AID released individual and small group Bulletins (6-2011 and 7-2011 respectively, which addressed these concerns. These Bulletins were both to take effect September 1, 2011 and included the following changes:

- 1) Individual rates that meet or exceed HHS' subject to review threshold must be approved before implementation (no deemer period).
- 2) Individual rate filings that meet or exceed HHS' subject to review threshold are only permitted at most once per year, though interim rate filings may be permitted under certain circumstances (e.g., to correct errors in rate calculations).

- 3) Individual rate filings must be accompanied by a certification from the actuary that the proposed rate or rate revision does not discriminate unfairly between policyholders.
- 4) Small group rates (HMO and non-HMO) must also be approved before they are implemented, though there is a 60-day deemer period.
- 5) Small group rates (or methodology) must be filed annually on June 1.
- 6) In order to be approved, small group rates cannot be excessive, inadequate, unreasonable, or unfairly discriminatory.
- 7) For both individual and small group, a list of required data and documentation was provided in the regulations, including Medical Loss Ratio (MLR) and all three of HHS' disclosure documents.

### Effective Rate Review Determination by CMS

Based on the Bulletins released by the AID, as well as Arkansas' other laws, regulations, and bulletins related to health care rate review, the Centers for Medicare and Medicaid Services (CMS) determined on July 1, 2011 that Arkansas has an effective rate review program. This determination is contingent on the AID providing access from its website to Parts I and II of the Preliminary Justification for the rate filings it reviews, as well as the AID providing a means for public input on proposed rate increases.

## Summary of Phase II Activities

In Phase II of this project, we performed the following activities:

- 1) Communications
  - a. Comprehensive review of AID website
  - b. Review of other states' websites
  - c. Recommendations for website
  - d. Sample communication strategy
- 2) Rate Review Transparency and Disclosure
- 3) Training
  - a. Analysis of AID's health insurance rate review training needs
  - b. Recommended approaches for addressing these needs
- 4) Rate review process
  - a. Developed recommendations for workflow
  - b. Job aids
  - c. Staffing recommendations

- 5) Rate review database
  - a. Developed recommended list of fields to include in rate review database
  - b. Created basic rate review database, with historical individual rate filings included

The rest of this report describes these activities and provides the recommendations that we developed.

## Results of Phase II Activities

### Communications

#### Website Analysis and Recommendations

In Phase II, we conducted an analysis of the AID's website versus other "best-in-class" state-sponsored insurance websites (see Appendix A for details). Based on this analysis, we concluded that the AID should redesign its website to improve the user experience and make it easier for users to find the information they need. Currently, website navigation is extremely poor, unintuitive, and often unclear. Our recommendations for redesigning the website are as follows:

- 1) The AID should **create a site map** to identify the main sections of the site and group related information together. We provided a recommended site map in our analysis.
- 2) **Content should be improved** to better engage consumers and make it easier for consumers to find the information they need. We provided specific suggestions for improving content.
- 3) The website should have a **brand identity**, and the **graphic look** should be improved. The current website is functional, but bland and boring. Graphics would help to break up large, overwhelming sections of text. Insurance can sometimes be difficult and frustrating for consumers; better design would help make the website more usable and understandable.

#### Communication Strategy

We also provided recommendations for the AID's communication strategy (see Appendix A), including:

- 1) General guidance for designing a communication strategy, and
- 2) Sample communication strategy documents.

### Rate Review Transparency and Disclosure

In Phase I Aon Hewitt identified that AID has not historically made rate filing information available to the public until it is deemed closed by the commissioner. Therefore, the AID has not historically sought consumer input prior to approving or disapproving a rate filing. If the AID wanted to improve transparency and the ability for the public to provide input prior to approving rates, the practice of holding rate filings confidential before they are deemed closed will need to be changed to allow the AID to provide information about proposed rate filings to the public. AID planned to clarify what constitutes "actuarial formulas and assumptions".

Since the release of the Phase I report:

- HHS has issued final regulations dealing with rate reviews (45 CFR Part 154),
- AID has issued Bulletins 6-2011 and 7-2011 dealing with Individual and Small Group rate filings, respectively; and
- HHS has determined that Arkansas has an effective rate review process.

HHS final regulations require that for a State with an Effective Rate Review Program that it must provide access from its website to the Parts I and II of the Preliminary Justifications of the proposed rate increases that it reviews and have a mechanism for receiving public comments on those proposed rate increases. Further, in Bulletins 6-2011 and 7-2011 AID states that for those increases subject to review all the information contained in Exhibits 1, 2, and 3 will be posted on the Department's website. Exhibits 1, 2, and 3 correspond to Parts I, II, and III of the HHS reporting requirements of 45 CFR Part 154.

In Bulletins 6-2011 and 7-2011 AID identifies those items from Exhibit 3 that may be considered confidential pursuant to Arkansas Code Annotated Section 23-61-103(d) and other applicable statutes. AID has identified those actuarial formulas and assumptions, that when certified by a qualified actuary, will be considered confidential and privileged.

Presently AID provides access through the website to closed rate filings. To fulfill its requirement of having an effective rate review process, AID must expand their website when necessary, to:

- post proposed rate filings, and
- receive public comments on the proposed rate filings.

## Training

In Phase II, we carried out an analysis of the AID's training needs, and we recommended some approaches for addressing these needs. See Appendix B for details. Below is a summary of our findings:

- 1) The carriers we interviewed consider AID rate review personnel to be experienced, knowledgeable, responsive, and approachable.
- 2) There is currently no formal training or training materials in-house, and outside training opportunities are limited.
- 3) In terms of staffing, the AID should consider requirements and job candidates with insurance financial experience, particularly underwriting and actuarial. If the AID does not have enough rate filings to warrant hiring a full-time actuary, a process should be developed to determine which filings get outsourced.
- 4) We recommend that the AID develop at a minimum three training modules, which would include at least some of the following topics:
  - a. Basics of Insurance (Introductory Module)
  - b. Cost of Insurance and Loss Ratios
  - c. Rate Manual Components

- d. Types of Insurance Pools
  - e. Experience Rating
- 5) We outlined suggested approaches for these training modules.
  - 6) We also provided a list of outside sources for training seminars and/or materials.

## Rate Filing Review Process

### Workflow

#### Summary of Phase I Observations

In Phase I, we reviewed sample rate filings and assessed the AID's review process for these filings. For one filing, we noticed that the methodology and assumptions in the rate filing were unclear and were not questioned until the rate filing was reviewed by the AID's outside actuarial consultants. Even after the actuarial consultants were involved, it took a few rounds of questioning before the methodology and assumptions were clearly understood, which cost the AID both in terms of expense (consulting hours) and staff time and the opportunity to assure that the review was performed in a comprehensive manner.

We also noticed that AID staff were not checking the assumptions of filings carefully, partly due to what appeared to be a lack of understanding of actuarial concepts, such as how to translate historical experience into a projected loss ratio using trend and previously filed rate increases. Assumptions were also not checked against benchmarks, such as national trend estimates, at least not before the filings were sent to outside actuaries.

Lastly, we noticed that the AID was not very prescriptive in terms of its rate filing requirements, and there were no internal checklists maintained to ensure and document that rate filings included required elements. A lack of structure in the rate filing submission and review process can sometimes lead to actuaries submitting intentionally vague rate filings, hoping that the reviewer will not notice that conservative assumptions were used, or short-cuts taken. Also, the fact that checklists are not used while reviewing increases the probability of error and makes it difficult to determine later what aspects of the filing the reviewer actually did review and assess for reasonability.

#### Recommendations

In order to improve the review process, we recommended in Phase I that the AID be more prescriptive in their rate filing requirements. The AID has addressed this concern in part by issuing Bulletins 6-2011 and 7-2011, which requires that carriers submit HHS' three Preliminary Justification documents with rate filings that are subject to review, along with the target loss ratio as calculated under federal guidelines. These bulletins also contain a detailed list of items that the AID will review, where applicable. Having this additional structure in place gives AID more of the data that they need to review filings effectively, and it also gives the AID pretext for asking for additional data (via the list of items that will be reviewed), in cases where actuaries have provided very limited information re: methodology and assumption. Additionally, since the AID will be mirroring the process put into place by HHS, carriers should be prepared to submit filings using the HHS process, whether for filings submitted to HHS or other states following similar guidelines. In other words, there should be some developing consistency on how filings are prepared and the AID is well positioned to benefit from this upcoming consistency.

To effectively make use of this new structure, we recommend that the AID staff do more initial checks on the front-end for each rate filing before sending the filing to actuaries for review. To this end, we have developed detailed checklists to be used by AID staff for each rate filing - one checklist for individual rate filings and one for small group rate filings. Using these checklists should help to minimize errors when reviewing filings and ensure that all of the data is present in the rate filing before a detailed review begins. We recommend that the reviewer fill out a checklist for each filing and keep the results in electronic and/or paper format, so that if a question comes up later (e.g., consumer complaint or audit), it will be easy to see if the proper checks were done in the initial review.

**Figure 1: AID Individual Rate Filing Checklist – Sample Rows**

<u>Individual Rate Filings</u>			
Company Name		ABC Insurance Company	
Segment (Indiv, Small Group, Large Group)		Individual	
Product (HMO, PPO, etc.)		HMO	
SERFF Tracking Number		123456	
Current Rate Filing Effective Date		9/1/2011	
Requested Rate Increase		6.0%	
#	Item	Done / Result	Comments
1	Rate filing submitted far enough in advance so that policyholders can be notified at least 30 days before effective date.		
2	Includes policy or contract form number?		
3	What is the # of persons in Arkansas affected by proposed rates?		
4	Includes description of type of filing?		
5	Separate filing for each form number?		
6	If proposed rate is for a contract or policy form not currently approved, does the form accompany the rate filing?		
7	Average requested rate increase		
8	Minimum requested rate increase		
9	Maximum requested rate increase		

If a carrier has not submitted all of the required data, we recommend that the AID immediately send a letter to the carrier requesting the additional data and stating that the review period (e.g., 60 days) does not start until the carrier has sent this data. The checklist also includes some checks that can be done using job aids that we have developed (see below). If the rate filing fails any of these checks, we recommend that the AID send a letter stating the problem and asking the carrier to revise the rate filing (again, stating that the review period starts once a response has been received).

These checklists should be considered to be living documents, to be updated and revised as the AID sees fit or when new developments (e.g., regulations) warrant a change in process or requirements.

## Job Aids

In our Phase I report, we recommended that basic job aids be developed to assist with the rate review process. In Phase II, we developed three job aids for the AID to use:

- 1) A **cumulative annual rate change calculator**, to combine multiple rate filings submitted within a year.
- 2) A tool to compare the **medical loss ratio (MLR)** against the federal MLR standards.

- 3) A tool to **calculate the annual trend assumptions** used by the actuary to trend between the historical (base) period and the current rate period, as well as between the current rate period and the future rate (projection) period.

### Cumulative Annual Rate Change Calculator

The subject to review threshold from HHS is on an annual basis, meaning that if carriers submit more than one filing per year, the combination of all of these increases should be compared with the threshold. Combining rate increases for multiple rate filings can be complex. The rate increases cannot simply be added together, since they are multiplicative. For example, assume a carrier submits the following rate filings:

- Effective 10/1/2010: -4.0%
- Effective 6/1/2011: +8.0%
- Effective 9/1/2011: +6.0%

The total rate increase that impacts members renewing 9/1/2011 is not simply  $-4.0\%+8.0\%+6.0\% = +10.0\%$ . Rather, the total rate increase is calculated as follows:

*Average annual rate increase effective 2/1/2011:  $(1-4.0\%) \times (1+8.0\%) \times (1+6.0\%) - 1 = +9.9\%$*

The impact of using the correct versus incorrect calculation is small here, but it can mean the difference between meeting the subject to review threshold and not meeting it.

In addition, the above increase requested for 2/1/2011 can have a different annual impact for members that renew in other months. For example, a member who renews effective 11/1/2011 would experience the following average increase:

*Average annual rate increase for members renewing 11/1/2011:  $(1+8.0\%) \times (1+6.0\%) - 1 = +14.5\%$*

This is because these members already received the average -4.0% rate increase that was effective 10/1/2010 when they last renewed on 11/1/2010.

While HHS does not specifically address this situation in the final regulation, the intent of the law is clearly to review rate increases that are over the subject to review threshold, even if they are for subsequent renewal months (not the first month of renewals after the filing takes effect). Because checking the issues above can be complex, we created a job aid to automatically calculate the annual renewal increases for each renewal month and identify rate increases that are subject to review (see picture below).



**Figure 3: Medical Loss Ratio Tool**

<b>Federal Minimum Loss Ratio (MLR) Standard</b>			
Company Name	ABC Insurance Company		
Segment (Indiv, Small Group, Large Group)	Individual		
Product (HMO, PPO, etc.)	HMO		
SERFF Tracking Number	123456		
Current Rate Filing Effective Date	9/1/2011		
Life-Years (Projected Members)	3,500		
Average Deductible	\$0		
Verify Base Target MLR or Use From Rate Filing?	Verify Target Base MLR		
<b>Projected:</b>			
Incurred Claims (\$)	\$360,000	[c]	
Earned Premiums (\$)	\$500,000	[p]	
Federal and State Taxes	Percent		
- Percent	0%		
- Dollar	\$0	[t]	
Licensing and Regulatory Fees	Percent		
- Percent	0%		
- Dollar	\$0	[f]	
Base Target MLR	72.0%		$= [c] / ([p] - [t] - [f])$
Credibility Adjustment	4.6%	[b]	
Deductible Adjustment	1.000	[d]	
Adjusted Target MLR, Incl. Rebate Estimates of:			$= [c] / ([p] - [t] - [f]) + ([b]*[d]) + u$
None	76.6%		
High	77.6%		
Medium	80.6%		
Low	83.6%		
Federal Minimum Loss Ratio Standard	80.0%		
<b>Less than Federal MLR Standard?</b>	<b>Yes, Using Medium Rebate Estimate Assumptions</b>		

### Annual Trend Assumption Calculator

In the individual and small group regulations released on June 29, 2011, the AID has asked carriers to submit HHS' preliminary justification (disclosure) documents as part of their rate filings, for any requested rate increases that exceed the subject to review threshold. The Rate Summary Worksheet that is part of these materials does include trend assumptions by service category (e.g., inpatient). However, there is no total trend assumption in this worksheet, and the trend assumptions are not on an annual basis. For example, if the midpoints of the base (historical) period and the current rate period are 9 months apart, the trend factors in this spreadsheet will only represent 9 months of trend. It is difficult to compare 9-month trend factors provided in a rate filing to benchmarks (e.g., national trends from consulting firms) that are on an annual basis.

When we reviewed sample rate filings in Phase I, we noticed one rate filing where it was not immediately clear that the actuary was using a high "trend" assumption. It took a few rounds of correspondence between the AID and the carrier (with the AID's outside consulting actuaries involved) to determine that the "trend" assumption was high, and really this was due to a durational rating model being used that wasn't even mentioned in the original rate filing. Checking trends quickly on the front-end would allow these issues to surface more quickly and would give the AID recourse to ask the actuaries to explain unusual trend assumptions earlier in the process.

To make it easier for the AID to compare trend factors in rate filings to national benchmarks, we developed an annual trend assumption calculator (see picture below). This calculator uses the Rate Summary Worksheet (Part I of the Preliminary Justification) as the starting point for the comparison. The

user would also need to enter average plan design features (office visit copay, deductible, and coinsurance), since trend can vary significantly by plan design due to “leveraging”<sup>3</sup>.

**Figure 4: Annual Trend Assumption Calculator**

<u>Trend</u>								
Company Name	ABC Insurance Company							
Segment (Indiv, Small Group, Large Group)	Individual							
Product (HMO, PPO, etc.)	HMO							
SERFF Tracking Number	123456							
Current Rate Filing Effective Date	9/1/2011							
	<b>Leveraging Factor</b>							
Average Office Visit Copay	High office visit copay (\$20/\$25) 0.2%							
Average Deductible	\$1,500							
Average Coinsurance	80% 1.7%							
<b><u>Base to Current:</u></b>								
National Core Trend for Time Period:	8.00%							
Leveraging Factors:	1.90%							
Total National Trend with Leveraging:	10.05%							
Implied Annual Trend (%) from Disclosure	5.67%							
<b>Exceeds National Trend by At least 1%?</b>	<b>No</b>							
<b><u>Current to Future:</u></b>								
National Core Trend for Time Period:	7.50%							
Leveraging Factors:	1.90%							
Total National Trend with Leveraging:	9.54%							
Implied Annual Trend (%) from Disclosure	9.97%							
<b>Exceeds National Trend by At least 1%?</b>	<b>No</b>							
<b><u>TABLES</u></b>								
From Aon Hewitt National Trend Projections as of 4/21/2011								
Year	Start Midpoint	End Midpoint	Active/Pre-65 Retiree			Midpoint of Rate Filing Data		
			Core Trend*			Base Period	Current	Future
Medical	Rx	Combined						
2007–2008	7/1/2007	7/1/2008	9.0%	3.5%	8.0%	10/30/2009	7/2/2010	7/2/2011
2008–2009	7/1/2008	7/1/2009	9.0%	6.5%	8.5%	10/30/2009	7/2/2010	7/2/2011
2009–2010	7/1/2009	7/1/2010	8.5%	5.5%	8.0%	10/30/2009	7/2/2010	7/2/2011

This tool is designed to use trend benchmarks as a comparator. We have pre-loaded the tool with Aon Hewitt’s national trend projections as of April 21, 2011<sup>4</sup>; however, these factors would need to be updated periodically with benchmark assumptions (either from Aon Hewitt or another source).

Once the inputs are loaded for a given rate filing, the tool calculates the national trend benchmarks for the time periods used in the rate filing. It also converts the trend factors in the rate filing (preliminary justification / disclosure) into annual trend assumptions. The tool then determines whether the annual

<sup>3</sup> If the total cost of an office visit is \$100, and the copay is \$10, the amount paid by the carrier is \$90. In the next year, assuming that physician costs increase by 10%, the office visit would cost \$110. If the copay is still \$10, the amount paid by the carrier is now \$100, and the “trend” felt by the carrier is  $\$100/\$90 - 1 = 11.1\%$ , which is higher than the physician cost increase of 10%. This effect is known as “leveraging”.

<sup>4</sup> The Aon Hewitt trends provided do not include the impact of health care reform. For example, the 2014 projected trends do not include any effect that the exchanges will have on provider costs or the average health status of enrollees.

trend assumptions in the rate filing (base period to current period, and current period to future period) exceed the benchmark trend assumptions by at least 1%. The AID could then question any rate filings with assumed trends more than 1% above the national benchmarks.

We have left the formulas and table unprotected, so that the AID can easily modify this 1% standard or update the benchmark trends.

## Summary Tab

We have also included a Summary tab in the job aids file, so that the results of all of the job aid calculations can be viewed quickly on one page.

## Staffing/Workload

In Bulletin 7-2011, the AID recently expanded their rate filing review to include small group rate filings, which will increase the rate filing review workload. This bulletin and Bulletin 6-2011 also required that additional data be provided in rate filings. In addition, health care reform will undoubtedly increase the complexity of rate filings. The ACA introduces more steps to the process (e.g., requirement to include consumer input on rate filings), and actuaries will likely cite the health care reform as a driver of required rate increases. The additional structure and steps that we have recommended should introduce some efficiency, in vetting out problems with filings early on, and they should increase the quality of rate filing review. But by increasing the intensity of the review, these changes will most likely require additional resources, at least initially.

As a result, the AID may need to consider allocating more internal staff time to the upfront review and checking process, while also relying more heavily on outside actuarial consultants to review the increased number of filings (due to adding small group rate filings). Alternatively, the AID could consider having an internal actuarial or underwriting resource, possibly on a part-time basis. Some of the job aids may also be difficult for staff without actuarial or underwriting training to understand. Therefore, the AID may want to consider additional training for existing staff (see Training section).

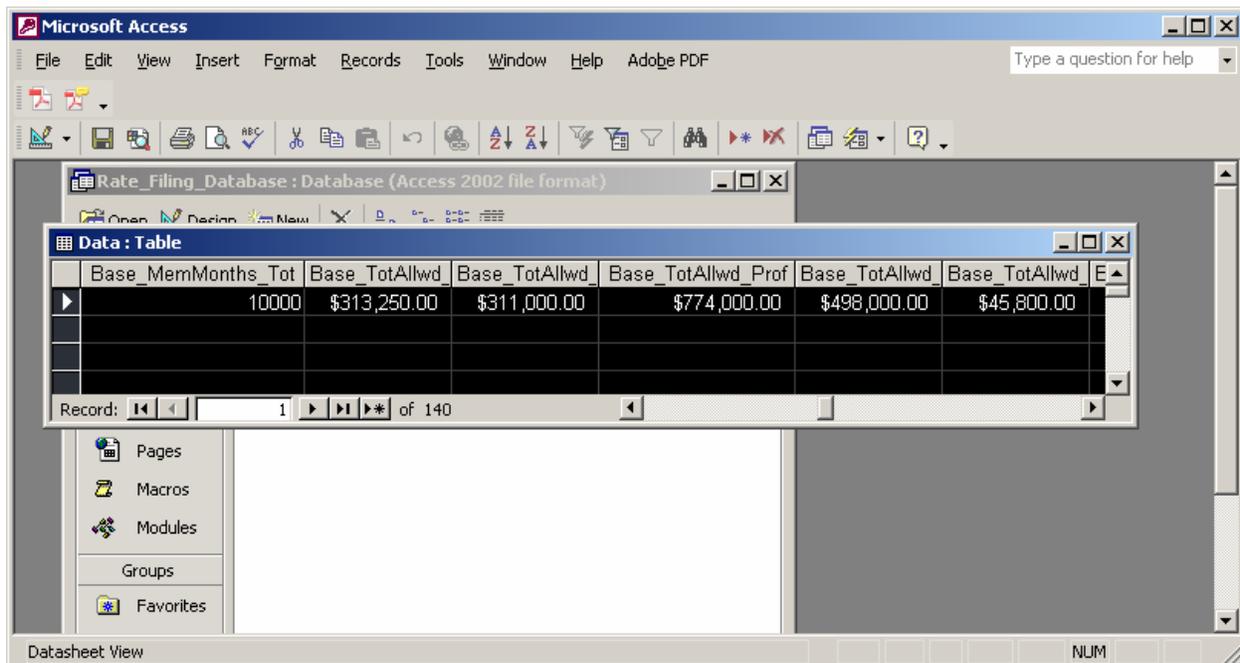
## Information Technology

### Rate Review Database

One of the job aids that we prepared for the AID assumes that a rate filing history is readily available. Also, having other historical rate filing data available will help reviewers to more effectively review filings. E.g., a reviewer could check whether assumptions were overly conservative in past filings, relative to the claims experience that actually emerged, and use this information to evaluate whether current assumptions are also overly conservative. Lastly, having rate filing data in database format would help the AID to assess the effect that process improvements are having on the average rate increase implemented.

The AID currently has a tracking log in Excel format that is used for all rate filings (not just health). However, this log does not include the data elements in HHS' Preliminary Disclosure documents or any other claims experience information. There are also no automated queries in this file, so the user would have to develop any analyses from scratch each time they are needed.

In order to be able to store rate filing data effectively and run automated queries on this data, we created a Rate Review Database. This database is in Microsoft Access format, but can readily be converted to a SQL format. Appendix C contains a list of the fields in this database, in addition to the fields that were already in the existing rate filing tracking log. We have added the AID's historical data for health rate filings, and we have also added the input fields in HHS' Preliminary Justification Rate Summary Worksheet, as well as some calculated fields (e.g., Total Allowed, Required Rate Increase). Initially, data entry into the database will need to be manual for each rate filing. However, data could potentially be downloaded directly from SERFF into this database, assuming that SERFF has the required data elements.



Base_MemMonths_Tot	Base_TotAllwd	Base_TotAllwd	Base_TotAllwd_Prof	Base_TotAllwd	Base_TotAllwd	Base_TotAllwd
10000	\$313,250.00	\$311,000.00	\$774,000.00	\$498,000.00	\$45,800.00	

We have included a query that can be used to populate the calculated fields after a new record is created. Other queries that could be developed in future work include:

- 1) **Pulling historical rate increases** for a given carrier/product combination. This rate history could then be used in the Cumulative Annual Rate Change job aid above.
- 2) Calculating the **average rate increase**, both initial and final.
- 3) Estimating the **average historical loss ratio** for a given carrier/product combination, given claims experience included in rate filings.

## Future Information Technology Enhancements

The rate review database mentioned above should be built upon and improved via enhancements such as:

- 1) Adding queries to analyze the data, as mentioned above,
- 2) Adding queries to check the integrity, consistency, and reasonability of data submitted for each rate filing,
- 3) Adding data from the Finance and Examination units, and
- 4) Automating the process of adding data to the database.

These enhancements could help to cut down on the manual work required to review rate filing and also enhance the AID's ability to effectively review rate filings and question unreasonable rate increases.

## Conclusions and Next Steps

The activities conducted in Phase II included regulatory enhancements, a comparative analysis of state websites, sample communications strategy documents, a rate review transparency and disclosure analysis, training recommendations, rate review process recommendations, checklists, job aids, and a basic rate review database. This work is intended to add more rigor and structure to the AID's rate review process, as well as to prepare the AID to meet the requirements of the ACA.

To further improve its process, the AID should consider some or all of the following steps:

- 1) Development of training modules for internal staff.
- 2) Expand rate review process and capabilities to;
  - a. review introduction of new rates, and
  - b. review **all** requested rate changes rather than those above a federal or state specific threshold.
- 3) Explore opportunities to expand staff in anticipation of additional rate filings and responsibilities, and enrich resources and advisors with actuarial backgrounds.
- 4) Developing additional communications materials, including member outreach pamphlets and videos to put on the website.
- 5) Improving the structure and branding/design of the website, including advancements supporting public outreach and commentary on proposed rate changes.
- 6) Implementation and advancements to the Excel based job aids provided with this Phase II material.

- 7) Implementation of, and improvements to the Rate Review Database, including queries and automation of the data entry process.
- 8) Incorporating other data sources in the Rate Review Database, including data from the Finance and Examination units.
- 9) Coordinate activities with other state agencies and local organizations to compile and share health care and health insurance data gathered from a variety of sources.
- 10) Conducting an analysis of how the rate review process could be used to enhance competitiveness of the Arkansas insurance market; improve member health (e.g., preventive screenings), align provider incentives with cost containment or member health goals; reduce waste; and ensure that premiums are spent efficiently.

<hr/> Laura Peck, FSA, MAAA	July 8, 2011
<hr/> Richard Rush, FSA, MAAA	(date)

## About Aon Hewitt

Aon Hewitt is the global leader in human capital consulting and outsourcing solutions. The company partners with organizations to solve their most complex benefits, talent and related financial challenges, and improve business performance. Aon Hewitt designs, implements, communicates, and administers a wide range of human capital, retirement, investment management, health care, compensation and talent management strategies. With more than 29,000 professionals in 90 countries, Aon Hewitt makes the world a better place to work for clients and their employees. For more information on Aon Hewitt, please visit [www.aonhewitt.com](http://www.aonhewitt.com).

Copyright 2011 Aon Hewitt Associates LLC.

This document is intended for general information purposes only and should not be construed as advice or opinions on any specific facts or circumstances. The comments in this summary are based upon Aon Hewitt's preliminary analysis of publicly available information. The content of this document is made available on an "as is" basis, without warranty of any kind. Aon Hewitt disclaims any legal liability to any person or organization for loss or damage caused by or resulting from any reliance placed on that content. Aon Hewitt reserves all rights to the content of this document.



Internal Training Analysis

For the Arkansas Insurance Department Premium Rate Review  
Process

## Contents

Summary	3
Training Needs	3
Training Modules	4
Training Approach	7
Other Resources	8
Conclusions & Recommendations	9

## Summary

In early 2011, the Arkansas Insurance Department (AID) in conjunction with Aon Hewitt began a thorough process of analyzing current health filing procedures and processes. In discussions with the AID, Aon Hewitt was asked to recommend training needs and approaches for staff regarding the review of rate filings for health insurance.

PPACA places a great deal of new responsibilities of regulators of insurance – particularly those with state insurance departments. The new scrutiny and review responsibilities on insurance rates combined with the transparency and disclosure opportunities afforded the public, places the insurance department staff as key contributors and authorities. To fulfill these responsibilities it will be critical for insurance regulators, such as staff at the Arkansas Insurance Department, to have proper training on health insurance basics and actuarial rate making principles.

As identified in Phase I based on our review and discussions with the major individual health carriers in the Arkansas market recognized the AID rate review personnel as:

- Experienced
- Knowledgeable
- Responsive, and
- Approachable.

However, there is currently no formal training conducted within the AID on how to effectively review rate filings. Additionally, there are no training materials in-house that could be used to train future staff. Educational opportunities provided by the National Association of Insurance Commissioners (NAIC) and other organizations are extremely limited and used sparingly on an as-needed basis.

This summary includes our analysis of the AID's training needs and some recommended approaches for addressing these needs. The focus of this document is in regard to health insurance rate and underwriting review, however we recognize that the same training needs may exist for other product lines filed and sold in the State of Arkansas. The training platform adopted for the health insurance review could be adapted to meet the needs for other insurance coverages.

## Training Needs

Aon Hewitt has identified that:

- AID has staff with varying levels of insurance knowledge and work responsibilities
- Although not all individuals focus on health insurance rate review, a basic level of understanding will be helpful to streamlining processes and for staffing.
- A number of employees of the AID are in the call center and will be handling basic questions and/or forwarding to the appropriate individual. A good understanding of the basics of rate and underwriting issues will assist in answering simple questions, and recognizing escalated questions.
- Technicians that complete the actual review of rates and underwriting need additional detailed training to assist in the analysis and understanding of the filing information
- Senior staff, who converse directly with the insurance companies' staff and actuaries, need a thorough understanding of health insurance rating, modeling and design.
- Training processes and materials need to be adaptable to changes in the marketplace and environment.
- Training needs to be available for existing employees and future hires.

## Training Modules

Due to the various levels of experience and need, we recommend that the AID develop at a minimum three training modules for its employees. Under the assumption that many entry level hires would have little or no insurance background, the first module will need to focus on the basics of insurance. This module would include common definitions, simple explanations of insurance with a focus on general insurance knowledge. Although this analysis is focused only on medical insurance, there are general insurance terms and concepts that will assist in any insurance product knowledge. Below is a sample Table of Contents for the Introductory Module.

Section	Topics Covered
<b>What is Insurance</b>	<ul style="list-style-type: none"> <li>• This section would focus on high level insurance concepts that apply to any insurance product</li> <li>• Why insurance</li> <li>• Who purchases insurance (individuals/groups/governments/etc)</li> <li>• What does insurance typically cover (ie., life insurance, disability, health, liability, etc.)</li> <li>• What are premiums; What are claims</li> </ul>
<b>Overview of Financial Statements</b>	<ul style="list-style-type: none"> <li>• Profit &amp; Loss Income Statements</li> <li>• Balance Sheets</li> <li>• Statutory Accounting/GAAP Accounting/Tax Accounting</li> </ul>
<b>Basics of Life and Health Insurance Design</b>	<ul style="list-style-type: none"> <li>• Medical Insurance</li> <li>• Dental Insurance</li> <li>• Disability Insurance</li> <li>• Life Insurance</li> <li>• Long Term Care Insurance</li> </ul>
<b>Other Insurance</b>	<ul style="list-style-type: none"> <li>• Property &amp; Casualty: Home and Auto</li> <li>• Workers' Compensation</li> <li>• Medical Malpractice</li> <li>• Other</li> </ul>

The second module would narrow the focus of insurance to health insurance

Section	Topics Covered
<b>Health Insurance Markets</b>	<ul style="list-style-type: none"> <li>• Individual</li> <li>• Group: small / large</li> <li>• Associations</li> <li>• Self-funding</li> </ul>
<b>Basics of Medical Insurance</b>	<ul style="list-style-type: none"> <li>• Plan variations               <ul style="list-style-type: none"> <li>○ Preferred Provider Organization (PPO)</li> <li>○ Health Maintenance Organization (HMO)</li> <li>○ Point of Service (POS)</li> <li>○ Indemnity</li> </ul> </li> <li>• Components of Health Costs               <ul style="list-style-type: none"> <li>○ Facility (inpatient and outpatient)</li> <li>○ Professional (office visits, physician services)</li> <li>○ Prescription Drug</li> <li>○ Other Goods and Services</li> </ul> </li> <li>• Plan Designs               <ul style="list-style-type: none"> <li>○ Deductible</li> <li>○ Coinsurance</li> <li>○ Out of Pocket Maximums</li> </ul> </li> <li>• Non-covered services</li> </ul>
<b>Variations on Plan Designs</b>	<ul style="list-style-type: none"> <li>• Health Savings Accounts (HSA)</li> <li>• Health Reimbursement Accounts (HRA)</li> <li>• Wellness Plans</li> <li>• HMO – staff model vs. IPA, etc.</li> <li>• Limited Benefit</li> <li>• Critical Illness</li> </ul>
<b>Cost of Insurance and Loss Ratios (claims divided by premiums)</b>	<ul style="list-style-type: none"> <li>• Medical and Prescription Drug expense</li> <li>• Claims administration Expense (including system costs)</li> <li>• Other administration Expense (wellness programs, network</li> </ul>

	<p>negotiation costs, etc)</p> <ul style="list-style-type: none"> <li>• Premium Tax</li> <li>• Profit/Margin</li> <li>• Commission</li> <li>• Incurred vs. Paid Claims</li> <li>• Reserves</li> <li>• Loss Ratio Calculation             <ul style="list-style-type: none"> <li>○ State regulatory Requirements</li> <li>○ Health Reform requirements</li> <li>○ Lifetime Loss Ratios (Individual and Association Group)</li> </ul> </li> </ul>
--	---

The third module for the training would be focused on more advanced topics with the target audience those that interact with insurance company actuaries, finalize the approval process, etc. Topics included in the third module might include the following topics of discussion:

Section	Topics Covered
<b>Types of insurance pools</b>	<ul style="list-style-type: none"> <li>• What is pooled risk?</li> <li>• Why self fund/experience rate?</li> <li>• Individual vs. small group vs true group rating components</li> </ul>
<b>Rate Manual Components</b>	<ul style="list-style-type: none"> <li>• Base Costs</li> <li>• Trend</li> <li>• Area Adjustments</li> <li>• Plan Design Adjustments</li> <li>• Age/Gender Adjustments</li> <li>• Durational Adjustments (Individual)</li> </ul>
<b>Credibility Theory</b>	<ul style="list-style-type: none"> <li>• What is credibility for purposes of insurance rating</li> </ul>
<b>Community Rating</b>	<ul style="list-style-type: none"> <li>• True Community Rating</li> <li>• Modified Community Rating</li> </ul>
<b>Experience Rating</b>	<ul style="list-style-type: none"> <li>• Credibility Rating – Large Group</li> <li>• Credibility of Pooled Risk</li> </ul>
<b>Trend Analysis</b>	<ul style="list-style-type: none"> <li>• How do carriers determine trend</li> <li>• Why does trend vary by product and design</li> </ul>

## Training Approach

In designing the training for the AID, there are a number of approaches that could be taken in order to achieve the most effective training. Actual class room time, led by an instructor may make sense for the initial roll-out if larger numbers of individuals need to be trained. Looking forward toward long term needs, however, an approach that also includes webinars, self paced tutorials and the like may also be useful, as it is not always practical to bring in a trainer for one or two individuals to be trained.

Below we have outlined some of the training platforms that could be considered, including some commentary on effectiveness and practicality.

Training Approach	Comments
<b>In person class/trainer</b>	<p>Effective when teaching a larger group of individuals. Can have interaction and review those areas that cause confusion or require extra review. Could consider training a staff individual to lead future classes</p> <p>Less practical for on-going training needs if low turn-over of AID and if not necessary for significantly larger audiences. Can also take individuals away from desk for long periods of times</p>
<b>Webinar</b>	<p>Similar to in person class, but completed through web based meetings. Advantage in that they can be abbreviated sessions that occur over multiple days and weeks, not overloading individuals with too much information at one time.</p> <p>Disadvantage is that they can be less interactive and individuals can tend to multi-task.</p>
<b>Self Paced Interactive Tutorials</b>	<p>These can be beneficial when it is challenging to bring multiple individuals together for training. Self Paced means that those that haven't mastered concepts can review and move more slowly.</p> <p>May want to require quiz and certification at the end to ensure that material is mastered.</p>

## Other Resources

When reviewing the best approach to take in developing a training manual/plan for the AID, we considered other external sources and also reviewed what some other states have to date on their web pages.

In general, the states that have the most interactive web pages regarding rating and underwriting training appear to have written the training specifically for their site. They do not appear to have incorporated information written through other organizations. We did review what is readily available for training, and list below some of the external resources.

Other resources	Comments
NAIC	<ul style="list-style-type: none"> <li>• NAIC has some useful information, however sparse training information. Resources are somewhat limited for development of training, and specific needs of each state varies, thus one consolidated effort not likely to occur</li> </ul>
Society of Actuaries	<ul style="list-style-type: none"> <li>• Does have some study notes and guides on line that would be available for reproduction. Most training information would assume a core understanding of insurance. However of those interacting with actuaries, a familiarity with some of this material could be helpful.</li> </ul>
CEBS (Certified Employee Benefit Specialists)	<ul style="list-style-type: none"> <li>• Course of several exams that provide designation in overall employee benefit programs and compensation.</li> <li>• Scope of this program would most likely be too broad and time-consuming to suit the needs of the AID.</li> <li>• Some material could be purchased and used for reference.</li> <li>• Focus is employee benefits</li> </ul>
LIMRA	<ul style="list-style-type: none"> <li>• Industry organization – provides LOMA exams that would provide insurance knowledge. Similar to CEBS in that would be too broad for the AID's purpose, but could be useful providing some reference materials.</li> </ul>
HHS/CMS/CCIIO	<ul style="list-style-type: none"> <li>• As part of the implementation of PPACA, there are developing outreach and education materials for the public. It will be helpful for the AID staff to be familiar with the material the public is directed to from other sources. Additionally there could be materials focused to regulators.</li> </ul>

## Conclusions and Recommendations

To perform the job duties necessary for the new requirements of under PPACA Aon Hewitt makes the following recommendations:

<b>Regarding Staffing</b>	When considering establishing, and then filling, job requirements, AID should consider requirements and candidates with insurance financial experience: particularly underwriting and actuarial.
	There are few individuals at the AID with sufficient knowledge and experience necessary to review the upcoming actuarial rate filings for individual and small group rates. AID needs to focus on succession planning related to these key positions, particularly now as current AID staff in these position are long-tenured and could retire soon.
	Presently the AID does not receive enough individual and small group medical filings to warrant hiring a credentialed health care actuary at the AID. The health actuarial field is complex and dynamic. Accordingly should the AID have other actuarial trained personnel in non-health areas (such as casualty and life areas) it is likely they will not have the health actuarial experience necessary for the more complex and important filings. Assuming it is not prudent for the AID to employ its own experienced and credentialed health actuary and continues to use consultants on certain filings, it will be important to develop a process to determine which filings get outsourced.

The training regiment for the AID should be comprehensive and logical.

<b>Regarding Training (new and ongoing)</b>	The first set of training should introduce the basic tenets of risk and insurance, including financial accounting. As an introductory set of material this training could be used for AID staff, not just those involved in health actuarial functions.
	Even without federal legislation such as PPACA, health insurance is such an important and complex form of insurance, focused training directly for health insurance should be available. Again, this training, in whatever form established, should be made available to all staff, particularly those working directly with health coverages.
	Finally, special training should be available to those limited number of staff members working directly in the area of health insurance rate filings. Material included in rate filings and actuarial memorandums should be included, and should prepare the AID staff members to work with actuarial resources at the carriers and those consulting to the AID.

These training materials can be expanded at some point for public outreach.

<b>Regarding accreditation and continuing education</b>	Providing training to AID staff should be supported by additional Human Resources initiatives and programs. AID needs a culture encouraging reaching advanced levels of professional degrees and accreditation.
	AID should work with NAIC and other related bodies to not only have the Department reach accredited status, but to develop staff and identify professional career paths, including obtaining professional designations.
	Work with Arkansas Office of Personnel Management and related agencies to support the accreditation and continuing education objectives of the AID.

We encourage the Arkansas Insurance Department to pursue additional and alternative funding in order to introduce and maintain the necessary training.



Communication Review and Recommendations

For the Arkansas Insurance Department Premium Rate  
Review Process Statewide Stakeholder Engagement  
Outreach Campaign

Contents

Summary

Website Review and Recommendations

Communication Strategy Development

## Summary

In May/June 2011, the Arkansas Insurance Department (the Department) launched a statewide stakeholder engagement outreach campaign to provide transparency and promote public awareness while educating the public regarding the premium rate review process in Arkansas. In discussions with the Department, Aon Hewitt Communication was asked to review the Department website as well as other “best-in-class” state-sponsored insurance websites. This summary includes our analysis of the Department’s website and other insurance websites to find best-in-class examples and recommendations to improve the Department’s existing website. In addition, we have provided a sample communication strategy that would support and enhance the Department’s communication strategies, both those that have been implemented and those that are planned for future implementation. These strategies include:

## Strategies Undertaken

- Create an active consumer-driven Advisory Council to help implement meaningful methods to improve consumer knowledge and involvement in the rate approval process.
- Work with the SERFF team to enhance the Department website and make rate review filings current and accessible to the public.
- Identify the appropriate target market for the Department’s outreach efforts.
- Develop outreach strategies to reach applicable stakeholder groups.
- Establish partnerships with stakeholder groups to gain public input into the premium rate review education planning process.
- Develop a Rate Review ‘Primer’ to explain the rate review process to consumers in “plain language.”
- Create tailored presentations and materials for consumer outreach and education for various target groups.
- Work with local partners to reach various consumer groups.
- Use social media such as Twitter and Facebook to reach consumers.
- Conduct a series of statewide public information and engagement meetings during the planning phase.

## Strategies Planned

- Issue press releases and public service announcements regarding outreach efforts.
- Develop print materials to post in municipal, county, and state offices and develop handouts for speaking engagements.
- Create a 1-800 consumer inquiry service.
- Develop email alerts for consumers to receive updates on companies’ rate request filings.
- Conduct webinars on health care and rate review topics.

## Website Review

### Heuristic Evaluation

We conducted a heuristic evaluation (a website review) of the Department’s website and five other state-sponsored insurance websites, including:

- Oregon
- Colorado
- South Carolina
- California
- Indiana

Our goal was to find best-in-class examples, so we purposely chose websites deemed to be “best in class” websites. We evaluated the user experience against research-based heuristics and their associated criteria to uncover best-in-class examples. We used 25 research-based criteria to evaluate the websites. Below is a list of the heuristics evaluated and a brief description of the criteria used.

Heuristic	Definition
<b>Value</b>	<ul style="list-style-type: none"> <li>• Does the homepage provide evidence that the user can complete her goal?</li> <li>• Is essential content available where needed?</li> <li>• Are essential content and function given priority on the page?</li> </ul>
<b>Navigation</b>	<ul style="list-style-type: none"> <li>• Are menu category and subcategory names clear and mutually exclusive?</li> <li>• Is the wording in the hyperlinks clear and informative?</li> </ul>
<b>Presentation</b>	<ul style="list-style-type: none"> <li>• Does the website content use language that’s easy to understand?</li> <li>• Does the website use graphics, icons, and symbols that are easy to understand?</li> <li>• Do text formatting and layout support easy scanning?</li> </ul>
<b>Trust</b>	<ul style="list-style-type: none"> <li>• Does the website present privacy and security policies in context?</li> <li>• Does website functionality provide clear feedback in response to user actions?</li> <li>• Does the website perform well?</li> </ul>

## Website Review Results

Each website receives a score from -2 to 2 for each of the 25 criteria. The value heuristic has four criteria, the navigation heuristic has six criteria, the presentation heuristic has nine criteria, and the trust heuristic has six criteria. The combined, total score can range from -50 to 50. Below are the results.

State	Value (4 criteria)	Navigation (6 criteria)	Presentation (9 criteria)	Trust (6 criteria)	Total Score (25 criteria)
<b>Oregon</b>	1	5	5	-5	<b>8</b>
<b>Colorado</b>	-3	-4	-4	-8	<b>-10</b>
<b>S. Carolina</b>	-1	4	4	-11	<b>-12</b>
<b>Arkansas</b>	-4	-8	0	-6	<b>-18</b>
<b>California</b>	-8	-5	0	-8	<b>-21</b>
<b>Indiana</b>	-1	-5	-7	-10	<b>-33</b>

## Summary of the Best-in-Class Websites

Each website revealed best-in-class examples as well as “what not to do.” We recommend that the Department take these examples into consideration when redesigning their website.

Heuristic	Best-in-class because...
<b>Value</b>	<p>To score well in value, a website must make it easy for users to accomplish their goals (i.e. to quickly and easily find the information they are looking for).</p> <p>Oregon’s homepage quickly informs the user that she can easily accomplish her goals. For example, let’s say a user wants to file a complaint. There is a link on the homepage titled <b>File a Complaint</b>, informing the user that she can accomplish her goal. If a user wants to buy health insurance, she will click on <b>Consumer Information</b> from the homepage and then <b>Health Insurance</b>. The user will then click on <b>Individual Health Insurance</b>, which takes her to a page that explains how to buy health insurance.</p>

**Navigation**

To score well in navigation, a website must have menu category and subcategory names that are clear and mutually exclusive. Websites should also immediately expose or describe their subcategories.

Oregon scored well in this category because its website’s content is logically organized and its hyperlinks are clear and informative. Instead of a link that says **Complaints**, it has a link that says **File a Complaint Here**. Instead of a link that says **Appeals**, it has a link that says **My health insurance claim was denied. How do I appeal?**

South Carolina scored well in this category because its homepage immediately exposes the subcategories for Consumers, Agencies, and Companies. Instead of requiring the user to click on **Consumers** to see what information the link contains, the homepage immediately exposes the subcategories:

<i>Consumers</i>	<i>Individuals/Agencies</i>	<i>Companies</i>
<ul style="list-style-type: none"> <li>• <a href="#"><u>Auto Insurance</u></a></li> <li>• <a href="#"><u>Coastal Insurance</u></a></li> <li>• <a href="#"><u>Health Insurance</u></a></li> <li>• <a href="#"><u>Homeowners Insurance</u></a></li> <li>• <a href="#"><u>Hurricane Information</u></a></li> <li>• <a href="#"><u>Life Insurance</u></a></li> <li>• <a href="#"><u>Long Term Care Insurance</u></a></li> <li>• <a href="#"><u>Market Assistance</u></a></li> <li>• <a href="#"><u>SC Health Insurance Pool (SCHIP)</u></a></li> <li>• <a href="#"><u>Consumer Complaint Form</u></a></li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#"><u>Adjuster</u></a></li> <li>• <a href="#"><u>Agency</u></a></li> <li>• <a href="#"><u>Appraiser</u></a></li> <li>• <a href="#"><u>Bondsman</u></a></li> <li>• <a href="#"><u>Continuing Education</u></a></li> <li>• <a href="#"><u>Pre-Licensing</u></a></li> <li>• <a href="#"><u>Producer</u></a></li> <li>• <a href="#"><u>Public Adjuster</u></a></li> <li>• <a href="#"><u>Rental Car Agency</u></a></li> <li>• <a href="#"><u>Surplus Lines Broker</u></a></li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#"><u>Company Licensing</u></a></li> <li>• <a href="#"><u>Company Information</u></a></li> <li>• <a href="#"><u>Rates, Rules and Forms Filings</u></a></li> <li>• <a href="#"><u>Taxation</u></a></li> <li>• <a href="#"><u>Premium Service</u></a></li> <li>• <a href="#"><u>Company Renewal Process</u></a></li> </ul>

**Presentation**

To score well in presentation, a website's content, graphics, icons, and symbols must be easy to understand. Text must also be easy to read. Oregon's content is easy to read and skim. The text on its website is large compared to other websites and the website allows the reader to increase or decrease the text size:

**Text Size:** [A+](#) | [A-](#) | [A](#)

Oregon uses bolded headings and each paragraph is two or three sentences. Oregon also uses bullets and easy-to-skim questions and answers throughout its site:

**Q: What do insurance companies consider when they decide whether to cancel or not renew policies?**

**A:** Insurance companies evaluate the risks associated with each policyholder to determine if you are a "good risk" or if your policy should be canceled or not renewed. Some of the areas insurance companies review:

- **Claims.** Do you file claims frequently or for large amounts?
- **Driving record:** Do you have a bad driving record (speeding, DUI, etc.)
- **Credit history.** Do you have bad credit? Have you filed for bankruptcy?

Oregon also uses different colors to represent health insurance, life insurance, auto insurance, and homeowner and renter insurance. Its pictures are clear and easy to understand:



**Trust**

To score well in trust, a website must 1) present privacy and security policies in context, 2) help the user recover from errors, and 3) tell the user what happened in response to user interaction with the website. To test this heuristic, we filed a complaint.

Oregon scored well because its website did all three of the above.

1. At the top of the complaint form, Oregon has a note, "To ensure your privacy, all information submitted is encrypted and is protected against disclosure to their parties." The website has a VeriSign Trusted image and an https website address. Oregon also has a link titled **Confidentiality of Complaint Records** with detailed information in English and Spanish.
2. If a user attempts to submit a claim without entering all of the required information, the website helps the user recover from errors by specifically stating what information she failed to provide. For example, if a user does not enter their zip code, the website says, **Error: The zip is required**. When the user clicks on the error message, she is taken directly to the portion of the form to enter her zip code.
3. After a claim is submitted, the user receives a confirmation page, **The following is a copy of the data that was submitted**. At the bottom of the page is a phone number for users to call if they do not receive a letter from Oregon Insurance Division within five days of submitting a complaint.

## Recommendations for the Arkansas Insurance Department’s Consumer Information Website

The current Arkansas Insurance Department’s website is a comprehensive website containing a significant amount of information appropriate to a user looking for consumer-related insurance information in the state of Arkansas. However, it is not well organized or easy to navigate. We recommend that the Department redesign its website to improve the user experience and make it easier for users to find the information they need.

Information is not always easy to access because website navigation is extremely poor. Navigation is not intuitive and it’s often unclear, leading to navigational confusion (Where am I? How do I get where I want to go? How do I get back to where I started?). When a user gets frustrated with a website, she will quickly leave the website rather than investing the time to figure out how to navigate it.

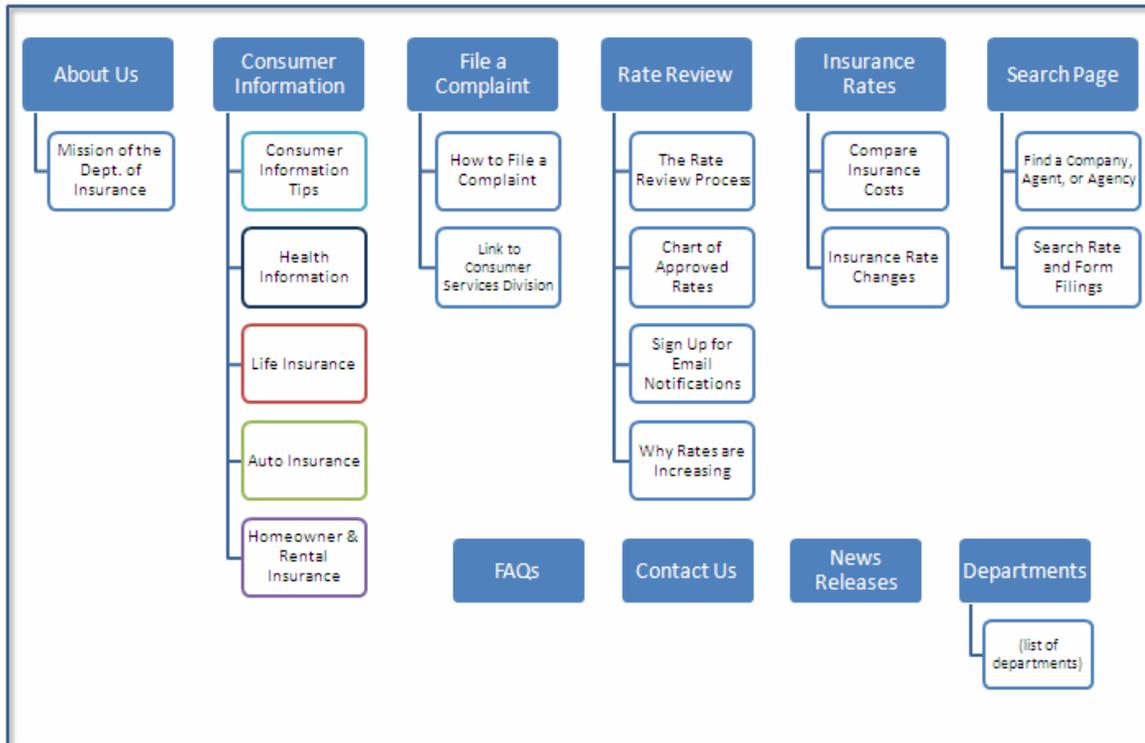
Following are our recommendations to assist the Department in redesigning the website.

### Site Map

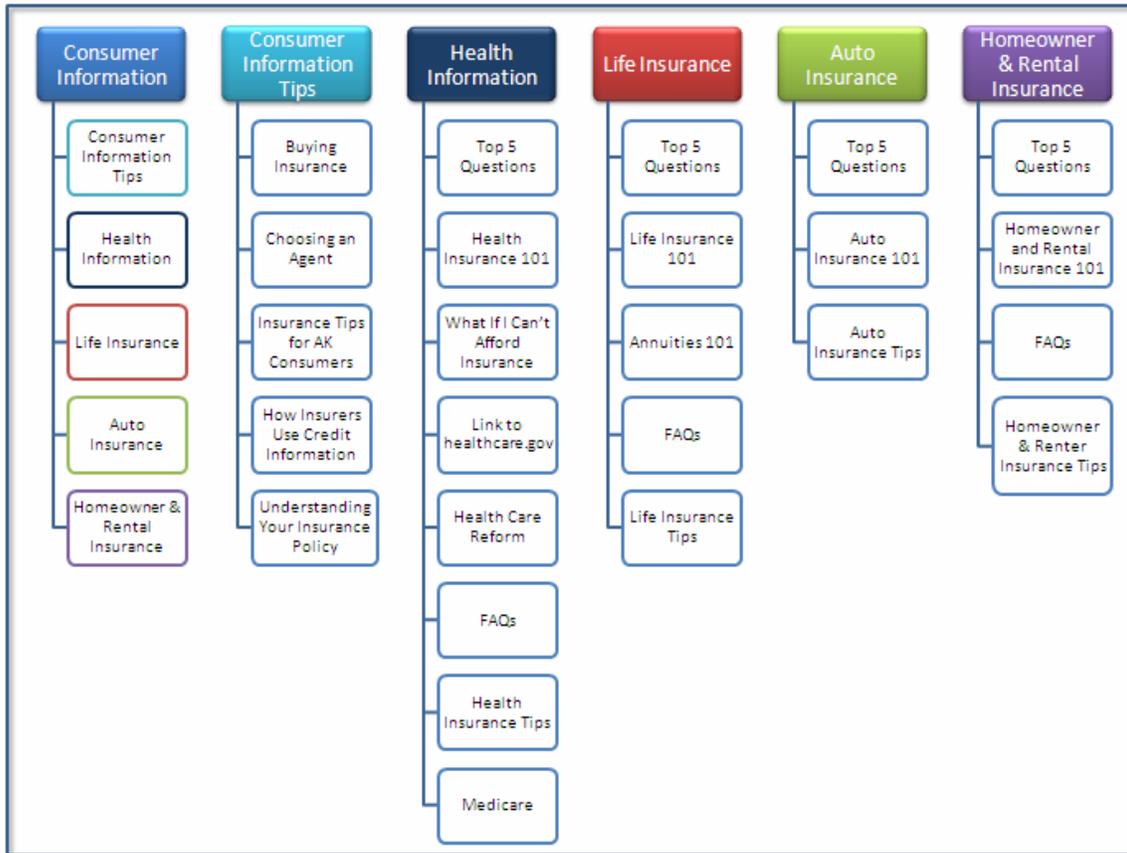
The first step to organizing the Department’s website is to identify the main sections of the site and group related information together. Inside each main section, the content can be broken into sub-categories to help the user find the exact information she is looking for.

We created a recommended site map to help the Department reorganize the content and determine what additional information would be useful.

### The Arkansas Insurance Department Homepage



The Arkansas Insurance Department Consumer Information Tab



## Content

When we evaluated the state-sponsored websites, we created a list of information that is needed and a list of information that would be helpful to consumers. THE DEPARTMENT already has most of the information needed; however, we believe that the content could be improved upon to better engage consumers and to make it easier for consumers to find the information they need. We recommend that the Department work on improving essential information first, in Phase 1, and work on improving and creating useful, but not necessarily essential, information in Phase 2.

### Phase 1

Essential Information	Recommendation
Mission of the Dept. of Insurance	<ul style="list-style-type: none"> <li>Draft content with information about the Department of Insurance and its purpose</li> </ul>
Insurance Rates and the Rate Review Process	<ul style="list-style-type: none"> <li>Create a link on the homepage titled <b>Insurance Rates and the Rate Review Process</b></li> </ul>
<ul style="list-style-type: none"> <li>The rate review process</li> </ul>	<ul style="list-style-type: none"> <li>Draft content about the rate review process</li> <li>Create a website similar to <a href="http://www.oregonhealthrates.org">www.oregonhealthrates.org</a></li> </ul>
<ul style="list-style-type: none"> <li>Insurance rate changes</li> </ul>	<ul style="list-style-type: none"> <li>Make the existing chart printer-friendly</li> <li>Allow users to download the existing chart as a PDF</li> </ul>
<ul style="list-style-type: none"> <li>Chart of approved rates</li> </ul>	<ul style="list-style-type: none"> <li>Upload a PDF with health insurance rate filings</li> </ul>
<ul style="list-style-type: none"> <li>Compare insurance costs</li> </ul>	<ul style="list-style-type: none"> <li>Change the link on the homepage titled <b>Insurance Cost Comparison</b> to <b>Compare Auto, Homeowner, and Medical Malpractice Insurance</b></li> <li>Improve the presentation of the cost comparison tools</li> </ul>
How to file a complaint	<ul style="list-style-type: none"> <li>Create a page dedicated to filing a complaint (i.e. remove links such as <b>Brochures, Alerts and Tips</b>, and <b>EAGLE Mediation Program</b> links that appear with the <b>How to File a Complaint</b> link)</li> <li>Improve online complaint form</li> <li>Add security notice(s) to the online complaint form</li> <li>Create a confirmation page with information explaining when consumers can expect a response from the Department</li> </ul>
Find a company, agent, or agency	<ul style="list-style-type: none"> <li>Create a link on the homepage for consumers to search for insurance companies, insurance agents, and insurance agencies</li> </ul>
Search rate and form filings	<ul style="list-style-type: none"> <li>Create a website similar to <a href="http://www.oregonhealthrates.org">www.oregonhealthrates.org</a> that allows consumers to search rate and form filings</li> </ul>

List of departments	<ul style="list-style-type: none"> <li>Organize the departments on the homepage</li> <li>Make each department link more descriptive</li> </ul>
Contact information	<ul style="list-style-type: none"> <li>Make the <b>Contact Information</b> link more noticeable on the homepage</li> </ul>

## Phase 2

Useful Information	Recommendation
Sign up for email notifications	<ul style="list-style-type: none"> <li>Change link on homepage title <b>Online Email Registration</b> to <b>Sign up for email notifications</b></li> <li>Update content on page</li> </ul>
Explanation of why rates are increasing	<ul style="list-style-type: none"> <li>Draft content explaining why rates are increasing</li> </ul>
News releases	<ul style="list-style-type: none"> <li>Update page with news releases</li> </ul>
FAQs	<ul style="list-style-type: none"> <li>Draft content</li> </ul>
Consumer Information	Recommendation
<ul style="list-style-type: none"> <li>Buying insurance</li> </ul>	<ul style="list-style-type: none"> <li>Draft content</li> <li>Move related brochures to the <b>Buying insurance</b> page</li> </ul>
<ul style="list-style-type: none"> <li>Choosing an agent</li> </ul>	<ul style="list-style-type: none"> <li>Draft content</li> <li>Move related brochures to the <b>Choosing an agent</b> page</li> </ul>
<ul style="list-style-type: none"> <li>Insurance tips</li> </ul>	<ul style="list-style-type: none"> <li>Move related brochures and alerts and tips to the <b>Insurance tips</b> page</li> </ul>
<ul style="list-style-type: none"> <li>How insurers use credit information</li> </ul>	<ul style="list-style-type: none"> <li>Draft content</li> </ul>
<ul style="list-style-type: none"> <li>Understanding your insurance policy</li> </ul>	<ul style="list-style-type: none"> <li>Draft content</li> <li>Create a link on Consumer Information page titled <b>Understanding your insurance policy</b></li> <li>Move related brochures and alerts and tips to the <b>Understanding your insurance policy</b> page</li> </ul>
Health Information	Recommendation
<ul style="list-style-type: none"> <li>Top 5 questions</li> </ul>	<ul style="list-style-type: none"> <li>Draft content</li> </ul>
<ul style="list-style-type: none"> <li>Health insurance 101</li> </ul>	<ul style="list-style-type: none"> <li>Draft content</li> <li>Move related brochures to the <b>Health insurance 101</b> page</li> </ul>
<ul style="list-style-type: none"> <li>What if I can't afford insurance?</li> </ul>	<ul style="list-style-type: none"> <li>Draft content</li> <li>Create a link on <b>Health Information</b> page titled <b>What if I can't afford insurance?</b></li> </ul>
<ul style="list-style-type: none"> <li>Health Care Reform</li> </ul>	<ul style="list-style-type: none"> <li>Move the <b>Arkansas Consumer Assistance Program</b> and</li> </ul>

	<p><b>Arkansas Pre-Existing Condition Insurance Plan</b> links from the homepage to the <b>Health Care Reform</b> page</p> <ul style="list-style-type: none"> <li>• Draft content about Health Care Reform</li> <li>• Place existing links for other websites (i.e. the <i>www.healthcare.gov</i> link) under a heading titled <b>Health Care Reform Websites</b></li> </ul>
<ul style="list-style-type: none"> <li>• FAQs</li> </ul>	<ul style="list-style-type: none"> <li>• Draft content and improve existing content</li> <li>• Remove health information on the <b>Consumer Alerts &amp; Tips</b> page and move it to the <b>Health Information FAQ</b> page (see site map)</li> </ul>
<ul style="list-style-type: none"> <li>• Health insurance tips</li> </ul>	<ul style="list-style-type: none"> <li>• Draft content and improve existing content</li> <li>• Remove health insurance tips on the <b>Consumer Brochures</b> page and move it to the <b>Health Insurance Tips</b> page (see site map)</li> </ul>
<ul style="list-style-type: none"> <li>• Medicare</li> </ul>	<ul style="list-style-type: none"> <li>• Draft content about Medicare</li> <li>• Move the <b>Arkansas Long-Term Care Partnership information</b> link from the homepage to the <b>Medicare</b> page</li> </ul>
<b>Life Insurance</b>	
<ul style="list-style-type: none"> <li>• Top 5 questions</li> </ul>	<ul style="list-style-type: none"> <li>• Draft content</li> </ul>
<ul style="list-style-type: none"> <li>• Life insurance 101</li> </ul>	<ul style="list-style-type: none"> <li>• Draft content</li> </ul>
<ul style="list-style-type: none"> <li>• Annuities 101</li> </ul>	<ul style="list-style-type: none"> <li>• Draft content</li> </ul>
<ul style="list-style-type: none"> <li>• FAQs</li> </ul>	<ul style="list-style-type: none"> <li>• Draft content</li> </ul>
<ul style="list-style-type: none"> <li>• Life Insurance Tips</li> </ul>	<ul style="list-style-type: none"> <li>• Draft content and improve existing content</li> <li>• Remove life insurance tips on the <b>Consumer Brochures</b> page and move it to the <b>Life Insurance Tips</b> page (see site map)</li> </ul>

Auto Insurance	
<ul style="list-style-type: none"> <li>• Top 5 questions</li> </ul>	<ul style="list-style-type: none"> <li>• Draft content</li> </ul>
<ul style="list-style-type: none"> <li>• Auto insurance 101</li> </ul>	<ul style="list-style-type: none"> <li>• Draft content</li> </ul>
<ul style="list-style-type: none"> <li>• Auto insurance tips</li> </ul>	<ul style="list-style-type: none"> <li>• Draft content and improve existing content</li> <li>• Move related brochures and alerts and tips to the <b>Auto insurance tips</b> page (see site map)</li> </ul>
Homeowner and Rental Insurance	
<ul style="list-style-type: none"> <li>• Top 5 questions</li> </ul>	<ul style="list-style-type: none"> <li>• Draft content</li> </ul>
<ul style="list-style-type: none"> <li>• Homeowner and rental insurance 101</li> </ul>	<ul style="list-style-type: none"> <li>• Draft content</li> <li>• Move related brochures and alerts and tips to the <b>Homeowner and rental insurance</b> page</li> </ul>
<ul style="list-style-type: none"> <li>• FAQs</li> </ul>	<ul style="list-style-type: none"> <li>• Draft content</li> </ul>
<ul style="list-style-type: none"> <li>• Homeowner and rental insurance tips</li> </ul>	<ul style="list-style-type: none"> <li>• Draft content and improve existing content</li> <li>• Remove homeowner and rental insurance tips on the <b>Consumer Brochures</b> page and move it to the <b>Homeowner and Rental Insurance Tips</b> page (see site map)</li> <li>• Move <b>Disaster Preparedness</b> from the homepage to the <b>Homeowner and Rental Insurance</b> page and change name to <b>How to prepare for a disaster</b></li> <li>• Move the <b>Arkansas Earthquake Authority Market Assistance Program</b> link to the <b>Homeowner and Rental Insurance</b> page</li> </ul>

## Brand Identity and Graphic Look

The Arkansas Insurance Department's website is "clean" with an uncluttered page layout. Unfortunately, the absence of a noticeable graphic treatment or style makes the website bland and boring. The website is content-driven, but graphics would enhance the website and break up large, overwhelming sections of text.

When it comes to websites, the importance of branding and design is often minimized or ignored altogether, whereas in other media, such as print publishing, the role of design is fairly well understood. An engaging, user-friendly website makes the most important information look like it is the most important information, etc. Carefully constructed and designed information hierarchies are the cornerstone of excellent usability. Good graphic design enhances and supports usability, rather than undermining it.

## Communication Strategy Development

A well-designed strategy will not be successful unless your stakeholders understand the strategy, and more importantly, what is in it for them. A comprehensive communication strategy should educate, engage, and empower your stakeholders to take action.

### Define objectives

Your goal is to promote education and provide transparency to statewide stakeholders regarding the premium rate review process in Arkansas, as defined by current regulations. This is a very broad and far-reaching goal. We recommend that the Department break this overreaching goal into specific goals for each of the stakeholder groups.

### Ascertain the “sacred cows”

Sacred cows are the roadblocks, rituals, invalid assumptions, and unwarranted fears and attitudes that stand in the way of success.

### Determine Your Guiding Principals

Clearly articulated guiding principals will support the strategy and are typically defined for each audience. All messaging should be measured against the guiding principles for consistent messaging. Here are several sample guiding principles:

- **Involve leadership** – leadership support contributes to the success of the initiative. Leadership should promote the initiative at meetings and take an interest in success and outcomes.
- **Involve consumer and consumer advocate group** – Getting consumers and consumer advocate groups involved at the very beginning is crucial. Setting up committees and having representation from a diverse group of individuals is key.
- **Promote often** – Promote the renewal process and the educational aspects of the initiative as often as possible. Visibility and repeated communications help ensure consistent participation and understanding.
- **Share stories** – Nothing motivates consumers like seeing results. Proving the program works through the sharing of success stories can keep involvement high.

### Identify Stakeholders/Audiences

Before beginning a project, we determine who needs to be involved in the process and who needs to be aware of the project. We also think about and identify those individuals or groups who could push back or derail the project. Defining the key stakeholders/audiences and developing specific communication objectives for each group is important. In the Department's case, stakeholders may include:

- Consumers
- The governor and legislators
- The Arkansas Insurance Department staff
- Agency leaders
- Media
- Others

What other stakeholder groups have influence or would need to be aware of our communication strategy and implementation plan within the Department?

## Create messaging for each audience

Think about what you know about your stakeholders and audiences as receivers of information about the insurance rate process and their perceptions of this information. This will help us identify stakeholder groups with special needs and uncover any potential sensitivities within the audience groups. It will also help us understand the current communication channels, demographics, values, affiliations and perceptions of and attitudes toward insurance and the rate review process in particular. Other areas typically explored in this step include communication leadership, planning, and sourcing.

## Design program identity and determine media (print, electronic, audio visual)

Every action an organization takes – or doesn't take – says something to its stakeholders. The printed messages in a brochure or spoken words in an audiovisual or meeting are only part of what we communicate. The look, feel, style, tone and design – the image – say the rest. When controlled, the image becomes an integral part of a successful communication and education campaign. But when the image and the message are unbalanced, the signals to the audience are confused. For instance, we obviously would not send consumers a glossy, rich-looking communication piece when communicating a need to reduce spending. Similarly, we wouldn't inappropriately "downplay" important messages by photocopying them and posting them on bulletin boards, because the perceived importance of the message is derived from the overall "look". Other areas typically explored in this step include image definition, image connection, design, and tone.

## Develop metrics and evaluate

The only way to evaluate a program's success is to measure it. We would do this by identifying indicators and changes that can be measured.

## Sample Strategy Documents

### Sample Strategy Calendar

Date	Name	Audience	Description/Objective	Key Message	Format/Media	Owner	Quantity	Cost
SEP. 05	<b>NC HealthSmart</b>							
Early Sept.	<b>General Awareness FLYER</b>	<ul style="list-style-type: none"> <li>CEOs</li> <li>HBRs</li> <li>Association publications</li> <li>Other State Entities with newsletters and websites</li> <li>Will be used in welcome packets and ongoing in new hire packets and handouts</li> </ul>	<ul style="list-style-type: none"> <li>A one-page front and back flyer using HD's standard flyer template with NCHS colors and logo.</li> <li>These are needed for CEO meetings and conferences starting in September, as well as for the welcome packets.</li> </ul>	Introduce NCHS and upcoming programs, stressing the 10/19 kick-off date. It will mention future availability of the website and Health Coach phone line.	Printed handout		• 16,000; bulk shipped to 3 – 4 locations	
Sept. 16	<b>SmartNews Newsletter Vol. 1; Issue 1</b>	Members	Quarterly self-mailer designed to coordinate with HD's templates, but using NCHS's colors.	Newsletter stressing kick-off date, Health Coaches, and website. An important purpose of this newsletter is to build trust for the program. This issue will include limited health/wellness articles. Announce NCHS phone number and website address. No other health awareness or disease specific posters will be used. Existing HD condition flyers will be updated with program URL/Phase and made available as PDF files.	Print; mailed third class to homes		5,000 340,000 + dependents over 18	
Sept. 19	<b>General Awareness Posters</b>		PDF files and emailed to HBR (email) and other groups	Announce NCHS phone number and website address.	Print and PDF		5500 (sent to ~23 sites or fewer)	
Sept. 30	<b>Provider Letter</b>	Providers/Doctors	Information to providers. Note, this date is subject to change based on the availability of data	Announce NCHS, explain Health Coaches and encourage doctors to recommend the program to member/patients	Print, first class mail			

## Sample Communication Stakeholder Guide

### Example 1

#### Goals Synopsis

NCHS Goal is to be a world-class health initiative:

- Member centric
- Health partner
- Wrap around program that supports the member in all aspects of their lives, work, home, etc.
- Ecosystem model
- Foundation on which the member can build a personal health support system that includes family, providers, SHP benefits, and worksite wellness
- Messages – timely, clear, consistent, accurate
- Clinical Content – 100% clinical accuracy in all health/condition-specific communication

#### Goals/Communication

Engage eligible SHP members and stakeholder groups in the NCHS initiative through education that is accurate and presented in multimedia formats.

"ENGAGE THROUGH EDUCATION"

#### Audiences

PRIMARY = member/customer

SECONDARY =

- HBRs and Personnel
- Stakeholders: Agencies, employer communication staff, and provider publications
- CEOs
- Legislators
- Providers

Example 2

Members		
<p>1. <b>Member Outreach</b>—Educate and inform all 412,000 eligible adult NCHS members about NCHS [#] of times in 12/06.</p> <p>2. <b>Expected Outcomes</b></p> <ul style="list-style-type: none"> <li>• Engage XX% of members in one or more NCHS programs               <ul style="list-style-type: none"> <li>▪ 30% of members take the HRA without incentives up to 80% of members with incentives</li> <li>▪ XX% contact a Health Coach</li> <li>▪ XX% of identified members with chronic conditions who contact a Health Coach</li> <li>▪ 80% member satisfaction by 11/06</li> </ul> </li> </ul>	<p>3. <b>Quantify</b></p> <ul style="list-style-type: none"> <li>• Must include members who are NOT using services</li> <li>• Member survey(s) (Health Dialogue)               <ul style="list-style-type: none"> <li>▪ Spot check surveys</li> <li>▪ Annual</li> <li>▪ Number of HRAs, web site hits and Health Coach calls</li> <li>▪ Capture information on where member learned about NCHS</li> <li>▪ Average speed of answers, for example, calls dropped, etc.</li> </ul> </li> <li>• Compare to benchmarks:               <ul style="list-style-type: none"> <li>○ Focus groups</li> <li>○ Phone surveys</li> <li>○ STEWAC feedback</li> </ul> </li> </ul>	
DIRECT COMMUNICATION FROM NCHS		
TIMING	ITEM	DESCRIPTION / PURPOSE
	Auto Dialog calls	Is an innovative outreach program that generates targeted outbound calls to members with either a chronic or preference sensitive condition. Using a speech recognition technology, Health Dialog is able to reach and deliver relevant, effective messages to large numbers of targeted recipients. This technology stimulates a one-on-one conversation by recognizing and interpreting the member's responses and guides the member to an appropriate course of action (e.g. transfer to a Health Dialog Health Coach).
	Chronic information sheets plus letter and co-morbidity booklet, if appropriate	Is a personalized letter with a fact sheet mailed to members targeted through claims data. The fact sheet provides members with clinically-based information on how to better understand and manage their specific condition.
	Flyer	
	Gap postcards	Identify possible gaps in care for the member's condition, according to clinical evidence. Each communication stresses the importance of members talking with their doctor about following their care plan.
	General awareness letter and flyer	

Example 3

Legislators			
Outreach: No less than six print and/or email communications interactions with them between October and December 2005			
WHAT PROVIDERS RECEIVE FROM NCHS			
TIMING	ITEM	DESCRIPTION / PURPOSE	EFFECT ON MEMBER
	Evidence-based IMH report		Policy changes
	Presentations		Policy changes
	Monthly legislative update		Policy changes
	Sample packet of all materials with letter		Policy changes
WHAT PROVIDERS RECEIVE FROM OTHER SOURCES TO WHICH NCHS PROVIDES INPUT			
MEDIA			
TBD	Radio		
TBD	Press releases		
TBD	TV		

# Sample Communication Action Plan

Communication Timeline									
January 2006	February 2006	February 2006	March 2006	March 2006	April 2006	April/May 2006 (April 16 – May 15)	May/June 2006	July 2006	July 1, 2006
Rollout Program Design	Rollout Communication Strategy	Pre-Announcement	Training	Announcement	Announcement	BEA Rollout	Health Management Education	Reinforcement and Measurement	Effective Date
PEBTF Board	PEBTF/Aon planning team	To eight DIs: To all employees	To all key communicators	To all employees	All employees	To all employees	To all employees	To all employees	All employees
<p>Board Approval (1/24)</p>	<p>Written Communication Strategy (2/16)</p> <p>Create an Identity</p> <p>Other Unions Briefing (2/24)</p>	<p>Union District Briefing (start 2/24)</p> <p>HR Regional Agency Briefing</p> <p>Employee Advisory Group</p>	<p>Train the trainer (8/8) (PEBTF all-union regional union reps)</p> <p>Questions and Answers (8/8)</p> <p>Announcement (3/16) (Overview of Health Management Program and Healthy Incentives, surgery, endocrinology, obesity management)</p> <p>Press Release To PEBTF (3/1)</p> <p>Post on EOC Intranet site (comparable union sites??)</p>	<p>Self-aider (Health Management and Incentives) (April 6)</p> <p>e-mail and Pop-up Reminders about surgery, endocrinology, obesity management</p> <p>Posters/Table Tents (Health Management Program)</p>	<p>Newsletter (Introduction from Health, Mark, Union representatives, general overview, what's changed/improving, when focus on obesity management)</p> <p>Surgery Evolution (to be pre-certified by 4/1 and surgery scheduled on or before 7/1)</p> <p>Posters/Table Tents (Obesity Management)</p> <p>Event Sign</p> <p>Employee and Spouse Meeting Invitation</p>	<p>Posters/Table Tents (Meeting reminder)</p> <p>Employee and Spouse Meeting (April 6 – May 1)</p> <p>CD Announcement Penn Dot, Corrections and other non-disk based employees (April 6)</p> <p>Health Risk Assessment</p> <p>Promotional Item</p>	<p>Health Management Highlights Brochure (obesity meeting)</p> <p>Feedback Questionnaire</p> <p>Benefit Service Reps</p> <p>Pedometer to encourage walking</p> <p>e-mail and Pop-up Reminders</p>	<p>Contribution waiver/ waiver Letter</p> <p>Questions and Answers</p> <p>Aligned Wallet Card (Program numbers with address)</p> <p>Benefit Service Reps</p> <p>Employee Self-service (Postal material, provide links to various web/online services)</p> <p>e-mail and Pop-up Reminders</p>	<p>Contributions (1) May - Month 7/1 - 7/15 pay date 7/15 (2) May - Month 7/1 - 7/15 pay date 7/15 (3) May - Month 7/1 - 7/15 pay date 7/15 (4) May - Month 7/1 - 7/15 pay date 7/15</p> <p>Waivers Expanded Disease Management</p> <p>Obesity Management</p> <p>Diabetes</p> <p>Chiropractic Centers of Excellence</p> <p>Local Newsletters (Articles and facts for union, PEBTF, Aon, newsletters, HR results, success stories, current disease management, answers to questions received through call center/other)</p> <p>Posters/Table Tents (Health Management Program)</p>

Note: All material posted on EOC Intranet site and Employee Self-service site

# Sample Year at a Glance Strategy Calendar

DAILY	WEEKLY	MONTHLY	QUARTERLY	ANNUAL
- 100 payables - 100 payables	24W 100% 24W 100% on form completion	- 100% 100% - 100% 100%	100% 100% 100% 100%	100% 100% 100% 100%
<b>January</b>				
	1 100% 100% 2 100% 100% 3 100% 100% 4 100% 100% 5 100% 100% 6 100% 100% 7 100% 100% 8 100% 100% 9 100% 100% 10 100% 100% 11 100% 100% 12 100% 100%			
<b>February</b>				
	1 100% 100% 2 100% 100% 3 100% 100% 4 100% 100% 5 100% 100% 6 100% 100% 7 100% 100% 8 100% 100% 9 100% 100% 10 100% 100% 11 100% 100% 12 100% 100%			
<b>March</b>				
	1 100% 100% 2 100% 100% 3 100% 100% 4 100% 100% 5 100% 100% 6 100% 100% 7 100% 100% 8 100% 100% 9 100% 100% 10 100% 100% 11 100% 100% 12 100% 100%			
<b>April</b>				
	1 100% 100% 2 100% 100% 3 100% 100% 4 100% 100% 5 100% 100% 6 100% 100% 7 100% 100% 8 100% 100% 9 100% 100% 10 100% 100% 11 100% 100% 12 100% 100%			
<b>May</b>				
	1 100% 100% 2 100% 100% 3 100% 100% 4 100% 100% 5 100% 100% 6 100% 100% 7 100% 100% 8 100% 100% 9 100% 100% 10 100% 100% 11 100% 100% 12 100% 100%			
<b>June</b>				
	1 100% 100% 2 100% 100% 3 100% 100% 4 100% 100% 5 100% 100% 6 100% 100% 7 100% 100% 8 100% 100% 9 100% 100% 10 100% 100% 11 100% 100% 12 100% 100%			
<b>July</b>				
		1 100% 100% 2 100% 100% 3 100% 100% 4 100% 100% 5 100% 100% 6 100% 100% 7 100% 100% 8 100% 100% 9 100% 100% 10 100% 100% 11 100% 100% 12 100% 100%		
<b>August</b>				
		1 100% 100% 2 100% 100% 3 100% 100% 4 100% 100% 5 100% 100% 6 100% 100% 7 100% 100% 8 100% 100% 9 100% 100% 10 100% 100% 11 100% 100% 12 100% 100%		
<b>September</b>				
		1 100% 100% 2 100% 100% 3 100% 100% 4 100% 100% 5 100% 100% 6 100% 100% 7 100% 100% 8 100% 100% 9 100% 100% 10 100% 100% 11 100% 100% 12 100% 100%		
<b>October</b>				
		1 100% 100% 2 100% 100% 3 100% 100% 4 100% 100% 5 100% 100% 6 100% 100% 7 100% 100% 8 100% 100% 9 100% 100% 10 100% 100% 11 100% 100% 12 100% 100%		
<b>November</b>				
		1 100% 100% 2 100% 100% 3 100% 100% 4 100% 100% 5 100% 100% 6 100% 100% 7 100% 100% 8 100% 100% 9 100% 100% 10 100% 100% 11 100% 100% 12 100% 100%		
<b>December</b>				
		1 100% 100% 2 100% 100% 3 100% 100% 4 100% 100% 5 100% 100% 6 100% 100% 7 100% 100% 8 100% 100% 9 100% 100% 10 100% 100% 11 100% 100% 12 100% 100%		

## Arkansas Insurance Department

### *Rate Review Database*

### *Proposed List of Fields*

*July 8, 2011*

The following is a proposed list of fields for a rate review database to be used by the Arkansas Insurance Department.

Note: calculated fields are in *blue bold italic font*.

#### Data Stored as Fields in SERFF

- 1) SERFF Tracking Number
- 2) Form Number
- 3) Company Name
- 4) Group Code
- 5) NAIC Company Code
- 6) PPACA (PPACA-Related or Not PPACA-Related)
- 7) PPACA Notes
- 8) Product Name
- 9) Deemer Date
- 10) Project Name
- 11) Project Number
- 12) Implementation Date Requested
- 13) Filing Type
- 14) Assigned To
- 15) Date Submitted
- 16) Submission Type
- 17) Market Type
- 18) Authors
- 19) Created By
- 20) Submitted By
- 21) Filing Description (long text field)
- 22) SERFF Status
- 23) Disposition Date
- 24) Initial Requested Rate Increase
- 25) Final Requested Rate Increase

#### Data to Extract from Disclosure Rate Summary Worksheet (Excel)

- 1) Base period start date
- 2) Base period end date
- 3) Base period member months
  - a. Inpatient

- b. Outpatient
  - c. Professional
  - d. Prescription drugs
  - e. Other
  - f. Capitation
  - g. Total (calculated field)**
- 4) Base period total allowed
- a. Inpatient
  - b. Outpatient
  - c. Professional
  - d. Prescription drugs
  - e. Other
  - f. Capitation
  - g. Total (calculated field; sum of a:f)**
  - h. Total PMPM (calculated field)**
- 5) Base period net claims
- a. Inpatient
  - b. Outpatient
  - c. Professional
  - d. Prescription drugs
  - e. Other
  - f. Capitation
  - g. Total (calculated field; sum of a:f)**
  - h. Total PMPM (calculated field)**
- 6) Current rate start date
- 7) Current rate end date
- 8) Current rate overall medical trend
- a. Inpatient
  - b. Outpatient
  - c. Professional
  - d. Prescription drugs
  - e. Other
  - f. Capitation
  - g. Total (calculated field)**
- 9) Current rate member's cost sharing
- a. Inpatient
  - b. Outpatient
  - c. Professional
  - d. Prescription drugs
  - e. Other
  - f. Capitation
  - g. Total (calculated field)**
- 10) Current rate projected allowed PMPM (calculated field)**
- 11) Current rate net claims PMPM (calculated field)**
- 12) Medical trend breakout (% format)
- a. Utilization
  - b. Unit cost
  - c. Other factors
- 13) Future rate start date
- 14) Future rate end date
- 15) Future rate overall medical trend

- a. Inpatient
  - b. Outpatient
  - c. Professional
  - d. Prescription drugs
  - e. Other
  - f. Capitation
  - g. Total (calculated field; sum of a:f)**
- 16) Future rate member's cost sharing
- a. Inpatient
  - b. Outpatient
  - c. Professional
  - d. Prescription drugs
  - e. Other
  - f. Capitation
  - g. Total (calculated field)**
- 17) Future rate allowed PMPM (calculated field)**
- 18) Future rate net claims PMPM (calculated field)**
- 19) Future rate administrative costs PMPM
- 20) Future rate underwriting gain/loss PMPM
- 21) Future rate – total rate PMPM (calculated field)**
- 22) Prior estimate of current rate net claims PMPM
- 23) Prior estimate of current rate administrative costs PMPM
- 24) Prior estimate of current rate underwriting gain/loss PMPM
- 25) Historical Year 1
- 26) Historical Year 2
- 27) Historical Year 3
- 28) New Form - Year 1 (Y/N)
- 29) New Form - Year 2 (Y/N)
- 30) New Form - Year 3 (Y/N)
- 31) Requested Rate Change – Year 1
- 32) Requested Rate Change – Year 2
- 33) Requested Rate Change – Year 3
- 34) Implemented Rate Change – Year 1
- 35) Implemented Rate Change – Year 2
- 36) Implemented Rate Change – Year 3
- 37) Number of Covered Individuals
- 38) Minimum Rate Increase
- 39) Maximum Rate Increase

#### Data From AID (Type in Manually)

- 1) New Fees
  - 2) Check No
  - 3) Date Received
  - 4) Letter Date
  - 5) Date Response Received
- Etc.