

**Health Insurance Rate Review Grant Program  
Cycle I Final Report Template**

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**Submission Date: January 18, 2012**

**State: Arkansas**

**Project Title: Arkansas Health Insurance Rate Review Grant Cycle I Final Report**

**Project Reporting Period: Final Report (08/09/2010-9/30/2011)**

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**Grant Performance Period-Cycle I:** August 9, 2010 to September 30, 2011

**Reporting Period:**

Quarterly Report 1:	August 9, 2010 through December 31, 2010
Quarterly Report 2:	January 1, 2011 through March 31, 2011
Quarterly Report 3:	April 1, 2011 through June 30, 2011
Quarterly Report 4:	July 1, 2011 through September 30, 2011
Final Report:	August 9, 2010 through September 30, 2011

**Timeframe for Delivery:** January 31, 2011-February, 28, 2011

April 30, 2011  
July 31, 2011  
October 31, 2011  
December 31, 2011

Section 1003 of the Affordable Care Act requires the Secretary of the Department of Health and Human Services (HHS), in conjunction with the States, to establish a process for the annual review of health insurance premiums to protect consumers from unreasonable, unjustified and/or excessive rate increases. Section 2974 of the Public Health Service Act (PPACA Section 1003) provides for a program of grants that enable states to improve the health insurance rate review and reporting processes.

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

The final report must be submitted by December 31, 2011 and must be submitted electronically through the Health Insurance Oversight System (HIOS).

The following reporting guidelines are intended as a framework and can be modified when agreed upon by the OCIIO grant project officer and the State. A complete final progress report must detail how grants funds were utilized, describe program progress, barriers, and provide an update on the measurable objectives of the grant program.

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### **PART I: FINAL NARRATIVE REPORT FORMAT**

#### **Introduction:**

Section 2794 of the Affordable Care Act (ACA) “Ensures That Consumers Get Value for Their Dollars.” Specifically, Section 2794 establishes a process for the annual review of health insurance rates to protect consumers from unreasonable rate increases.

On July 1, 2011, Steve Larsen, CCIIO Director, officially notified Commissioner Jay Bradford that the Arkansas Department of Insurance had met the applicable criteria and had been designated an ‘Effective Rate Review Program’ in all markets. (*See Attachment #15*)

On September 20, 2011, the AID received notice of a Cycle II Grant award of \$3,874,000 (*See Attachment #7*)

On December 16, 2011, the Arkansas Legislative Council (ALC) officially approved the Cycle II Grant.

The Arkansas Insurance Department (AID) Rate Review Division (RR) is committed to expanding and strengthening its ability to support health care reform through meaningful and transparent processes that align health insurance rate review, approval, analyses, reporting and public notification processes with the agency’s mission of “consumer protection through insurer solvency and market conduct regulation, and fraud prosecution and deterrence.” The principal goal of the AID RR will always be to protect consumers from unreasonable, unjustified, or excessive rate increases.

The AID RR has expanded its legal authority for health insurance ‘rate review’ through revision of AID Bulletins (*See Attachments #13,#14*); enhanced expertise for health rate reviews; enhanced technology and programmatic infrastructure to effectively collect, analyze, track and report health insurance rate filings; and created a health insurance rate review education, outreach, and training program dedicated to information dissemination about rate approval processes and rate trends to diverse stakeholders including the general public and special consumer populations, policymakers, health insurers, health care providers, and the business community.

The HHS/CCIIO funding has been effectively used to: 1) enhance staff and technical expertise/efficiency for rate reviews through actuarial information technology, consultation and process improvements, and automation to the extent possible; 2) increase the size of the AID rate review staff; 3) create an active consumer-driven advisory committee to assist with implementing meaningful methods to improve consumer knowledge and involvement in rate approval processes; and 4) equip a modern, state-of-the-art Rate Review Center (*see Attachment #17*) at AID that will serve as the “nerve center” for health insurance rate review information exchange with the general public, legislators, state agencies, stakeholders, and professional health industry groups. The Rate Review Media Center will greatly improve AID’s ability to train and upgrade its internal staff as well as house RR “Public Hearings.”

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### **Goals, Objectives, and Milestones:**

Rate Review Department Analysis Cycle I funds allowed the AID to engage a nationally known and reputable firm to comprehensively analyze the entire rate review process of the Arkansas Insurance Department (AID) and to make specific recommendations to AID for improvements which will enable the AID RR staff to:

- a. more efficiently process, review, and track rate requests  
(See Attachments #9 & #9a)
- b. accurately track 'Minimum Loss Ratio' data,
- c. track medical trends by categories,
- d. automate processes,
- e. establish an effective training program for all rate review personnel
- f. create transparency for the public
- g. directly involve Arkansas consumers in the rate review process.

Increased Authority. The Arkansas Insurance Department (AID) obtained new and effective authority to review and approve individual and small employer group rates through the issuance of Bulletins 6-2011 and 7-2011. These Bulletins add new review criteria and consumer comment periods (See Attachments# 13 & #14).

AID RR Media Center. On September 15, 2011, the AID RR Media Center became fully operational. This facility is 'state of the art' and will be the communication center of AID RR. Arkansas consumers and stakeholders, in groups as large as sixty, will visit the Media Center to receive educational and knowledge based presentations inside the facility while RR simultaneously broadcasts the presentation to other geographical sites utilizing podcasts, webcasts, teleconferencing, and/or videoconferencing.

The Media Center will also be utilized to produce educational material for consumers such as 'easy to understand' consumer guides, electronically tape meetings and hearings for replay on the improved website, conduct town hall "type" meetings and broadcast to offsite locations state-wide, and train AID personnel and affiliated groups in professional rate review

Improved Website. Phase 1 of the renovation of the AID Rate Review Website was completed September 30, 2011. Phase I was primarily designed for the Arkansas consumer. The website (See Attachment #18 & #19) will be:

- Consumer oriented and informative
- Educational,
- Interactive, and
- User-friendly.

Phase II of the RR website renovation will be very comprehensive and will be bid & completed during the Cycle II grant funding period. Phase II will provide:

- Posting of rate review requests and commissioner's rate review decisions
- Posting of full information on rate requests prior to decisions
- Posting of consumer comments
- Interactive consumer tools for education, research, and rate review involvement.

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Social Media. The AID RR launched an innovative social media campaign. This includes a Facebook page and Twitter feed to provide consumers with new and relevant information pertaining to healthcare insurance and the ACA.

Data Acquisition. Create an effective data acquisition process (*see Attachment #12*) which will allow accurate healthcare data analytics, including but not limited to:

- data collection,
- data processing,
- data analysis,
- benchmarking,
- identification of applicable rate trends,
- forecasting.

### **Final Progress Summary:**

- Total Funds Expended: (\$787,169)
- Total Staff Hired: (Four)
- Total Contracts in Place: (Four)
- Introduced Legislation: (Yes)
- Enhanced IT for Rate Review: (Yes)
- Submitted Rate Filing Data to HHS: (Yes)
- Enhanced Consumer Protections: (Yes)
  - Consumer-Friendly Website: (Yes)
  - Rate Filings on Website: (Yes)

### **Program Implementation Status:**

#### **Accomplishments of Cycle I:**

- A. Hired an excellent staff and obtained very functional office space and equipment
- B. AID RR was officially designated as having an ‘Effective Rate Review Program’
- C. Completed three very innovative and successful Requests for Proposals (RFPs)
  - 1) AON Hewitt completed a professional and comprehensive assessment of the entire AID rate review program followed by a very thorough across-the board set of recommendations, nearly all of which are currently being implemented.
  - 2) “State of the art” Media Center was completed and is fully operational.
  - 3) Renovated and upgraded AID RR website.
- D. AID Bulletins were modified in order to implement rate review enhancements
- E. Contracted and partnered with SERFF to improve rate review reporting
- F. Planned, designed, and developed improved rate review filing applications for the AID RR database.
- G. AID RR was awarded a \$3.874 million Cycle II Rate Review Grant.

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### A. **Hired an excellent staff and obtained very functional office space and equipment**

- Deputy Commissioner, Rate Review Director hired December 1, 2010.
- Managing Attorney Rate Review hired January 1, 2011.
- Communications Director Rate Review hired January 1, 2011.
- Database Administrator hired November 1, 2012.
- The Rate Review Division moved into its new office space on March 1, 2011.

### B. **AID RR was officially designated as having an ‘Effective Rate Review Program’**

Steve Larsen, CCIIO Director, officially notified Commissioner Jay Bradford on July 1, 2011, that the Arkansas Department of Insurance had met the applicable criteria and had been designated an ‘Effective Rate Review Program’ in all markets. (*See Attachment #15*)

### C. **Completed three very innovative and successful Requests for Proposals (RFPs)**

- 1) **AON Hewitt completed a professional and comprehensive assessment** of the entire AID rate review program followed by a very thorough across-the-board set of recommendations, nearly all of which are currently being implemented. (*See Attachments #9 & 9a*)

AON Hewitt was awarded a \$198,600 RFP to perform a comprehensive and quality assessment of all components of the current AID health insurance rate review process on April 1, 2011 which generated two reports, Phase I and Phase II. AON’s Phase I response identified changes needed in the current AID rate review process, including AID regulatory reporting, needed to fully comply with the mandates of HHS/PPACA. The Phase I report, in great detail, assessed AID personnel, AID resources, legislation and regulations, internal and external actuarial functions and procedures, scope of use of external actuarial services, operating standards and guidelines, the AID web site, information technology, database management, core reporting capabilities, historic rate review performance, filing and processing of public contacts and requests, level of consumer service, current and future use of SERFF capacities, management reporting, training of internal rate review personnel, outreach, and process transparency.

AON submitted its Phase II report which provided detailed recommendations on 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.

- 2) **“State of the art” Media Center was completed and is fully operational.**

The Rate Review Division awarded the Media Center contract to Jay Stanley and Associates on July 12, 2011. Phase I equipment was installed on September 27, 2011. The Media Center will be a useful tool when conducting meetings related to our outreach programs and hearings held over rate filings. The Media Center is a 1440 square foot open area located contiguous to the rate review offices. The Media Center space can comfortably accommodate up to sixty attendees.

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The capabilities of the Media Center, with two 70” screens, 40” monitor screen, and professional microphone and sound equipment, include but are not limited to, video presentations, video conferencing and bridging services, teleconferencing, digital and video recording with computer graphics display, DVD/BlueRay, cable access, document camera, compact disc, MP3 audio recorder, webcasts, podcasts, and computer graphics display.

AID RR will fully utilize the newly operational rate review media center for public and professional training, education, and information dissemination activities including, but not limited to, public hearings and media presentations. The AID Insurance Rate Review Media Center will serve as the “nerve center” for rate review education and outreach efforts. Training methodologies will include classes, seminars, and interactive webinars or interactive video conferences augmented by PowerPoint presentations, course syllabi, video clips, and classes for healthcare professionals.

A further adjunct to the Media Center is the new AID RR Social Media addition. The AID RR has launched a social media campaign targeting Arkansas consumers. This includes a Facebook page and Twitter feed to provide consumers with new and relevant information pertaining to healthcare insurance and the ACA.

### **3) Renovated and upgraded AID RR website.**

Phase I of the renovation of the AID Rate Review Website was completed September 30, 2011. Phase I was primarily designed for the Arkansas consumer. The website (*See Attachment #18*) is:

- Consumer oriented and informative
- Educational,
- Interactive
- User-friendly.

Phase II of the RR website renovation will be very comprehensive and bid & completed during the Cycle II grant funding period. Phase II will provide:

- Posting of rate review requests and commissioner’s rate review decisions
- Posting of full information on rate requests prior to decisions
- Posting of consumer comments
- Interactive consumer tools for education, research, and rate review

### **D. AID Bulletins were modified in order to implement rate review enhancements**

AID released its proposed Bulletins 6-2011 and 7-2011 for comment which were later adopted with effective dates of September 1, 2011 (*See Attachments #13 & 14*). Both Bulletins have been subsequently modified to accommodate CMS’s most recent requirements on “Associations.”

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### **E. Contracted and partnered with SERFF to improve rate review reporting**

The Rate Review Division used Cycle I funding to contract with SERFF to improve the filing applications. The total contract was \$18, 808 and was signed on November, 10, 2010. AID RR has already contracted with SERFF for Cycle II enhancements.

**Data Collection from Industry:** The SERFF system will be enhanced to assist with collection of all parts of the industry Preliminary Justification for rate increases. Part I, the Rate Increase Summary Worksheet, will be collected as an attachment to a Submission Requirement. The SERFF system will parse this attachment into database fields to allow for search and export capabilities. Part II, the Written Explanation of Rate Increase, will also be collected with the filing submission—which is Part III, Rate Filing Documentation. Finally, a Submission Requirement will be added to collect the Consumer Disclosure form.

**State Data Input:** SERFF will be modified to allow the states to enter a Summary of Rate Review and/or a State Filing Summary. The state will be able to submit the Summary of Rate Review to HHS via SERFF following the review process.

**Enhancements to HFAI:** The Health Filing Access Interface (HFAI) will be enhanced to allow states to display the information above and to accept and process public comments on rate filings. States will have the option to make the Rate Increase Summary Worksheet, the Consumer Disclosure Form, the State Filing Summary, and the Summary of Rate Review available to the public via HFAI or SERFF's existing public access. States may choose if and when these pieces are made public, using their existing guidelines for public access. Additionally, HFAI and SERFF will be enhanced to support the collection of public comments via HFAI and to provide states an interface to manage the collection and posting of those comments from SERFF.

### **F. Planned, designed, and developed improved rate review filing applications for the AID RR database.** (See Attachment #9a & #12)

Because AID now requires all filings to be electronic, the Rate Review Division hosted a high level data development task force meeting on June 14, 2011, attended by the state healthcare leaders which resulted in the planning for an All Payer Claims Database (APCD). This development is expected to be critical in the ability of AID Rate Review to fulfill future data needs.

**Data Acquisition and Analytics.** To improve rate review, AID RR is creating an effective data acquisition process (see Attachment # 9a & 12) which will allow accurate healthcare data analytics, including but not limited to:

- data collection,
- data processing,
- data analysis,
- benchmarking,
- identification of applicable rate trends
- forecasting.

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### **G. AID RR was awarded a \$3.874 million Cycle II Rate Review Grant.**

On July 22, 2011, the AID Rate Review Division submitted a formal application for the 93.511 Rate Review Cycle II Phase I grant in the amount of \$3,874,098 for the designated three year period of 2011-2014. On September 20, 2011 HHS notified AID of the \$3,874,098 Cycle II Grant Award. (*See Attachment #7*) After a tremendous amount of preparation and work by AID RR, the Arkansas Legislative Council formally approved the Cycle II budget on 12.16.11.

### **Challenges and Responses of Cycle I:**

- A. Dealing with state purchasing and the delays therein. Professional Services RFP drafted 10-10-10. It took the Office of State Purchasing until 4-16-11 to award contract and accept contract. The Media Center RFP was submitted to OSP 4-2-11 but was not awarded until 7-12-11.
- B. Lack of legislative authority. Legislation on rate review was introduced in February, 2011, but was not acted on. Legislature does not meet again until February of 2013.

### **Significant Activities Undertaken:**

#### Rate Review Authority:

Under existing law, the Arkansas Insurance Department has prior approval authority over rates for individual health policies and contracts for all markets. Ark. Code Ann §23-70-109(a)(1)(A). Rates may be disapproved if they are unreasonable, Ark. Code Ann. §23-79-110(5). For small employer plans, the Department has the authority to review an insurance company's rating practices and underwriting practices. The Department can review all information and documents that demonstrate that the carrier's rating methods and practices are based on accepted actuarial assumptions, Ark. Code Ann. §23-86-204. For all groups policies issued by Hospital and Medical Corporations and Health Maintenance Organization, the Department has prior approval authority for rate.

To further clarify the filing requirements for individual rate filings, the Department issued Bulletin 6-2011 on July 7, 2011. This Bulletin will require all carriers to submit the Rate Summary Worksheet, and an Explanation of the rate filing for all rate filings. For all rate filings above the required threshold, carriers will be required to file the Part III Justification.

To clarify the filing requires for rate filings in the small group market, the Department issued Bulletin 7-2011. This Bulletin expanded the number of employees from 25 to 50 for filing requirements. For all small group filings, carriers will be required to submit Parts I and II of the Preliminary Justification. This filing must be done by June 1 of each year.

To address the rate filing requirements set forth in the 45 CFR 154 as it relates to association business, the Department revised Bulletins 6-2011 and 7-2011. Revised Bulletins 6-2011 and 7-2011 was issued December 1, 2011. (*See Attachment #13 &14*)

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Under the revised Bulletin 6-2011, all individually underwritten certificates of insurance issued through an association group policy will be subject to review by the Department. This will apply to all certificates or evidence of coverage issued to residents of Arkansas regardless of the state in which the policy was issued.

Under the revised Bulletin 7-2011, all policies or certificates of insurance issued to small employer groups through an association will be subject to the same filing requirements as all other small employer group rate filings. The Department will review these association filings using the same guidelines applied to other small employer group filings.

### Minimum Loss Ratio (MLR):

Several new programs will greatly affect the rate review process for health insurance. The new Medical Loss Ratio standards (MLR) and the reinsurance, risk corridor and risk adjustment programs will impact health insurance rates in the upcoming years.

The MLR standards went into effect in 2011 and will cause possible rate rebates by the carriers beginning in 2012. The MLR reporting requirements create new tracking and audit needs that AID must address. Due to the impact on rates, the Rate Review Division has been given the task of implementing new procedures and processes for the Department.

Our first phase for MLR implementation will determine all of the reporting requirements and the best ways for the Department to track and process the data supplied by the carriers. New software applications will need to be developed for all of these tracking needs. In Phase 2 the Rate Review Division will develop procedures that will allow the Department to factor in MLR data into the rate review process. For instance, a proposed rate increase may be determined to be unreasonable if the projected MLR for the product line is well below the allowable standard.

Phase 1 will need to be completed prior to the MLR reporting date of April 1, 2012. An audit process must also be in place shortly after that time. Phase 2 will have a completion date shortly after the rebate calculation date of August 1, 2012. Evidence of a rebate will be a clear indication that the prior approved rates were based on improper assumptions. These assumptions will need to be corrected in future rate filings.

A much more complex program affecting rates will be the reinsurance, risk corridor and risk adjustment program that will go into effect in 2014. The Rate Review Division has been assigned with the task of monitoring the planning and implementation of these programs at the state and federal level.

Currently, it appears that the risk adjustment program will be implemented at the federal level along with the risk corridor program. RRD will work with consultants, industry and other stakeholders to determine if the transitional reinsurance program should be operated at the state level. If AID determines that this program should be operated at the state level, then the RRD will need to determine how this can be implemented. This will include selecting the non-profit entity that will operate the program for AID and participating in the planning process.

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Since these programs are not effective until 2014, our timeframe for implementation is not as restricted as the MLR program. Our first task will be to develop a list of areas that will need to be addressed. We will then determine if an outside consultant is needed to assist us in this planning process. This first phase should be completed by mid 2012.

### **Significant Activities Unmet:**

Prior to 2011, AID did not have sufficient legislative authority for optimal rate review as defined in the ACA. AID proposed needed legislation in 2011, but the AID legislation failed. In the place of new legislation, the Department issued Bulletins to comply with ACA in order to be deemed as having an effective rate review program. AID will resubmit suitable legislation at the first available opportunity. This submission will begin in late 2011, and be voted on in 2012.

As stated earlier, federal grants awarded to recipients in the State of Arkansas have to comply with state statutes and regulations just as if the funds had originated as Arkansas general revenue. State mandated procurement and hiring processes have been very problematic and continue to cause considerable delays. AID RR has a formal plan of action for filling the remaining positions during Cycle II. The AID RR plans to continue to strive to successfully meet all such activities through the current use of a no-cost extension and Cycle II grant funds.

### **Operational/Policy Developments/Issues:**

There have been significant barriers, issues, and problems that occurred throughout the past grant year. Great care was taken to insure that potential barriers were eliminated before they could become major problems. This was not always possible. For example, the exchange planning grant also resides within the AID. The “exchange planning” quickly became controversial to certain Arkansas state legislators. An attempt was made by certain legislators to completely block exchange planning funding. Unfortunately, because Rate Review also resides within the AID, it has suffered from unintended negative consequences by association.

As stated in previous reports, our federal grant has to comply with Arkansas statutes and regulations just as if the funds had originated as Arkansas general revenue. Obviously, Arkansas mandated procurement and hiring processes have been very problematic and caused considerable delays. ‘Bidding’ the Media Center was delayed by months of “red tape.” AID RR is working diligently to overcome all of these limitations.

### **Final Rate Filing Data Summary:**

Highlight important trends in the reported rate filing data from Cycle I, for example as part of the final report narrative, please discuss the following:

1. Increase/s in the number of rate filings accepted, reviewed and reported (*See Part II: Health Insurance Rate Data Collection*)
2. Provide additional context for any denied rate filings over the past twelve months, for example if a rate filing was initially denied, or renegotiated please discuss the process and final disposition.

In 8 filings the Department negotiated lower rates.

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3. Describe the impact of the program on rising health insurance rates.

Increases were lower than previous years. The number of rate filings during the reporting period did not increase dramatically from the previous year. The Department does not allow more than one rate filing during any 12 month period so the number remains fairly constant. During this period the Department did disapprove 7 rate filings which is higher than previous years. The average requested increase for these filings was 14.31%. In addition to the 7 disapproved filings the Department negotiated lower rates in another 8 filings. The average requested increase for these filings was 13.18%. The average approved rate for these filings was 6.66%. For the 5 filings that were approved as requested, the average increase was 12.88%. However, this figure is distorted due to an approved rate increase of 30%. This unusually high increase was granted to a domestic HMO that had just entered the individual market and had not filed for a rate increase in three years. Excluding this increase, the average approved as filed increase was 8.6%. Overall the Department approved rate increases in the individual market at an average increase of 8.88%. Again excluding the one 30% increase, the average for the remaining increases was 7.26%. Overall the approved rate increases were below the accepted medical trend for Arkansas during this period.

**Public Access Activities:**

During this Cycle I grant period, RR created and implemented a communication outreach campaign with the goal being to educate consumers with meaningful information regarding the health insurance premium rate review process and what health care costs mean to them. Communication strategies for this grant cycle include: a newly constructed website, social media campaign, Primer '101' and optimal utilization of the Media Center.

Rate Review contracted with a vendor to develop the first phase of a new consumer friendly website. The focus is on clearly presenting and explaining to insurance consumers what premium health insurance rate review is, why it's important to policy holders and how consumers can get involved and have a voice in rising premium costs. A component of the website includes a diagram of the rate review process using graphics and text boxes to explain the rate review process. We included a Consumer Guide page as a 'one-stop-shop' of information for consumers; it provides a description of what Rate Review is, why rates matter to them and a 'Helpful Links' section. AID has satisfied the web-posting and public disclosure requirement by providing consumers with the link to the product-specific consumer disclosure on CMS' HealthCare.gov website which is posted on our RR main page.

Our goal is and will be in the next phase of web upgrades in Cycle II to continue providing meaningful rate review and health care cost information to the consumer. We will specifically focus on the explanation of Medical Loss Ration (MLR) and how it applies to the consumer, posting of consumer comments and providing interactive consumer tools for education, research, and rate review involvement.

The AID Facebook page and Twitter feed were launched to make more information readily available to the public and provide another tool for consumers to learn about health insurance and premium rate review.

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The Media Center was constructed during Cycle I and made fully operational. It serves as a communications center for various stakeholders including legislators, consumers, various task forces and industry officials. This multi-media center's capabilities include: video conferencing, teleconferencing, computer graphics display, document camera and digital audio/video recording components. (*See Attachment 17*) It will be used to conduct meetings and various presentations in house with various stakeholders across the state and country to disseminate meaningful rate review information. We have started the planning process to host a National Rate Review meeting for spring of 2012.

To enhance transparency and consumer knowledge, a Primer '101' and FAQ brochure were developed. The Primer contains basic educational information, such as a definition of "health insurance premium", how to reduce insurance premiums, etc. This is a "living document" and will continue to be refined in Cycle II.

### **Collaborative Efforts:**

The Rate Review Division (RR) of the Arkansas Insurance Department (AID) has enjoyed a very successful grant year. No small part of the credit for that success can be attributed to its collaborative efforts. The following organizations have been extremely helpful in advancing the objectives of the AID Rate Review Program.

The NAIC (National Association of Insurance Commissioners) was specifically mentioned sixteen times in the Accountable Care Act (ACA). The NAIC has provided effective staff support during the grant period to the AID RR with weekly conference calls, research, legal opinions, white papers, workshops, seminars, relevant industry news, legislative reviews, model laws, webinars, and training.

Another effective collaborative partner continues to be SERFF (System for Electronic Rate and Form Filing) which is managed by the NAIC and enables insurance companies to streamline and store their rate and form filings electronically and in a secure environment. SERFF has incorporated submission of federally mandated Rate Filing Disclosure Forms and Justifications that are required to be filed under provisions of the Affordable Care Act. SERFF has a strong working relationship with HHS and has provided data to AID RR in a usable electronic format and provides the applicable state training. The SERFF staff provides constant communications and assistance to the AID RR staff.

The Arkansas Center for Health Improvement (ACHI) is lead by the Arkansas Surgeon General. ACHI sponsors monthly meetings of the Governor's Roundtable on Health Care to address comprehensive health care reform in Arkansas. The AID RR Director attends and participates in these discussions on Improving Arkansans' health and productivity through optimal program development, community support, and empowerment of individuals.

Two direct advantages of this relationship with AID RR is that ACHI is leading establishment of the only Arkansas 'all payer claims database' (APCD) as a source of needed healthcare data, and is recruiting politically engaged advocates to secure support for implementation (legislative/private sector) of APCD recommendations.

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On going collaborative efforts with various stakeholder groups, the Arkansas Office of Healthcare Information Technology (OHIT), the University of Arkansas for Medical Sciences (UAMS), Arkansas state agencies, and the Arkansas Legislature continued in a robust fashion during this grant cycle.

### **Materials Produced During Cycle I:**

To reach our goal to educate consumers about rate review we've developed consumer handouts and upgraded the Rate Review website. (*See Attachment 19*) [www.insurance.arkansas.gov/hirrd](http://www.insurance.arkansas.gov/hirrd) The focus of the website is on clearly presenting and explaining to insurance consumers what premium health insurance rate review is, why it's important to policy holders and how consumers can get involved and have a say in rising premium costs. A component of the web page includes a diagram of the rate review process using graphics and text boxes to explain to process. The website officially went live on October 3, 2011.

In addition, consumer handouts such as a Primer '101' and FAQ brochure were developed. The Primer contains basic educational information, such as a definition of "health insurance premium", how to reduce insurance premiums, etc. This is a "living document" and will continue to be refined during Cycle II. (*See Attachments 20 & 21*) Materials have been handed out during a variety of outreach engagements and events.

During the Cycle I reporting period, one of the most important documents produced was the Phase I and II reports completed by AON. This included a detailed review of the current AID rate review process and numerous recommendations to improve the process. As previously stated, the AID rate review process had been in place since 1979 with the publication of Bulletin 4-79. The ability to work with an outside consultant helped us understand how an optimally automated rate review process would greatly assist the Department in its statutory duties.

### **Impact:**

One of our primary goals for this grant cycle was to educate the consumer about the rate review process. We've done so by posting an explanation of the process and providing consumers with a visual aid on our Rate Review website and 'Primer 101' which has been distributed during various outreach engagements. Also included on the website is a Consumer Guide page which was specifically designed as a 'one stop shop' of information for consumers.

Cycle I funding gave the Department the opportunity to review its entire rate review process. The process to review rate filings had been in place since 1979 with very few changes. In addition, the Department was able to fund a full review by outside actuaries. Until recently, there was no formal tracking system for rate filings. The Department was unable to compare a new filing with any previous filings.

In regards to the filing process itself, we have added a new checklist that can be used with every filing. Training needs have been identified as well as new data requirements under our new Bulletins.

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### **Lessons Learned:**

We have learned that there is an enormous lack of knowledge related to both general health care and health insurance as we have compiled our research within our state during this grant cycle. There have been tremendous challenges in explaining technical aspects of the rate review process to the average consumer. For example: The approved overall rate does not trend to actual increases for some individuals.

### **Final Budget Summary:**

The Arkansas Insurance Department (AID) Rate Review (RR) Division filed its 4<sup>th</sup> Quarter Cycle I Report with HHS/CCIIO on October 28, 2011. Complete financial data was filed within this report which included all final transactions completed through 9.30.11 and a SF-425.

Between 9.30.11 and 12.31.11, the AID RR Division has been operating exclusively from funding made possible by a “No Cost Extension” (NCE) of Cycle I funding.

Even though CMS/CCIIO was very timely in its mid-September Cycle II grant award, the State of Arkansas rules and regulations did not allow the AID RR division to access any Cycle II funds until the Cycle II grant funding had been approved by the Arkansas Legislative Council (ALC) after which the Arkansas Department of Finance and Administration (DFA) must authorize and establish the applicable accounts. This process was completed on December 27, 2011.

Although AID RR started the process as soon as notice of the grant award was made, it was not possible to get scheduled with the legislative PEER Review Committee (precursor to ALC) until December 1<sup>st</sup> for the Cycle II grant hearing.

AID RR formally presented the Cycle II RR grant to the Arkansas Legislative PEER Review Committee on December 1<sup>st</sup> and the full ALC on December 16, after which Cycle II funding was finally approved along with several other Miscellaneous Federal Grants (MFGs). Our legislative testimony lasted more than forty five minutes in the PEER hearing and more than an hour at the ALC hearing. This scrutiny was due entirely to our perceived relationship with the Arkansas Exchange grant application.

It was very encouraging that entire three years of the grant was approved by the ALC on December 16<sup>th</sup> and not just the first year. We have remaining some grant personnel issues (state approval of certain new positions). However, we will continue to work very diligently until we solve these issues.

The first Cycle II funds did not become available until December 27, 2011. Therefore, for all practical purposes, AID RR could have no official Cycle II activities in the first Quarter of the Cycle II grant (10.1.11 through 12.31.11). AID RR officially started Cycle II activities on January 2<sup>nd</sup> or at the beginning date of the 2<sup>nd</sup> quarter of Cycle II (1.1.12 through 3.31.12).

## Health Insurance Rate Review Grant Program Cycle I Final Report Template

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<b>Cycle I Categories</b>	<b>Spent/Projected</b>	<b>Budgeted</b>	<b>Variance</b>
Salary	213,648	329,650	116,002
Fringe Benefits	69,597	88,624	19,027
Travel	2,465	14,135	11,670
Other	10,168	13,168	3,000
Rental	64,836	58,717	(6,119)
Professional Services/Contracts	313,631	276,808	(36,823)
Supplies and Other Office Expenses	33,488	97,778	64,290
Capital	79,335	121,120	41,785
<b>Total</b>	<b>787,169</b>	<b>1,000,000</b>	<b>212,831</b>

In the State of Arkansas, federal grant recipients within state agencies are required to process Federal grant funds just as if the funds originated from state general revenue. As a result, federal grant recipients must comply with all mandated and applicable Arkansas State rules and regulations. These rules and regulations are very complicated and restrictive in regard to hiring grant personnel. These restrictions made it very difficult to fill two important grant positions on a timely basis. The delay in filling these positions account for most of the balance of overage of \$212,831 indicated in the previous budget summary.

The current allocation of grant funds follows the progression of the detailed budget provided in AID's original grant application. All grant funds, expended to date, have been used to enhance the rate review process, and no funds have been used to replace any current department expenditures for rate review. AID, at all times, has fully complied with federal "Maintenance of Effort" requirements.

### **Budget Narrative Exhibits**

- Exhibit 1 - Detailed grant budget 12.31.11
- Exhibit 2 – NCE 8.31.11
- Exhibit 3 – NCE 12.22.11
- Exhibit 4 - SF-425 12.31.11
- Exhibit 5 – Original grant budget (Attachment 6)

### **Final Work Plan and Timeline:**

*(See Attachment #1)*

# Health Insurance Rate Review Grant Program Cycle I Final Report Template

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## **Enclosures/Attachments:**

Attachment	1	Timeline
Attachment	2	SF-425
Attachment	3	Summary Operating Budget
Attachment	4	Detailed Operating Budget
Attachment	5	No-cost Extension (NCE)
Attachment	6	Original Grant Budget
Attachment	7	Notice of Grant Award
Attachment	8	HIOS Report
Attachment	9	AON Phase II Report
Attachment	9a	AON Rate Summary Template
Attachment	10	Plain Language Rate Summary
Attachment	11	AID Org Chart
Attachment	12	AID Required Data Fields
Attachment	13	AID Bulletin “Individual”
Attachment	14	AID Bulletin “Small Group”
Attachment	15	CCIIO “Effective Rate Review” Letter
Attachment	16	CCIIO ‘Association’ Rate Review Determination Letter
Attachment	17	Media Center IFB
Attachment	18	Website Proposal
Attachment	19	Website Screenshots
Attachment	20	Primer 101
Attachment	21	Brochure

## Health Insurance Rate Review Grant Program Cycle I Final Report Template

### **PART II: HEALTH INSURANCE RATE DATA COLLECTION**

#### **Tables A-D: Rate Volume Tables**

**Table A. Rate Review Volume**

<b>State</b>	<b>Quarter 1</b>	<b>Quarter 2</b>	<b>Quarter 3</b>	<b>Quarter 4</b>	<b>Annual Total</b>
Number of submitted rate filings	2	2	3	4	11
Number of policy rate filings requesting increase in premiums	2	2	2	4	10
Number of filings reviewed for approval/denial, etc.	2	2	3	4	11
Number of filings approved	1	1	1	1	4
Number of filings denied	0	1	1	3	5
Number of filings deferred *	1	0	1	0	2

**\*Approved rate lower than requested.**

**Table B. Number and Percentage of Rate Filings Reviewed – Individual Group**

<b>State</b>	<b>Quarter 1</b>	<b>Quarter 2</b>	<b>Quarter 3</b>	<b>Quarter 4</b>	<b>Annual Total</b>
Product Type (PPO, HMO, etc.)	<b>HMO-0 PPO-1 Other-1</b>	<b>HMO-1 PPO-0 Other-1</b>	<b>HMO-0 PPO-1 Other-1</b>	<b>HMO-0 PPO-2 Other-2</b>	<b>HMO-1 PPO-4 Other-5</b>
Number of Policy Holders	<b>37,802</b>	<b>2242</b>	<b>12</b>	<b>1399</b>	<b>41455</b>
Number of covered lives affected	<b>66,153</b>	<b>3691</b>	<b>15</b>	<b>2279</b>	<b>72138</b>

## Health Insurance Rate Review Grant Program Cycle I Final Report Template

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**Table C. Number and Percentage of Rate Filings Reviewed – Small Group**

<b>State</b>	<b>Quarter 1</b>	<b>Quarter 2</b>	<b>Quarter 3</b>	<b>Quarter 4</b>	<b>Annual Total</b>
Product Type (PPO, HMO, etc.)	NA	NA	HMO-1	NA	1
Number of Policy Holders			67		67
Number of covered lives affected			1113		1113

**Table D. Number and Percentage of Rate Filings Reviewed – Large Group**

<b>State</b>	<b>Quarter 1</b>	<b>Quarter 2</b>	<b>Quarter 3</b>	<b>Quarter 4</b>	<b>Annual Total</b>
Product Type (PPO, HMO, etc.)					NA
Number of Policy Holders					NA
Number of covered lives affected					NA

**Table E. (SERFF Users): Number and Percentage of Rate Filings Reviewed –Combined**

<b>State</b>	<b>Quarter 1</b>	<b>Quarter 2</b>	<b>Quarter 3</b>	<b>Quarter 4</b>	<b>Annual Total</b>
Product Type (PPO, HMO, etc.)	HMO-0 PPO-1 Other-1	HMO-1 PPO-0 Other-1	HMO-1 PPO-1 Other-1	HMO-0 PPO-2 Other-2	HMO-2 PPO-4 Other-5
Number of Policy Holders					41,522
Number of covered lives affected					73, 251

# Attachment 1

## AID RR Timeline

December 16, 2011	ACL approved Cycle II Grant
November 10, 2011	Initial RR 'Media Center' Videoconference (AON)
November 1-5, 2011	National Fall NAIC Meeting
November 7, 2011	ACHI 'All Payer Claims Database' (APCD) workshop
October 17, 2011	PIO attended Digital Government Summit
October 14, 2011	'Search Engine Optimization' final recommendations determined
October 12, 2011	RR website marketing strategy meeting
October 7, 2011	CMS launched new rate review page, AID posted on Arkansas RR page.
October 4, 2011	Media Center training by Stanley & Associates
October 3, 2011	Renovated Phase I RR web site goes "live"
September 28, 2011	Aristotle Search Engine Optimization conference call
September 20, 2011	HHS Official Notice of \$3,874,098 Cycle II Grant Award to AID
September 19, 2011	Media Center became fully operational
September 12, 2011	Aristotle web meeting, contract signed
September 8, 2011	SERFF training & overview
September 7, 2011	Invitation for Bid (IFB) RR web site awarded
September 1, 2011	Invitation for Bid (IFB) issued for RR web site development
September 1, 2011	PIO attended social media seminar hosted by Ark. Dept. of Health
August 22, 2011	RR Website development meeting
August 9, 2011	Launch of AID Facebook page and Twitter feed

July 22, 2011 The AID Rate Review Division submitted a formal application for the Rate Review Cycle II Phase I grant in the amount of \$3,874,098 for years 2011-2014.

July 8, 2011 AON Hewitt issued its final report to AID with the Phase II Rate Review Recommendations.

July 7, 2011 AID Bulletins 6-2011 and 7-2011 adopted effective 9-1-11

July 6, 2011 Scheduled In-Person presentation of AON Final Phase *II* report

July 5, 2011 The Media Center bid was awarded to Jay Stanley & Associates

July 1, 2011 Steve Larsen, CCIIO Director, officially notified Commissioner Jay Bradford that the Arkansas Department of Insurance had met the applicable criteria and had been designated an 'Effective Rate Review Program' in all markets

July 1, 2011 AON Phase 2 Report transmitted to AID RR

July 1, 2011 Voluntary Letter of Intent to apply for CFDA: 93.511 Cycle II Grant

June 30, 2011 Interim Drafts of Bulletins 6-2011 & 7-2011 sent to Commissioner

June 30, 2011 Additional discussions with AON on Phase II Report

June 27, 2011 Response from AID on Revised Phase II Report

June 22, 2011 Revised Phase II report submitted for review

June 21, 2011 Media Center IFB bid opening date

June 20, 2011 AON develops training materials

June 17, 2011 Response from AID on Phase II Report

June 15, 2011 Draft Phase II Report to AID

June 14, 2011 The AID Rate Review Division hosted a high level data development task force meeting attended by the state healthcare leaders which resulted in the implementation of an All Payer Claims Database (APCD). This development

is expected to be critical in the ability of AID Rate Review to fulfill future data needs.

June 10, 2011	AID released its proposed Bulletins 6-2011 and 7-2011 for comment which were later adopted with effective dates of September 1, 2011.
June 10, 2011	Develop tools and processes to implement enhancements
June 8, 2011	AON to meet with AID to discuss possible tools, processes, and training materials to implement enhancements.
June 2, 2011	On-site presentation of Final Phase I report
May 31, 2011	Anticipated date for posting of remaining two staff positions
May 27, 2011	Final Phase I Report to AID
May 26, 2011	Anticipated launch of Facebook and Twitter
May 26, 2011	On-site visit for Media Center
May 18, 2011	First meeting with newly developed Consumer Advisory Group
May 18, 2011	AON Phase I Draft Report & conference call
May 17, 2011	Department wide social media outreach kick-off meeting
May 17, 2011	Rate Review Primer disseminated at SHIIP outreach event
May 16, 2011	Follow-up conference call with AON on RR communication strategy with AON supplementary suggestions and ideas on enhancements to implementation of outreach plan.
May 13, 2011	Phase I Draft Report from AON
May 12, 2011	Media Center IFB issued
May 11, 2011	Conference call with AON on RR communication strategy
May 9, 2011	Remainder of supplies and additional office furniture ordered
May 9, 2011	Temp position filled

May 3, 2011	Additional computer equipment ordered to facilitate outreach plan
May 3, 2011	Additional staff positions posted.
May 2, 2011	Social media outreach meeting with Chief Deputy Commissioner and Director of Information Technology
April 20, 2011	First post contract call with AON to discuss work plan and timeline
April 15, 2011	AON contract approved and finalized
April 5, 2011	Second stakeholder meeting to update group on progress and seek feedback
March 21, 2011	Rate Review web site created, went live
March 15, 2011	Engaged in face to face outreach with consumers; handed out print materials and answered questions regarding rate review
March 15, 2011	Anticipated date for issuance of Media Center RFP
March 9, 2011	Primer "101" created
February 24, 2011	First onsite organization meeting with AON RFP team.
February 21, 2011	Move-in date for new offices
February 21, 2011	Anticipated date for hard-line phone installation
February 14, 2011	RFP final award given to AON Hewitt
February 3, 2011	Stakeholder meeting to receive ideas and input regarding premium rate review outreach campaign.
February 3, 2011	Hired Rate Review Attorney, Bob Alexander
January 31, 2011	RFP anticipated award granted to AON Hewitt, posted on web
January 21, 2011	RFP proposal submission deadline. Eight vendors submitted proposals, one disqualified.
January 20, 2011	Office supplies acquired
January 11, 2011	Hired Public Information Officer, Sandra McGrew

January 11, 2011	Office furniture and equipment acquired
December 21, 2010	Answers to vendor's questions posted online
December 14, 2010	Vendor questions for clarification deadline
December 4, 2010	Office space acquired, 2 <sup>nd</sup> floor of AID
December 3, 2010	Professional Services RFP Number: ID-11-1001 issued for Premium Rate Review Grant Professional Services.
October 15, 2010	Hired Rate Review Manager, Dr. Lowell Nicholas
August 9, 2010	HHS grant funding awarded
June 7, 2010	Submission of grant application to HHS

12/16/2011

# Attachment 2

## FEDERAL FINANCIAL REPORT

(Follow form instructions)

1. Federal Agency and Organizational Element to Which Report is Submitted DHHS-CC110	2. Federal Grant or Other Identifying Number Assigned by Federal Agency (To report multiple grants, use FFR Attachment) 1IPRPR100015-01-00	Page 1	of pages
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3. Recipient Organization (Name and complete address including Zip code)  
 ARKANSAS INSURANCE DEPARTMENT  
 1200 WEST THIRD STREET, LITTLE ROCK, AR 72201

4a. DUNS Number 810501558	4b. EIN 71-0847443	5. Recipient Account Number or Identifying Number (To report multiple grants, use FFR Attachment)	6. Report Type <input checked="" type="radio"/> Quarterly <input type="radio"/> Semi-Annual <input type="radio"/> Annual <input type="radio"/> Final	7. Basis of Accounting <input checked="" type="checkbox"/> Cash <input type="checkbox"/> Accrual
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8. Project/Grant Period From: (Month, Day, Year) 08/09/2010	To: (Month, Day, Year) 12/31/2011	9. Reporting Period End Date (Month, Day, Year) 09/30/2011
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10. Transactions Cumulative

*(Use lines a-c for single or multiple grant reporting)*

<b>Federal Cash (To report multiple grants, also use FFR Attachment):</b>	
a. Cash Receipts	582,572.00
b. Cash Disbursements	544,509.00
c. Cash on Hand (line a minus b)	38,063.00

*(Use lines d-o for single grant reporting)*

<b>Federal Expenditures and Unobligated Balance:</b>	
d. Total Federal funds authorized	1,000,000.00
e. Federal share of expenditures	544,509.00
f. Federal share of unliquidated obligations	189,664.00
g. Total Federal share (sum of lines e and f)	734,173.00
h. Unobligated balance of Federal funds (line d minus g)	265,827.00

<b>Recipient Share:</b>	
i. Total recipient share required	
j. Recipient share of expenditures	
k. Remaining recipient share to be provided (line i minus j)	

<b>Program Income:</b>	
l. Total Federal program income earned	
m. Program income expended in accordance with the deduction alternative	
n. Program income expended in accordance with the addition alternative	
o. Unexpended program income (line l minus line m or line n)	

	a. Type	b. Rate	c. Period From	Period To	d. Base	e. Amount Charged	f. Federal Share
11. Indirect Expense							
g. Totals:							

12. Remarks: Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation:

13. Certification: By signing this report, I certify that it is true, complete, and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent information may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)

a. Typed or Printed Name and Title of Authorized Certifying Official  <p style="text-align: center;"><b>Jay Bradford, State Insurance Commissioner</b></p>	c. Telephone (Area code, number and extension) 501-683-3638  d. Email address jay.bradford@arkansas.gov
b. Signature of Authorized Certifying Official  	e. Date Report Submitted (Month, Day, Year) 10/26/2011

Standard Form 425  
 OMB Approval Number: 0348-0061  
 Expiration Date: 10/31/2011

**Paperwork Burden Statement**  
 According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is 0348-0061. Public reporting burden for this collection of information is estimated to average 1.5 hours per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0060), Washington, DC 20503.

**RATE REVIEW GRANT**  
**Ten Months Actual (December thru September) Plus Encumbered Expenses**

Attachment 3

Category	Spent/Projected	Budgeted	Variance
Salary	161,909	329,650	167,741
Fringe Benefits	52,806	88,624	35,818
Travel	1,077	14,135	13,058
Other	10,168	13,168	3,000
Rental	49,771	58,717	8,946
Professional Services/Contracts	313,768	276,808	(36,960)
Supplies and Other Office Expenses	29,904	97,778	67,874
Capital	79,335	121,120	41,785
Total	698,740	1,000,000	301,261

	ACTUAL										Encumbered	Dec 2010 to Sept 2011	Budgeted Amount	Remaining Balance
	December-10	January-11	February-11	March-11	April-11	May-11	June-11	July-11	August-11	September-11	Encumbered			
Monthly Totals	18,937	6,070	44,466	44,210	34,154	31,056	32,718	143,550	33,902	169,131	140,546	698,740	1,000,000	301,261
Regular Salary	8,184	8,990	14,133	16,151	16,151	16,151	18,388	24,397	16,264	16,864	6,237	161,909	329,650	167,741
Total Fringe Benefits	3,596	3,768	4,812	5,198	5,229	5,198	5,648	7,143	5,385	5,512	1,317	52,806	88,624	35,818
Total Professional/Contract Services	7,138	(7,138)	18,808	7,434	209	2,115	5,961	101,318	5,764	60,714	111,445	313,768	276,808	(14,425)
Total Office Supplies and Other	20	210	1,766	10,479	7,617	2,645	2,461	649	1,168	1,683	1,205	29,904	97,778	65,803
Total Travel	-	240	-	-	-	-	260	-	299	-	278	1,077	14,135	13,058
Total Rental	-	-	4,948	4,948	4,948	4,948	-	10,043	5,022	5,022	9,895	49,771	58,717	8,946
Capital									-	79,335	-	79,335	121,120	41,785
Total Other											10,168	10,168	13,168	3,000

**RATE REVIEW GRANT**  
**Ten Months Actual (December through September) Plus Encumbered Expenses**

Attachment 4

Category	Spent/Projected	Budgeted	Variance
Salary	161,909	329,650	167,741
Fringe Benefits	52,806	88,624	35,818
Travel	1,077	14,135	13,058
Other	10,168	13,168	3,000
Rental	49,771	58,717	8,946
Professional Services/Contracts	313,768	276,808	(36,960)
Supplies and Other Office Expenses	29,904	97,778	67,874
Capital	79,335	121,120	41,785
<b>Total</b>	<b>698,740</b>	<b>1,000,000</b>	<b>301,261</b>

	ACTUAL										Encumbered	Dec 2010 to Sept 2011	Budgeted Amount	Remaining Balance
	December-10	January-11	February-11	March-11	April-11	May-11	June-11	July-11	August-11	September-11	Encumbered			
<b>Monthly Totals</b>	18,937	6,070	44,466	44,210	34,154	31,056	32,718	143,550	33,902	169,131	140,546	698,740	1,000,000	301,261
Regular Salary	8,184	8,990	14,133	16,151	16,151	16,151	18,388	24,397	16,264	16,864	6,237	161,909	329,650	167,741
FICA & Medicare	598	660	1,049	1,193	1,193	1,193	1,364	1,824	1,201	1,247	462	11,983	44,508	32,525
Agency Cost of ARCAP	28	28	40	43	43	43	43	43	43	43	15	411	400	(11)
Employee Retirement	1,020	1,120	1,773	2,012	2,012	2,012	2,291	3,286	2,191	2,272	840	20,830	23,400	2,570
Health Insurance	1,950	1,950	1,950	1,950	1,950	1,950	1,950	1,950	1,950	1,950	-	19,500	19,500	-
Unemployment Comp	-	7	-	-	31	-	-	41	-	-	-	79	484	405
Workers Comp	-	4	-	-	-	-	-	-	-	-	-	4	332	328
<b>Total Fringe Benefits</b>	<b>3,596</b>	<b>3,768</b>	<b>4,812</b>	<b>5,198</b>	<b>5,229</b>	<b>5,198</b>	<b>5,648</b>	<b>7,143</b>	<b>5,385</b>	<b>5,512</b>	<b>1,317</b>	<b>52,806</b>	<b>88,624</b>	<b>35,818</b>
Actuarial Consultants	7,138	(7,138)	-	-	-	-	-	99,800	-	-	99,800	199,600	205,000	5,400
SERFF	-	-	18,808	-	-	-	-	-	-	-	-	18,808	18,808	-
Web Design	-	-	-	-	-	-	-	-	-	8,630	10,895	19,525	-	(19,525)
Other Consultants	-	-	-	-	-	-	-	-	2,261	-	750	3,011	-	(3,011)
Data Center	-	-	-	7,434	209	1,603	2,991	-	2,249	50,632	-	65,119	50,000	(15,119)
Temporary Staffing	-	-	-	-	-	512	2,970	1,518	1,254	1,452	-	7,706	3,000	(4,706)
<b>Total Professional/Contract Services</b>	<b>7,138</b>	<b>(7,138)</b>	<b>18,808</b>	<b>7,434</b>	<b>209</b>	<b>2,115</b>	<b>5,961</b>	<b>101,318</b>	<b>5,764</b>	<b>60,714</b>	<b>111,445</b>	<b>313,768</b>	<b>276,808</b>	<b>(36,960)</b>

**RATE REVIEW GRANT**  
**Ten Months Actual (December through September) Plus Encumbered Expenses**

Category	Spent/Projected	Budgeted	Variance
Salary	161,909	329,650	167,741
Fringe Benefits	52,806	88,624	35,818
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<b>Total</b>	<b>698,740</b>	<b>1,000,000</b>	<b>301,261</b>

	ACTUAL										Encumbered	Dec 2010 to Sept 2011	Budgeted Amount	Remaining Balance
	December-10	January-11	February-11	March-11	April-11	May-11	June-11	July-11	August-11	September-11	Encumbered			
<b>Monthly Totals</b>	18,937	6,070	44,466	44,210	34,154	31,056	32,718	143,550	33,902	169,131	140,546	698,740	1,000,000	301,261
Binding Copying & Collating	-	-	-	29	-	-	-	-	-	-	-	29	2,200	2,171
Printing	-	-	-	-	-	-	68	-	-	-	-	68	15,000	14,932
Postage	20	-	-	-	-	50	-	-	-	-	-	70	150	80
Telecom Wired (Landline)	-	210	294	178	116	113	-	38	82	85	246	1,362	1,500	138
Network Services (Cellular)	-	-	707	434	313	419	378	378	378	378	378	3,765	4,500	735
Freight	-	-	-	32	5	13	-	-	-	7	6	63	250	187
Office Supplies	-	-	659	1,137	3,239	(232)	785	222	697	530	502	7,539	4,910	(2,629)
Low Value Assets	-	-	-	8,523	2,676	1,991	821	-	-	-	-	14,011	64,172	50,161
Software Licenses	-	-	-	-	1,002	246	-	-	-	-	-	1,248	930	(318)
Subscriptions, Publications & Dues	-	-	-	-	145	-	355	-	-	264	-	764	1,000	236
Shred - It	-	-	-	18	53	35	18	-	-	-	58	181	200	20
Water & Sewage (spring water)	-	-	-	-	34	11	16	10	10	15	14	110	200	90
Miscellaneous	-	-	106	128	35	-	21	-	-	404	-	695	2,766	-
<b>Total Office Supplies and Other</b>	<b>20</b>	<b>210</b>	<b>1,766</b>	<b>10,479</b>	<b>7,617</b>	<b>2,645</b>	<b>2,461</b>	<b>649</b>	<b>1,168</b>	<b>1,683</b>	<b>1,205</b>	<b>29,904</b>	<b>97,778</b>	<b>65,803</b>

**RATE REVIEW GRANT**  
**Ten Months Actual (December through September) Plus Encumbered Expenses**

Category	Spent/Projected	Budgeted	Variance
Salary	161,909	329,650	167,741
Fringe Benefits	52,806	88,624	35,818
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Supplies and Other Office Expenses	29,904	97,778	67,874
Capital	79,335	121,120	41,785
<b>Total</b>	<b>698,740</b>	<b>1,000,000</b>	<b>301,261</b>

	ACTUAL										Encumbered	Dec 2010 to Sept 2011	Budgeted Amount	Remaining Balance
	December-10	January-11	February-11	March-11	April-11	May-11	June-11	July-11	August-11	September-11	Encumbered			
<b>Monthly Totals</b>	18,937	6,070	44,466	44,210	34,154	31,056	32,718	143,550	33,902	169,131	140,546	698,740	1,000,000	301,261
<b>Travel</b>														
Mileage												-	6,695	6,695
Meals & Lodging												-	3,840	3,840
Common Carrier												-		-
Ground Transportation												-		-
Parking Fees												-		-
National Meetings												-	2,400	2,400
Registration Fees	-	240	-	-	-	-	260	-	299	-	278	1,077	1,200	123
<b>Total</b>	-	240	-	-	-	-	260	-	299	-	278	1,077	14,135	13,058
<b>Rent of Office Equip</b>														-
Arkansas Copier Lease														-
Overage Charges														-
Maintenance (keys, move copier, copier plug move)														-
<b>Rental of Office Space</b>	-	-	4,948	4,948	4,948	4,948	-	10,043	5,022	5,022	9,895	49,771	58,717	8,946
<b>Total Rental</b>	-	-	4,948	4,948	4,948	4,948	-	10,043	5,022	5,022	9,895	49,771	58,717	8,946
<b>Capital</b>										-	79,335		121,120	41,785
<b>Advertising</b>											10,168	10,168	10,168	-
<b>Special Needs</b>													2,000	2,000
<b>Copier</b>													1,000	1,000
<b>Total Other</b>											10,168	10,168	13,168	3,000

# Attachment 5

**Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
Office of Consumer Information and Insurance Oversight**

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

**NOTICE OF GRANT AWARD  
AUTHORIZATION (Legislation/Regulations)  
Section 2794 of the Public Health Service Act (Section 1003 of the  
Affordable Care Act)**

<b>1. DATE ISSUED</b> (Mo./Day/Yr.) 09/28/2011	<b>2. CFDA NO.</b> 93.511
<b>3. SUPERCEDES AWARD NOTICE</b> dated 08/03/2010 except that any additions or restrictions previously imposed remain in effect unless specifically rescinded	
<b>4. GRANT NO.</b> 4 IPRPR100015-01-01 Formerly:	<b>5. ADMINISTRATIVE CODES</b> IPR
<b>6. PROJECT PERIOD</b> Mo./Day/Yr. From 08/09/2010	Through 12/31/2011
<b>7. BUDGET PERIOD</b> Mo./Day/Yr. From 08/09/2010	Through 12/31/2011

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

**9. GRANTEE NAME AND ADDRESS**

a. Arkansas Insurance Department  
b. 1200 W 3rd St  
c.  
d. Little Rock e. AR f. 72201-1904

**10. DIRECTOR OF PROJECT** (PROGRAM DIRECTOR/PRINCIPLE INVESTIGATOR)  
(LAST NAME FIRST AND ADDRESS)  
Jay Bradford  
1200 W 3rd St  
Little Rock, AR 72201  
Phone: 501-371-2621

<b>11. APPROVED BUDGET</b> (Excludes HHS Direct Assistance)	
I HHS Grant Funds Only	
II Total project costs including grant funds and all other financial participation (Select one and place NUMERAL in box) <span style="float: right; border: 1px solid black; padding: 2px;">II</span>	
a. Salaries and Wages .....	329,650
b. Fringe Benefits .....	90,455
c. Total Personnel Costs .....	420,105
d. Consultants Costs .....	
e. Equipment .....	79,355
f. Supplies .....	4,910
g. Travel .....	14,135
h. Patient Care – Inpatient .....	
i. Patient Care – Outpatient .....	
j. Alterations and Renovations .....	
k. Other .....	204,687
l. Consortium/Contractual Costs .....	276,808
m. Trainee Related Expenses .....	
n. Trainee Stipends .....	
o. Trainee Tuition and Fees .....	
p. Trainee Travel .....	
q. TOTAL DIRECT COSTS	1,000,000
r. INDIRECT COSTS (rate of )	0
s. TOTAL APPROVED BUDGET	\$ 1,000,000
t. SBIR Fee	0
u. Federal Share	\$ 1,000,000
v. Non-Federal Share	\$ 0

<b>12. AWARD COMPUTATION FOR GRANT</b>	
a. Amount of HHS Financial Assistance (from item 11.u)	1,000,000
b. Less Unobligated Balance From Prior Budget Periods	0
c. Less Cumulative Prior Award(s) This Budget Period	1,000,000
d. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	0

<b>13. RECOMMENDED FUTURE SUPPORT</b> (Subject to the availability of funds and satisfactory progress of the project):			
YEAR	TOTAL DIRECT COSTS	YEAR	TOTAL DIRECT COSTS
a. 2		d. 5	
b. 3		e. 6	
c. 4		f. 7	

<b>14. APPROVED DIRECT ASSISTANCE BUDGET</b> (IN LIEU OF CASH):	
a. AMOUNT OF HHS Direct Assistance	0
b. Less Unobligated Balance From Prior Budget Periods	
c. Less Cumulative Prior Award(s) This Budget Period	
d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION	0

**15. PROGRAM INCOME SUBJECT TO 45 CFR PART 74, SUBPART F, OR 45 CFR 92.25, SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:**  
(Select one and place LETTER in box.)

a. DEDUCTION  
 b. ADDITIONAL COSTS  
 c. MATCHING  
 d. OTHER RESEARCH (Add / Deduct Option)  
 e. OTHER (See REMARKS)

**16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, HHS ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:**

a. The grant program legislation cited above  
b. The grant program regulation cited above.  
c. This award notice including terms and conditions, if any, noted below under REMARKS.  
d. HHS Grants Policy Statement including addenda in effect as of the beginning date of the budget period.  
e. 45 CFR Part 74 or 45 CFR Part 92 as applicable

In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system

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

This Notice of Award approves the 3 month No Cost Extension as per the grantee's request dated August 31, 2011.

GRANTS MANAGEMENT OFFICER:  (Signature) (Name - Typed/Print) Ms. Feagins, Michelle (Title) Senior Grants Management Specialist

<b>17. OBJ CLASS</b> 4121	<b>18. CRS - EIN</b> 1710847443A9	<b>19. LIST NO.</b>	<b>CONG. DIST.:</b> 02
<b>FY-CAN</b> 0-199RE19	<b>DOCUMENT NO.</b> b. IPRPRO015A	<b>AMT ACTION FIN ASST</b> c. IPR	<b>AMT ACTION DR ASST</b> d. 0 e. 0
<b>20. a.</b>	<b>b.</b>	<b>c.</b>	<b>d.</b>
<b>21. a.</b>	<b>b.</b>	<b>c.</b>	<b>d.</b>
<b>22. a.</b>	<b>b.</b>	<b>c.</b>	<b>d.</b>

## Attachment 6

PERSONNEL					
Position	Annual Salary	FFY'10 Request	FFY'11 Request	Total Grant Request	Comments
Deputy Commissioner Rate Review Manager	85,536	7,128	85,536	92,664	TBH - 9/2010 - Doctoral Degree with high level management, health care industry, and government experience. Will direct day-to-day operations/reporting.
Rate Review Compliance Attorney	73,116	0	73,116	73,116	TBH - 10/2010 - Attorney with pertinent experience will lead and monitor legal and legislative health insurance rate review issues.
Rate Review Compliance Officer	73,116	0	73,116	73,116	TBH - 10/2010 - Experience with health insurance rate reviews and working with actuaries. Will perform technical rate reviews and provide process consultation.
Rate Review Public Information/Outreach Mgr	45,377	0	45,377	45,377	TBH - 10/2010 - Expert communications and systems knowledge and skills, with health industry, education, and consumer advocacy experience.
Rate Review System Analyst	45,377	0	45,377	45,377	TBH - 10/2010 - Experience with health care information technology and supports within complex systems; ability to communicate with non-IT experts.
<b>Salary Subtotal</b>		<b>7,128</b>	<b>322,522</b>	<b>329,650</b>	
<b>FRINGE Subtotal</b>		<b>1,831</b>	<b>88,624</b>	<b>90,455</b>	20.223% + \$4,680/position for insurance
<b>PROFESSIONAL SERVICES (Sub-award) COSTS</b>					
Actuarial/IT Consultant		25,000		25,000	Phase I - to assess AID skills and processes and make recommendations for rate review improvements
Actuarial/Rate Review/IT Consultant(s)			140,000	140,000	Phase II - Design and assist with implementation of rate review technical and expertise process improvements. May be separate or consolidated contract
Actuary-Rate Filing Review			40,000	40,000	\$10,000 per month, June - September 2011 ( <b>See Attachment for more detail</b> )
SERFF IT Enhancement		18,808		18,808	Data base/reporting enhancements as proposed by NAIC ( <b>see attachment</b> )
Data Center			50,000	50,000	Analyses and reporting needs TBD
UAMS Partners for Inclusive Communities			3,000	3,000	Consumer focus groups for disability/LTC populations; materials review for readability - will include travel across Arkansas.
<b>Contractual Subtotal</b>		<b>43,808</b>	<b>233,000</b>	<b>276,808</b>	
<b>EQUIPMENT</b>					
Rate Review Training Center Capital Equipment*		79,355		79,355	Computer/Video Projector (\$9,556); AV Control System (\$11,757); Presentation Lectern (\$6,248); Audio System Video Conf/Teleconference (\$8,147); Video Conference CODEC; HD (\$29, 890); Camera System (\$8221); Tax \$5,536
<b>Equipment Subtotal</b>		<b>79,355</b>		<b>79,355</b>	<b>*See Attachment X</b>
<b>SUPPLIES</b>					
Office Supplies		1,200	2,990	4,190	Paper, postage, pens, cartridges, etc. No indirect costs charged.
Lunches for Adv. Council			720	720	estimated 15 people X \$12 X 4 meetings/year
<b>Supplies Subtotal</b>		<b>1,200</b>	<b>3,710</b>	<b>4,910</b>	<b>* No Indirect Costs Charged</b>
<b>TRAVEL</b>					
Registration Fees			1,200	1,200	Arkansas Meeting Exhibits
Intrastate Mileage			6,695	6,695	1328 mi/month X 0.42/mile
Intrastate Per Diem			3,840	3,840	\$160 X 24 trips(1 overnight; 2 days' meals)
National Meetings			2,400	2,400	\$200 reg. + \$400 airfare + \$385 hotel (2 nghts) + \$165 meals (3 days) + \$50 ground transportation.
<b>Travel Subtotal</b>			<b>14,135</b>	<b>14,135</b>	
<b>OTHER</b>					
Rent		1,517	57,200	58,717	1400 sf @ \$13/sf X 1 mo. for Rate Review Center (RRC) in year 1; 4400 sf @ \$13/sf (3000 sf office/mtg space; 1400 sf RRC) -Yr 2; no indirect costs charged.

New Staff Position Office Furnishings		4,597	18,442	23,039	Dell Laptop (\$1588); LaserJet Printer (\$388); ATT Speakerphone (\$249), 4 Dr. File Cabinet (\$198); Bookcase (\$121); High Back Desk Chair (\$320); Desk (\$609); Connector (\$358), 48"return (\$256); 2 Side Chairs @ \$96 ea (\$192); tax (\$1644) - X 5 employees
SQL Server DBMS		15,050		15,050	For Rate Review Data base; Includes licenses
Alpha Five Application Server Licenses		930		930	To support IT expansion
Rate Review Training Center Furniture*		19,922		19,922	Conf. Table (\$2850); 8 Conf. Chairs @ \$300 each (\$2,400); 80 Stacking Chairs @ \$60 each (\$4,800); 30 Folding Tables @ \$187 ea. (\$5610); Refreshment Center (Refrig. @\$886; Microwavie @ \$144; 2 Coffee makers @ \$188; Cook top @ \$149; Sink, faucet, and cabinets @ \$889; garbage disposal @ \$198; and installation @ \$518); tax (\$1,290)
Rate Review Training Center Non-Capital Equipment*		19,211		19,211	Electric Projection Screen (\$2,763); Wireless Lavalier Microphone System (\$1,242); Lectern Microphone (\$373); DVD/VCR Combo Player (\$611); Video Projector Switcher/Scaler (\$2,200); Rack Mounting and Power Distribution (\$2479); Document Camera (\$3,844); System Connection Plate (\$920); LCD Monitors/Mount (\$3,439); tax (\$1340)
Implementation Technical Plan/Training*		4,935		4,935	Rate Review Training and Outreach Center
System Installation*		26,715		26,715	Rate Review Training & Outreach Center equipment installation, AC power and conduit pathways, installation and wiring of projection screen, LAN circuits, proper lighting (incl. design assist.)
Traveling Exhibit Board			2,000	2,000	For information dissemination at meetings/conferences, etc.
Printing			15,000	15,000	Brochures, manuals, informational pieces
Telecommunications			6,000	6,000	Telephone expenses (desk, cells, blackberries)
Copier Expenses			1,000	1,000	Pro-rated for 5 positions
Special Needs.			2,000	2,000	Translators, special equipment, etc.for hearings, educational sessions
Advertisements			10,168	10,168	For hearings, community meetings, AID web, etc
<b>Other Subtotal</b>		<b>92,877</b>	<b>111,810</b>	<b>204,687</b>	
<b>GRAND TOTAL</b>		<b>226,199</b>	<b>773,801</b>	<b>1,000,000</b>	
* See Attachment Rate Review Center Equipment detail in XYZ					
AID Agrees to Maintain Current Rate Review MOE @ \$14,500 annually.					

# Attachment 7

**Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
Office of Acquisitions and Grants Management**

7500 Security Boulevard  
Baltimore, MD 21244-1850

**NOTICE OF GRANT AWARD**  
AUTHORIZATION (Legislation/Regulations)  
Section 2794 of the Public Health Service Act (Section 1003 of the  
Affordable Care Act)

<b>1. DATE ISSUED</b> (Mo./Day/Yr.) 10/05/2011	<b>2. CFDA NO.</b> 93.511
<b>3. SUPERCEDES AWARD NOTICE</b> dated 09/20/2011 except that any additions or restrictions previously imposed remain in effect unless specifically rescinded	
<b>4. GRANT NO.</b> 6 PRPPR120006-01-01 <i>Formerly:</i>	<b>5. ADMINISTRATIVE CODES</b> IPR
<b>6. PROJECT PERIOD</b> Mo./Day/Yr. From 10/01/2011	Mo./Day/Yr. Through 09/30/2014
<b>7. BUDGET PERIOD</b> Mo./Day/Yr. From 10/01/2011	Mo./Day/Yr. Through 09/30/2014

**8. TITLE OF PROJECT (OR PROGRAM)** (Limit to 56 spaces)  
Grants to Support States in Health Insurance Rate Review Grant Cycle II

**9. GRANTEE NAME AND ADDRESS**

a. Arkansas Insurance Department  
b. 1200 W 3rd St  
c. Administration  
  
d. Little Rock e. AR f. 72201-1904

**10. DIRECTOR OF PROJECT** (PROGRAM DIRECTOR/PRINCIPLE INVESTIGATOR)  
(LAST NAME FIRST AND ADDRESS)  
Lowell Nicholas  
Administration  
1200 West 3rd Street  
Little Rock, AR 72201  
  
Phone: 5016833683

**11. APPROVED BUDGET** (Excludes HHS Direct Assistance)

I HHS Grant Funds Only

II Total project costs including grant funds and all other financial participation II  
(Select one and place NUMERAL in box)

a. Salaries and Wages	1,178,607
b. Fringe Benefits	294,651
c. Total Personnel Costs	1,473,258
d. Consultants Costs	
e. Equipment	121,784
f. Supplies	136,551
g. Travel	148,079
h. Patient Care – Inpatient	
i. Patient Care – Outpatient	
j. Alterations and Renovations	
k. Other	458,675
l. Consortium/Contractual Costs	1,535,751
m. Trainee Related Expenses	
n. Trainee Stipends	
o. Trainee Tuition and Fees	
p. Trainee Travel	
q. TOTAL DIRECT COSTS	3,874,098
r. INDIRECT COSTS (rate of )	0
s. TOTAL APPROVED BUDGET	\$ 3,874,098
t. SBIR Fee	0
u. Federal Share	\$ 3,874,098
v. Non-Federal Share	\$ 0

**12. AWARD COMPUTATION FOR GRANT**

a. Amount of HHS Financial Assistance (from item 11.u)	3,874,098
b. Less Unobligated Balance From Prior Budget Periods	0
c. Less Cumulative Prior Award(s) This Budget Period	3,874,098
d. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	0

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

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

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

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

**15. PROGRAM INCOME SUBJECT TO 45 CFR PART 74, SUBPART F, OR 45 CFR 92.25, SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:**  
(Select one and place LETTER in box.)

a. DEDUCTION	
b. ADDITIONAL COSTS	
c. MATCHING	
d. OTHER RESEARCH (Add / Deduct Option)	
e. OTHER (See REMARKS)	

**16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, HHS ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:**

a. The grant program legislation cited above.  
b. The grant program regulation cited above.  
c. This award notice including terms and conditions, if any, noted below under REMARKS.  
d. HHS Grants Policy Statement including addenda in effect as of the beginning date of the budget period 45 CFR Part 74 or 45 CFR Part 92 as applicable.  
e. In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

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

This Notice of Award approves the revised budget of the original award dated September 20, 2011. The Terms and Conditions have been updated to reflect the three year period of performance and budget cycle.

GRANTS MANAGEMENT OFFICER: 	(Signature)	(Name – Typed/Print) <b>Ms. Feagins, Michelle</b>	(Title) Senior Grants Management Specialist
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<b>17. OBJ CLASS</b> 4115	<b>18. CRS - EIN</b> 1710847443A9	<b>19. LIST NO.</b>	<b>CONG. DIST.:</b> 02
<b>FY-CAN</b>	<b>DOCUMENT NO.</b>	<b>ADMINISTRATIVE CODE</b>	<b>AMT ACTION FIN ASST</b>
20. a. 1-5992933	b. PRPPR0006A	c. IPR	d. 0 e. 0
21. a.	b.	c.	d. e.
22. a.	b.	c.	d. e.

# AWARD ATTACHMENTS

Arkansas Insurance Department

6 PRPPR120006-01-01

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1. Terms and Conditions

**The Health Insurance Rate Review Grant Program  
Grants to Support States in Health Insurance Rate Review – Cycle II**

**Standard Terms & Conditions  
Attachment A**

- 1. The CMS/Center for Consumer Information and Insurance Oversight (CCIIO) Project Officer.** The Project Officer assigned with responsibility for technical and programmatic questions from the grantee is Jacqueline Roche (email is [Jacqueline.Roche1@cms.hhs.gov](mailto:Jacqueline.Roche1@cms.hhs.gov) and telephone is 301-492-4122).
- 2. The CMS Grants Management Specialist.** The Grants Management Specialist assigned with the responsibility for the financial and administrative aspects (non-programmatic areas) of grants administration questions from the grantee is Iris Grady in the Division of Grants Management (email is [Iris.Grady@cms.hhs.gov](mailto:Iris.Grady@cms.hhs.gov) and telephone is 301-492-4321).
- 3. The HHS Grants Policy Statement (HHS GPS).** This Grant Agreement is subject to the requirements of the HHS GPS that are applicable to the Grantee based on your recipient type and the purpose of this award. This includes any requirements in Part I and II (available at <http://www.hhs.gov/grantsnet/adminis/gpd/index.htm>) of the HHS GPS that apply to an award.

Although consistent with the HHS GPS, any applicable statutory or regulatory requirements, including 45 CFR 92, directly applies to this award apart from any coverage in the HHS GPS.

- 4. Cost Principles for State, Local and Indian Tribal Governments (OMB Circular A-87).** This grant is subject to the requirements as set forth in Title 2 Part 225, State, Local, and Indian Tribal Governments (previously A-87).
- 5. Subaward Reporting and Executive Compensation.** This grant is subject to the reporting requirements of the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109-282), as amended by section 6202 of Public Law 110-252 and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier subaward of \$25,000 or more in Federal funds and executive total compensation for the recipient's and subrecipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170. Information about the Federal Funding and Transparency Act Subaward Reporting System (FSRS) is available at [www.fsrs.gov](http://www.fsrs.gov). For additional assistance, please contact Iris Grady, the Grants Management Specialist assigned to monitor the subaward reports and executive compensation at [divisionofgrantsmanagement@hhs.gov](mailto:divisionofgrantsmanagement@hhs.gov).
- 6. Funding for Grants to Support States in Health Insurance Rate Review – Cycle II.** All funds provided under this grant will be used by the Grantee exclusively for the Grants to States for Health Insurance Rate Review as defined in Section 1003 of the Affordable Care

The Health Insurance Rate Review Grant Program  
Grants to Support States in Health Insurance Rate Review – Cycle II  
Standard and Special Terms and Conditions

Act and as described in the grant funding opportunity announcement. If the Grantee uses these funds for any purpose other than those awarded through the Grants to Support States in Health Insurance Rate Review – Cycle II (or those modifications that have the prior written approval of the CCIIO Project Officer), then all funds provided under this grant may be required to be returned to the United States Treasury.

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

**Special Terms & Conditions**  
**Attachment B**

1. **Acceptance Letter and Assurance.** The grant award is subject to the recipient providing CCIIO a letter as acknowledgement of the award and the acceptance of all Standard and Special Terms and Conditions (STCs) within 30 days of the date of issuance of the award package. With the acceptance of this grant award, the Grantee agrees to ensure that the project is administered in accordance with the grant requirements as indicated in these STCs and that the Grantee is in compliance with the requirements of the grant funding opportunity announcement (FOA).
2. **Award period.** The project period and budget period for the Rate Review Grant Program Cycle II is three years, beginning October 1, 2011 and ending September 30, 2014.
3. **Revised Budget.** When the Notice of Grant Award requires the Grantee to submit a revised budget (e.g., a revised timeline, budget narrative and SF-424A section b only), these documents must be submitted within 60 days of the start of the project period or 60 days after the request.
4. **Personnel Changes.** The Grantee is required to notify the CCIIO Project Officer and the HHS Grants Management Specialist within thirty (30) days of any personnel changes affecting the grant's Project Director, Assistant Project Director, or the Financial Officer as well as any named Key Contractor staff.
5. **Collaborative Responsibilities.** At the request of CCIIO, Grantees may be required to participate in scheduled activities and communications to identify and share "best practices" for health insurance premium review, including discussion of state proposals and sharing of information via public websites. CCIIO will post general summaries of the state proposals on the CCIIO website. Quarterly and Final reports may also be posted on the CCIIO website. The Grantee is required to participate in all required communications (e.g., monitoring calls, guidance calls) as requested by CCIIO.

The Health Insurance Rate Review Grant Program  
Grants to Support States in Health Insurance Rate Review – Cycle II  
Standard and Special Terms and Conditions

**6. Required Grant Reporting.**

**A. Requirement to Report Data to the Secretary.** For Cycle II, (like Cycle I) each grant awardee is required to provide certain rate filing data to the Secretary of Health and Human Services. Included as an attachment is the template for providing the required rate filing data to the CCIIO Rate Review Grant Program. As stated in the FOA, States are permitted to use grant funds to enhance their authority and capacity to collect and report the required rate filing data. The Rate Review Grant Program will continue to provide technical assistance to all state awardees and continue to work with the National Association of Insurance Commissioners (NAIC) System for Electronic Rate And Form Filing (SERFF) over the course of the grant period to fulfill the data reporting requirements. All rate filing data is required to be submitted through the Health Insurance Oversight System (HIOS), Rate Review Grant Reporting System.

**B. Quarterly, Annual and Final (Progress) Reports**

1. The Grantee is required to submit Quarterly Progress Reports, an Annual Report and one Final Report via email to the CCIIO Project Officer and the CMS Grants Management Specialist. Quarterly Progress Reports and Annual Progress Reports are due within 30 days after the end of the quarter or budget period (in the case of the annual report). These reports must comply with the format provided in the attachments to the Notice of Grant Award and these STCs: the *Health Insurance Rate Review Grant Program Cycle II Quarterly Report Template* and the *Health Insurance Rate Review Grant Program Cycle II Annual Report Template*.
  2. The Grantee is required to submit a Final Report to the CCIIO Grant Project Officer and the CMS Grants Management Specialist within 90 days after the project period ending date. This report must comply with the format provided in the attachments to the Notice of Grant Award and these STCs: the *Health Insurance Rate Review Grant Program Cycle II, Final Report Template*.
  3. In each progress report (quarterly, annual and final), the Grantee must describe the progress, and provide data on, the Grantee's impact on enhancing the rate review process for health insurance premiums in the state and provide context on the data on health insurance premiums provided to the Rate Review Grant Program. The Grantee will describe each activity performed in the quarter/year and how that activity was linked to enhanced rate review practices.
  4. All quarterly, annual and final (progress) reports must be submitted electronically via the HIOS system.
- 7. Required Financial Reports.** The Federal Financial Report (FFR or Standard Form 425) has replaced the SF-269, SF-269A, SF-272, and SF-272A financial reporting forms. All

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grantees must utilize the FFR to report cash transaction data, expenditures, and any program income generated.

Grantees must report, on a quarterly basis, cash transaction data via the Payment Management System (PMS) using the FFR in lieu of completing a SF-272/SF272A. The FFR, containing cash transaction data, is due within 30 days after the end of each quarter. The quarterly reporting due dates are as follows: 1/30, 4/30, 7/30, 10/30. A Quick Reference Guide for completing the FFR in PMS is at:

[www.dpm.psc.gov/grant\\_recipient/guides\\_forms/ffr\\_quick\\_reference.aspx](http://www.dpm.psc.gov/grant_recipient/guides_forms/ffr_quick_reference.aspx).

In addition to submitting the quarterly FFR to PMS, Grantees must also provide, on an annual basis, a hard copy FFR to CMS which includes their expenditures and any program income generated in lieu of completing a Financial Status Report (FSR) (SF269/269A). Expenditures and any program income generated should only be included on the annually submitted FFR, as well as the final FFR.

Each hard-copy FFR should contain cash transaction data, expenditures, and any program income generated. Annual hard-copy FFRs should be mailed and received within 30 calendar days of the applicable budget period end date. The final FFR should be mailed and received within 90 calendar days of the project period end date (September 30, 2014). Grantees should access the following link in order to electronically complete and print the FFR: [http://www.whitehouse.gov/omb/grants\\_forms/](http://www.whitehouse.gov/omb/grants_forms/). See the charts below for more information on reporting due dates for hard-copy FFRs.

See below for due dates for the annual hard-copy FFR:

<b>Budget Period</b>	<b>Reporting Period Due Date</b>
October 1, 2011 to September 30, 2012	October 30, 2012
October 1, 2012 to September 30, 2013	October 30, 2013

See below for the due date for the **final** hard-copy FFR:

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<i>Project Period</i>	<i>Reporting Period Due Date</i>
October 1, 2011 to September 30, 2014	Final report – 3 year reporting period October 1, 2011 to September 30, 2014 Due: December 30, 2014

The hard-copy FFRs should be mailed to the attention of Grants Management Specialist, Iris Grady, at the following address:

Centers for Medicare and Medicaid Services (CMS)  
 Center for Consumer Information and Insurance Oversight (CCIIO)  
 200 Independence Ave., S.W.  
 Room 733H-02  
 Washington, DC 20201

**Grantees shall liquidate all obligations incurred under the award not later than 90 days after the end of the project period and before the final FFR submission. It is the Grantee’s responsibility to reconcile reports submitted to PMS and to CMS. Failure to reconcile final reports in a timely manner may result in canceled funds.**

For additional guidance, please contact your Grants Management Specialist, Iris Grady.

**8. Data Center Requirements.** As outlined in the Cycle II FOA, up to \$500,000 in grant funds are permitted to be used to establish an optional data center as described in Section 2794 of the Public Health Service Act. All states choosing to use grants funds to support a data center must provide the following information either in the Cycle II application or in a subsequent submission to the Rate Review Grants Program.

- a. Name, location, and governance of Data Center. Please make certain that the data center meets the requirements as outlined in the Affordable Care Act.
- b. Full description of Data Center’s current mission;
- c. Described function and scope of work for data center;
- d. Describe how proposed research will add to existing body of available fee schedule data;
- e. Plans for public disclosure of data; and
- f. Full and/or modified budget for the data center with a line-item breakout.

Note all proposals for a data center must be free from conflict of interests as outlined in section 2794(d)(2). Once reviewed, the State will receive a letter from the Rate Review Grant Program indicating approval or denial of the proposed data center. Please note the letter of approval or denial may come after the Cycle II Notice of Grant Award; however, a State cannot begin

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implementation of the proposed data center until an official letter of approval is provided to the State from the Rate Review Grant Program.

- 9. Acceptance of Application and Terms of Agreement.** Initial expenditure of funds by the grantee constitutes acceptance of this award.

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**ATTACHMENT A:**

**Grants to States for Health Insurance Rate Review – Cycle II, Phase I**

**TIMELINE**

**October 1, 2011– September 30, 2014**

<b><u>ACTIVITY</u></b>	<b><u>TIMELINE</u></b>
Notice of Grant Award (NGA)	September 20, 2011
Project period begins	October 1, 2011
Due Date to Accept Award Package	October 20, 2011
Notify CCIIO of Fiscal Agent/Officer Responsible for completing the Financial Forms	October 30, 2011
Revised Budget and SF-424A (only when applicable)	Due within 60 days of October 1, 2011 (by November 30, 2011)

**Programmatic Reports:**

Quarterly Progress Reports	Due 30 days after the end of each Federal Fiscal Quarter
Annual Report	Due 30 days after the end of the Budget Period
Final Programmatic Report	Due 90 days after the conclusion of the Project Period

**Please note the Health Insurance Rate Review Grant Program will schedule technical assistance calls both before and after report due dates as necessary and upon request**

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Awardees must respond to requests necessary for the evaluation of the Health Insurance Rate Review Grants

Ongoing and as requested by CCIIO

**Federal Financial Reports:**

Federal Financial Report (FFR SF 425)

Quarterly FFR including cash transactions data due within 30 days after the end of each Federal quarter.

Annual hard-copy FFR including cash transactions and expenditures data due annually within 30 days after the budget period end date.

Final hard-copy FFR including cash transactions and expenditures data due within 90 days of the project period end date.

Liquidation of all Obligations

Due 90 days after the project period end date and prior to filing of the final Federal Financial Report (SF-425).

No Cost Extension Request

Should the State need a no cost extension, a written request to the Project Officer and Grants Management Specialist must be received no later than 30 days prior to the project period end date of September 30, 2014 (*recommend submission of request no later than 90 days prior to the project period end date*).





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.

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<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**

<b>Individual Rate Filings</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	
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**

<b><u>Trend</u></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							
	<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).

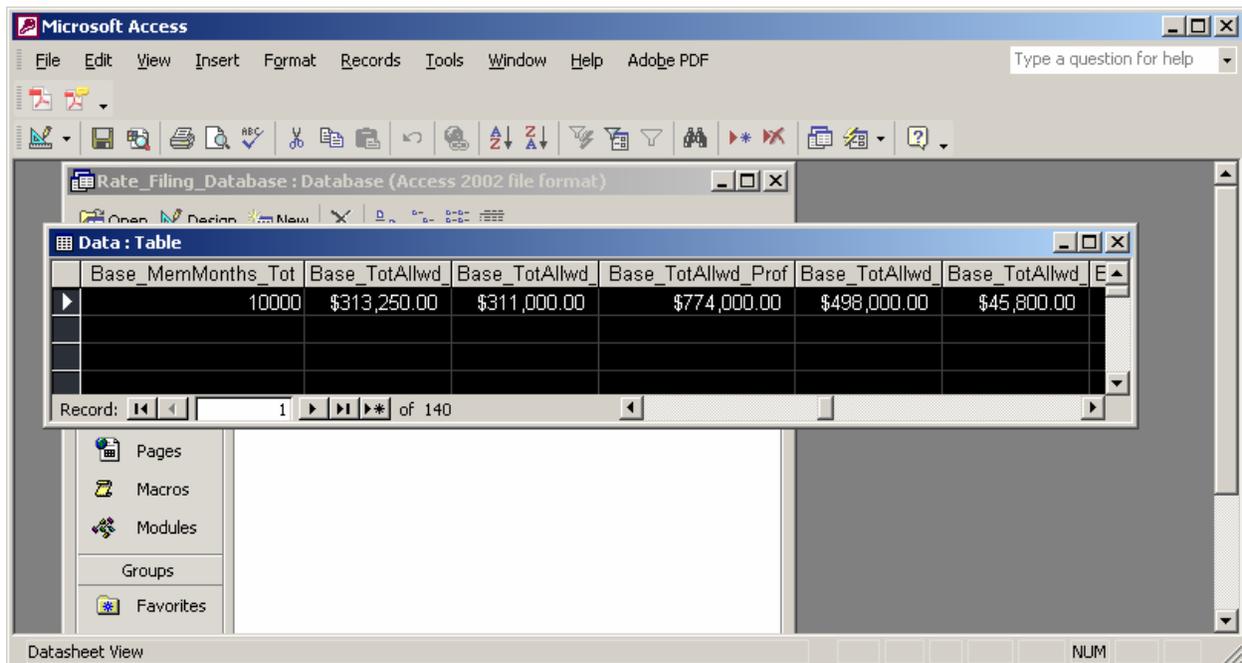
## Information Technology

### 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).

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Internal Training Analysis

For the Arkansas Insurance Department Premium Rate Review  
Process

## Contents

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## 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>
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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. 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)
Oregon	1	5	5	-5	<b>8</b>
Colorado	-3	-4	-4	-8	<b>-10</b>
S. Carolina	-1	4	4	-11	<b>-12</b>
Arkansas	-4	-8	0	-6	<b>-18</b>
California	-8	-5	0	-8	<b>-21</b>
Indiana	-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.

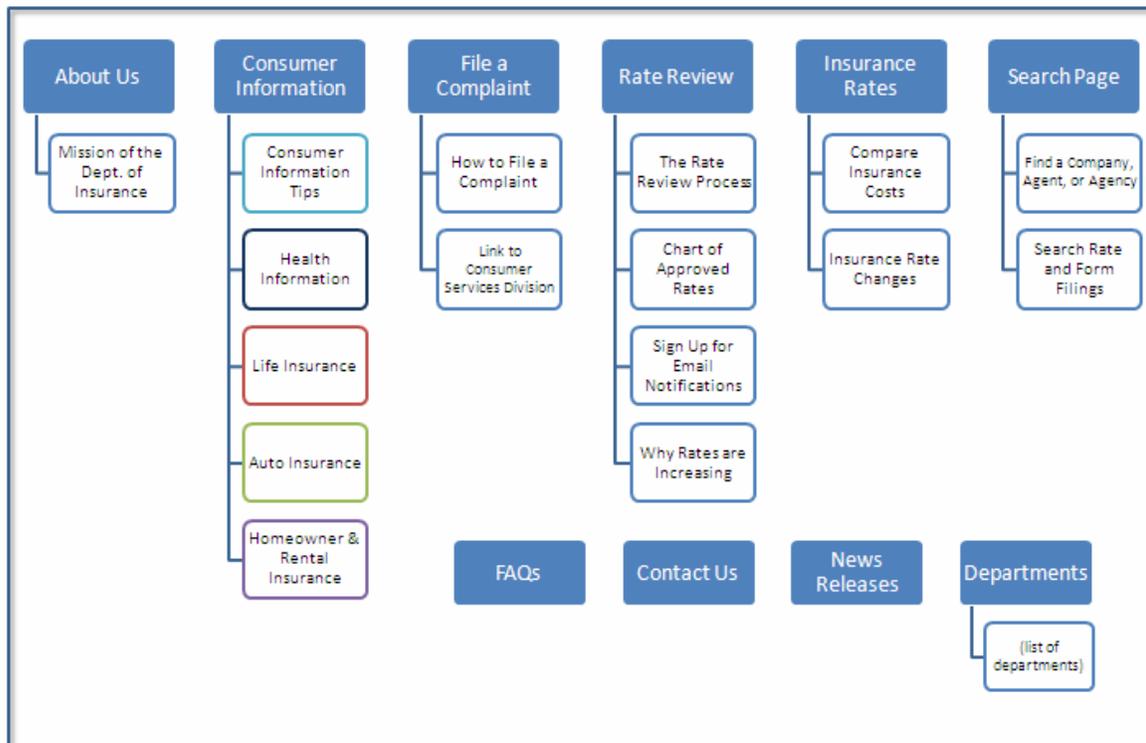
Following are our recommendations to assist the Department in redesigning the website.

### Site Map

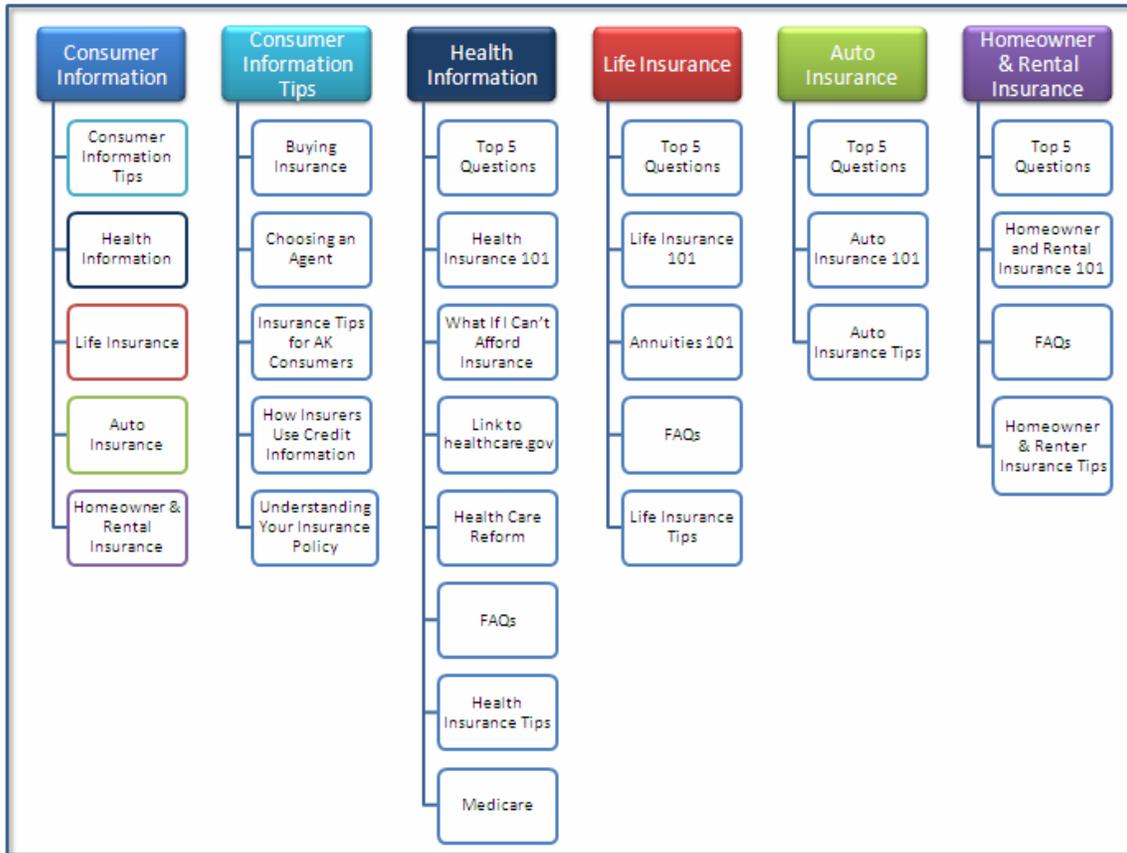
The first step to organizing the Department’s website is to identify the main sections of the site and group related information together. Inside each main section, the content can be broken into sub-categories to help the user find the exact information she is looking for.

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> <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> </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 2005	February 2005	February 2005	March 2005	March 2005	April 2005	April/May 2005 (April 16 - May 15)	May/June 2005	July 2005	July 1, 2005
Rollout Program Design	Rollout Communication Strategy	Pre-announcement	Training	Announcement	Announcement	REA Rollout	Health Management Education	Reinforcement and Measurement	Effective Date
PEBTF Board	PEBTF/Aon planning team	To eight Districts To all employees	To all key communicators	To all employees	All employees	To all employees	To all employees	To all employees	All employees
 Board Approval (12*)	 Written Communication Strategy (2/16)   Create an Identity   Other Union Briefing (2/24)	 Union District Briefing (start 2/24)   HR Regional/Agency Briefing   Employee Advisory Group	 Train the trainer   Questions and Answers   Announcement (3/16)   Press Release   Post on EOC Intranet site (comparable union sites??)	 Newsletter   e-mail and Pop-up Reminders about health/supersobesity management   Posters/Table Tents (Health/Incentives/Pharmacy)	 Newsletter   e-mail and Pop-up Reminders about health/supersobesity management   Posters/Table Tents (Company Management)   Employee and Spouse Meeting Invitation	 Posters/Table Tents (Health/Incentives/Pharmacy)   Employee and Spouse Meeting Invitation   Health Risk Assessment   Promotional Item	 Health Management Education   Feedback Questionnaire   Benefit Service Reps   Pedometer to encourage walking   e-mail and Pop-up Reminders	 Contribution waiver/voicemail Letter   Questions and Answers   e-mail and Pop-up Reminders   Benefit Service Reps   Employee Self-service   e-mail and Pop-up Reminders	 Contributions   Waivers Expanded Disease Management Obesity Management DBE Online/Prado Centers of Excellence   Local Newsletters   Posters/Table Tents (Health/Incentives/Pharmacy)

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.

Per the Instructions, health insurance issuers proposing rate increases above the threshold fill in only those cells that are highlighted in GREY. The other cells are auto-populated.

**A. Base Period Data**

Start Period: [ ] End Period: [ ]

Service Categories	Member Months	Total Allowed	Net Claims	Cost Sharing	Cost Sharing PMPM	Net PMPM	Allowed PMPM
Inpatient				\$ 0.00	#DIV/0!	#DIV/0!	#DIV/0!
Outpatient				\$ 0.00	#DIV/0!	#DIV/0!	#DIV/0!
Professional				\$ 0.00	#DIV/0!	#DIV/0!	#DIV/0!
Prescription Drugs				\$ 0.00	#DIV/0!	#DIV/0!	#DIV/0!
Other				\$ 0.00	#DIV/0!	#DIV/0!	#DIV/0!
Capitation				\$ 0.00	#DIV/0!	#DIV/0!	#DIV/0!
<b>Total</b>		\$ 0.00	\$ 0.00	\$ 0.00	#DIV/0!	#DIV/0!	#DIV/0!

**B. Claim Projections**

**B1. Adjustment to the Current Rate**

Start Period: [ ] End Period: [ ]

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Cost Sharing
Inpatient		#DIV/0!	#DIV/0!	
Outpatient		#DIV/0!	#DIV/0!	
Professional		#DIV/0!	#DIV/0!	
Prescription Drugs		#DIV/0!	#DIV/0!	
Other		#DIV/0!	#DIV/0!	
Capitation		#DIV/0!	#DIV/0!	
<b>Total</b>		#DIV/0!	#DIV/0!	#DIV/0!

**B2. Claims Projection for Future Rate**

Start Period: [ ] End Period: [ ]

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Cost Sharing
Inpatient		#DIV/0!	#DIV/0!	
Outpatient		#DIV/0!	#DIV/0!	
Professional		#DIV/0!	#DIV/0!	
Prescription Drugs		#DIV/0!	#DIV/0!	
Other		#DIV/0!	#DIV/0!	
Capitation		#DIV/0!	#DIV/0!	
<b>Total</b>		#DIV/0!	#DIV/0!	#DIV/0!

**B3. Medical Trend Breakout**

Factor	Impact
Utilization	
Unit Cost	
Other Factors	

**C. Components of Current and Future Rates**

	Future Rate		Prior Estimate of Current Rate		Difference	
	PMPM	%	PMPM	%	PMPM	%
1. Projected Net Claims	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!
2. Administrative Costs		#DIV/0!		#DIV/0!	\$ 0.00	#DIV/0!
3. Underwriting Gain/Loss		#DIV/0!		#DIV/0!	\$ 0.00	#DIV/0!
4. Total Rate	#DIV/0!	#DIV/0!	\$ 0.00	#DIV/0!	#DIV/0!	#DIV/0!
5. Overall Rate Increase		#DIV/0!				

**D. Components of Rate Increase**

Claims Components	Impact on Rate	Percent
1. Inpatient	#DIV/0!	#DIV/0!
2. Outpatient	#DIV/0!	#DIV/0!
3. Professional	#DIV/0!	#DIV/0!
4. Prescription Drugs	#DIV/0!	#DIV/0!
5. Other	#DIV/0!	#DIV/0!
6. Capitation	#DIV/0!	#DIV/0!
7. Cost Share	#DIV/0!	#DIV/0!
8. Correction of Prior Net Claims Estimate	#DIV/0!	#DIV/0!
9. Total	#DIV/0!	#DIV/0!

**Claims Restatement for Current Rate Period**

8.a. Prior Net Claims Estimate for Current Rate Period	\$ 0.00
8.b. Re-Estimate of Net Claims PMPM for Current Rate Period	#DIV/0!

**E. List of Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years**

Calendar Year	New Form	Requested	Implemented

**F. Range and Scope of Proposed Increase**

Number of Covered Individuals	Threshold Rate Increase
-------------------------------	-------------------------

	Range of Rate Increase
Minimum % Increase	
Maximum % Increase	

# Attachment 10

In August 2008, \_\_\_\_\_ (“\_\_\_\_\_”) introduced its first Individual Insurance Product, \_\_\_\_\_. In the 36 months since \_\_\_\_\_ has introduced this product, it has not requested nor has it received any increase in rates. In March 2011, \_\_\_\_\_ filed a request to increase the \_\_\_\_\_ rates with the Arkansas Insurance Department. The Department has approved the requested increase. All affected \_\_\_\_\_ members will be mailed a detailed letter describing how their rates will be impacted by this increase. The new rates will apply to 1,552 members on September 1, 2011. The members still in their first twelve months of coverage will not be affected by the increase until their anniversary date.

The approved increase averages out to less than \_\_\_\_\_% a year since the product was introduced. Based upon \_\_\_\_\_ consultant actuary, this percentage of increase is actually less than the national claims trends.

The approved increase has been driven by several market factors. As shown in the chart below, the \_\_\_\_\_ Loss Ratio has been consistently increasing since the product was introduced.

Time Period	Member Months	Premiums	Medical Claims	Prescription Claims	Underwriting Claims	Loss Ratio
8/2008- 7/2009	##	##	##	##	##	##
8/2009-7/2010	##	##	##	##	##	##
8/2010- Present	##	##	##	##	##	##

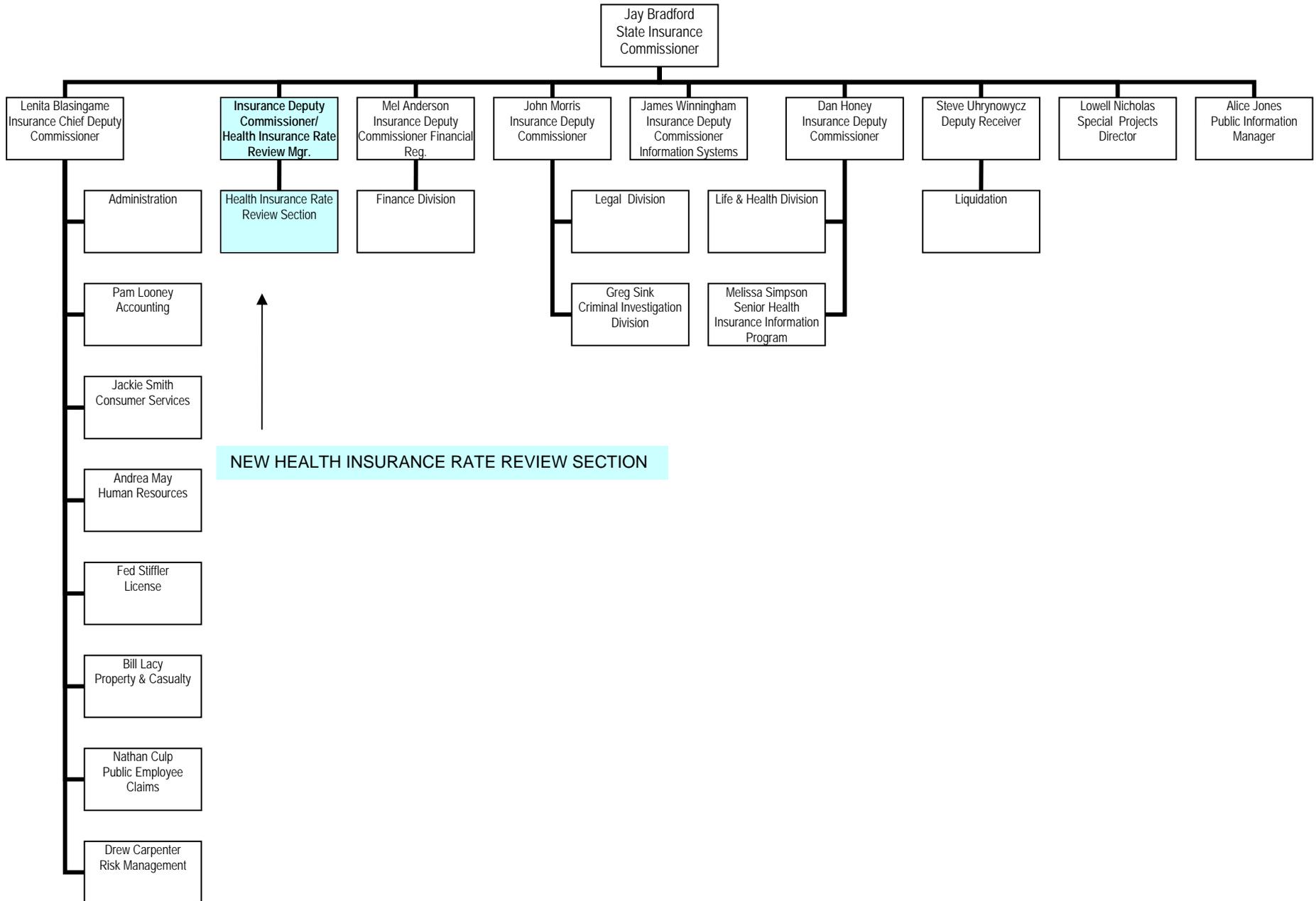
This increasing loss ratio is related to the increases in medical management. The trends showed significant increases in costs from August 2008, when the product was introduced. Prescription medications are up \_\_\_\_\_%, hospital inpatient costs are up \_\_\_\_\_%, hospital outpatient costs are up \_\_\_\_\_%, and professional costs are up \_\_\_\_\_%.

This increase also includes adjustments necessary to cover expanded benefits and consumer protections granted in the Federal Patient Protection and Affordable Care Act signed into law by President Obama in March 2010. For example, the following regulations have contributed \_\_\_\_\_% to the rate increase: 1) Coverage for dependent children up to age 26; 2) No member cost sharing on preventative services; 3) No application of pre-existing condition clauses on children under age 19; and 4) the elimination of lifetime maximums.

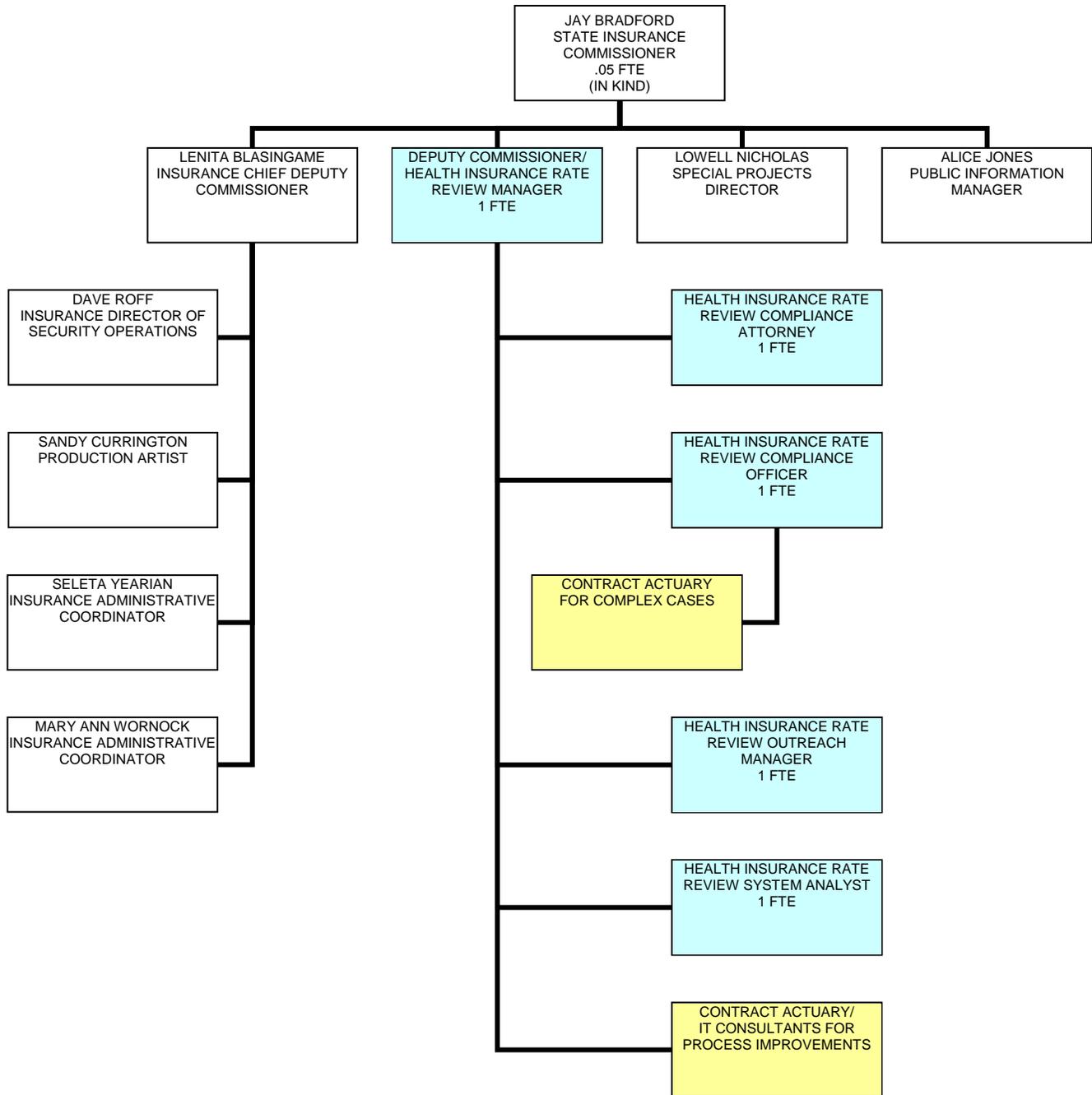
In addition to increased medical and regulatory costs, \_\_\_\_\_ has also experienced increased administrative costs. For example, due to the increasing amount of applications containing potentially inaccurate information, \_\_\_\_\_ has had to perform more thorough medical background checks.

Please note, if you have completed your first twelve months of coverage and you are enrolled in the automatic bank withdrawal, the first increased monthly premium will be withdrawn on August 24, 2011. Also be aware that if you are changing age bands or ranges during this time, your premium will increase due to your age range in addition to the approved overall rate increase.

### ARKANSAS INSURANCE DEPARTMENT PREMIUM RATE REVIEW CYCLE 1



**ARKANSAS INSURANCE DEPARTMENT  
ADMINISTRATION DIVISION  
PREMIUM RATE REVIEW CYCLE 1**



NEW HEALTH INSURANCE RATE REVIEW SECTION

CONTRACT EMPLOYEES

## Attachment 12

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

### 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
- 6) Etc.

# Arkansas Insurance Department

Mike Beebe  
Governor



Jay Bradford  
Commissioner

July 7, 2011

## BULLETIN NO. 6-2011

**TO:** ALL LICENSED INSURERS, HEALTH MAINTENANCE ORGANIZATIONS, FRATERNAL BENEFIT SOCIETIES, FARMERS' MUTUAL AID ASSOCIATIONS OR COMPANIES, HOSPITAL MEDICAL SERVICE CORPORATIONS, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, PRODUCER AND COMPANY TRADE ASSOCIATIONS, AND OTHER INTERESTED PARTIES.

**FROM:** ARKANSAS INSURANCE DEPARTMENT

**SUBJECT:** PREMIUM APPROVAL FOR INDIVIDUAL MAJOR MEDICAL POLICIES

**EFFECTIVE DATE:** SEPTEMBER 1, 2011

Pursuant to Ark Code Ann. §§23-79-109, 23-76-112 and 23-75-111, all premium rates for individual accident and health insurance policies or contracts must be approved by the Commissioner prior to those rates being implemented. Bulletin 4-79 sets forth the filing requirements for all such policies and contracts. This bulletin will supersede Bulletin 4-79 as it applies to individual major medical policies as defined in AID Rule 18, Section 7E to which 45 CFR Part 154 is applicable, and for which rate filings are made which meet or exceed the state-specific threshold or, if no state-specific has been established, the threshold established by the Secretary of HHS. Insurers, Hospital Medical Service Corporations and Health Maintenance Organizations making premium rate filings that meet or exceed the applicable threshold shall furnish the following data:

- (1) A description of the policy or contract form number affected by the rate filing.
- (2) For all rate filings that represent a rate increase, a rate summary worksheet as described in Exhibit 1, a written description justifying the rate increase as described in Exhibit 2, and all of the reporting requirements set forth in Exhibit 3.
- (3) A statement of the approximate number of persons in Arkansas affected by the rate increase.
- (4) An actuarial certification indicating that, in the belief of the actuary, the proposed rate or rate revision does not discriminate unfairly between policyholders or contract holders.
- (5) The Medical Loss Ratio as calculated under federal guidelines including the actual data elements used in the MLR calculation.

An officer of the carrier shall certify the completeness and accuracy of the data furnished in the filing.

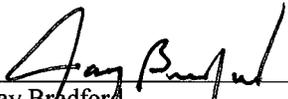
In reviewing all rate filings under this Bulletin, the Arkansas Insurance Department will review the following to the extent applicable to the filing under review:

1. The impact of medical trend changes by major service categories;
2. The impact of utilization changes by major service categories;
3. The impact of cost-sharing changes by major service categories;
4. The impact of benefit changes;
5. The impact of changes in enrollee risk profile;
6. The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase;
7. The impact of changes in reserve needs;
8. The impact of changes in administrative costs related to programs that improve health care quality;
9. The impact of changes in other administrative costs;

10. The impact of changes in applicable taxes, licensing or regulatory fees;
11. Medical Loss Ratio;
12. The carrier's capital and surplus; and
13. Consumer comments regarding the rate filing.

The information contained in Exhibits 1, 2 and 3 will be posted on the Department's website. At the Commissioner's discretion, carriers may be required to submit part or all of the data included in Exhibit 3 as part of the Department's review of any rate filing. Consumers will be encouraged to submit to the Insurance Department comments on the proposed rate filing.

Carriers shall make rate filings no more than once per 12 month period. However, the Commissioner may, at his or her sole discretion, consider interim rate filings in circumstances in which such filings are justified, to correct substantial errors in rate calculations, to correct rates found to be inadvertently excessive or inadequate, to preserve solvency or competition in the applicable market, or under other circumstances deemed sufficient by the Commissioner.

  
Jay Bradford  
Insurance Commissioner  
State of Arkansas

## EXHIBIT 1

### Instructions for Completing Rate Summary Worksheet, Part I of Preliminary Justification

#### Information

Carriers must use a standardized Excel worksheet for completing Part I of the Preliminary Justification, the Rate Summary Worksheet. A sample of a completed version of the worksheet is provided at the end of the instructions.

Sections A and B of the worksheet require issuers to provide historical and projected claims experience data (referred to on the form as the 'Base Period' data and 'Projection Period' data, respectively):

- **Base Period Data:** The base period data are the source data for the rate projections that are calculated in the Rate Summary Worksheet. The base period data may include data from other products or sources if the experience for the product is not fully credible (e.g., national level data). In general, this section should be completed using the same data that were used to develop the rate increase and/or prepare any applicable state rate filing.
- **Projection Period:** The allowed costs are projected from the base period to the projection period for the proposed rates in two steps. Section B1 projects allowed costs from the base period to the 12-month period immediately preceding the effective date of the proposed rate change based on updated pricing assumptions. Section B2 further projects allowed costs from the projection period for the current rate to the projection period representing the effective dates of the proposed rate. The projection periods are 12-month periods immediately before and after the effective date of the proposed rate increase.

The claims data entered in the base period are trended forward for each of the projection periods by an overall medical trend factor. Issuers must enter an overall medical trend factor for each of the claims service categories provided on the worksheet. The overall medical trend factor should reflect all of an issuer's cost, utilization, changes in covered benefits and other trend assumptions for the projection periods.

Carriers should use the following definitions for reporting service category data on the worksheet:

- **Inpatient:** Includes non-capitated facility charges for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other inpatient facilities.
- **Outpatient:** Includes non-capitated facility charges for surgery, emergency room, lab, radiology, observation and other outpatient facilities.
- **Professional:** Includes non-capitated primary care, specialist, therapy, the professional component of radiology, and other professional services.
- **Prescription Drugs:** Includes drugs dispensed by a pharmacy.
- **Other:** Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, and other services.
- **Capitation:** Includes capitation for laboratory, professional, mental health and other capitated services.

## B. Description of Worksheet Data Elements

### Section A: Base Period Data

- **Base Period Data - Start and End Dates:** Enter the beginning and end dates of the base period in “MM/DD/YYYY” format.
- **Member Months:** Enter the total member months for the base period data for each service category.
- **Total Allowed Cost:** Enter claims dollars for the base period by service category on an allowable basis including estimates of unpaid claims. Total allowed costs are summed automatically.
- **Member’s Cost Sharing:** Calculated automatically by service category excluding capitation from total allowed dollars and net claims (dollars).
- **Net Claims:** Enter incurred claims dollars for the base period by service category including estimates of unpaid claims and net of member cost sharing. The capitation net claims (dollars) line is populated as capitation allowed costs (dollars). Total net claims (dollars) are summed automatically.
- **Member Cost Share Per Member Per Month (PMPM):** Calculated automatically by service category and in total based on member’s cost sharing (dollars) and member months.
- **Net PMPM:** Calculated automatically by service category and in total based on net claims and member months.
- **Allowed PMPM:** Calculated automatically by service category and total based on allowed dollars and member months.

### Section B Claims Projections

#### B1 Adjustment to the Current Rate

This section projects allowed costs from the base period to the projection period for the current rate based on updated pricing assumptions.

- **Start and End Dates:** Enter the starting date of the projection period for the current rate, which is 12 months prior to the effective date of the proposed rate increase. Enter the ending date of the projection period for the current rate, which is one day prior to the effective date of the proposed rate change. Dates should be entered in “MM/DD/YYYY” format.
- **Overall Medical Trend:** Enter the overall medical trend factor for each service category in the format “.xxx”
- **Projected Allowed PMPM:** Calculated automatically by service category as the product of the base period allowed PMPM, and the overall medical claims trend in this section (projection period for current rate).
- **Member’s Cost Share:** Enter the average of all member’s cost share for the projection period for the current rate (for example, deductibles, co-pays, and coinsurance) by service category in the format “.xxx”. This factor is used to calculate net claims PMPM from projected allowed PMPM. The total member cost share factor is calculated automatically as 1 minus the ratio of net claims PMPM to total projected allowed PMPM.

- **Net Claims PMPM:** Calculated automatically by service category based on projected allowed PMPM and member's cost sharing PMPM. Total net claims PMPM is summed automatically.

### **B2 Claims Projection for the Future Rate**

This section projects the claims experience from the midpoint of the projection period for the current rate to the midpoint of projection period for the future rate.

- **Projection Period for Future Rate - Start and End Date:** Enter the effective date of the proposed rates, for example, 01/01/2012. The end date should be exactly one year after the start date.
- **Overall Medical Trend:** Enter the overall medical trend factor for each service category in the format "1.xxx".
- **Projected Allowed PMPM:** Calculated automatically by service category as the product of the current rate allowed PMPM, and the overall medical claims trend in this section (projection period for the future rate).
- **Member's Cost Share:** Enter the average of all member's cost share for the projection period for the future rate (for example, deductibles, copays, and coinsurance) by service category in the format ".xxx". This factor is used to calculate net claims PMPM from projected allowed PMPM. The total member's cost share factor is calculated automatically as 1 minus the ratio of total net claims PMPM to total projected allowed PMPM.
- **Net Claims PMPM:** Calculated automatically by service category based on projected allowed PMPM and member's cost sharing PMPM. Total net claims PMPM is summed automatically.

### **Section C: Components of Current and Future Rates**

This section collects information on the net claims, administrative, and underwriting gain/loss components of the current and future rates. The administrative and underwriting gain/loss components should be reported consistent with how these terms are determined for state rate filings and financial reporting and should adhere to Generally Accepted Accounting Principles (GAAP).

#### **Future Rate**

- **Line 1 – Projected Net Claims:** Populated based on net claims amount in Section B2.
- **Lines 2 – Administrative Costs:** Enter estimated administrative costs for the future rate.
- **Line 3 – Underwriting Gain/Loss:** Enter the gain loss estimate for the future rate.
- **Line 4 – Total Rate:** Calculated automatically as the sum of lines 1 through 3.
- **Line 5 – Overall Rate Increase:** Calculated automatically.
- **Percentage of Rate (Lines 1-4):** Calculated automatically.

#### **Prior Estimate of Current Rate**

Complete these fields with the net claims PMPM and projected non-claim expenses PMPM based on the pricing assumptions in an earlier rate filing for the current rate.

- **Line 1 – Projected Net Claims:** Enter prior estimate of net claims from prior rate filing.

- **Line 2 – Administrative Costs:** Enter prior estimate of estimated administrative costs for the current rate from the prior rate filing.
- **Line 3 – Underwriting Gain/Loss:** Enter prior estimate of the underwriting gain/loss for the current rate period.
- **Line 4 – Total Rate:** Calculated automatically as the sum of lines 1 through 3.
- **Percentage of Rate (Lines 1-4):** Calculated automatically.

#### **Difference**

These fields are calculated automatically.

#### **Section D: Components of Medical Claims Changes**

This section displays the difference in medical claims between the projected rate and the current rate.

- **Line 1 – Inpatient:** Calculated automatically as the product of the overall trend for inpatient entered in B2 (the projection period for future rate) minus 1 and the inpatient net claims amount in B1 (the projection period for the current rate).
- **Line 2 – Outpatient:** Calculated automatically as the product of the overall trend for outpatient entered in B2 (the projection period for future rate) minus 1 and the outpatient net claims amount in B1 (the projection period for the current rate).
- **Line 3 – Professional:** Calculated automatically as the product of the overall trend for professional entered in B2 (the projection period for future rate) minus 1 and the professional net claims amount in B1 (the projection period for the current rate).
- **Line 4 – Prescription Drugs:** Calculated automatically as the product of the overall trend for prescription drugs entered in B2 (the projection period for future rate) minus 1 and the prescription drugs net claims amount in B1 (the projection period for the current rate).
- **Line 5 – Other:** Calculated automatically as the product of the overall trend for other entered in B2 (the projection period for future rate) minus 1 and the other net claims amount in B1 (the projection period for the current rate).
- **Line 6 – Capitation:** Calculated automatically as the product of the overall trend for other entered in B2 (the projection period for future rate) minus 1 and the other net claims amount in B1 (the projection period for the current rate).
- **Line 7 – Cost Share Change:** Calculated automatically by summing the products of:
  - the difference in cost sharing amounts entered in B2 and B1 (the projection periods for the future and current rate) for each service category, and
  - the net claims amount in B2 for each service category.

- **Line 8 – Correction of Prior Net Claims Estimate:** Calculated automatically based on the difference between 8b and 8a.
  - **Line 8a – Prior Net Claims Estimate for Current Rate Period:** Populated as the projected net claims for the current rate prior estimate in Section C, line 1.
  - **Line 8b – Re-Estimate of Net Claims PMPM for Current Rate Period:** Populated as the total net claims PMPM for the projection period for the current rates in Section B1.
- **Line 9 – Total:** Calculated automatically as the sum of lines 1-8.

#### **Section D: Components of the Rate Increase**

This section displays the difference in the medical and non-medical claims between the projected rate and the current rate for the claims and non-claims components.

#### **Section E: List of the Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years**

- For the past three calendar years enter:
  - The average rate increase that was requested for this product(s). A zero value should be entered for any year where there was no rate increase.
    - The average rate increase that was implemented for this product. A zero value should be entered for any year where there was no rate increase.

#### **Section F: Range and Scope of Premium Changes Due to Rate Increase**

- **Number of Covered Individuals:** Enter the estimated number of covered individuals as of the effective date of the increase.
- **Number of Covered Policyholders:** Enter the estimated number of covered policyholders as of the effective date of the increase.
- **Minimum Current Premium:** Enter the minimum current PMPM *premium* amount for an individual.
- **Minimum Proposed Premium:** Enter the minimum proposed PMPM *premium* for an individual.
- **Maximum Current Premium:** Enter the maximum current PMPM *premium* for an individual.
- **Maximum Proposed Premium:** Enter the maximum proposed PMPM *premium* for an individual.
- **Percent Change:** Calculated automatically.

## Exhibit 2

### **III: Instructions for Completing Exhibit 2 of the Preliminary Justification**

Provide a brief, non-technical description of why the issuer is requesting this rate increase. This explanation should help consumers interpret the rate summary data provided in Exhibit 1 of the Preliminary Justification. Accordingly, it should identify and explain the key drivers of the rate increase in Exhibit 1 of the Preliminary Justification. For example, if inpatient costs are reported as the main factor of the rate increase, the written explanation should describe why inpatient costs are increasing.

The explanation should include information on the following components related to the rate increase:

- Scope and range of the rate increase: Provide the number of individuals impacted by the rate increase. Explain any variation in the increase among affected individuals (e.g., describe how any changes to the rating structure impact premium).
- Financial experience of the product: describe the overall financial experience of the product, including historical summary-level information on historical premium revenue, claims expenses and profit. Discuss how the rate increase will affect the projected financial experience of the product.
- Changes in Medical Service Costs: Describe how changes in medical service costs are contributing to the overall rate increase. Discuss cost and utilization changes as well as any other relevant trend factors that are impacting overall service costs. Changes in benefits: Describe any changes in benefits and explain how benefit changes affect the rate increase. Issuers should explain whether the applicable benefit changes are required by law.
- Administrative costs and anticipated profits: Identify the main drivers of changes in administrative costs. Discuss how changes in anticipated administrative costs and profit are impacting the rate increase.

There is no standardized reporting form for Exhibit 2 of the Preliminary Justification, but carriers are expected to cover items listed above in their submissions. The written statement must be submitted as a *Word* file.

## Exhibit 3

### **Instructions for Completing Exhibit 3 of the Preliminary Justification**

Health Insurance carriers are required to complete Exhibit 3 of the Preliminary Justification for any rate approval.

Issuers must provide information on all of the reporting elements listed below and must clearly identify and explain any reporting element that is not relevant to the development of the rate increase. Health insurance carriers have the discretion to select the format in which they present the required Part III reporting elements. As a general rule, Exhibit 3 submissions must contain sufficient detail to allow the Department to conduct a thorough actuarial review of the rate increase. Exhibit 3 submissions must clearly describe the rate making methodology, underlying data, and assumptions that were used to develop the rate increase.

Carriers may submit one or more files using PDF, Microsoft Excel, or Microsoft Word format.

#### **List of Exhibit 3 Reporting Requirements:**

- 1. Description of the type of policy, benefits, renewability, general marketing method and issue age limits.**
  - a. Insurance Company Name
  - b. NAIC Company Code
  - c. Contact Person and Title
  - d. Contact Telephone Number and Email
  - e. Date of Submission
  - f. Proposed Effective Date
  - g. Insurance Company's Filing Number
  - h. Form Number
  - i. Product Number
  - j. Market Type (Individual/Small group)
  - k. Status: Open/Closed Block)
  - l. Brief Description:
    - i. Type of Policy
    - ii. Benefits
    - iii. Renewability
    - iv. General Marketing Method
    - v. Underwriting Method
    - vi. Premium Classifications
    - vii. Age Basis and Issue Age
- 2. Scope and reason for the rate increases.**
- 3. Average annual premium per policy, before and after the rate increase.**
  - a. Outline of Past Rate Increases
  - b. Description of Proposed Increase in Dollar Amount

**4. Past experience, and any other alternative or additional data used.**

- a. Number of Policyholders
- b. Number of Covered Lives
- c. Total Written Premium
- d. Evaluation Period, Experience Period, Projection Period
- e. Past Experience, including:
  - i. Cumulative Loss Ratio (Historical/Past)
  - ii. Any Alternative Experience Data Used
- f. Credibility Analysis
- g. Incurred But Not Reported (IBNR) Claims
- h. Contract Reserves

**5. A description of how the rate increase was determined, including the general description and source of each assumption used.**

- a. Expenses
  - i. Profit and Contingency
  - ii. Commissions and Brokers Fees
  - iii. Taxes, License and Fees
  - iv. General Expenses
  - v. Other Administrative Costs
  - vi. Reinsurance
- b. Impact of Statutory Changes, including Mandates
- c. Overall Premium Impact of Proposed Increase:
  - i. Average Annual Premium Per Policy
  - ii. Before and After Rate Increase
- d. Descriptive Relationship of Proposed Rate Scale to Current Rate Scale
- e. Premium Basis
  - i. Brief Description of How Revised Rates were Determined, including:
    - 1. General Description
    - 2. Source of Each Assumption Used
  - ii. For expenses, including:
    - 1. Percent of Premium
    - 2. Dollars Per Policy or Dollars Per Unit of Benefit or All
  - iii. Trend Assumptions
  - iv. Interest Rate Assumptions
  - v. Other Assumptions, including Morbidity, Mortality and Persistency
- f. Company Financial Condition
  - i. Risk Based Capital
  - ii. Company Surplus

**6. The cumulative loss ratio and a description of how it was calculated.**

- a. Loss Ratio Exhibit

- 7. The projected future loss ratio and a description of how it was calculated.**
  - a. Loss Ratio Exhibit: Anticipated lifetime loss ratio that combines cumulative and future experience, and description of how it was calculated
  
- 8. The projected lifetime loss ratio that combines cumulative and future experience, and a description of how it was calculated.**
  - a. Loss Ratio Exhibit
  
- 9. The Federal medical loss ratio (MLR) standard in the applicable market to which the rate increase applies, accounting for any adjustments allowable under Federal law.**
  - a. Loss Ratio Exhibit:
    - i. Anticipated loss ratio presumed reasonable according to the guidelines including adjustment for credibility if applicable
    - ii. Quality Improvement Costs
  
- 10. If the result under (7.) is less than the standard under (9.), a justification for this outcome is required.**

AN INSURER MAY REQUEST THAT ITEMS BE TREATED AS CONFIDENTIAL AND THE COMMISSIONER SHALL DETERMINE IF THE ITEMS SHOULD BE CONSIDERED AS CONFIDENTIAL PURSUANT TO ARK. CODE ANN. § 23-61-103 AND OTHER APPLICABLE STATUTES.

**Summary Worksheet**

**Per the Instructions, health insurance issuers proposing rate increases above the threshold fill in only those cells that are highlighted in GREY. The other cells are auto-populated.**

**A. Base Period Data**

Start Period: 05/01/2009

End Period: 04/30/2010

Service Categories	Member Months	Total Allowed	Net Claims	Member's Cost Sharing	Member's Cost Sharing PMPM	Net PMPM	Allowed PMPM
Inpatient	10,000	\$ 313,250.00	\$ 244,355.00	\$ 68,895.00	\$ 6.89	\$ 24.44	\$ 31.33
Outpatient	10,000	\$ 311,000.00	\$ 242,560.00	\$ 68,420.00	\$ 6.84	\$ 24.26	\$ 31.10
Professional	10,000	\$ 774,000.00	\$ 603,720.00	\$ 170,280.00	\$ 17.03	\$ 60.37	\$ 77.40
Prescription Drugs	10,000	\$ 498,000.00	\$ 368,500.00	\$ 129,500.00	\$ 12.95	\$ 36.85	\$ 49.80
Other	10,000	\$ 45,800.00	\$ 35,700.00	\$ 10,100.00	\$ 1.01	\$ 3.57	\$ 4.58
Capitation	10,000	\$ 75,000.00	\$ 75,000.00	\$ -	\$ -	\$ 7.50	\$ 7.50
<b>Total</b>	<b>10,000</b>	<b>\$ 2,017,050.00</b>	<b>\$ 1,569,855.00</b>	<b>\$ 447,195.00</b>	<b>\$ 44.72</b>	<b>\$ 156.99</b>	<b>\$ 201.71</b>

**B. Claim Projections**

**B1. Adjustment to the Current Rate**

Start Period: 01/01/2010

End Period: 12/31/2010

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Member's Cost Sharing
Inpatient	1.0154	\$ 31.81	\$ 25.13	0.21
Outpatient	1.0462	\$ 32.54	\$ 25.70	0.21
Professional	1.0284	\$ 79.60	\$ 62.88	0.21
Prescription Drugs	1.0869	\$ 53.13	\$ 39.85	0.25
Other	1.0155	\$ 4.85	\$ 3.67	0.21
Capitation	1.0100	\$ 7.58	\$ 7.58	0.00
<b>Total</b>		<b>\$ 209.30</b>	<b>\$ 164.81</b>	<b>0.21</b>

**B2. Claims Projection for Future Rate**

Start Period: 01/01/2011

End Period: 12/31/2011

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Member's Cost Sharing
Inpatient	1.0783	\$ 34.30	\$ 26.75	0.22
Outpatient	1.1185	\$ 36.39	\$ 28.39	0.22
Professional	1.0877	\$ 86.58	\$ 67.53	0.22
Prescription Drugs	1.1316	\$ 60.12	\$ 44.79	0.26
Other	1.0812	\$ 5.03	\$ 3.92	0.22
Capitation	1.0210	\$ 7.73	\$ 7.73	0.00
<b>Total</b>		<b>\$ 230.15</b>	<b>\$ 179.11</b>	<b>0.22</b>

**C. Components of Current and Future Rates**

	Future Rate		Prior Estimate of Current Rate		Difference	
	PMPM	%	PMPM	%	PMPM	%
1. Projected Net Claims	\$ 179.11	76.20%	\$ 159.20	75.73%	\$ 19.91	80.22%
2. Administrative Costs	\$ 45.75	19.46%	\$ 43.33	20.61%	\$ 2.42	9.75%
3. Underwriting Gain/Loss	\$ 10.19	4.34%	\$ 7.70	3.65%	\$ 2.49	10.03%
4. Total Rate	\$ 235.05	100.00%	\$ 210.23	100.00%	\$ 24.82	100.00%
5. Overall Rate Increase		11.81%				

**D. Components of Rate Increase**

	Impact on Rate	Percent
Claims Components		
1. Inpatient	\$ 1.97	9.87%
2. Outpatient	\$ 3.05	15.30%
3. Professional	\$ 5.51	27.68%
4. Prescription Drugs	\$ 5.24	26.32%
5. Other	\$ 0.30	1.50%
6. Capitation	\$ 0.16	0.80%
7. Cost Share Change	\$ (1.82)	-9.66%
8. Correction of Prior Net Claims Estimate	\$ 5.61	28.18%
9. Total	\$ 19.91	100.00%

**Claims Restatement for Current Rate Period (1/1/2010-12/31/2010)**

8.a. Prior Net Claims Estimate for Current Rate Period	\$ 159.20
8.b. Re-Estimate of Net Claims PMPM for Current Rate Period	\$ 164.81

**E. List of Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years**

Calendar Year	Requested	Implemented
2010	10.00%	10.00%
2009	8.00%	8.00%
2008	13.00%	7.00%

**F. Range and Scope of Proposed Increase**

Number of Covered Individuals	900
Number of Covered Policyholders	800

	Current Premium (Individual)	Proposed Premium (Individual)	% Change
Minimum % Increase	\$ 200.00	\$ 210.00	5.00%
Maximum % Increase	\$ 220.00	\$ 250.00	13.64%

Attachment 14

# Arkansas Insurance Department

Mike Beebe  
Governor



Jay Bradford  
Commissioner

July 7, 2011

**BULLETIN NO. 7 -2011**

**TO: ALL LICENSED INSURERS, HEALTH MAINTENANCE ORGANIZATIONS, FRATERNAL BENEFIT SOCIETIES, FARMERS' MUTUAL AID ASSOCIATIONS OR COMPANIES, HOSPITAL MEDICAL SERVICE CORPORATIONS, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, PRODUCER AND COMPANY TRADE ASSOCIATIONS, AND OTHER INTERESTED PARTIES.**

**FROM: ARKANSAS INSURANCE DEPARTMENT**

**SUBJECT: PREMIUM REVIEW FOR SMALL EMPLOYER GROUP MAJOR MEDICAL POLICIES**

**EFFECTIVE DATE: SEPTEMBER 1, 2011**

Pursuant to Ark Code Ann. §§23-79-109, 23-76-112, 23-75-111 and 23-86-207, the following requirements shall apply to all Insurers, Health Maintenance Organizations and Medical Service Corporations:

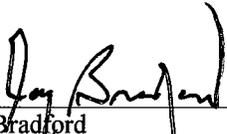
- (1) Each small employer carrier shall file annually on June 1 with the Commissioner its schedule of rates or methodology for determining rates. No schedule of rates, or amendment thereto, may be used in conjunction with any small group accident and health policy until either a copy of the schedule of rates or the methodology for determining rates has been filed and approved by the Commissioner.
- (2) Either a specific schedule of rates or a methodology for determining rates shall be established in accordance with actuarial principles for various categories of enrollees, provided that rates applicable to an individual enrollee in a small group policy shall not be individually determined based on the status of the enrollee's health.
- (3) The rates shall not be excessive, inadequate, unreasonable, or unfairly discriminatory.
- (4) A certification by a qualified actuary as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with the adequate supporting information.
- (5) The Commissioner, within a reasonable period, shall approve any schedule of rates or methodology for determining rates if the requirements of subsection (2) are met.
- (6) The schedule of rates or methodology cannot be implemented until they are approved by the Commissioner.
- (7) If the Commissioner disapproves the schedule of rates or the methodology, he or she shall notify the filer promptly.
- (8) In the notice of disapproval, the commissioner shall specify the reasons for his or her disapproval and the findings of fact and conclusions that support the decision.
- (9) If the Commissioner does not disapprove any schedule of rates filing within 60 days of the filing and the period has not been extended by mutual agreement, the schedule of rates shall be deemed approved.

- (10) The Commissioner may require the submission of additional information he or she deems relevant to determine whether to approve or disapprove a filing.
- (11) A small employer for the purposes of this Bulletin as defined in Ark. Code Ann. § 23-86-303(34) shall be all employers with at least two employees but no more than 50 employees.
- (12) Carriers must include the Medical Loss Ratio for the small employer group filing.

In reviewing all rate filings under this Bulletin, the Arkansas Insurance Department will review the following, to the extent applicable, to the filing under review:

1. The impact of medical trend changes by major service categories;
2. The impact of utilization changes by major service categories;
3. The impact of cost-sharing changes by major service categories;
4. The impact of benefit changes;
5. The impact of changes in enrollee risk profile;
6. The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase;
7. The impact of changes in reserve needs;
8. The impact of changes in administrative costs related to programs that improve health care quality;
9. The impact of changes in other administrative costs;
10. The impact of changes in applicable taxes, licensing or regulatory fees;
11. Medical Loss Ratio;
12. The carrier's capital and surplus; and
13. Consumer comments regarding the rate filing.

The information contained in Exhibits 1, 2 and 3 will be posted on the Department's website. Consumers will be encouraged to submit to the Insurance Department comments on the proposed rate filing with the Department.

  
\_\_\_\_\_  
Jay Bradford  
Insurance Commissioner  
State of Arkansas

## EXHIBIT 1

### Instructions for Completing Rate Summary Worksheet, Part I of Preliminary Justification

#### Information

Carriers must use a standardized Excel worksheet for completing Part I of the Preliminary Justification, the Rate Summary Worksheet. A sample of a completed version of the worksheet is provided at the end of the instructions.

Sections A and B of the worksheet require issuers to provide historical and projected claims experience data (referred to on the form as the 'Base Period' data and 'Projection Period' data, respectively):

- **Base Period Data:** The base period data are the source data for the rate projections that are calculated in the Rate Summary Worksheet. The base period data may include data from other products or sources if the experience for the product is not fully credible (e.g., national level data). In general, this section should be completed using the same data that were used to develop the rate increase and/or prepare any applicable state rate filing.
- **Projection Period:** The allowed costs are projected from the base period to the projection period for the proposed rates in two steps. Section B1 projects allowed costs from the base period to the 12-month period immediately preceding the effective date of the proposed rate change based on updated pricing assumptions. Section B2 further projects allowed costs from the projection period for the current rate to the projection period representing the effective dates of the proposed rate. The projection periods are 12-month periods immediately before and after the effective date of the proposed rate increase.

The claims data entered in the base period are trended forward for each of the projection periods by an overall medical trend factor. Issuers must enter an overall medical trend factor for each of the claims service categories provided on the worksheet. The overall medical trend factor should reflect all of an issuer's cost, utilization, changes in covered benefits and other trend assumptions for the projection periods.

Carriers should use the following definitions for reporting service category data on the worksheet:

- **Inpatient:** Includes non-capitated facility charges for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other inpatient facilities.
- **Outpatient:** Includes non-capitated facility charges for surgery, emergency room, lab, radiology, observation and other outpatient facilities.
- **Professional:** Includes non-capitated primary care, specialist, therapy, the professional component of radiology, and other professional services.
- **Prescription Drugs:** Includes drugs dispensed by a pharmacy.
- **Other:** Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, and other services.
- **Capitation:** Includes capitation for laboratory, professional, mental health and other capitated services.

## B. Description of Worksheet Data Elements

### Section A: Base Period Data

- **Base Period Data - Start and End Dates:** Enter the beginning and end dates of the base period in “MM/DD/YYYY” format.
- **Member Months:** Enter the total member months for the base period data for each service category.
- **Total Allowed Cost:** Enter claims dollars for the base period by service category on an allowable basis including estimates of unpaid claims. Total allowed costs are summed automatically.
- **Member’s Cost Sharing:** Calculated automatically by service category excluding capitation from total allowed dollars and net claims (dollars).
- **Net Claims:** Enter incurred claims dollars for the base period by service category including estimates of unpaid claims and net of member cost sharing. The capitation net claims (dollars) line is populated as capitation allowed costs (dollars). Total net claims (dollars) are summed automatically.
- **Member Cost Share Per Member Per Month (PMPM):** Calculated automatically by service category and in total based on member’s cost sharing (dollars) and member months.
- **Net PMPM:** Calculated automatically by service category and in total based on net claims and member months.
- **Allowed PMPM:** Calculated automatically by service category and total based on allowed dollars and member months.

### Section B Claims Projections

#### B1 Adjustment to the Current Rate

This section projects allowed costs from the base period to the projection period for the current rate based on updated pricing assumptions.

- **Start and End Dates:** Enter the starting date of the projection period for the current rate, which is 12 months prior to the effective date of the proposed rate increase. Enter the ending date of the projection period for the current rate, which is one day prior to the effective date of the proposed rate change. Dates should be entered in “MM/DD/YYYY” format.
- **Overall Medical Trend:** Enter the overall medical trend factor for each service category in the format “.xxx”
- **Projected Allowed PMPM:** Calculated automatically by service category as the product of the base period allowed PMPM, and the overall medical claims trend in this section (projection period for current rate).
- **Member’s Cost Share:** Enter the average of all member’s cost share for the projection period for the current rate (for example, deductibles, co-pays, and coinsurance) by service category in the format “.xxx”. This factor is used to calculate net claims PMPM from projected allowed PMPM. The total member cost share factor is calculated automatically as 1 minus the ratio of net claims PMPM to total projected allowed PMPM.

- **Net Claims PMPM:** Calculated automatically by service category based on projected allowed PMPM and member's cost sharing PMPM. Total net claims PMPM is summed automatically.

### **B2 Claims Projection for the Future Rate**

This section projects the claims experience from the midpoint of the projection period for the current rate to the midpoint of projection period for the future rate.

- **Projection Period for Future Rate - Start and End Date:** Enter the effective date of the proposed rates, for example, 01/01/2012. The end date should be exactly one year after the start date.
- **Overall Medical Trend:** Enter the overall medical trend factor for each service category in the format "1.xxx".
- **Projected Allowed PMPM:** Calculated automatically by service category as the product of the current rate allowed PMPM, and the overall medical claims trend in this section (projection period for the future rate).
- **Member's Cost Share:** Enter the average of all member's cost share for the projection period for the future rate (for example, deductibles, copays, and coinsurance) by service category in the format ".xxx". This factor is used to calculate net claims PMPM from projected allowed PMPM. The total member's cost share factor is calculated automatically as 1 minus the ratio of total net claims PMPM to total projected allowed PMPM.
- **Net Claims PMPM:** Calculated automatically by service category based on projected allowed PMPM and member's cost sharing PMPM. Total net claims PMPM is summed automatically.

### **Section C: Components of Current and Future Rates**

This section collects information on the net claims, administrative, and underwriting gain/loss components of the current and future rates. The administrative and underwriting gain/loss components should be reported consistent with how these terms are determined for state rate filings and financial reporting and should adhere to Generally Accepted Accounting Principles (GAAP).

#### **Future Rate**

- **Line 1 – Projected Net Claims:** Populated based on net claims amount in Section B2.
- **Lines 2 – Administrative Costs:** Enter estimated administrative costs for the future rate.
- **Line 3 – Underwriting Gain/Loss:** Enter the gain loss estimate for the future rate.
- **Line 4 – Total Rate:** Calculated automatically as the sum of lines 1 through 3.
- **Line 5 – Overall Rate Increase:** Calculated automatically.
- **Percentage of Rate (Lines 1-4):** Calculated automatically.

#### **Prior Estimate of Current Rate**

Complete these fields with the net claims PMPM and projected non-claim expenses PMPM based on the pricing assumptions in an earlier rate filing for the current rate.

- **Line 1 – Projected Net Claims:** Enter prior estimate of net claims from prior rate filing.

- **Line 2 – Administrative Costs:** Enter prior estimate of estimated administrative costs for the current rate from the prior rate filing.
- **Line 3 – Underwriting Gain/Loss:** Enter prior estimate of the underwriting gain/loss for the current rate period.
- **Line 4 – Total Rate:** Calculated automatically as the sum of lines 1 through 3.
- **Percentage of Rate (Lines 1-4):** Calculated automatically.

#### **Difference**

These fields are calculated automatically.

#### **Section D: Components of Medical Claims Changes**

This section displays the difference in medical claims between the projected rate and the current rate.

- **Line 1 – Inpatient:** Calculated automatically as the product of the overall trend for inpatient entered in B2 (the projection period for future rate) minus 1 and the inpatient net claims amount in B1 (the projection period for the current rate).
- **Line 2 – Outpatient:** Calculated automatically as the product of the overall trend for outpatient entered in B2 (the projection period for future rate) minus 1 and the outpatient net claims amount in B1 (the projection period for the current rate).
- **Line 3 – Professional:** Calculated automatically as the product of the overall trend for professional entered in B2 (the projection period for future rate) minus 1 and the professional net claims amount in B1 (the projection period for the current rate).
- **Line 4 – Prescription Drugs:** Calculated automatically as the product of the overall trend for prescription drugs entered in B2 (the projection period for future rate) minus 1 and the prescription drugs net claims amount in B1 (the projection period for the current rate).
- **Line 5 – Other:** Calculated automatically as the product of the overall trend for other entered in B2 (the projection period for future rate) minus 1 and the other net claims amount in B1 (the projection period for the current rate).
- **Line 6 – Capitation:** Calculated automatically as the product of the overall trend for other entered in B2 (the projection period for future rate) minus 1 and the other net claims amount in B1 (the projection period for the current rate).
- **Line 7 – Cost Share Change:** Calculated automatically by summing the products of:
  - the difference in cost sharing amounts entered in B2 and B1 (the projection periods for the future and current rate) for each service category, and
  - the net claims amount in B2 for each service category.

- **Line 8 – Correction of Prior Net Claims Estimate:** Calculated automatically based on the difference between 8b and 8a.
  - **Line 8a – Prior Net Claims Estimate for Current Rate Period:** Populated as the projected net claims for the current rate prior estimate in Section C, line 1.
  - **Line 8b – Re-Estimate of Net Claims PMPM for Current Rate Period:** Populated as the total net claims PMPM for the projection period for the current rates in Section B1.
- **Line 9 – Total:** Calculated automatically as the sum of lines 1-8.

#### **Section D: Components of the Rate Increase**

This section displays the difference in the medical and non-medical claims between the projected rate and the current rate for the claims and non-claims components.

#### **Section E: List of the Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years**

- For the past three calendar years enter:
  - The average rate increase that was requested for this product(s). A zero value should be entered for any year where there was no rate increase.
  - The average rate increase that was implemented for this product. A zero value should be entered for any year where there was no rate increase.

#### **Section F: Range and Scope of Premium Changes Due to Rate Increase**

- **Number of Covered Individuals:** Enter the estimated number of covered individuals as of the effective date of the increase.
- **Number of Covered Policyholders:** Enter the estimated number of covered policyholders as of the effective date of the increase.
- **Minimum Current Premium:** Enter the minimum current PMPM *premium* amount for an individual.
- **Minimum Proposed Premium:** Enter the minimum proposed PMPM *premium* for an individual.
- **Maximum Current Premium:** Enter the maximum current PMPM *premium* for an individual.
- **Maximum Proposed Premium:** Enter the maximum proposed PMPM *premium* for an individual.
- **Percent Change:** Calculated automatically.

## Exhibit 2

### **III: Instructions for Completing Exhibit 2 of the Preliminary Justification**

Provide a brief, non-technical description of why the issuer is requesting this rate increase. This explanation should help consumers interpret the rate summary data provided in Exhibit 1 of the Preliminary Justification. Accordingly, it should identify and explain the key drivers of the rate increase in Exhibit 1 of the Preliminary Justification. For example, if inpatient costs are reported as the main factor of the rate increase, the written explanation should describe why inpatient costs are increasing.

The explanation should include information on the following components related to the rate increase:

- **Scope and range of the rate increase:** Provide the number of individuals impacted by the rate increase. Explain any variation in the increase among affected individuals (e.g., describe how any changes to the rating structure impact premium).
- **Financial experience of the product:** describe the overall financial experience of the product, including historical summary-level information on historical premium revenue, claims expenses and profit. Discuss how the rate increase will affect the projected financial experience of the product.
- **Changes in Medical Service Costs:** Describe how changes in medical service costs are contributing to the overall rate increase. Discuss cost and utilization changes as well as any other relevant trend factors that are impacting overall service costs. **Changes in benefits:** Describe any changes in benefits and explain how benefit changes affect the rate increase. Issuers should explain whether the applicable benefit changes are required by law.
- **Administrative costs and anticipated profits:** Identify the main drivers of changes in administrative costs. Discuss how changes in anticipated administrative costs and profit are impacting the rate increase.

There is no standardized reporting form for Exhibit 2 of the Preliminary Justification, but carriers are expected to cover items listed above in their submissions. The written statement must be submitted as a *Word* file.

## Exhibit 3

### **Instructions for Completing Exhibit 3 of the Preliminary Justification**

Health Insurance carriers are required to complete Exhibit 3 of the Preliminary Justification for any rate approval.

Issuers must provide information on all of the reporting elements listed below and must clearly identify and explain any reporting element that is not relevant to the development of the rate increase. Health insurance carriers have the discretion to select the format in which they present the required Part III reporting elements. As a general rule, Exhibit 3 submissions must contain sufficient detail to allow the Department to conduct a thorough actuarial review of the rate increase. Exhibit 3 submissions must clearly describe the rate making methodology, underlying data, and assumptions that were used to develop the rate increase.

Carriers may submit one or more files using PDF, Microsoft Excel, or Microsoft Word format.

#### **List of Exhibit 3 Reporting Requirements:**

- 1. Description of the type of policy, benefits, renewability, general marketing method and issue age limits.**
  - a. Insurance Company Name
  - b. NAIC Company Code
  - c. Contact Person and Title
  - d. Contact Telephone Number and Email
  - e. Date of Submission
  - f. Proposed Effective Date
  - g. Insurance Company's Filing Number
  - h. Form Number
  - i. Product Number
  - j. Market Type (Individual/Small group)
  - k. Status: Open/Closed Block)
  - l. Brief Description:
    - i. Type of Policy
    - ii. Benefits
    - iii. Renewability
    - iv. General Marketing Method
    - v. Underwriting Method
    - vi. Premium Classifications
    - vii. Age Basis and Issue Age
- 2. Scope and reason for the rate increases.**
- 3. Average annual premium per policy, before and after the rate increase.**
  - a. Outline of Past Rate Increases
  - b. Description of Proposed Increase in Dollar Amount

**4. Past experience, and any other alternative or additional data used.**

- a. Number of Policyholders
- b. Number of Covered Lives
- c. Total Written Premium
- d. Evaluation Period, Experience Period, Projection Period
- e. Past Experience, including:
  - i. Cumulative Loss Ratio (Historical/Past)
  - ii. Any Alternative Experience Data Used
- f. Credibility Analysis
- g. Incurred But Not Reported (IBNR) Claims
- h. Contract Reserves

**5. A description of how the rate increase was determined, including the general description and source of each assumption used.**

- a. Expenses
  - i. Profit and Contingency
  - ii. Commissions and Brokers Fees
  - iii. Taxes, License and Fees
  - iv. General Expenses
  - v. Other Administrative Costs
  - vi. Reinsurance
- b. Impact of Statutory Changes, including Mandates
- c. Overall Premium Impact of Proposed Increase:
  - i. Average Annual Premium Per Policy
  - ii. Before and After Rate Increase
- d. Descriptive Relationship of Proposed Rate Scale to Current Rate Scale
- e. Premium Basis
  - i. Brief Description of How Revised Rates were Determined, including:
    - 1. General Description
    - 2. Source of Each Assumption Used
  - ii. For expenses, including:
    - 1. Percent of Premium
    - 2. Dollars Per Policy or Dollars Per Unit of Benefit or All
  - iii. Trend Assumptions
  - iv. Interest Rate Assumptions
  - v. Other Assumptions, including Morbidity, Mortality and Persistency
- f. Company Financial Condition
  - i. Risk Based Capital
  - ii. Company Surplus

**6. The cumulative loss ratio and a description of how it was calculated.**

- a. Loss Ratio Exhibit

- 7. The projected future loss ratio and a description of how it was calculated.**
  - a. Loss Ratio Exhibit: Anticipated lifetime loss ratio that combines cumulative and future experience, and description of how it was calculated
  
- 8. The projected lifetime loss ratio that combines cumulative and future experience, and a description of how it was calculated.**
  - a. Loss Ratio Exhibit
  
- 9. The Federal medical loss ratio (MLR) standard in the applicable market to which the rate increase applies, accounting for any adjustments allowable under Federal law.**
  - a. Loss Ratio Exhibit:
    - i. Anticipated loss ratio presumed reasonable according to the guidelines including adjustment for credibility if applicable
    - ii. Quality Improvement Costs
  
- 10. If the result under (7.) is less than the standard under (9.), a justification for this outcome is required.**

AN INSURER MAY REQUEST THAT ITEMS BE TREATED AS CONFIDENTIAL AND THE COMMISSIONER SHALL DETERMINE IF THE ITEMS SHOULD BE CONSIDERED AS CONFIDENTIAL PURSUANT TO ARK. CODE ANN. § 23-61-103 AND OTHER APPLICABLE STATUTES.

**Summary Worksheet**

**Per the Instructions, health insurance issuers proposing rate increases above the threshold fill in only those cells that are highlighted in GREY. The other cells are auto-populated.**

**A. Base Period Data**

Start Period: 05/01/2009

End Period: 04/30/2010

Service Categories	Member Months	Total Allowed	Net Claims	Member's Cost Sharing	Member's Cost Sharing PMPM	Net PMPM	Allowed PMPM
Inpatient	10,000	\$ 313,250.00	\$ 244,355.00	\$ 68,895.00	\$ 6.89	\$ 24.44	\$ 31.33
Outpatient	10,000	\$ 311,000.00	\$ 242,560.00	\$ 68,420.00	\$ 6.84	\$ 24.26	\$ 31.10
Professional	10,000	\$ 774,000.00	\$ 603,720.00	\$ 170,280.00	\$ 17.03	\$ 60.37	\$ 77.40
Prescription Drugs	10,000	\$ 498,000.00	\$ 368,500.00	\$ 129,500.00	\$ 12.95	\$ 36.85	\$ 49.80
Other	10,000	\$ 45,800.00	\$ 35,700.00	\$ 10,100.00	\$ 1.01	\$ 3.57	\$ 4.58
Capitation	10,000	\$ 75,000.00	\$ 75,000.00	\$ -	\$ -	\$ 7.50	\$ 7.50
<b>Total</b>	<b>10,000</b>	<b>\$ 2,017,050.00</b>	<b>\$ 1,569,855.00</b>	<b>\$ 447,195.00</b>	<b>\$ 44.72</b>	<b>\$ 156.99</b>	<b>\$ 201.71</b>

**B. Claim Projections**

**B1. Adjustment to the Current Rate**

Start Period: 01/01/2010

End Period: 12/31/2010

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Member's Cost Sharing
Inpatient	1.0154	\$ 31.81	\$ 25.13	0.21
Outpatient	1.0462	\$ 32.54	\$ 25.70	0.21
Professional	1.0284	\$ 79.60	\$ 62.88	0.21
Prescription Drugs	1.0869	\$ 53.13	\$ 39.85	0.25
Other	1.0155	\$ 4.65	\$ 3.67	0.21
Capitation	1.0100	\$ 7.58	\$ 7.58	0.00
<b>Total</b>		<b>\$ 209.30</b>	<b>\$ 164.81</b>	<b>0.21</b>

**B2. Claims Projection for Future Rate**

Start Period: 01/01/2011

End Period: 12/31/2011

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Member's Cost Sharing
Inpatient	1.0783	\$ 34.30	\$ 26.75	0.22
Outpatient	1.1185	\$ 36.39	\$ 28.39	0.22
Professional	1.0877	\$ 86.58	\$ 67.53	0.22
Prescription Drugs	1.1316	\$ 60.12	\$ 44.79	0.26
Other	1.0812	\$ 5.03	\$ 3.92	0.22
Capitation	1.0210	\$ 7.73	\$ 7.73	0.00
<b>Total</b>		<b>\$ 230.15</b>	<b>\$ 179.11</b>	<b>0.22</b>

**C. Components of Current and Future Rates**

	Future Rate		Prior Estimate of Current Rate		Difference	
	PMPM	%	PMPM	%	PMPM	%
1. Projected Net Claims	\$ 179.11	76.20%	\$ 159.20	75.73%	\$ 19.91	80.22%
2. Administrative Costs	\$ 45.75	19.46%	\$ 43.33	20.61%	\$ 2.42	9.75%
3. Underwriting Gain/Loss	\$ 10.19	4.34%	\$ 7.70	3.65%	\$ 2.49	10.03%
4. Total Rate	\$ 235.05	100.00%	\$ 210.23	100.00%	\$ 24.82	100.00%
5. Overall Rate Increase		11.81%				

**D. Components of Rate Increase**

	Impact on Rate	Percent
Claims Components		
1. Inpatient	\$ 1.97	9.87%
2. Outpatient	\$ 3.05	15.30%
3. Professional	\$ 5.51	27.68%
4. Prescription Drugs	\$ 5.24	26.32%
5. Other	\$ 0.30	1.50%
6. Capitation	\$ 0.16	0.80%
7. Cost Share Change	\$ (1.82)	-9.66%
8. Correction of Prior Net Claims Estimate	\$ 5.61	28.18%
9. Total	\$ 19.91	100.00%

**Claims Restatement for Current Rate Period (1/1/2010-12/31/2010)**

8.a. Prior Net Claims Estimate for Current Rate Period	\$ 159.20
8.b. Re-Estimate of Net Claims PMPM for Current Rate Period	\$ 164.81

**E. List of Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years**

Calendar Year	Requested	Implemented
2010	10.00%	10.00%
2009	8.00%	8.00%
2008	13.00%	7.00%

**F. Range and Scope of Proposed Increase**

Number of Covered Individuals	900
Number of Covered Policyholders	800

	Current Premium (Individual)	Proposed Premium (Individual)	% Change
Minimum % Increase	\$ 200.00	\$ 210.00	5.00%
Maximum % Increase	\$ 220.00	\$ 250.00	13.64%



200 Independence Avenue SW  
Washington, DC 20201

July 1, 2011

Honorable Jay Bradford  
Commissioner  
Arkansas Insurance Department  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201-1904

Re: Effective Rate Review Program Determination

Dear Commissioner Bradford:

Section 2794 of the Public Health Service Act, as added by the Affordable Care Act requires the Secretary of Health and Human Services, in conjunction with the States, to establish a process for review of “unreasonable increases in premiums for health insurance coverage.” The final rule implementing section 2794, at 45 C.F.R. 154.210(b), provides that the Center for Medicare & Medicaid Services (CMS) will adopt a State’s determination regarding the reasonableness of a proposed rate increase if the State meets the criteria for an effective rate review program listed in 45 C.F.R. 154.301. These include:

1. Has the authority to collect the information and perform the analysis described in 154.301(a),
2. Provides access from its Web site to Parts I and II of the Preliminary Justifications for the proposed rate increases it reviews;
3. Provides a means for public input on proposed rate increases; and
4. Provides to CMS its final determination as to whether a rate increase is unreasonable within five days of the determination.

The Center for Consumer Information and Insurance Oversight (CCIIO) reviewed Arkansas’ laws, regulations, and bulletins, and confirmed with your agency that it will conduct reviews in accordance with the criteria set forth in the regulation. Based on this information, we have determined that Arkansas has an Effective Rate Review Program in all markets.

As a next step, we ask that you send an email to [ratereview@hhs.gov](mailto:ratereview@hhs.gov) stating the name and contact information of the person who will serve as the liaison between our office and yours for rate review program matters. During the month of July, CCIIO will notify your contact person of procedures to follow for scheduling training sessions and securing access to the CMS web-based rate review system for your staff.

We applaud your efforts to provide an effective rate review program for your State’s insurance consumers that meet the criteria outlined in the Affordable Care Act. Many States’ laws and programs exceed the standards set forth in the ACA and our regulations, and we encourage all States to continue their efforts to ensure that rates charged to health insurance consumers in their State are reasonable.

Sincerely,

Steve Larsen, Director

Center for Consumer Information and Insurance Oversight

# Attachment 16



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW  
Washington, DC 20201

October 19, 2011

Honorable Jay Bradford  
Commissioner  
Arkansas Insurance Department  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201-1904

Re: Effective Rate Review Program Determination for Association Products

Dear Commissioner Bradford:

Section 2794 of the Public Health Service Act, as added by the Affordable Care Act requires the Secretary of Health and Human Services, in conjunction with the States, to establish a process for review of “unreasonable increases in premiums for health insurance coverage.” The final rule implementing section 2794, at 45 C.F.R. §154.210(b), provides that the Center for Medicare & Medicaid Services (CMS) will adopt a State’s determination regarding the reasonableness of a proposed rate increase if the State meets the criteria for an Effective Rate Review Program listed in 45 C.F.R. §154.301. The final rule was amended in September 2011 (76 Fed. Reg. 54969, September 6, 2011), to provide that non-grandfathered coverage which would be regulated as individual or small group market coverage if it were not sold through an association is subject to rate review as individual or small group market coverage.

As a result of the amendment, the Center for Consumer Information and Insurance Oversight (CCIIO) has reviewed your state laws and regulations and any information and documentation you made available in communication with our staff about your agency’s authority to review association products that, effective November 1, 2011, will be subject to the provisions of 45 C.F.R. Part 154. Based on this review, we have determined that, in accordance with the criteria set forth in 45 C.F.R. §154.301, Arkansas will have an Effective Rate Review Program for all association product types in both the individual and small group markets contingent upon publication of the updated bulletins that will extend the State’s review authority to all association plans. As confirmed in discussions with the Department on October 20, 2011, these bulletins will be published by December 30, 2011.

We applaud your efforts to provide your State’s insurance consumers with an Effective Rate Review Program for association coverage and we encourage all States to continue their efforts to ensure that rates charged to health insurance consumers in their State are reasonable.

Sincerely,

A handwritten signature in blue ink, appearing to read "Steve Larsen".

Steve Larsen, Director  
Center for Consumer Information and Insurance Oversight



STATE OF ARKANSAS  
INVITATION FOR BID

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**DELIVERY OF RESPONSE DOCUMENTS**

In accordance with the Arkansas Procurement law and Regulations, it is the responsibility of vendors to submit bids at the place, and on or before the date and time, set in the bid solicitation documents. Bid documents received at the Office of State Procurement after the date and time, designated for the bid opening are considered late bids and shall not be considered. Bid documents arriving late, which are to be returned and are not clearly marked, may be opened to determine for which bid the submission is intended.

**MINORITY BUSINESS POLICY**

Minority participation is encouraged in this and all other procurements by state agencies. "Minority" is defined by Arkansas Code Annotated § 1-2-503 as "Black or African American, Hispanic American, American Indian or Native American, Asian, and Pacific Islander". The Arkansas Economic Development Commission conducts a certification process for minority businesses. Bidders unable to include minority-owned business as subcontractors "may explain the circumstances preventing minority inclusion".

Check minority type:

<input type="checkbox"/>	African American	<input type="checkbox"/>	Hispanic American	<input type="checkbox"/>	American Indian
<input type="checkbox"/>	Native American	<input type="checkbox"/>	Asian	<input type="checkbox"/>	Pacific Islander

AR Certification number \_\_\_\_\_

**CURRENCY**

All bids and proposals pricing and cost must be listed in United States dollars and cents.

**LANGUAGE**

Bids and proposals will only be accepted in the English language.

**REQUIREMENT OF ADDENDUM**

THIS IFB MAY BE MODIFIED ONLY BY ADDENDUMS WRITTEN AND AUTHORIZED BY THE OFFICE OF STATE PROCUREMENT. Vendors are cautioned to ensure they have received or obtained and responded to any and all addendums to the bid prior to submission. There will be no addendums to a bid 72 hours prior to the bid opening. It is the responsibility of the vendor to check the OSP website, <http://www.arkansas.gov/dfa/procurement/bids/index.php> for any and all addendums up to that time.

**ALTERATION OF ORIGINAL IFB DOCUMENTS**

The original written or electronic language of the IFB shall not be changed or altered except by approved written addendum issued by the Office of State Procurement. This does not eliminate an Offeror from taking exception(s) to non mandatory terms and conditions, but does clarify that the Offeror cannot change the original document's written or electronic language. If the Offeror wishes to make exception(s) to any of the original language, it must be submitted by the Offeror in separate written or electronic language in a manner that clearly explains the exception(s). If Offeror's/Contractor's submittal is discovered to contain alterations/changes to the original written or electronic documents, the Offeror's response may be declared as "non-responsible" and the response shall not be considered.

**ADDITIONAL TERMS AND CONDITIONS**

The Office of State Procurement objects to and shall not consider any additional mandatory agreement terms and/or conditions submitted by a bidder, including any appearing in documents attached as part of a bidder's response. In signing and submitting its bid, a bidder agrees that any additional mandatory agreement terms or conditions, whether submitted intentionally or inadvertently, shall have no force or effect. Failure to comply with mandatory terms and conditions, including those specifying information that must be submitted with a bid, shall be grounds for rejecting a bid.

**ACT 157 of 2007 EMPLOYMENT OF ILLEGAL IMMIGRANTS**

Pursuant to Act 157 of 2007, all bidders must certify prior to award of the contract that they do not employ or contract with any illegal immigrants in its contract with the State. Bidders shall certify online at: <https://www.ark.org/dfa/immigrant/index.php/disclosure/submit/new>

**EO-98-04 GOVERNOR'S EXECUTIVE ORDER:**

Required to be completed by the successful bidder prior to award

STATE OF ARKANSAS  
INVITATION FOR BID

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**EQUAL EMPLOYMENT OPPORTUNITY POLICY**

In compliance with Act 2157 of 2005, the Office of State Procurement is required to have a copy of the vendor's Equal Opportunity Policy prior to issuing a contract award. EO Policies may be submitted in electronic format to the following email address: [eeopolicy.osp@dfa.arkansas.gov](mailto:eeopolicy.osp@dfa.arkansas.gov), or as a hard copy accompanying the solicitation response. The Office of State Procurement will maintain a file of all vendor EO policies submitted in response to solicitations issued by this office. The submission is a one time requirement but vendors are responsible for providing updates or changes to their respective policies and of supplying EO policies upon request to other state agencies that must also comply with this statute. Vendors that do not have an established EO policy will not be prohibited from receiving a contract award, but are required to submit a written statement to that effect.

**ANTICIPATION OF AWARD**

After complete evaluation of the bid, the anticipated award will be posted on the OSP website (<http://www.dfa.arkansas.gov/offices/procurement/Pages/default.aspx>) and/or the legal section of a newspaper of statewide circulation. The purpose of the posting is to establish a specific time in which vendors and agencies are aware of the anticipated award. The bid results will be posted for a period of fourteen (14) days prior to the issuance of any award. Vendors and agencies are cautioned that these are preliminary results only, and no official award will be issued prior to the end of the fourteen day posting period. Accordingly, any reliance on these preliminary results is at the agency's/vendor's own risk.

The Office of State Procurement reserves the right to waive this policy, The Anticipation to Award, when it is in the best interest of the State. Vendors are responsible for viewing the Anticipation to Award section of the OSP web site at [http://www.arkansas.gov/dfa/procurement/pro\\_intent.php](http://www.arkansas.gov/dfa/procurement/pro_intent.php).

**PAST PERFORMANCE**

In accordance with provisions of The State Procurement Law, R7: 19-11-229 Competitive Sealed Bidding - Bid Evaluation paragraph (E)(i) & (ii): a vendor's past performance with the state may be used in the evaluation of any offer made in response to this solicitation. The past performance should not be greater than three years old and must be supported by written documentation on file in the Office of State Procurement at the time of the bid opening. Documentation may be in the form of either a written or electronic report, VPR; memo, file or any other appropriate authenticated notation of performance to the vendor files.

**VISA ACCEPTANCE**

Awarded contractors should have the capability of accepting the State's authorized VISA Procurement Card (P-card) as a method of payment. Price changes or additional fee(s) may not be assessed when accepting the p-card as a form of payment. The successful bidder may receive payment from the State by the p-card in the same manner as other VISA purchases. VISA acceptance is preferred, but is not the exclusive method of payment.

**OUTSTANDING TAX LIABILITY**

Bidders must disclose the existence, as of the date of bid submission, of any unsatisfied lien, certificate of indebtedness, certificate of assessment, writ of execution, writ of garnishment, business closure order, civil action, or other indication of delinquency against Bidders for any outstanding tax liability owed by Bidders to any state taxing authority. Bidders acknowledge that a search of public records may be conducted to discover the existence of any unsatisfied tax assessments. Bidders further acknowledge that any unsatisfied liens, certificates of indebtedness, certificates of assessment, writs of execution, writs of garnishment, business closure orders, civil action, or other indication of delinquency for any outstanding tax liability owed by Bidders may result in Bidders being deemed non-responsible and their bids rejected.

**AWARDING INSTRUCTIONS**

This Invitation for Bid shall be awarded to the lowest responsible, responsive bidder on the Grand Total on an All or None basis.

**DELIVERY**

All delivery, installation, and invoicing must be completed no later than **August 19, 2011**.

STATE OF ARKANSAS  
INVITATION FOR BID

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**SECTION 1: GENERAL INFORMATION**

**INTRODUCTION**

Vendors are invited to submit bids for a fully integrated audio, video, audiovisual, videoconferencing, and control system including, but not limited to, installation, defined warranties, maintenance, service, and training. The installation to be in the Rate Review Meeting Room of the Arkansas Insurance Department, located in Suite 201, 1200 Third St., Little Rock, Arkansas, 72201.

**ISSUING OFFICE**

The Office of State Procurement (OSP) issues this Invitation for Bid (IFB) on behalf of the Arkansas Insurance Department (AID). The issuing office is the sole point of contact in the State for the selection process. Vendor questions regarding IFB related matters should be made through the State's buyer: Jaime Kaufman at (501) 371-6065 or [Jaime.Kaufman@dfa.arkansas.gov](mailto:Jaime.Kaufman@dfa.arkansas.gov).

**MANDATORY SITE VISIT**

The one time site visit will be held at the AID Meeting Room located at Suite 201, 1200 Third St., Little Rock, Arkansas, 72201 on May 26, 2011 @ 1:00 p.m. CT.

All prospective bidders **MUST** attend the mandatory site visit to submit a bid. Signed documentation of proof of the site visit must be included with bid submission. Signed and dated by Jaime Kaufman or Lowell Nicholas or their designee for the bid to be considered.

**IFB FORMAT**

Any statement in this document that contains the word "must" or "shall" or "will" means that compliance with the intent of the statement is mandatory, and failure by the bidder to satisfy that intent will cause the bid to be rejected.

**ACCOUNTING PROVISIONS**

In the event of any contract resulting from this IFB, the Contractor shall be required to maintain all pertinent financial and accounting records and evidence pertaining to the contract in accordance with generally accepted principles of accounting and other procedures specified by the State of Arkansas. Access will be granted upon request, to State or Federal Government entities or any of their duly authorized representatives. Financial and accounting records shall be made available, upon request, to the State of Arkansas' designee(s) at any time during the contract period and any extension thereof, and for five (5) years from expiration date and final payment on the contract or extension thereof.

**PERFORMANCE BOND**

In order to assure full performance of all obligations imposed on a vendor by contracting with the State of Arkansas, the vendor will be required to furnish a Performance Bond or other form of surety to the Office of State Procurement in the amount of \$ 20,000.00, payable to the State of Arkansas within ten (10) business days after the letter of intent to award the contract is received. In extenuating circumstances, an extension may be granted to secure the bond. The form of bond(s) required to secure the performance shall be the standard form of performance bond(s) such as is usually and customarily written and issued by surety companies licenses and authorized to do business in Arkansas. An irrevocable letter of credit(s) from an Arkansas bank is also acceptable. The award shall be made upon acceptance of the performance bond by the Office of State Procurement.

If a respondent fails to deliver the required Performance Bond or other form of surety, his bid shall be rejected.

In the event of a breach of contract, within the control of the vendor, the Office of State Procurement shall notify the vendor of the default in writing. If, after notification of default the vendor is unable to remedy the State's damages within ten (10) working days, the State Procurement Official may initiate procedures for collection against the vendor's performance bond for the amount of damages incurred.

**CLARIFICATION OF IFB**

If additional information is necessary to enable respondents to better interpret the information contained in the IFB or discovered during the site visit, written questions will be accepted until the time and date specified in the Anticipated Procurement Timeline. Vendor questions will be consolidated and responded to by the State. The Q & A will be posted on the OSP website at the time and date specified in the Anticipated Procurement Timeline. Answers to verbal questions may be given as a matter of courtesy and must be evaluated at vendor's risk. Questions should be sent to Jaime Kaufman at [Jaime.Kaufman@dfa.arkansas.gov](mailto:Jaime.Kaufman@dfa.arkansas.gov).

STATE OF ARKANSAS  
INVITATION FOR BID

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**CONTRACT INFORMATION**

- A. The State of Arkansas may not contract with another party:
  - 1. To indemnify and defend that party for any liability and damages. However, the State Procurement Official may agree to hold the other party harmless from any loss or claim resulting directly from and attributable to the State's use or possession of equipment or software and reimburse that party for the loss caused solely by the State's uses or possession.
  - 2. Upon default, to pay all sums to become due under a contract.
  - 3. To pay damages, legal expenses or other costs and expenses of any party.
  - 4. To continue a contract once the equipment has been repossessed.
  - 5. To conduct litigation in a place other than Pulaski County, Arkansas
  - 6. To agree to any provision of a contract which violates the laws or constitution of the State of Arkansas.
- B. A party wishing to contract with the State of Arkansas should:
  - 1. Remove any language from its contract which grants to it any remedies other than:
    - a. The right to possession.
    - b. The right to accrued payments.
    - c. The right to expenses of de-installation.
    - d. The right to expenses of repair to return the equipment to normal working order, normal wear and tear excluded.
    - e. The right to recover only amounts due at the time of repossession and any unamortized nonrecurring cost as allowed by Arkansas Law.
  - 2. Include in its contract that the laws of the State of Arkansas govern the contract.
  - 3. Acknowledge that contracts become effective when awarded by the State Procurement Official.

**DEFINITION OF TERMS**

The State Procurement Official has made every effort to use industry-accepted terminology in this IFB and will attempt to further clarify any point of item in question. The words "bidder," "respondent," and "vendor/offeror" are used as synonyms in this document. The words "contractor/successful vendor" refer to the vendor selected in the event of a resulting contract. The word "Agency" or "Department" refers to the Arkansas Insurance Department (AID).

**CONDITIONS OF CONTRACT**

The successful vendor shall at all times observe and comply with federal and State laws, local laws, ordinances, orders, and regulations existing at the time of or enacted subsequent to the execution of this contract which in any manner affect the completion of the work. The successful vendor shall indemnify and save harmless the agency and all its officers, representatives, agents, and employees against any claim or liability arising from or based upon the violation of any such law, ordinance, regulation, order or decree by an employee, representative, or subcontractor of the successful vendor.

**TERM OF CONTRACT**

The overall length of the contract is three years. The three year period of time will cover all support/service requirements. All training must be completed within the first six months of the contract. All equipment delivery and installations must occur by **August 19, 2011**.

**VENDOR REQUIREMENTS**

- Vendor will certify that all equipment will meet current FCC regulations.
- Documentation proving the vendor is an authorized service center for all brands of equipment the vendor is offering.

**STATEMENT OF LIABILITY**

The State will demonstrate reasonable care but shall not be liable in the event of loss, destruction, or theft of contractor-owned items or technical literature to be delivered or to be used in the installation of deliverables. The vendor is required to retain total liability for items and technical literature until the services have been accepted by the "authorized agency official." At no time will the State be responsible for or accept liability for any vendor-owned items.

**AWARD RESPONSIBILITY**

The State Procurement Official will be responsible for award and administration of any contract resulting from this IFB.

**INDEPENDENT PRICE DETERMINATION**

By submission of this proposal, the bidder certifies, and in the case of a joint proposal, each party thereto certifies as to its own organization, that in connection with this proposal:

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- A. The prices in the proposal have been arrived at independently, without collusion and that no prior information concerning these prices has been received from or given to a competitive company.
- B. If there is sufficient evidence of collusion to warrant consideration of this proposal by the Attorney General, all bidders shall understand that this paragraph may be used as a basis for litigation.

**SUBCONTRACTORS**

The contractor is fully responsible for all work performed under any resulting contract. The contractor may, with the consent of AID, enter into written subcontracts for performance of certain parts of its functions under a contract resulting from this IFB. Subcontracts must be approved in writing by the Contract Administrator prior to the effective date of any subcontract. The contractor will maintain the duties of performance associated with the contract. The service provider must notify the Office of State Procurement immediately regarding a claim that is filed by a Subcontractor against the contractor.

**PUBLICITY**

News release(s) by a respondent/vendor pertaining to this IFB or any portion of the project shall not be made without prior written approval of the State Procurement Official. Failure to comply with this requirement is deemed to be a valid reason for disqualification of the vendor’s proposal. The State Procurement Official will not initiate any publicity relating to any resulting procurement action resulting from this IFB before a contract award is completed.

**ANTICIPATED PROCUREMENT TIMELINE**

May 18, 2011	Invitation For Bid (IFB) Release Date
May 26, 2011	Mandatory Site Visit @ 1:00pm 1200 W Third St. 2 <sup>nd</sup> Floor, Little Rock
May 31, 2011	Vendor Questions for Clarification Deadline <a href="mailto:Jaime.Kaufman@dfa.arkansas.gov">Jaime.Kaufman@dfa.arkansas.gov</a>
June 7, 2011	Answers to Vendor’s Questions Posted <a href="http://www.arkansas.gov/dfa/procurement/bids/index.php">http://www.arkansas.gov/dfa/procurement/bids/index.php</a>
June 21, 2011*	Anticipation to Award Posted
July 6, 2011*	End of Anticipation to Award Period

\*approximate dates

**SECTION 2: SCOPE OF WORK**

**GENERAL**

The Arkansas Insurance Department (“AID”) is seeking bids for equipping its AID Rate Review Meeting Room (“MR”) with an integrated audio, video, audiovisual, videoconferencing, and control system. AID is seeking an integrated and functional system for the MR, cost of all components described herein, including, but not limited to, equipment, installation, warranties, service, and training. Equipment should be “state of the art” and of the highest quality. Where brand names are listed herein, it is to establish the level of expected quality.

The AID Rate Review Division (RR) is located on the second floor of the AID building at 1200 W. Third St., Little Rock, Arkansas. The MR is one large open room approximately 1500 square feet in size with a flat carpeted floor. Sixteen offices are on the perimeter of the MR and open up into the MR. The ceiling type is “drop’ with 2’ x 4’ tiles. Floor to drop ceiling measures 8’6”. There are approximately thirty (30) recessed fluorescent fixtures (2’ x4’). The room is rectangular, approximately 30’ x 50’.

Unless otherwise noted in this document, all equipment will be new, rack-mounted in lecterns or professional equipment racks and covered under full manufacturer’s warranty with warranty and service upon AID acceptance of completed system. The successful vendor will file all warranty and registration document listing AID as the owner. The successful vendor will serve as the contact point for all warranty service.

The contractor will provide and install all presentation equipment and all ancillary devices and materials necessary to meet the presentation requirements listed in this document.

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**PRESENTATION REQUIREMENTS**

**CONTROL SYSTEM**

The control system should be turned on and off from the touch-panel screen. Audio, video, and media controls should function as one system.

- It will turn on and off all equipment and the system itself.
- It will control all standard functions of each presentation device.
- It will have volume controls of active media devices, including the ability to mute the microphones and active media.
- Touch panels will be AMX Modero Series or approved equal.
- Graphical User Interface (GUI) — The GUI shall be based on the InfoComm International® Dashboard for Controls initiative.
- Each primary presentation device and media source (computer, laptop, DVD, and document camera) will have a discreet button on the touch-panel screen.
- Video sources will activate a video window on the touch screen. This window will be expandable to full screen by touching the window. Touching the full screen window will return the screen to the original configuration.
- Separate audio preset levels will be defined for each discreet input.
- When a source is selected, it will be switched to the display(s) (if it is a video source) and to the program audio speakers. It will also be sent to all recording devices, and to all external routing points (if any). The selected source button will be highlighted on the touch-panel screen.
- Any source with device controls will activate a control window on the touch-panel screen with standard control buttons using universal symbols for control functions. If additional controls are available, a "MORE" or "ADVANCED" button will be displayed. An audio control window will display a media volume control, user-programmable preset button, device mute button, and, if applicable, an "ADVANCED" button allowing access to tone and balance controls.
- There will a digital display of current time and date on the touch-panel screen at all times.
- The system will allow direct switching between sources. The video/data will not blank between sources of the same type.
- The system will have user-definable automatic shut-off time, preset by the programmer to 11:30 p.m.
- The system will have user-definable projector time-out duration (the time the projector lamp remains on while the system is in "No Media", preset by the programmer to 60 minutes.
- A maximum of two touches will be required to begin a presentation with a primary source from the main touch-panel screen (i.e. press "DVD" then press "PLAY").
- For video sources, the system will confirm the on/off status and input source of the display(s). It shall be impossible to unsynchronize the displays from the control system.
- For audio-only sources and NO MEDIA, the displays will be blanked (no output). If the displays were in the off mode, they will not be turned on.
- Start-up - The system will turn on the audio system and all presentation devices and media sources with the exception of the displays. It will go into a "NO MEDIA" mode, which should be the upper-left button on the touch-panel screen. The displays will turn on the first selection of a video source.
- There will be a "RECORD" button with single push start and stop for operating the digital audio recorder. The digital recorder will report time remaining and elapsed time on the touch panel. The touch panel will allow selection of three different record quality settings.

**TOUCH PANELS**

Touch panels will be AMX Modero Series 10” touch panels or approved equal with an active-matrix display, Aspect Ratio of 16:9 and a screen resolution (HV): 800 x 480 pixels with 18- bit color depth (Display colors: 256 K). AMX control hardware will be dictated by design.

**FLAT PANELS**

Two wall-mounted 70”, LCD TV screens, diagonally positioned, flat panels shall be provided and installed for primary display. The intent is to provide two full size images for far site video and computer graphics. (Sony KDL-70XBR3 70” LCD TV or approved equal)

**LECTERN**

- A full-height lectern of adequate size to meet the design criteria. It will be finished to match the appearance of the room.

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- The top surface of the lectern will be large enough for the touch-panel, a wide format computer monitor, 17 inch, (AID provided) a standard size notebook/laptop computer, electrical outlets, reading light, microphone, and the laptop wiring harnesses.
- The lectern will house sub-switching system and computer equipment.
- The lectern will have a keyboard drawer and document camera drawer. It will have four (4) grounded electrical power outlets on the top for temporary use by the presenter. All built-in equipment will be powered from a surge-protected power supply in the lectern. All built- in equipment will be rack-mounted.
- An appropriate network switch will be provided and installed in the lectern, with the capacity for all networkable devices installed in the lectern, a network connection for the laptop connections, and at least one (1) additional network connection available for future or temporary use. This network switch will be connected to the AID network via the data jack(s) located in the floor box.
- There will be a user-adjustable, weighted base, removable, BNC connected 18-inch gooseneck reading light with LED lamp on the top surface of the lectern. (Littlite18G- LE D or approved equal)

**MICROPHONES**

- The successful vendor will supply and install seven (7) microphones for use in the room.
  - One (1) wireless lavalier microphone (Shure WL184 or approved equal) with
    - Wireless body pack (Shure ULX1J1 or approved equal)
  - Two (2) wireless handheld microphones (ULX2/SM58 Cardioid Microphone or approved equal) with
    - Wireless Receiver (Shure ULXP4 diversity receiver or approved equal)
    - Stand and Adaptor (Atlas MS-12C or approved equal)
  - One (1) wired gooseneck lectern microphone (Audio-Technica U857QL microphone/AT8666 stand or approved equal)
  - Two (2) ceiling microphones (Audio Science or approved equal)
  - One (1) PZM microphone (Crown, PZM30D or approved equal)

**DOCUMENT CAMERA**

30 frames per second image capture, minimum SXGA (1280x1024) native resolution with an HDTV 1280x720 dot DVI-D output, 64x zoom (16x optical, 4x digital), Flexible camera and light arms (Elmo P100 or approved equal).

**VIDEO CONFERENCING**

- A videoconferencing CODEC and all necessary ancillary equipment to allow use of the room as either an originating source or a far-site in videoconference mode. The videoconference signal will be displayed on one of the primary displays. The presenter may select from the touch panel distant site, near site or both the near and distant (P-I-P) on the primary displays. Additionally, it shall have a button to allow ACTIVE MEDIA to over ride the FAR, NEAR PIP, selection so when media is selected it is displayed for the presenter but when a videoconference camera is selected it uses the FAR, NEAR, PIP selection. This selection is independent from the Confidence monitor selection (Tandberg C60 with NPP, dual video and two-year agreement or approved equal).
- The videoconference cameras will be Sony EVI-HD3V remote controlled pan/tilt/zoom/focus cameras. One (1) for presenter and one (1) for audience.

**AUDIO CONFERENCING**

The successful vendor will supply and install an audio conferencing system separate from the videoconferencing CODEC allowing call origination and call receiving. AID will provide an active analog telephone jack. Each microphone input shall have a dedicated acoustic echo canceller (Clearone XAP, Biamp Audia or approved equal).

**PODCASTING**

The successful vendor will supply and install a digital audio recording system designed to produce packaged podcasts (Marantz PMD570 or approved equal).

**SPEECH REINFORCEMENT SYSTEM**

Speech reinforcement will be via a distributed speaker system providing a constant level throughout the room, optimized for an audience of seated adults including provisions for the hearing impaired. Use Minimum Overlap equation from Sound System Engineering by Don and Carolyn Davis to establish appropriate speaker overlap (JBL Control 24T or approved equal).

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**ASSISTED LISTENING SYSTEM**

The successful vendor will supply and install an ADA-compliant assistive listening system with multi-channel receivers with all accessories for five (5) hearing- impaired audience members. Four signs indicating the availability of the receivers and channel number will be supplied.

**AUDIO DISTRIBUTION SYSTEM**

The successful vendor will supply and install an audio distribution system that provides discreet and controllable audio signals. Each microphone input shall have a dedicated acoustic echo canceller. The entire audio system shall be GSM hardened. The signal shall be routed to the following:

- Sound reinforcement system.
- Assistive listening system.
- Conferencing output. Conferencing audio will be provided to the videoconferencing CODEC.
- For audio conferencing, a separate, discreet audio feed will be provided to the audio conferencing hybrid.
- Recording. An audio feed will be provided for recording audio for podcasting.

**CONFIDENCE MONITOR**

A 42" wall-mounted, LCD TV, confidence monitor shall be provided in MR that is equipped for videoconference. In Presentation Mode, the monitor will show the ACTIVE MEDIA source at its' native resolution. In Videoconference Mode, the touch panel will allow selection between FAR ONLY, NEAR ONLY, NEAR+FAR (PIP) (Sharp 42" PN Series or approved equal). Additionally, it shall have a button to allow ACTIVE MEDIA to over ride the FAR, NEAR PIP selection so when media is selected it is displayed for the presenter but when a videoconference camera is selected it uses the FAR, NEAR, PIP selection. This monitor shall be located on the opposite wall from the presenter.

**BLU-RAY DVD PLAYER**

- Universal player (Blu-ray, SA-CD & DVD Audio compatible), internet video streaming, onscreen display GUI, full HD audio format decoding, dual USB ports, multi-media capability, ir ports, front panel input USB, Playback – Picture CD, CD-R/RW, DVD-R/-RW, MP3, JPEG, DVD-Video.
- 3D ready, 1080p/24Hz-compatible HDMI video output, 1080p playback for DVDs, photos and personal video data. Update capability via internet, Progressive Scan, Dolby Digital/DTS Decoders, Super Audio CD, DVD-Audio Playback, Audio DACs 192 kHz / 24 bit, Front Panel Input USB (WMV/MP3/WMA/JPEG), RS-232C Interface

**TV CABLE**

An RG59 cable with an "F" connector shall be installed inside the MR for reception of cable TV signals. AID will supply the successful vendor with a cable box prior to installation. Cable box to be a controllable source in the control system.

**WARRANTY REQUIREMENTS**

- A one (1) year full warranty of all equipment, programming, labor, and technical support must be included in the bid proposal. The warranty shall be explicitly with the successful bidder/vendor. All equipment manufacturers' warranties will be serviced through the vendor's facilities for the duration of the warranty.
- Optional warranty costs for years 2 and 3 must be included as line item bids on the Official Price Sheet in the bid response, and must be guaranteed rates, should AID decide to purchase this in the future. AID reserves the right to purchase extended warranty support on a year-by-year basis.
- The successful vendor must establish one point of contact where all problem(s) will be reported. The personnel at this location will be responsible for coordinating all efforts to correct the problem(s) and will update requesting agency at intervals to be established by agency and the vendor.
- The agency must be able to initiate the escalation procedure and on-site successful vendor support must be provided with next business day support.

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**SUPPORT/SERVICE REQUIREMENTS**

- Three (3) years of Support Service shall begin upon AID acceptance of completed system.
- The successful vendor must provide procedure with contact information (i.e. names, titles, phone numbers, and pager numbers) for support.
- Successful vendor must provide help desk support with ability to track reported issues via Internet and shall be available during normal business hours (8am-5pm CT).
- Successful vendor must be responsible for keeping all applicable software current for the term of the agreement.
- Restoration of service after catastrophic events such as fires, storms, earthquakes, or accidental damage shall be on a timely basis.
- The successful vendor must acknowledge receipt of trouble reports from the agency in conjunction with the services being provided under this contract.
- Upon notification of a request for support, the successful vendor must initiate corrective action within 24 hours. Corrective action by qualified vendor personnel may be provided remotely by telephone. However, if the situation cannot be rectified by telephone, vendor must provide on-site, next business day support.
- Repairs longer than 24 hours, vendor will be required to supply a loaner or replacement until such time as the original equipment can be repaired and placed back into service free of charge.
  - Loaners or replacements must be of the same quality or better

**TRAINING REQUIREMENTS**

- Comprehensive on-site training of designated AID key support staff and primary users will be required.
- On-site training shall be provided for a minimum of six (six) non-consecutive half days during the first six months.
- Training shall include Presenter and Administrator functions.
  - Presenter Training – train the end user in the overall use and operation of the integrated system.
  - System Administrator Training – The training shall include software management functions and system security. The training shall also include any system back-up and reload procedures.
- The Successful vendor shall provide all instructors and instructional material including four (4) trainees’ workbooks, four (4) instructor guides, four (4) training aids, and two (2) technical manuals.
- Vendor must train four (4) applicable personnel to keep the system up and running properly.

**DOCUMENTATION**

- The bidder will supply a detailed inter connect drawing of the proposed system with bid.
- The bidder will provide product specification sheets on all proposed items with bid.
- Successful Vendor shall provide User’s and Owner’s manuals to the agency once the installation has been completed.
- Successful Vendor shall provide supporting documentation for software reflecting upgrades and enhancements as they become available during the contract period or extension(s).
- Successful Vendor shall provide complete printed and electronic documentation for the integrated system and the instrument interfaces, including installation instructions; system administration and maintenance, technical reference any other manuals relevant to the operation of the integrated system upon completion.

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**OFFICIAL PRICE SHEET**

<b>DESCRIPTION</b>	<b>PRICE</b>
Equipment, Installation, Training, One (1) Year Warranty	\$ _____
Three (3) Years Support/Service	\$ _____ Per Year
<b>GRAND TOTAL</b>	<b>\$ _____</b>
<hr/>	
Optional Warranty Year 2	\$ _____ Per Year
Optional Warranty Year 3	\$ _____ Per Year

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**MANDATORY SITE VISIT FORM**

All prospective bidders must attend the mandatory site visit to submit a bid. Proof of the site visit must be included with bid submission. Proof must be signed and dated by Jaime Kaufman, Lowell Nicholas, or their designee(s) and included with your bid submission or bid may be rejected.

\_\_\_\_\_  
**AID / OSP Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Vendor**

\_\_\_\_\_  
**Date**

attended the mandatory site visit @ the AID Meeting Room located at Suite 201, 1200 Third St., Little Rock, Arkansas, 72201.

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**STANDARD TERMS & CONDITIONS**

**GENERAL:** Any special terms and conditions included in the invitation for bid override these standard terms and conditions. The standard terms and conditions and any special terms and conditions become part of any contract entered into if any or all parts of the bid are accepted by the State of Arkansas.

**ACCEPTANCE AND REJECTION:** The State reserves the right to accept or reject all or any part of a bid or any and all bids, to waive minor technicalities, and to award the bid to best serve the interest of the State.

**BID SUBMISSION:** Bids must be submitted to the Office of State Procurement on this form, with attachments when appropriate, on or before the date and time specified for bid opening. If this form is not used, the bid may be rejected. The bid must be typed or printed in ink. The signature must be in ink. Unsigned bids will be disqualified. The person signing the bid should show title or authority to bind his firm in a contract. Each bid should be placed in a separate envelope completely and properly identified. Late bids will not be considered under any circumstances.

**PRICES:** Quote F.O.B. destination. Bid the unit price. In case of errors in extension, unit prices shall govern. Prices are firm and not subject to escalation unless otherwise specified in the bid invitation. Unless otherwise specified, the bid must be firm for acceptance for thirty days from the bid opening date. "Discount from list" bids are not acceptable unless requested in the bid invitation.

**QUANTITIES:** Quantities stated in term contracts are estimates only, and are not guaranteed. Bid unit price on the estimated quantity and unit of measure specified. The State may order more or less than the estimated quantity on term contracts. Quantities stated on firm contracts are actual requirements of the ordering agency.

**BRAND NAME REFERENCES:** Any catalog brand name or manufacturer's reference used in the bid invitation is descriptive only, not restrictive, and used to indicate the type and quality desired. Bids on brands of like nature and quality will be considered. If bidding on other than referenced specifications, the bid must show the manufacturer, brand or trade name, and other descriptions, and should include the manufacturer's illustrations and complete descriptions of the product offered. The State reserves the right to determine whether a substitute offered is equivalent to and meets the standards of the item specified, and the State may require the bidder to supply additional descriptive material. The bidder guarantees that the product offered will meet or exceed specifications identified in this bid invitation. If the bidder takes no exception to specifications or reference data in this bid he will be required to furnish the product according to brand names, numbers, etc., as specified in the invitation.

**GUARANTY:** All items bid shall be newly manufactured, in first-class condition, latest model and design, including, where applicable, containers suitable for shipment and storage, unless otherwise indicated in the bid invitation. The bidder hereby guarantees that everything furnished hereunder will be free from defects in design, workmanship and material, that if sold by drawing, sample or specification, it will conform thereto and will serve the function for which it was furnished. The bidder further guarantees that if the items furnished hereunder are to be installed by the bidder, such items will function properly when installed. The bidder also guarantees that all applicable laws have been complied with relating to construction, packaging, labeling and registration. The bidder's obligations under this paragraph shall survive for a period of one year from the date of delivery, unless otherwise specified herein.

**SAMPLES:** Samples or demonstrators, when requested, must be furnished free of expense to the State. Each sample should be marked with the bidder's name and address, bid number and item number. If samples are not destroyed during reasonable examination they will be returned at bidder's expense, if requested, within ten days following the opening of bids. All demonstrators will be returned after reasonable examination.

**TESTING PROCEDURES FOR SPECIFICATIONS COMPLIANCE:** Tests may be performed on samples or demonstrators submitted with the bid or on samples taken from the regular shipment. In the event products tested fail to meet or exceed all conditions and requirements of the specifications, the cost of the sample used and the reasonable cost of the testing shall be borne by the bidder.

**AMENDMENTS:** The bid cannot be altered or amended after the bid opening except as permitted by regulation.

**TAXES AND TRADE DISCOUNTS:** Do not include state or local sales taxes in the bid price. Trade discounts should be deducted from the unit price and the net price should be shown in the bid.

**AWARD:** Term Contracts: A contract award will be issued to the successful bidder. It results in a binding obligation without further action by either party. This award does not authorize shipment. Shipment is authorized by the receipt of a purchase order from the ordering agency. Firm Contracts: A written state purchase order authorizing shipment will be furnished to the successful bidder.

**LENGTH OF CONTRACT:** The invitation for bid will show the period of time the term contract will be in effect.

**DELIVERY ON FIRM CONTRACTS:** The invitation for bid will show the number of days to place a commodity in the ordering agency's designated location under normal conditions. If the bidder cannot meet the stated delivery, alternate delivery schedules may become a factor in an award. The Office of State Procurement has the right to extend delivery if reasons appear valid. If the date is not acceptable, the agency may buy elsewhere and any additional cost will be borne by the vendor.

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**DELIVERY REQUIREMENTS:** No substitutions or cancellations are permitted without written approval of the Office of State Procurement. Delivery shall be made during agency work hours only 8:00 a.m. to 4:30 p.m., unless prior approval for other delivery has been obtained from the agency. Packing memoranda shall be enclosed with each shipment.

**STORAGE:** The ordering agency is responsible for storage if the contractor delivers within the time required and the agency cannot accept delivery.

**DEFAULT:** All commodities furnished will be subject to inspection and acceptance of the ordering agency after delivery. Back orders, default in promised delivery, or failure to meet specifications authorize the Office of State Procurement to cancel this contract or any portion of it and reasonably purchase commodities elsewhere and charge full increase, if any, in cost and handling to the defaulting contractor. The contractor must give written notice to the Office of State Procurement and ordering agency of the reason and the expected delivery date. Consistent failure to meet delivery without a valid reason may cause removal from the bidders list or suspension of eligibility for award.

**VARIATION IN QUANTITY:** The State assumes no liability for commodities produced, processed or shipped in excess of the amount specified on the agency's purchase order.

**INVOICING:** The contractor shall be paid upon the completion of all of the following: (1) submission of an original and the specified number of copies of a properly itemized invoice showing the bid and purchase order numbers, where itemized in the invitation for bid, (2) delivery and acceptance of the commodities and (3) proper and legal processing of the invoice by all necessary State agencies. Invoices must be sent to the "Invoice To" point shown on the purchase order.

**STATE PROPERTY:** Any specifications, drawings, technical information, dies, cuts, negatives, positives, data or any other commodity furnished to the contractor hereunder or in contemplation hereof or developed by the contractor for use hereunder shall remain property of the State, be kept confidential, be used only as expressly authorized and returned at the contractor's expense to the F.O.B. point properly identifying what is being returned.

**PATENTS OR COPYRIGHTS:** The contractor agrees to indemnify and hold the State harmless from all claims, damages and costs including attorneys' fees, arising from infringement of patents or copyrights.

**ASSIGNMENT:** Any contract entered into pursuant to this invitation for bid is not assignable nor the duties thereunder delegable by either party without the written consent of the other party of the contract.

**OTHER REMEDIES:** In addition to the remedies outlined herein, the contractor and the State have the right to pursue any other remedy permitted by law or in equity.

**LACK OF FUNDS:** The State may cancel this contract to the extent funds are no longer legally available for expenditures under this contract. Any delivered but unpaid for goods will be returned in normal condition to the contractor by the State. If the State is unable to return the commodities in normal condition and there are no funds legally available to pay for the goods, the contractor may file a claim with the Arkansas Claims Commission. If the contractor has provided services and there are no longer funds legally available to pay for the services, the contractor may file a claim.

**DISCRIMINATION:** In order to comply with the provision of Act 954 of 1977, relating to unfair employment practices, the bidder agrees that: (a) the bidder will not discriminate against any employee or applicant for employment because of race, sex, color, age, religion, handicap, or national origin; (b) in all solicitations or advertisements for employees, the bidder will state that all qualified applicants will receive consideration without regard to race, color, sex, age, religion, handicap, or national origin; (c) the bidder will furnish such relevant information and reports as requested by the Human Resources Commission for the purpose of determining compliance with the statute; (d) failure of the bidder to comply with the statute, the rules and regulations promulgated thereunder and this nondiscrimination clause shall be deemed a breach of contract and it may be cancelled, terminated or suspended in whole or in part; (e) the bidder will include the provisions of items (a) through (d) in every subcontract so that such provisions will be binding upon such subcontractor or vendor.

**CONTINGENT FEE:** The bidder guarantees that he has not retained a person to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee, except for retention of bona fide employees or bona fide established commercial selling agencies maintained by the bidder for the purpose of securing business.

**ANTITRUST ASSIGNMENT:** As part of the consideration for entering into any contract pursuant to this invitation for bid, the bidder named on the front of this invitation for bid, acting herein by the authorized individual or its duly authorized agent, hereby assigns, sells and transfers to the State of Arkansas all rights, title and interest in and to all causes of action it may have under the antitrust laws of the United States or this State for price fixing, which causes of action have accrued prior to the date of this assignment and which relate solely to the particular goods or services purchased or produced by this State pursuant to this contract.

**DISCLOSURE:** Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that order, shall be a material breach of the terms of this contract. Any contractor, whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the agency.

# ARISTOTLE®

***RATE REVIEW DIVISION  
WEBSITE DESIGN PROPOSAL***

***PREPARED FOR:  
ARKANSAS INSURANCE  
DEPARTMENT***

***SEPTEMBER 1, 2011***

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## OVERVIEW

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Thank you for considering Aristotle as your marketing firm. We look forward to developing a powerful online presence for the Arkansas Insurance Department Rate Review Division. We have prepared this document to define the proposed scope of work and cost estimates for the design and programming of your website.

## OBJECTIVES

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The AID Rate Review Division desires an easy-to-use and informative website that accomplishes the following objectives:

- o Educates Arkansans about insurance rate review
- o Encourages consumer involvement and provides ways for consumers to get involved in the insurance rate review process
- o Provides helpful, basic information **about health insurance (think “Health Insurance 101”)** that can be easily found through search engines and through site navigation / content organization

## AUDIENCES

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The main page and interior page designs will take into account the AID Rate Review Division’s target audiences and the focus of the design will appeal to Arkansans of minimum employment age and older who have insurance policies.

## EXPECTATIONS

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Aristotle is skilled in understanding the preferences and patterns of use for site visitors when they visit a government website. Our focus on visitor patterns and preferences allows us to design your website guided by the following customer expectations:

- o A colorful, attractive, and informative website that allows visitors to view information about the AID Rate Review Division
- o Seeing engaging service-related images
- o An easily navigable, accessible and unambiguous website

## MEASURES OF SUCCESS

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A website offers unique opportunities to specifically track visitor activity and interest, over and above other media such as radio, television or print. Aristotle recommends that the AID Rate Review Division measure the success of the website and social media efforts through the following:

- o Website Traffic
- o Engagement on Website
  - Pages liked and shared with friends through social media share tools
  - Quantity and quality of comments on blog posts
- o E-Alerts Signups
- o Number of Facebook Likes
- o Number of Twitter Followers
- o Engagement on Facebook
- o Engagement on Twitter

## WEBSITE DESIGN SUMMARY

The focus of the website will be on clearly presenting and explaining to insurance consumers what **insurance rate review is, why it's important to insurance policy holders, and** how consumers can get involved to make a difference. To help make this information more appealing and interesting to consumers, Aristotle will create a graphic-intensive site design and present the information as interactive components when possible.

### SITE NAVIGATION

The following table shows the expected primary/secondary site navigation.

Primary Navigation (Main page)	Secondary Navigation (Interior pages)
What is Rate Review?	What is Rate Review?
The Review Process	The Review Process
Search Rate Requests & Filings	(Rate Rate Requests & Filings Database & Advanced Search)
Rates Q&A	Rates Q&A
News	News Articles
Consumer Guide to Health Insurance	Glossary of Health Insurance Terms
	Health Care Reform
	Health Insurance Tips
	Types of Health Insurance Policies
	How to Shop for Individual Health Insurance

Aristotle will create a site map that provides text links to the major sections of the website. The site map provides an understandable reference to the overall architecture of the site for visitors and allows search engines an effective mechanism to index the entire website.

### MAIN PAGE & INTERIOR PAGE DESIGN

Aristotle will consult with the AID Rate Review Division to develop the look and feel of the website that captures the attention of Arkansan insurance consumers and provides clear calls to action. The design will be graphic-intensive, include bright colors and a clean layout, which will set it apart from typical government websites, while still being accessible to people with vision impairments. We will develop a consistent global navigation system for the site, and develop the images and text to download quickly so visitors can quickly and easily access the information they seek.

An accessible and attractive interior design is important to provide easy navigation of the website. Aristotle will create an interior design that will continue the theme of the main page design. From any page of the site, visitors will be able to easily access any of the other key sections within the site. This includes the creation of **six (6) section headers** for each of the principal interior pages as described above.

In addition, Aristotle will treat up to **10 photos** for optimal web display, which includes converting, cropping and sizing. The Main Page will also include a video that illustrates the **rate review process and explains why it's important for consumers, as well as three promotional graphics**—or calls to action—that will motivate site visitors to take the following actions:

1. Sign-up for E-Updates
2. Get Involved
3. Search Rate Requests & Filings

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## CONTENT MANAGEMENT SYSTEM

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Aristotle will develop a robust, comprehensive Content Management System (CMS) for the AID Rate Review Division website to allow your staff to add, edit and remove website information as needed without having to return to Aristotle for website changes. Making a site easy to manage for your staff, no matter what their level of technical expertise, is critical to success.

Aristotle uses .NET and SQL programming for the CMS components of the websites we program. **Aristotle's Web programmers are licensed Microsoft Developer Network** members who use standard coding protocol and nationally recognized database development software (.NET, Java, Java Script, HTML, standard DLL structures, etc.). **Unlike some developers who insist on "off the shelf/out of the box" software products with substantial yearly licensing fees and cloaked code, Aristotle's** databases could be viewed and understood by any Level II or Level III programmer in the market.

Should the AID Rate Review Division **require features that aren't identified in Aristotle's scope** below, we can add modules to match the project needs.

**Through Aristotle's CMS,** the AID Rate Review Division staff can log in anytime to update website content, upload photos, create new web pages and carry out other important website maintenance tasks. Your Aristotle Producer Team will train the AID Rate Review Division staff to use the CMS (through WebEx or in-person training and written documentation) to ensure that the AID Rate Review Division staff is comfortable with and able to update website content with confidence. Our CMS is currently supporting more than 200 websites, including the Albuquerque Convention and Visitor Bureau, whose marketing director finds the technology makes her life easier:

*"Hi, Just a little note that I have been playing with the CMS for the pages all day and it is one of the most elegant, simple and easy-to-use systems I have used. Please pass on my gratitude to the programming team who worked on it. It will simplify my life in so many ways."*

*—Maresa Thompson, Albuquerque Convention & Visitors Bureau*

Once Aristotle trains your staff to use the CMS, the AID Rate Review Division will be fully empowered to execute the following website maintenance tasks without engaging Aristotle:

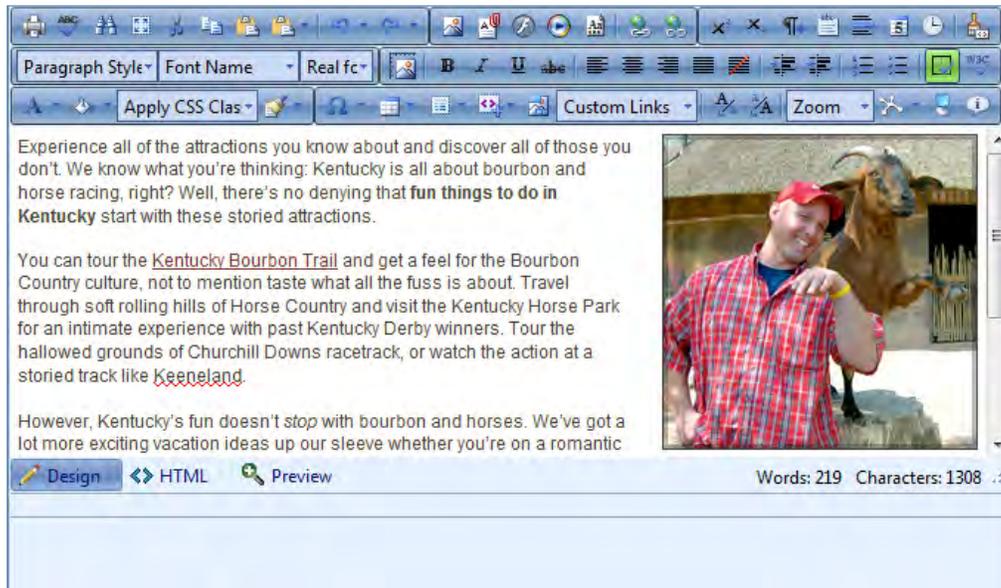
1. Edit and format text through a "WYSIWYG" editor (includes standard Word processing features)
2. Edit HTML code to embed social media widgets and other code (such as Flickr galleries, YouTube videos, Facebook plugins and more)
3. Upload and resize photos, images, and graphics
4. Upload documents and files (PDFs, Word documents, etc.), and create links to those documents
5. Add links to video files or embed YouTube videos on any page of the website
6. Create new sub-pages with no limit to the level of sub-page depth
7. Add, edit and remove sub and tertiary navigation
8. Post story/text links in more than one area through Relational Administration Tools
9. Select from templates or create pages completely from scratch through HTML
10. View changes before publishing to the live website through an auto-preview function
11. Mark pages as active or inactive

12. Optimize web pages for search engine performance by adding meta keywords, descriptions and page titles
13. Write alt attributes and descriptions for photos and videos
14. Create custom, search engine friendly URLs for new web pages

### **“WYSIWYG” Text Formatting Editor**

Aristotle will develop functionality in the content management tool that gives the AID Rate Review Division the ability to make formatting changes on the text that is included in the website. Aristotle will implement a control panel for formatting text information similar to the following panel.

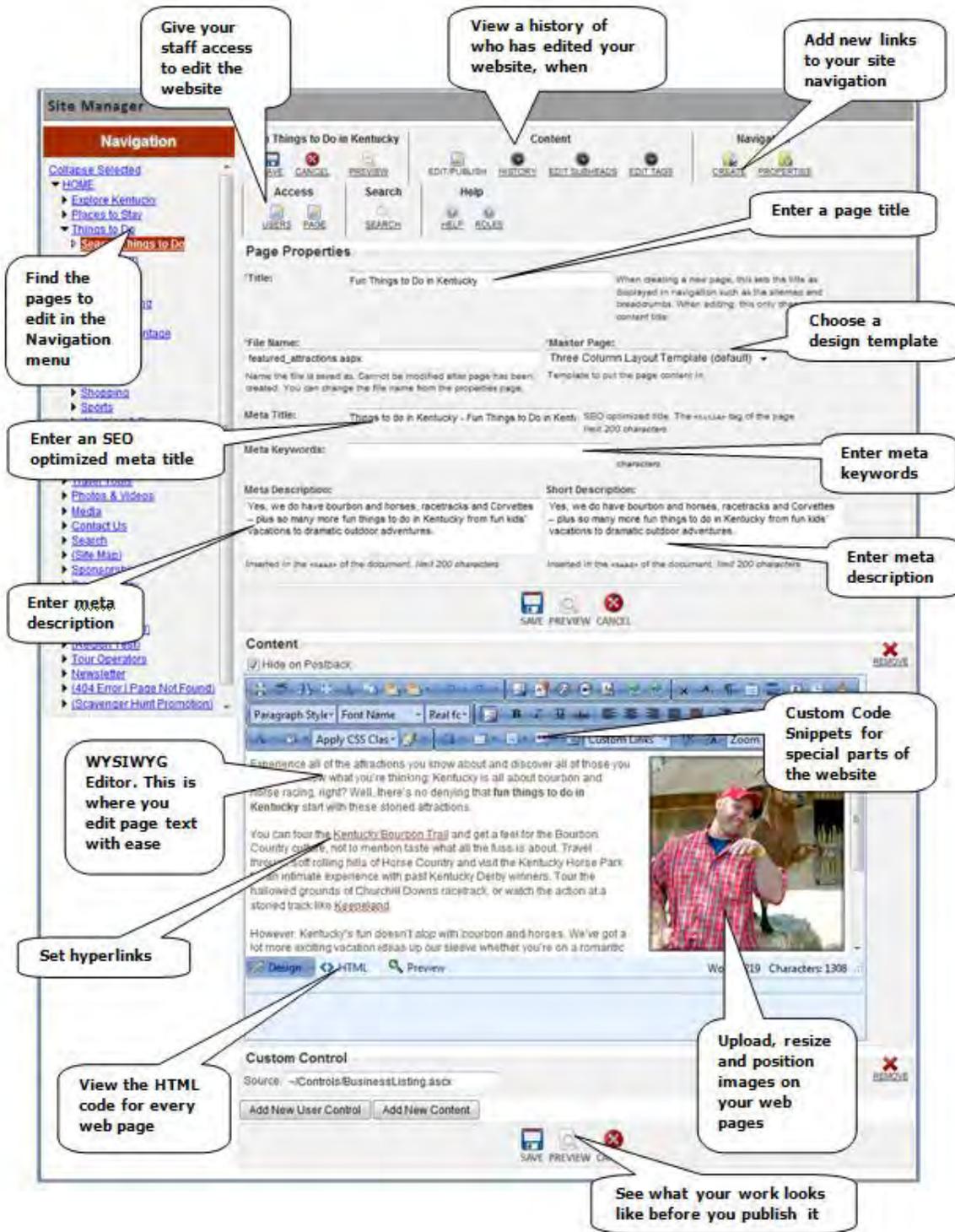
This control panel will allow staff members to not only add, edit and remove basic text, but also to include formatting for the text, such as making a line of text bold, underlined or italicized.



### **Sub-Page Creation and Page Editor**

Aristotle will program the AID Rate Review Division website to give the staff the ability to add, edit and remove pages of the website as needed. Aristotle will program the CMS to allow the staff to develop infinite levels of sub-sections under each major website section. This will allow visitors to link directly to the various sub-sections that display on the introductory page of each section.

When a website visitor selects a link, they will be taken to the page with information about the topic they selected. These sub-sections will also display in the drop-down navigation of the website's main page.



### Image Upload and Resize Tool

Aristotle will program an image upload tool, which will allow your staff to upload web-ready photographs and images to the website, resize them within the WYSIWYG Editor, and publish them to your website. Once an image has been uploaded to the site it can be re-used on many pages.

### Meta Tag Update Tool

Aristotle will develop management tools to allow your staff to add, edit and remove Meta tag information throughout the website. These management tools will include text fields for title tags, description tags and keyword tags. Additionally, Aristotle will program the tools to allow your staff

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to assign page file names. The tags and file names will help the website pages perform better in search engines for the specific terms entered for the section.

**Password Protection**

Aristotle will develop one login and password for the AID Rate Review Division website. Aristotle is capable of developing a multi-level password and login system, which will allow the AID Rate Review Division staff to have various levels of access to the Content Management Tools. For the purposes of this document we have provided the cost estimate for the basic level of password protection.

**RATE REQUESTS & FILINGS DATABASE / ADVANCED SEARCH**

Aristotle will create an Arkansas Rate Requests & Filings Database with an Advanced Search feature that allows site visitors to quickly find rate filings and view details, requests and decisions in an easy-to-read format. The Arkansas Rate Filings Database and Advanced Search will be based on the Oregon Health Insurance Rate Review tool found at [www.OregonHealthRates.org](http://www.OregonHealthRates.org).

**Oregon Health Insurance Rate Review Advanced Search**  
[http://www.oregonhealthrates.org/?fuseaction=home.show\\_search](http://www.oregonhealthrates.org/?fuseaction=home.show_search)

**Advanced Search Results Page**  
[http://www.oregonhealthrates.org/index.cfm?fuseaction=home.show\\_filings](http://www.oregonhealthrates.org/index.cfm?fuseaction=home.show_filings)

State Tracking Number	Company Name	Type of Insurance	% Change Requested	% Change Approved	No. of Members	Effective Date	Status	Rate Filing Documents
04-0095-02	AETNA LIFE INSURANCE COMPANY	Small Employee	9.4%	9.4%	189	07/01/2010	APPROVED	View Request View Decision View Request View Decision
04-0096-03	AETNA LIFE INSURANCE COMPANY	Individual (Major Medical)	-31.2%	-31.2%	19	07/01/2010	APPROVED	View Request View Decision

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The AID Rate Review Division will have an Admin tool within the CMS for posting new rate filings to the database. Aristotle will build a user-friendly display from the data saved in the database.

**Database Fields will include:**

- State Tracking Number
- Health Insurance Company Name
- Type of Insurance
  - Individual
  - Portability
  - Small Employer
- Percentage Change Requested
- Percentage Change Approved
- Number of Members
- Effective Date
- Status
  - Pending
  - Approved
  - Disapproved
  - Closed
- Rate Filing Documents
  - View Request (PDF document)
  - View Decision (PDF document)

**Advanced Search fields will include:**

- Insurance Company Name
  - Company Name 1
  - Company Name 2
  - Company Name 3
- Insurance Type
  - Individual
  - Portability
  - Small Employer
- State Tracking #
- Status
  - Pending
  - Approved
  - Disapproved
  - Closed
  - All
- Sort
  - Company Name
  - Date Effective
  - Insurance Type
  - Status

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**NEWS**

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Aristotle will develop a News section for the AID Rate Review Division website that will include a list of news articles and press releases available for use by the media and site visitors. Possible news topics include announcing new rate increase requests, explaining health care reform in plain English, discussing why health insurance rates keep increasing, etc. Your staff will have the ability to login to the CMS to add, edit and remove stories seamlessly.

As an additional option, this section can be promoted with a main page promotional icon and can have a corresponding RSS Feed to inform the press and other interested parties when new stories have been added to the site. Furthermore, Aristotle can add commenting ability in the future if the AID Rate Review Division decides to allow and encourage public commenting on news articles.

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**SOCIAL MEDIA & USABILITY FEATURES**

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Aristotle will build the site with several features on every Interior Page that will enhance usability and allow visitors to easily share site content with connections in their social media networks.

**SEARCH**

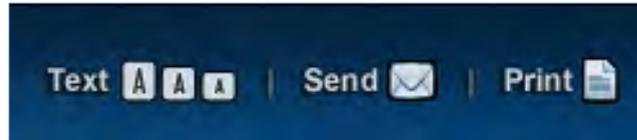
---

Aristotle will include programming for a Google Mini website search feature. This allows site visitors to enter keywords to search all web content using Google Mini technology. The search feature can be accessed easily from the main page and interior pages of the website. This text search feature will return a page title and introductory text for the page, with a link to the page that displays the information.

The search feature will include a tracking system that will allow the AID Rate Review Division staff to have a clearer understanding of what visitors are searching for on the website. The AID Rate Review Division staff will have access to an admin where search data and reports can be viewed.

**TEXT / SEND / PRINT**

Aristotle will include several tools on all Interior Pages that allow site visitors to adjust the page text size, send a link to the page they're viewing to a friend via email, and print the page.



**SHARE TOOLBAR**

Adding a social networking toolbar to your website can help increase your website's ranking in search engines as well as the amount of site traffic. Aristotle can add this Bookmark and Share toolbar to your site and include analytic reports to help you understand how visitors are sharing content. Reports provide sharing trends over a certain amount of time, what content has been shared the most and which sharing feature is the most popular.



**FACEBOOK LIKE BUTTON**

The Like button lets site visitors "Like" your website content and automatically share them with their friends on your website and on Facebook. Site visitors can press the Facebook "Like" button at the top of any story, add a comment if they want, and approve it. A post saying that they have "Liked" the story will appear on their Facebook wall and as part of your News Feed. For logged-in Facebook users, the button will highlight friends who have also liked the page.

For example, if you "Like" a pair of jeans on Levis.com, your action will be shared with your friends on Facebook, where they can comment on it. You can also see which of your friends like the jeans on Levis.com.

*Aristotle will integrate the "Like Button" on all interior pages of the website. This will allow people who use their Facebook login to "Like" all content on the website.*

**Example Like Button: <http://www.arkansasstateparks.com/park-finder/>**



## SOCIAL MEDIA BADGES

Aristotle will place social media badges on the website to help site visitors quickly connect with the AID Rate Review Division on Facebook and Twitter. Badges are simply the Facebook and Twitter logo with a direct link to the AID Rate Review Division's respective social media profiles.

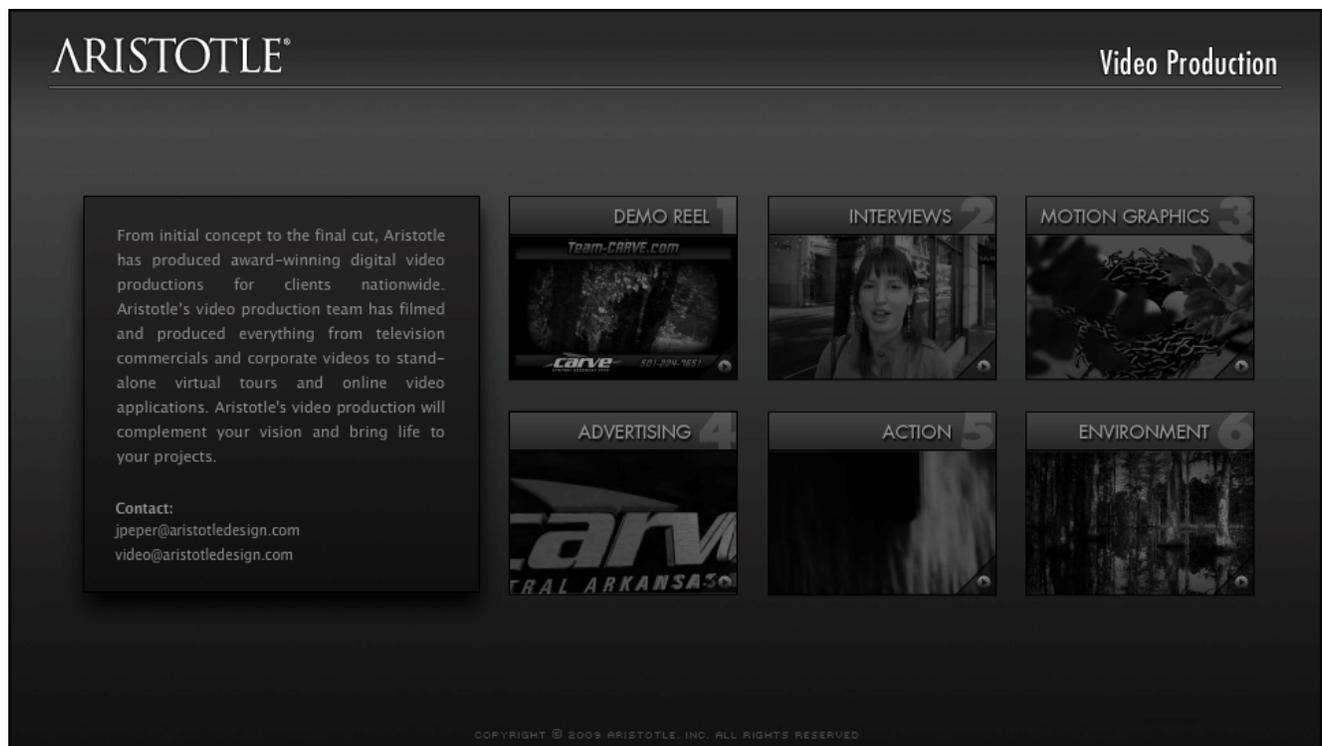
## VIDEO DEVELOPMENT

To help clearly explain the insurance rate review process, why it's important to consumers and how they can get involved, Aristotle highly recommends telling the story through a series of videos or animations.

From initial concept to the final cut, Aristotle has produced award-winning video productions for clients nationwide. We can help the AID Rate Review Division craft a vision, or take an edited piece and deploy it using the latest web delivery applications. Our video team has filmed and produced everything from television commercials and corporate videos to stand-alone virtual tours and online video applications.

This work includes everything from developing the script for videos and commercials, through shooting the video and producing the video for the final medium and compressing any video that will be used on the web. In addition, Aristotle can offer consulting on the best method to deliver the final video, including live streaming to offering files for download from the website or embedded YouTube video files.

Aristotle's video production will complement your vision and bring life the AID Rate Review Division website. For examples of Aristotle's video production, please view our interactive portfolio at <http://video-production.aristotle.net/>



### Interactive Video Production Portfolio

Aristotle will initially create **two (2) videos, up to one finished minute in length each**, for use on the website. One video will feature a filmed spokesperson, and the other video will be an

animation that illustrates a difficult-to-grasp concept about health insurance and the rate review process. Our proposed effort and list of items to be delivered includes the following tasks:

- Aristotle will coordinate and schedule all **meetings** to create the concept for the piece.
- Aristotle will conduct a discovery **scouting** trip to the site in preparation for storyboarding.
- We will produce a **script**.
- We will produce functional **storyboards**.
- We will drive the **schedule** based on client availability.
- Aristotle will **shoot on location** in Little Rock, Arkansas as need. Aristotle typically anticipates 10 hour days. We will be responsible for crew and equipment.
- We will **edit** the video in-house at Aristotle. We will keep an open dialogue with AID Rate Review Division during the editing process to ensure the video is progressing in a manner felt best represents the piece.
- Using Aristotle's Final Cut Pro Server, Aristotle will allow access to the raw footage and rough edits so the AID Rate Review Division staff can **review** progress and make comments.
- We will **deliver** a master DVD of the final edit. Aristotle can deliver additional copies of the final edit with b-roll available for use on other projects, and multiple encodes of the final edit for use on the Web, kiosks, digital signage screens and any other format that may be required.

Aristotle will provide a one-day (10 hours per day) video shoot with one fully trained crew member. The cost estimate includes the on location video shoot, post-production processing for one finished minute of video, and deliverables. Aristotle will hold the usage rights, but B-roll is available for purchase. This estimate does not include pass-through travel, lodging, and food expenses – these will be billed separately after the shoot is completed and expenses are calculated, if applicable, although we do not anticipate additional expenses because the video shoot will take place in Little Rock.

Additionally, Aristotle will **encode and optimize both videos for YouTube** so that people can find the videos for relevant search terms and share them virally.

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## E-UPDATES SYSTEM

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To inform consumers about insurance rate reviews, Aristotle highly recommends sending out notifications through an E-Updates System that people can opt-in to receive through the website. Users must provide, at a minimum, their name and email address. The AID Rate Review Division can then send E-Updates to people who have registered to receive them as often as needed, although we recommend sending E-Updates at least monthly and no more than weekly.

As an award-winning provider of marketing services and Internet and email technologies, Aristotle enables organizations to create, deliver and measure email newsletters and campaigns. Our complete email marketing solutions include design, message, segmentation and tracking.

### MAILSAGE SETUP

Aristotle will setup the AID Rate Review Division in the MailSage program for managing the subscriber base, composing and sending emails and tracking deliverability and click-through rates.

**Aristotle's proprietary MailSage email list management program puts your company in control over your email campaigns and e-newsletter communications.** MailSage provides a cost-effective way for your



company to create custom lists, change the look and feel of you newsletters, upload graphics, and track the performance of each campaign.

### **List & Address Management**

Aristotle's MailSage will allow you to import your own lists or will be set up to sign up subscribers from your current site.

- Build and merge lists with online tools
- Create new lists or list sub groups
- Upload pre-existing lists
- Email list merge
- Add/Delete subscribers manually
- Automate email de-duplication
- Unsubscribe groups of participants

### **Campaign Creation & Maintenance**

MailSage makes campaign management and personalization easy.

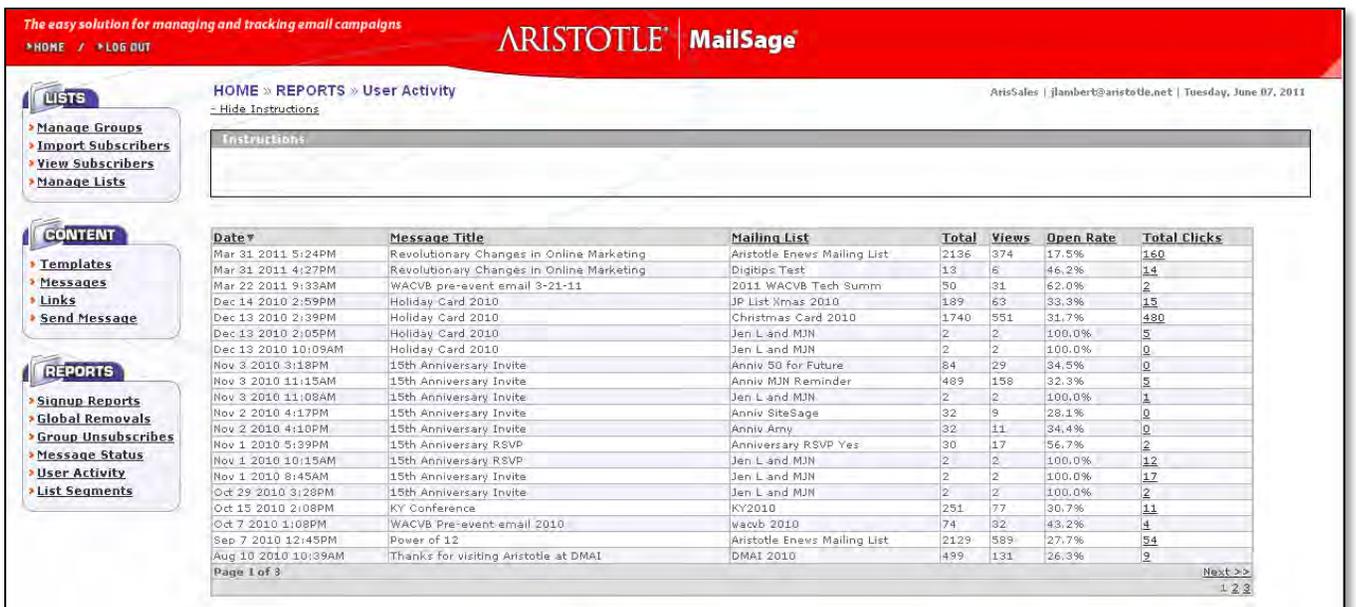
- Personal content library- upload images & files
- Cross platform compatibility (MAC or PC)
- HTML WYSIWYG editor
- Preview drafts
- Upload pre-existing HTML templates
- Pull HTML content from external site sources for dynamic content creation
- Personalized message content
- Target specific demographics (including 10 custom fields)

### **Tracking & Reporting**

MailSage includes advanced tracking features.

- Open rates tracked by campaign
- Click- through rates for HTML links
- Hard bounces
- Undeliverables
- Sign-up and Removal history
- ROI link tracking
- Numeric reports

Aristotle's MailSage is a custom-built software that is powered by a unique operating system to ensure high performance and security. Designed to meet the needs of the world's largest enterprise email campaigns, **Aristotle's MailSage contains** advanced mail delivery features such as robust queue management, bounce handling and connection management. This system ensures that your email infrastructure is never overwhelmed - even during pernicious virus or spam attacks. MailSage can deliver email at a rate of over 900,000 messages per hour – faster than most traditional email delivery applications.



## E-UPDATES TEMPLATE

Aristotle will design one E-Updates template with a simple header and body text to be used for sending to subscribers. The E-Updates template will coordinate with the website design and will include the following:

- Preview-pane friendly and viewable in the most popular email clients and Web mail interfaces, such as Microsoft Outlook, Microsoft Outlook Express, AOL, Yahoo! Email, Microsoft Hotmail and Gmail
- Formatted with an image-to-text ratio of below 50% to avoid triggering spam filters, since spam emails often contain higher image-to-text ratios
- Opt-in/Opt-out and privacy policies included in the design
- **Forward to a Friend** capability included for sharing

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## SEARCH ENGINE OPTIMIZATION

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Designing an effective website is just the initial step in developing an effective online presence. For a site to be successful, visitors must be able to find it when searching for the information or services the site provides. Aristotle offers a number of coordinated Internet marketing strategies designed to boost search engine rankings and increase traffic to websites. Aristotle is expert in the ever-changing rules that govern search engine website rankings and has developed highly effective methods for improving the search engine performance of our **clients' websites**.

Keywords are the important words and phrases that your target audience uses to find your website in search engines such as Google and Bing. In many cases, a website will only rank well for its company name, but Aristotle explores a wide variety of keyword phrases that could be used to **drive quality traffic to a client's website, which may include name, location, services, attractions** and more. Search engines determine the importance or relevancy of keywords for each website page based on the information included in the search engine optimization and external links to the website. Search engine optimization involves selecting popular, relevant keyword phrases and including those terms in strategic areas of the site.

### Aristotle's Optimization Tasks

Aristotle will evaluate the current text and layout of your website and the information that you provide to begin the keyword research process. Aristotle will explore all possible traffic-producing keyword phrases via our industry software to generate keyword recommendations for each of your website pages to be optimized. Our recommendations will be based on our extensive SEO **knowledge, industry keyword research tools, competitive analyses and Aristotle's proprietary techniques**.

Upon your approval, Aristotle will infuse the keyword phrases into the title tags, Meta description tags, Meta keyword tags, image alt attributes, image names, visible text, h1 tags and hypertext links on the **Main Page** and up to **5 Interior Pages**. In addition, Aristotle will employ cross-linking methods to enhance your optimization results. Your team will conduct a final review of the updated website text and tags before Aristotle posts the revisions to the site.

### SEO includes:

- Keyword Research
- Tags: Title, Meta Keywords, Meta Description, Image Alt Attributes
- Keyword Infusion: Visible Text, H1 tags, Hypertext Cross-Links, Image File Names
- Hypertext Cross-Linking: Adding Additional Keyword-Rich Links

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## USABILITY RESEARCH

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Aristotle will conduct a Usability Study of the redesigned AID Rate Review Division website and **provide a written report of our findings along with recommendations for further improving the site's usability**.

The purpose of the study is to assess what aspects of the web design may need to be changed or revised in order to make the site easier to use and more appealing to site visitors. Input in several areas will provide in-depth insight into how the website can work even better to provide useful information to insurance consumers and help them understand basic information about health insurance and the rate review process.

Aristotle will recruit and test up to five (5) participants that will represent a broad range of web savvy, age and gender. Our goals will be to determine what is or is not working successfully on the **new web site from the users' perspective. We will look for information such as:**

- o Do users complete each task successfully?
- o If so, how fast do they perform each task?
- o Is that fast enough to satisfy them?
- o What paths do they take in trying?
- o Do those paths seem efficient to them?
- o Where do they stumble?
- o What problems do they have?
- o Where do they get confused?
- o **What words or paths are they looking for which aren't in the web site?**

Aristotle employees will read aloud five (5) tasks for the study participants to complete using the AID Rate Review Division website. Aristotle will not provide any further guidance or answer any additional questions the users may have pertaining to the task assigned until it is either complete or they were not able to finish the task. Aristotle will then observe and note the path and process taken by each user to reach the end of the task. Following each testing session, Aristotle will issue an exit questionnaire for participants to complete based on their experience with the website.

Finally, Aristotle will create a written report covering the results of the sessions and all recommendations based on observations, participant feedback and survey responses.

### **Budget Breakdown:**

Honorarium (\$50/person):	\$250
Recruitment, Scheduling & Set-Up (\$300/person):	\$1,500
Screeener & Discussion Guide Sheet	\$400
Interviews (\$300/person):	\$1,500
Report & Recommendations (Overall & 5 topics):	\$1,800

**Total: \$5,450**

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### **SOCIAL MEDIA CONSULTING**

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There's a science and an art to using Facebook, Twitter and other social media to create measureable results. Aristotle can help by providing six (6) months of Social Media Consulting to support the Arkansas Insurance Rate Review Division in maintaining and growing its presence in the social media sphere. With consulting services, Aristotle's Social Media Specialist will support you by:

- Answering questions
- Training you to use Facebook, Twitter, YouTube, LinkedIn, blogs and other relevant social media sites
- Coaching you on ways to maximize your presence on social media sites and have meaningful conversations with Facebook users
- Offering tips and techniques for gaining fans and followers
- Explaining and demonstrating how to create authentic interactions with your connections and build relationships online
- **Auditing your organization's** presence across the social networks and communicating ways to improve it
- **Analyzing your competition's presence across the social networks, identifying their tactics** and giving you ideas that you can implement to shake their hold in your industry
- Keeping you abreast of new social media platforms and developments in online relationship marketing that can have an impact on the Arkansas Department of Insurance Rate Review Division

At the end of the six month consulting period, the Arkansas Department of Insurance Rate Review Division will be completely empowered to maximize social networking platforms for your business growth.

**Cost: \$500 per month**

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## WEBSITE HOSTING

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Aristotle understands that the AID Rate Review Division website will need to be hosted on a server provided by the State of Arkansas. Aristotle will build the website on an Aristotle server, then migrate it to the AID Rate Review server and test / launch it there. In order for Aristotle to build the website as described in this proposal, Aristotle will require a Windows server and a SQL database.

## DOMAIN NAME REGISTRATION

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Aristotle can register a domain name for the AID Rate Review Division with Network Solutions, a registering company, for up to 10 years. Registration costs are shown below.

1 year	\$60	2 years	\$70
3 years	\$79	4 years	\$89
5 years	\$99	6 years	\$109
7 years	\$118	8 years	\$128
9 years	\$138	10 years	\$148

Based on our initial research, the list below identifies some potential domain names that are currently available:

- o [www.ARHealthInsurance.org/net](http://www.ARHealthInsurance.org/net)
- o [www.AR-HealthInsurance.com/org/net](http://www.AR-HealthInsurance.com/org/net)
- o [www.ARIInsuranceReview.com/org/net](http://www.ARIInsuranceReview.com/org/net)
- o [www.HealthInsurance-AR.com/org/net](http://www.HealthInsurance-AR.com/org/net)

## STATISTICAL REPORTING PACKAGE

As part of Aristotle's hosting service, the AID Rate Review Divisions will have 24/7/365 access to online visitor tracking data through Urchin. This comprehensive statistical reporting software provides a powerful tool for evaluating website success.



Aristotle will train your staff to read and interpret the data if needed. In addition, Aristotle has a wealth of experience with this tool and can advise on its most effective uses.

Although the statistical reporting package contains a large number of reports to assist in evaluation, Aristotle recommends focusing on the following sections:

- o Visits
- o Page Views
- o Average Time spent by Visitor Online
- o Most Popular Pages
- o Most Popular Downloaded Files
- o Most Popular Directories
- o Search Terms Referring to Website
- o Top Referring Sites

For an additional fee, Aristotle can provide tracking and reporting services, including detailed monthly site traffic reports that are easy to understand and Enhanced Analytics with custom analysis and recommendations in every report.

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## PROJECT ASSUMPTIONS

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Anything not specifically detailed within this document is excluded from the scope of the project. While Aristotle can provide additional services, services not included were either not requested or need further discussion. If the AID Rate Review Division requests any additional services, a new document will need to be produced.

Aristotle may request additional written approval from the AID Rate Review Division prior to undertaking any significant alterations to the design, content or functionality of the website.

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## ARISTOTLE'S RESPONSIBILITIES

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Unless otherwise noted in this document, Aristotle is responsible for the following:

1. Producing the website design and programming as defined in this proposal and during any subsequent meetings.
2. Providing one round of revisions to the design concept based on the AID Rate Review Division's feedback.
3. Analyzing site content and developing the data model for administrative databases, if any.
4. Providing a remote training session for the administrative sections of the site, if any.

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## AID RATE REVIEW DIVISION'S RESPONSIBILITIES

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Unless otherwise noted in this document, the AID Rate Review Division is responsible for the following:

1. Development of any original text, photography, video or audio.
2. Providing all text, photography and other content to Aristotle in electronic format in as few deliveries as possible. Aristotle will not be responsible for delays that result from content that does not meet format or schedule requirements.

Text should be provided in Microsoft Word format, photos should be scanned and saved on CD/DVD, and database information should be provided in Excel, Access or a tab/comma delimited format.

3. Population of any database.
4. Alterations or revisions to the design, functionality or content of the website after this phase of development.
5. Integrity and legality of all content.
6. Hosting the domain and final website on an AID server.
7. On-site installation, training or assistance costs. In cases when on-site work is required, there will be an associated travel and training cost. Aristotle bills all time in minute increments. Travel costs for traveling outside of the metropolitan Little Rock area are not included in this proposal.

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## THE ARISTOTLE DIFFERENCE

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Aristotle recognizes that choosing a web design firm is not an easy decision. We are confident though, that our 25-year background in software and interactive application design, our legacy of research and strategic implementation, and the fact that we have over 14 years of web, CD, and online marketing experience will greatly benefit the project. Aristotle has the perfect combination of B2B and B2C marketing expertise that can greatly benefit your company.

### A FULL SERVICE COMPANY

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What differentiates Aristotle from other companies? We are a full-service interactive media, Internet, marketing and web design agency. Not only do we provide exceptional website design but we also supply a complete line of online marketing and advertising services. ALL work is done in-house: Kiosk, CD, and DVD production; full-service search engine and email marketing and optimization; full-service video production; and fully integrated online campaigns.

This means we can quickly provide feedback on how to design a database to optimize well in search engines. Aristotle also knows how to tag a photo to meet both ADA and Google image search requirements and how to integrate tracking and tagging code that will not disrupt the load time.

### RESEARCH AND TRACKING EXPERTS

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Aristotle was one of the first interactive companies to speak nationally in 1997 about its revolutionary online tourism conversion studies. Aristotle performs first-person usability studies, with experts from all vertical markets within the technology field relying on our findings to increase their knowledge of web interfaces. **Aristotle's CEO and VP have been** keynote speakers on a variety of online-related topics, including tourism, economic development, non-profits, social networking and the Internet for more than 8 years at national, regional and state conferences.

### ISP

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What else differentiates Aristotle? We are an Internet Service Provider. Aristotle understands the implications of download speeds, new versions of Flash, Java Script and online applications. **Our technical support team hears about every possible "interruption" in using a website or the Internet. We have an intimate relationship with "first-hand user research" that none of our contemporaries share.**

**Aristotle's ISP President is a trained intellectual property attorney and the chair of several national committees on SPAM and Virus law. Our clients experience substantial benefits and "first hand" legal information from the industry.**

The combination of our innovative programming, marketing savvy and creative design talent has made us a leader in website design, multimedia development and branding. Aristotle is a comprehensive company that can truly meet all of your business needs.

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## ADDITIONAL ARISTOTLE SERVICES

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In addition to providing all of the services you expect from a leading website design and hosting firm, Aristotle offers a wide range of other innovative services you may not normally associate with a web design firm. These additional services will help you promote your business and offer your products and services to your clients. These additional options can be integrated into your website or business at any time.

- **Signature Mail/Outsourced Email** – Aristotle offers email hosting and allows you to use your domain name for your business email address. With our Signature Mail product, Aristotle can ensure all of your staff can have an email branded with your company name no matter where the employee is located. In addition, our Signature Mail product can also be used as an innovative fundraising and marketing tool, by offering your supporters the chance to have an email address at your domain.
- **Email Filtering** – Aristotle offers enterprise-level email filtering that blocks Spam and other malicious emails. This means you spend less time fighting your inbox and more time addressing your real email.
- **Audio/Video Production** – Aristotle has an on-staff videographer to shoot and produce promotional videos for your business. In addition, Aristotle has an on-site sound production facility and voice recording studio. These services allow Aristotle to think creatively when developing promotional materials for your website.
- **High-Speed Internet Access** – Aristotle can offer your business broadband Internet connectivity of up to 10 megs (depending on location), allowing you to connect to the world at a faster pace. This will allow you to move large files more quickly while still allowing the staff access to the online applications they need.
- **Wireless (WiFi) Solutions** – Aristotle experts will conduct an on-site evaluation to determine the type of network that best fits your needs. Aristotle can set up a network in one location or implement “mesh networking” technology to extend the reach and coverage of your wireless network.
- **Kiosks** – Aristotle specializes in the development of customized kiosks that can drive traffic to your business. From touch screen interfaces to secure Internet-based kiosk applications, Aristotle provides you with a one-source solution to your interactive ambassador needs.
- **Online Promotions** – In addition to our search engine optimization services, Aristotle offers a list of online promotions one would expect from a major electronic presence firm, including pay-per-click campaign management and banner ad development and placement. In addition, Aristotle also offers innovative ways to promote your website through email promotions and press release optimization.

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**COST ESTIMATE**


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The following estimate assumes the total development costs for the AID Rate Review Division's website:

FEATURE	AMOUNT
<b>CUSTOM WEBSITE DESIGN:</b>	
<ul style="list-style-type: none"> <li>• <b>MAIN PAGE AND INTERIOR PAGE DESIGN AND PROGRAMMING</b></li> <li>• <b>ARTWORK FOR 6 GRAPHIC SUBSECTION HEADERS</b></li> <li>• <b>3 PROMOTIONAL ICONS</b></li> <li>• <b>UP TO 10 IMAGES TREATED FOR WEB DISPLAY</b></li> <li>• <b>FAVICON</b></li> <li>• <b>SITE MAP</b></li> </ul>	<b>\$ 17,320</b>
<b>CONTENT MANAGEMENT SYSTEM</b>	<b>\$ 4,825</b>
<b>RATE FILINGS DATABASE &amp; ADVANCED SEARCH</b>	<b>\$ 4,435</b>
<b>NEWS SECTION</b>	<b>\$ 2,340</b>
<b>SOCIAL MEDIA &amp; USABILITY FEATURES</b>	<b>\$ 2,245</b>
<b>VIDEO DEVELOPMENT &amp; CONSULTING:</b>	
<ul style="list-style-type: none"> <li>• <b>1 FILMED VIDEO WITH SPOKESPERSON</b></li> <li>• <b>1 ANIMATED VIDEO</b></li> <li>• <b>YOUTUBE OPTIMIZATION FOR 2 VIDEOS</b></li> </ul>	<b>\$ 14,745</b>
<b>E-UPDATES SYSTEM &amp; TEMPLATE (MAILSAGE ACCOUNT, SETUP + 1 TEMPLATE)</b>	<b>\$ 2,805</b>
<b>SEARCH ENGINE OPTIMIZATION (MAIN PAGE + 5 INTERIOR PAGES)</b>	<b>\$ 2,400</b>
<b>USABILITY RESEARCH</b>	<b>\$ 5,450</b>
<b>SOCIAL NETWORKING CONSULTING (6 MONTHS)</b>	<b>\$ 3,000</b>
<b>TOTAL</b>	<b>\$ 59,565</b>

### **MailSage (E-Updates) Monthly Send Fee Pricing**

Aristotle determines your first tier based on the number of records in your email database. **Aristotle determines your monthly fee based on the number of emails you send.** (See "Pieces sent" rate chart below.) For example, if you send to your entire email list once in a month, you will be charged based on the number of email addresses in your email database. If you send to your entire list three times each month, you will be charged for the total number of email addresses in your database times three. If you do not send any emails in a given month, you will be charged based on the total number of email records in your email database. You can choose to select a higher tier at any time based on the number of emails you need to send.

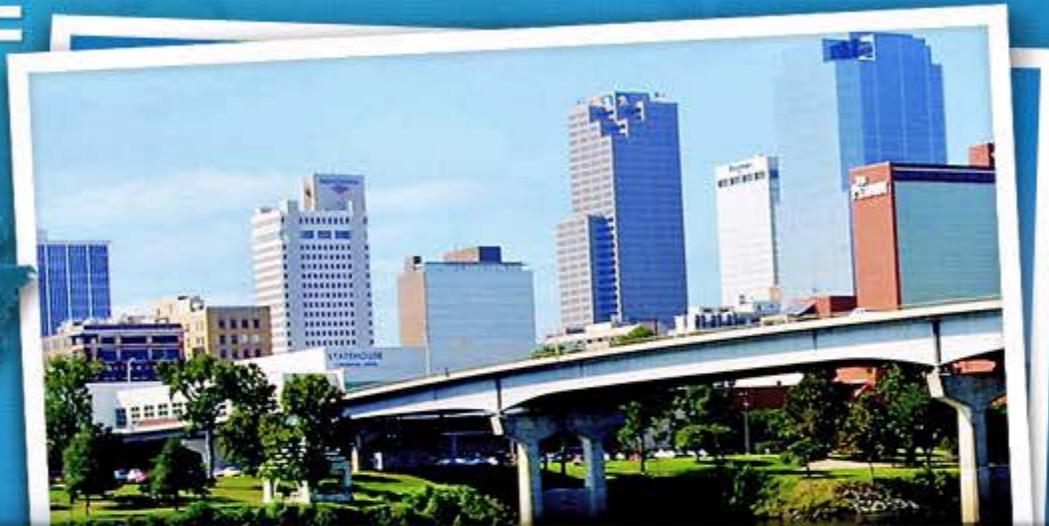
<b>Tier</b>	<b>Minimum Pieces Sent</b>	<b>Maximum Pieces Sent</b>	<b>Monthly Base Price</b>	<b>Cost every 1,000 over maximum</b>
1	0	5,000	\$31	\$9.36
2	5,001	25,000	\$57	\$3.43
3	25,001	50,000	\$90	\$2.69
4	50,001	100,000	\$155	\$2.32
5	100,001	150,000	\$220	\$2.20
6	150,001	250,000	\$350	\$2.10
7	250,001	500,000	\$675	\$2.02
8	500,001	750,000	\$1,000	\$2.00
9	750,001	1,000,000	\$1,325	\$1.99
10	1,000,001	2,000,000	\$2,625	\$1.97
11	Over 2,000,000		\$3,100	n/a

# ARKANSAS INSURANCE DEPARTMENT

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Attachment 19

## HEALTH INSURANCE PREMIUM RATE REVIEW DIVISION



REVIEW PROCESS

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### About Us

The Health Insurance Premium Rate Review (HIPRR) Division of the Arkansas Insurance Department (AID) is charged with protecting consumers from unreasonable health insurance premium rate increases.

The Affordable Care Act (ACA) requires states to establish a process for reviewing these increases. Under this rate review program, health insurers seeking to increase rates must now provide consumers with easy-to-understand information about the reasons





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These steps are expected to bring greater transparency, accountability and help moderate premium increases and provide those who buy insurance with greater value for their premium dollar.

[WHY DO RATES MATTER TO ME?](#)

[LOOK UP LATEST FILINGS](#)



**TALK TO US:**  
For complaints or questions regarding health insurance premium rates, contact the Consumer's Assistance Program at **855-332-2227** OR **501-371-2645**

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## HEALTH INSURANCE PREMIUM RATE REVIEW DIVISION




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## Consumer Guide

### Why rates matter to me?

Rates affect your health insurance premium costs. A rate is a base price for health benefits. A premium is the specific amount you pay as a policyholder. The actual premium you pay may be higher or lower than a rate based on factors such as your age and where you live.

When a company submits a premium rate increase request at or above the 10% threshold for individual or small employer health plans, consumers will be notified through our website. There will be a 30 day public comment period.

You may email your comments to [insurance.hirr@arkansas.gov](mailto:insurance.hirr@arkansas.gov) or mail to: Attn: Health Insurance Premium Rate Review Division, 1200 West Third Street, Little Rock, Arkansas 72201. Consumer comments will be taken into consideration when the AID makes its final rate determinations. Those comments will also be posted online.

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2011. Consumer comments will be taken into consideration when the AID makes its final rate determinations. Those comments will also be posted online.

» Click Here to [Search Public Filings](#)

Here's an overview of AID's [Health Insurance Rate Review Process](#).

**Helpful links:**

- [Health Care Government website](#)
- [Centers for Medicare & Medicaid Services](#)
- [Arkansas Insurance Department](#)
- [CMS Determination Letter](#)
- [Shedding Light on Insurance Industry Practices](#)
- [Nearly \\$200 Million Available to Help States Fight Health Insurance Premium Increases](#)
- [Consumer Definitions](#)
- [Bulletin 7-2011](#)
- [Bulletin 6-2011](#)
- [Rate Increase and Disclosure Rule](#)
- [National Association of Insurance Commissioners](#)
- [Arkansas Bureau of Legislative Research](#)

**Talk to us:**

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**Press releases:**

- December 8, 2010 - [Nicholas to Lead Rate Review Efforts](#)

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## Rate Review Process



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### Frequently Asked Questions

1. [What is an insurance premium?](#)
2. [How do insurance companies determine premium health insurance rates?](#)
3. [What is the Arkansas Insurance Department's \(AID\) role in setting health insurance premiums?](#)
4. [How do rates determine my health insurance premium?](#)
5. [Why do my premiums go up?](#)
6. [What if I feel my health insurance premium increased incorrectly?](#)
7. [How can I reduce my insurance premiums?](#)

**Q. What is an insurance premium?**

**A.** A premium is the amount paid for your health insurance or plan. You and/or your

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**A.** A premium is the amount paid for your health insurance or plan. You and/or your employer usually pay monthly, quarterly, or yearly.

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**A.** Insurance companies look at a number of lifestyle factors including smoking and alcohol use when determining health insurance premium rates. Factors such as your age, sex, where you live, and health status play a role.

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**Q. What is the Arkansas Insurance Department's (AID) role in setting health insurance premiums?**

**A.** The Arkansas Insurance Department reviews and must approve all premiums charged by insurance companies for individual major medical policies and policies sold to employers with less than 50 employees. During the premium rate review process, consumers will be provided an opportunity to submit comments on specific rate increases proposed by the insurance companies.

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**Q. How do rates determine my health insurance premium?**

**A.** When an individual applies for individual health insurance coverage, they are requested to provide health information about themselves and/or their family members. When determining rates, the insurance companies use the medical information on the application and additional information which the company may obtain from the applicant's physician. Once the company has determined the health status, the applicant will be assigned a base rate and could be rated up (charged a higher rate) based on the applicant's health status. Once the policy is issued and the rate established, the consumer will be placed in a pool with other individuals who have the same type of policy. Any rate increases on the block of business is not determined by individual claims, but by the claims experience of the entire pool.



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**Q. Why do my premiums go up?**

**A.** Medical costs are driven by everything from increases in hospital and doctor charges to greater use of medical care due to new technologies and increased usage of prescription drugs. This is commonly referred to as the medical trend.

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**Q. What if I feel my health insurance premium increased incorrectly?**

**A.** If consumers feel their health insurance premium has increased incorrectly, contact the **Consumer's Assistance Program (CAP)** at 855-332-2227 or 501-371-2645. Consumers may also log onto [www.insurance.arkansas.gov](http://www.insurance.arkansas.gov). CAP is a federally funded program and works to assist consumers with filing complaints and appeals, enrolling into health coverage, and educating consumers on their rights and responsibilities with respect to group health plans and health insurance coverage.

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**Q. How can I reduce my insurance premiums?**

- A.**
1. Shop around for health insurance.
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# ARKANSAS INSURANCE DEPARTMENT

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U.S. Health and Human Services Rate Review Grant Program

- [Cycle 1 Grant Application Abstract](#)
- [Cycle 1 Grant Application](#)
- [Cycle II Grant Application](#)
- [First Quarterly Report:](#)
- [Second Quarterly Report:](#)
- [Third Quarterly Report:](#)
- [Rate Review Media Center IFB](#)
- [AID Rate Review Grant Professional Services Request for Proposal](#)

AON Hewitt Reports:

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#### AON Hewitt Reports:

- [Phase 1](#)
- [Phase 2](#)

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# Health Insurance Premium Rate Review Division

## About us:

The Health Insurance Premium Rate Review (HIPRR) Division of the Arkansas Insurance Department (AID) is charged with protecting consumers and employers from unreasonable health insurance premium rate increases. HIPRR was created under the Affordable Care Act (ACA) to bring an unprecedented level of scrutiny and transparency to health insurance rate increases.

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Link to Search Public Filings: <https://a5w.insurance.arkansas.gov/LHFOI/LHFOI.a5w>

### **Helpful links:**

[www.Healthcare.gov](http://www.Healthcare.gov)

<https://www.cms.gov/> Centers for Medicare&Medicaid Services

[www.insurance.arkansas.gov](http://www.insurance.arkansas.gov) Arkansas Insurance Department

<http://www.healthcare.gov/news/blog/shedlight.html>

[www.naic.org](http://www.naic.org) National Association of Insurance Commissioners

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# **FAQ:**

## **Q. What is an insurance premium?**

**A.** A premium is the amount paid for your health insurance or plan. You and/or your employer usually pay monthly, quarterly, or yearly.

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**Q. How can I reduce my insurance premiums?**

A.

1. Shop around for health insurance.
2. Consider raising your deductible.
3. Live a healthy lifestyle.
4. Get educated on health insurance and understand your benefits.

# Glossary of Health Insurance and Medical Terms

- This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate. You can get a copy of the policy at [[www.insurancecompany.com](http://www.insurancecompany.com)] or you may call [[1-800-xxx-xxxx](tel:1-800-xxx-xxxx).]
- **Bold** text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

## Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

## Appeal

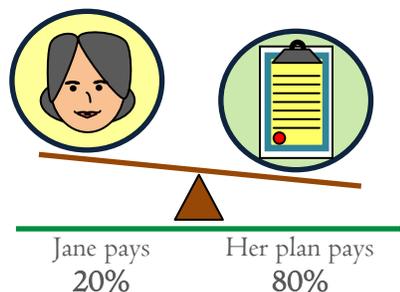
A request for your health insurer or **plan** to review a decision or a **grievance** again.

## Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may *not* balance bill you.

## Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance *plus* any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.



(See page 4 for a detailed example.)

## Complications of Pregnancy

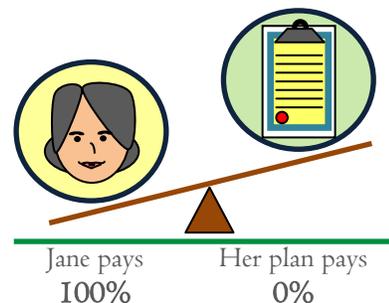
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

## Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

## Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

## Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

## Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

## Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

## Emergency Room Care

**Emergency services** received in an emergency room.

## Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

## Excluded Services

Health care services that your **health insurance** or **plan** doesn't pay for or cover.

## Grievance

A complaint that you communicate to your health insurer or **plan**.

## Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

## Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

## Home Health Care

Health care services a person receives at home.

## Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

## Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

## Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

## In-network Co-insurance

The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to providers who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

## In-network Co-payment

A fixed amount (for example, \$15) you pay for covered health care services to providers who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

## Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

## Network

The facilities, providers and suppliers your health insurer or **plan** has contracted with to provide health care services.

## Non-Preferred Provider

A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or **plan**, or if your health insurance or **plan** has a "tiered" **network** and you must pay extra to see some providers.

## Out-of-network Co-insurance

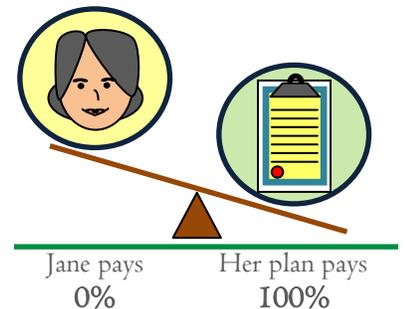
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

## Out-of-network Co-payment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

## Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, balance-billed charges or health care your health insurance or **plan** doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, **co-insurance** payments, out-of-network payments or other expenses toward this limit.



(See page 4 for a detailed example.)

## Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

## Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

## Preauthorization

A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

## Preferred Provider

A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

## Premium

The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

## Prescription Drug Coverage

**Health insurance** or **plan** that helps pay for **prescription drugs** and medications.

## Prescription Drugs

Drugs and medications that by law require a prescription.

## Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

## Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

## Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

## Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

## Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

## Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

## Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

## UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

## Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

# How You and Your Insurer Share Costs - Example

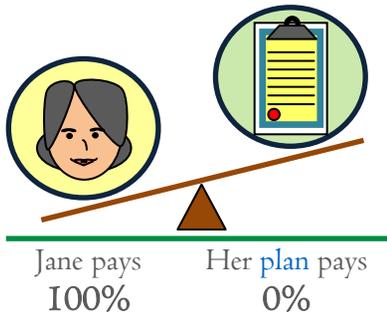
Jane's Plan Deductible: \$1,500

Co-insurance: 20%

Out-of-Pocket Limit: \$5,000

January 1<sup>st</sup>  
Beginning of Policy Period

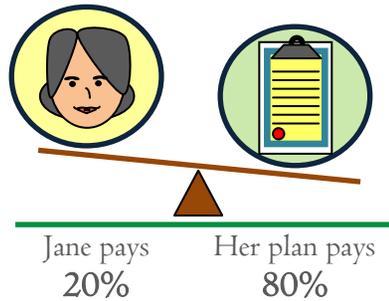
December 31<sup>st</sup>  
End of Policy Period



**Jane hasn't reached her \$1,500 deductible yet**

Her plan doesn't pay any of the costs.  
Office visit costs: \$125  
Jane pays: \$125  
Her plan pays: \$0

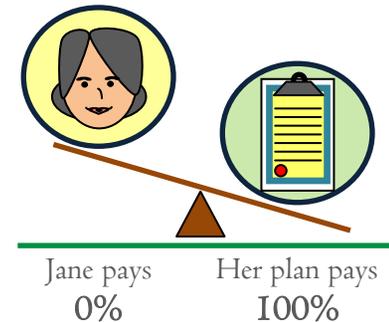
→  
more costs



**Jane reaches her \$1,500 deductible, co-insurance begins**

Jane has seen a doctor several times and paid \$1,500 in total. Her plan pays some of the costs for her next visit.  
Office visit costs: \$75  
Jane pays: 20% of \$75 = \$15  
Her plan pays: 80% of \$75 = \$60

→  
more costs



**Jane reaches her \$5,000 out-of-pocket limit**

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.  
Office visit costs: \$200  
Jane pays: \$0  
Her plan pays: \$200

## Health Insurance Premium Rate Review Division



The Health Insurance Premium Rate Review (HIPRR) Division of the Arkansas Insurance Department (AID) is charged with protecting consumers and employers from unreasonable health insurance premium rate increases.

### Health Insurance Premium Rate Review Division

**Arkansas Insurance Department**  
1200 West Third Street  
Little Rock, Arkansas 72201  
Phone: 501.371.2600  
insurance.hirr@arkansas.gov



[@ArkInsuranceDept](https://www.facebook.com/ArkansasInsuranceDepartment)

# Health Insurance Premium Rate Review Division

Arkansas Insurance Department

**For complaints or questions  
regarding your health  
insurance premium rates,  
contact us.**

Phone: 501.371.2600  
insurance.hirr@arkansas.gov

## Frequently Asked Questions



FAQ

[www.insurance.arkansas.gov/hirrd](http://www.insurance.arkansas.gov/hirrd)

**Q. How do insurance companies determine premium health insurance rates?** A. Insurance companies look at a number of lifestyle factors including smoking and alcohol use when determining health insurance premium rates. Factors such as your age, sex, where you live, and health status play a role.

**Q. What is an insurance premium?**

A. A premium is the amount paid for your health insurance or plan. You and/or your employer usually pay monthly, quarterly, or yearly.

**Q. Why do my premiums go up?**

A. Medical costs are driven by everything from increases in hospital and doctor charges to greater use of medical care due to new technologies and increased usage of prescription drugs. It's commonly referred to as the medical trend.

**Q. What is the Arkansas Insurance Department's (AID) role in setting health insurance premiums?**

A. The Arkansas Insurance Department reviews and must approve all premiums charged by insurance companies for individual major medical policies and policies sold to employers with less than 50 employees. During the premium rate review process, consumers will be provided an opportunity to submit comments on specific rate increases proposed by the insurance companies.

**Q. How can I reduce my insurance premiums?**

Shop around for health insurance.

Consider raising your deductible.

Live a healthy lifestyle.

Get educated on health insurance and understand your benefits.

**Q. How do rates determine my health insurance premium?**

A. When an individual applies for individual health insurance coverage, they are requested to provide health information about themselves and/or family members. When determining rates, the insurance companies use the medical information on the application and additional information which the company may obtain from the applicant's physician. Once the company has determined the health status, the applicant will be assigned a base rate and could be rated up (charged a higher rate) based on the applicant's health status. Once the policy is issued and the rate established, the consumer will be placed in a pool with other individuals who have the same type of policy. Any rate increases on the block of business is not determined by individual claims, but by the claims experience of the entire pool.

**Q. What if I feel my health insurance premium increased incorrectly?** A. Contact the **Consumer's Assistance Program (CAP)** at 855-332-2227 or 501-371-2645.

**RATE REVIEW GRANT**  
**Thirteen Months Actual (December 1, 2010 through December 31, 2011) Plus Encumbered Expenses**

Exhibit 1

Category	Spent/Projected	Budgeted	Variance
Salary	218,012	329,650	111,638
Fringe Benefits	70,540	88,624	18,084
Travel	2,465	14,135	11,670
Other	-	13,168	13,168
Rental	64,836	58,717	(6,119)
Professional Services/Contracts	313,381	276,808	(36,573)
Supplies and Other Office Expenses	34,278	97,778	63,500
Capital	79,335	121,120	41,785
Total	782,847	1,000,000	217,154

	ACTUAL													Encumbered	Dec 2010 to Dec 2011	Budgeted Amount	Remaining Balance
	December-10	January-11	February-11	March-11	April-11	May-11	June-11	July-11	August-11	September-11	October	November	December	Encumbered			
Monthly Totals	18,937	6,070	44,466	44,210	34,154	31,056	32,718	143,550	33,902	169,131	36,095	131,746	46,917	9,895	782,847	1,000,000	217,154
Regular Salary	8,184	8,990	14,133	16,151	16,151	16,151	18,388	24,397	16,264	16,864	16,324	16,661	29,355	-	218,012	329,650	111,638
Total Fringe Benefits	3,596	3,768	4,812	5,198	5,229	5,198	5,648	7,143	5,385	5,512	5,432	5,469	8,150	-	70,540	88,624	18,084
Total Professional/Contract Services	7,138	(7,138)	18,808	7,434	209	2,115	5,961	101,318	5,764	60,714	7,278	101,850	1,930	-	313,381	276,808	(36,573)
Total Office Supplies and Other	20	210	1,766	10,479	7,617	2,645	2,461	649	1,168	1,683	1,711	1,505	2,362	-	34,278	97,778	61,774
Total Travel	-	240	-	-	-	-	260	-	299	-	328	1,239	99	-	2,465	14,135	11,670
Total Rental	-	-	4,948	4,948	4,948	4,948	-	10,043	5,022	5,022	5,022	5,022	5,022	9,895	64,836	58,717	(6,119)
Capital	-	-	-	-	-	-	-	-	-	79,335	-	-	-	-	79,335	121,120	41,785
Total Other	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	13,168	13,168

# Exhibit 2

**Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
Office of Consumer Information and Insurance Oversight**

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

**NOTICE OF GRANT AWARD  
AUTHORIZATION (Legislation/Regulations)  
Section 2794 of the Public Health Service Act (Section 1003 of the  
Affordable Care Act)**

<b>1. DATE ISSUED</b> (Mo./Day/Yr.) 09/28/2011	<b>2. CFDA NO.</b> 93.511
<b>3. SUPERCEDES AWARD NOTICE</b> dated 08/03/2010 except that any additions or restrictions previously imposed remain in effect unless specifically rescinded	
<b>4. GRANT NO.</b> 4 IPRPR100015-01-01 Formerly:	<b>5. ADMINISTRATIVE CODES</b> IPR
<b>6. PROJECT PERIOD</b> Mo./Day/Yr. From 08/09/2010	Through 12/31/2011
<b>7. BUDGET PERIOD</b> Mo./Day/Yr. From 08/09/2010	Through 12/31/2011

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

**9. GRANTEE NAME AND ADDRESS**

a. Arkansas Insurance Department  
b. 1200 W 3rd St  
c.  
d. Little Rock  
e. AR f. 72201-1904

**10. DIRECTOR OF PROJECT** (PROGRAM DIRECTOR/PRINCIPLE INVESTIGATOR)  
(LAST NAME FIRST AND ADDRESS)  
Jay Bradford  
1200 W 3rd St  
Little Rock, AR 72201  
Phone: 501-371-2621

<b>11. APPROVED BUDGET</b> (Excludes HHS Direct Assistance)	
I HHS Grant Funds Only	
II Total project costs including grant funds and all other financial participation (Select one and place NUMERAL in box) <span style="float: right; border: 1px solid black; padding: 2px;">II</span>	
a. Salaries and Wages .....	329,650
b. Fringe Benefits .....	90,455
c. Total Personnel Costs .....	420,105
d. Consultants Costs .....	
e. Equipment .....	79,355
f. Supplies .....	4,910
g. Travel .....	14,135
h. Patient Care – Inpatient .....	
i. Patient Care – Outpatient .....	
j. Alterations and Renovations .....	
k. Other .....	204,687
l. Consortium/Contractual Costs .....	276,808
m. Trainee Related Expenses .....	
n. Trainee Stipends .....	
o. Trainee Tuition and Fees .....	
p. Trainee Travel .....	
q. TOTAL DIRECT COSTS	1,000,000
r. INDIRECT COSTS (rate of )	0
s. TOTAL APPROVED BUDGET	\$ 1,000,000
t. SBIR Fee	0
u. Federal Share	\$ 1,000,000
v. Non-Federal Share	\$ 0

<b>12. AWARD COMPUTATION FOR GRANT</b>	
a. Amount of HHS Financial Assistance (from item 11.u)	1,000,000
b. Less Unobligated Balance From Prior Budget Periods	0
c. Less Cumulative Prior Award(s) This Budget Period	1,000,000
d. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	0

<b>13. RECOMMENDED FUTURE SUPPORT</b> (Subject to the availability of funds and satisfactory progress of the project):			
YEAR	TOTAL DIRECT COSTS	YEAR	TOTAL DIRECT COSTS
a. 2		d. 5	
b. 3		e. 6	
c. 4		f. 7	

<b>14. APPROVED DIRECT ASSISTANCE BUDGET</b> (IN LIEU OF CASH):	
a. AMOUNT OF HHS Direct Assistance	0
b. Less Unobligated Balance From Prior Budget Periods	
c. Less Cumulative Prior Award(s) This Budget Period	
d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION	0

**15. PROGRAM INCOME SUBJECT TO 45 CFR PART 74, SUBPART F, OR 45 CFR 92.25, SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:**  
(Select one and place LETTER in box.)

a. DEDUCTION b. ADDITIONAL COSTS c. MATCHING d. OTHER RESEARCH (Add / Deduct Option) e. OTHER (See REMARKS)	<input style="width: 50px; height: 20px;" type="checkbox"/>
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**16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, HHS ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:**

a. The grant program legislations cited above.  
 b. The grant program regulation cited above.  
 c. This award notice including terms and conditions, if any, noted below under REMARKS.  
 d. HHS Grants Policy Statement including addenda in effect as of the beginning date of the budget period.  
 e. 45 CFR Part 74 or 45 CFR Part 92 as applicable.

In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

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

This Notice of Award approves the 3 month No Cost Extension as per the grantee's request dated August 31, 2011.

<b>GRANTS MANAGEMENT OFFICER:</b>  (Signature)	(Name – Typed/Print) <b>Ms. Feagins, Michelle</b>	(Title) Senior Grants Management Specialist
<b>17. OBJ CLASS</b> 4121	<b>18. CRS - EIN</b> 1710847443A9	<b>19. LIST NO.</b> <b>CONG. DIST.:</b> 02
<b>FY-CAN</b>	<b>DOCUMENT NO.</b>	<b>ADMINISTRATIVE CODE</b>
20. a. 0-199RE19	b. IPRPR0015A	c. IPR
21. a.	b.	c.
22. a.	b.	c.

# Exhibit 3

1. DATE ISSUED MM/DD/YYYY 01/06/2012	2. CFDA NO. 93.511	3. ASSISTANCE TYPE Project Grant
1a. SUPERSEDES AWARD NOTICE dated 09/28/2011 except that any additions or restrictions previously imposed remain in effect unless specifically rescinded		
4. GRANT NO. 4 IPRPR100015-01-02 Formerly		5. ACTION TYPE Post Award Amendment
6. PROJECT PERIOD From 08/09/2010		Through 09/30/2012
7. BUDGET PERIOD From 08/09/2010		Through 09/30/2012

**Department of Health and Human Services**  
**Centers for Medicare & Medicaid Services**  
**Office of Consumer Information and Insurance Oversight**  
 Grants, Contracts and Integrity Division  
 7501 Wisconsin Ave West Tower  
 Room 10-15  
 Bethesda, MD 20814-6519

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

8. TITLE OF PROJECT (OR PROGRAM) 2010 Grants to States for Health Insurance Premium Review-Cycle I	
9a. GRANTEE NAME AND ADDRESS Arkansas Insurance Department 1200 W 3rd St Little Rock, AR 72201-1904	9b. GRANTEE PROJECT DIRECTOR Mr. Jay Bradford 1200 W 3rd St Little Rock, AR 72201 Phone: 501-371-2621

10a. GRANTEE AUTHORIZING OFFICIAL Mr. Jay Bradford 1200 WEST THIRD ST LITTLE ROCK, AR 1904 Phone: 501-371-2621	10b. FEDERAL PROJECT OFFICER Ms. Jacqueline Roche 200 Independence Ave Sw Rm 738-G Washington, DC 20201 Phone: 202-260-6094
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11. APPROVED BUDGET (Excludes HHS Direct Assistance)		12. AWARD COMPUTATION FOR GRANT	
I HHS Grant Funds Only		a. Amount of HHS Financial Assistance (from item 11m) 1,000,000.00	
II Total project costs including grant funds and all other financial participation <input checked="" type="checkbox"/>		b. Less Unobligated Balance From Prior Budget Periods 0.00	
a. Salaries and Wages ..... 329,650.00		c. Less Cumulative Prior Award(s) This Budget Period 1,000,000.00	
b. Fringe Benefits ..... 90,455.00		d. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION 0.00	
c. Total Personnel Costs ..... 420,105.00		13. Total Federal Funds Awarded to Date for Project Period 1,000,000.00	
d. Equipment ..... 79,355.00		14. RECOMMENDED FUTURE SUPPORT	
e. Supplies ..... 4,910.00		(Subject to the availability of funds and satisfactory progress of the project):	
f. Travel ..... 14,135.00		YEAR TOTAL DIRECT COSTS YEAR TOTAL DIRECT COSTS	
g. Construction ..... 0.00		a. 2 b. 3 c. 4 d. 5 e. 6 f. 7	
h. Other ..... 204,687.00		15. PROGRAM INCOME SUBJECT TO 45 CFR PART 74, SUBPART F, OR 45 CFR 92.25, SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:	
i. Contractual ..... 276,808.00		a. DEDUCTION	
j. TOTAL DIRECT COSTS → 1,000,000.00		b. ADDITIONAL COSTS	
k. INDIRECT COSTS (rate of) 0.00		c. MATCHING	
l. TOTAL APPROVED BUDGET 1,000,000.00		d. OTHER RESEARCH (Add / Deduct Option)	
m. Federal Share 1,000,000.00		e. OTHER (See REMARKS)	
n. Non-Federal Share 0.00		16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, HHS ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:	
		a. The grant program legislation cited above.	
		b. The grant program regulations cited above.	
		c. This award notice including terms and conditions, if any, noted below under REMARKS.	
		d. HHS Grants Policy Statement including addenda in effect as of the beginning date of the budget period.	
		e. 45 CFR Part 74 or 45 CFR Part 92 as applicable.	
		In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.	

REMARKS (Other Terms and Conditions Attached -  Yes  No)

This Notice of Award approves the 9 month No Cost Extension as per the grantee's request dated December 22, 2011.

GRANTS MANAGEMENT OFFICER / *Michelle Feagins*, Grants Management Officer

17. OBJ CLASS 4121	18a. VENDOR CODE 1710847443A9	18b. EIN 710847443	19. DUNS 081501558	20. CONG. DIST. 02
FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	AMT ACTION FIN ASST	APPROPRIATION
21. a. 0-199RE19	b. IPRPR0015A	c. IPR	d. \$0.00	e. 75040112
22. a.	b.	c.	d.	e.
23. a.	b.	c.	d.	e.

# Exhibit 4

## FEDERAL FINANCIAL REPORT

(Follow form instructions)

1. Federal Agency and Organizational Element to Which Report is Submitted <b>DHHS-CC110</b>	2. Federal Grant or Other Identifying Number Assigned by Federal Agency (To report multiple grants, use FFR Attachment) <b>11PRPR100015-01-00</b>	Page 1	of  pages
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2. Recipient Organization (Name and complete address including Zip code)  
**Arkansas Insurance Department**  
**1200 West Third Street, Little Rock, AR 72201**

4a. DUNS Number <b>810501558</b>	4b. EIN <b>71-0847443</b>	5. Recipient Account Number or Identifying Number (To report multiple grants, use FFR Attachment)	6. Report Type <input checked="" type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual <input type="checkbox"/> Final	7. Basis of Accounting <input checked="" type="checkbox"/> Cash <input type="checkbox"/> Accrual
-------------------------------------	------------------------------	--	--	---

8. Project/Grant Period From: (Month, Day, Year) <b>08-09-2010</b>	To: (Month, Day, Year) <b>12-31-2011</b>	9. Reporting Period End Date (Month, Day, Year) <b>12-31-2011</b>
--	---	---

10. Transactions Cumulative

*(Use lines a-c for single or multiple grant reporting)*

<b>Federal Cash (To report multiple grants, also use FFR Attachment):</b>	
a. Cash Receipts	<b>772,058.00</b>
b. Cash Disbursements	<b>759,267.00</b>
c. Cash on Hand (line a minus b)	<b>12,791.00</b>

*(Use lines d-o for single grant reporting)*

<b>Federal Expenditures and Unobligated Balance:</b>	
d. Total Federal funds authorized	<b>1,000,000.00</b>
e. Federal share of expenditures	<b>759,267.00</b>
f. Federal share of unliquidated obligations	<b>0.00</b>
g. Total Federal share (sum of lines e and f)	<b>759,267.00</b>
h. Unobligated balance of Federal funds (line d minus g)	<b>240,733.00</b>

**Recipient Share:**

i. Total recipient share required	
j. Recipient share of expenditures	
k. Remaining recipient share to be provided (line i minus j)	

**Program Income:**

l. Total Federal program income earned	
m. Program income expended in accordance with the deduction alternative	
n. Program income expended in accordance with the addition alternative	
o. Unexpended program income (line l minus line m or line n)	

11. Indirect Expense	a. Type	b. Rate	c. Period From	Period To	d. Base	e. Amount Charged	f. Federal Share
g. Totals:							

12. Remarks: Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation:

13. Certification: By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements and cash receipts are for the purposes and intent set forth in the award documents. I am aware that any false, fictitious, or fraudulent information may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)

a. Typed or Printed Name and Title of Authorized Certifying Official  <p style="text-align: center;"><b>Jay Bradford, State Insurance Commissioner</b></p>	c. Telephone (Area code, number and extension) <b>501-683-3638</b>
b. Signature of Authorized Certifying Official  	d. Email address <b>jay.bradford@arkansas.gov</b>
	e. Date Report Submitted (Month, Day, Year) <b>12-31-2011</b>

14. Agency use only:

Standard Form 425 5HYLVHG  
 OMB Approval Number: 0348-0061  
 Expiration Date: 10/31/2011

**Paperwork Burden Statement**  
 According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is 0348-0061. Public reporting burden for this collection of information is estimated to average 1.5 hours per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0061), Washington, DC 20503.

# Exhibit 5

PERSONNEL					
Position	Annual Salary	FFY'10 Request	FFY'11 Request	Total Grant Request	Comments
Deputy Commissioner Rate Review Manager	85,536	7,128	85,536	92,664	TBH - 9/2010 - Doctoral Degree with high level management, health care industry, and government experience. Will direct day-to-day operations/reporting.
Rate Review Compliance Attorney	73,116	0	73,116	73,116	TBH - 10/2010 - Attorney with pertinent experience will lead and monitor legal and legislative health insurance rate review issues.
Rate Review Compliance Officer	73,116	0	73,116	73,116	TBH - 10/2010 - Experience with health insurance rate reviews and working with actuaries. Will perform technical rate reviews and provide process consultation.
Rate Review Public Information/Outreach Mgr	45,377	0	45,377	45,377	TBH - 10/2010 - Expert communications and systems knowledge and skills, with health industry, education, and consumer advocacy experience.
Rate Review System Analyst	45,377	0	45,377	45,377	TBH - 10/2010 - Experience with health care information technology and supports within complex systems; ability to communicate with non-IT experts.
<b>Salary Subtotal</b>		<b>7,128</b>	<b>322,522</b>	<b>329,650</b>	
<b>FRINGE Subtotal</b>		<b>1,831</b>	<b>88,624</b>	<b>90,455</b>	20.223% + \$4,680/position for insurance
<b>PROFESSIONAL SERVICES (Sub-award) COSTS</b>					
Actuarial/IT Consultant		25,000		25,000	Phase I - to assess AID skills and processes and make recommendations for rate review improvements
Actuarial/Rate Review/IT Consultant(s)			140,000	140,000	Phase II - Design and assist with implementation of rate review technological and expertise process improvements. May be separate or consolidated contract
Actuary-Rate Filing Review			40,000	40,000	\$10,000 per month, June - September 2011 ( <b>See Attachment for more detail</b> )
SERFF IT Enhancement		18,808		18,808	Data base/reporting enhancements as proposed by NAIC ( <b>see attachment</b> )
Data Center			50,000	50,000	Analyses and reporting needs TBD
UAMS Partners for Inclusive Communities			3,000	3,000	Consumer focus groups for disability/LTC populations; materials review for readability - will include travel across Arkansas.
<b>Contractual Subtotal</b>		<b>43,808</b>	<b>233,000</b>	<b>276,808</b>	
<b>EQUIPMENT</b>					
Rate Review Training Center Capital Equipment*		79,355		79,355	Computer/Video Projector (\$9,556); AV Control System (\$11,757); Presentation Lectern (\$6,248); Audio System Video Conf/Teleconference (\$8,147); Video Conference CODEC; HD (\$29, 890); Camera System (\$8221); Tax \$5,536
<b>Equipment Subtotal</b>		<b>79,355</b>		<b>79,355</b>	<b>*See Attachment X</b>
<b>SUPPLIES</b>					
Office Supplies		1,200	2,990	4,190	Paper, postage, pens, cartridges, etc. No indirect costs charged.
Lunches for Adv. Council			720	720	estimated 15 people X \$12 X 4 meetings/year
<b>Supplies Subtotal</b>		<b>1,200</b>	<b>3,710</b>	<b>4,910</b>	<b>* No Indirect Costs Charged</b>
<b>TRAVEL</b>					
Registration Fees			1,200	1,200	Arkansas Meeting Exhibits
Intrastate Mileage			6,695	6,695	1328 mi/month X 0.42/mile
Intrastate Per Diem			3,840	3,840	\$160 X 24 trips(1 overnight; 2 days' meals)
National Meetings			2,400	2,400	\$200 reg. + \$400 airfare + \$385 hotel (2 nghts) + \$165 meals (3 days) + \$50 ground transportation.
<b>Travel Subtotal</b>			<b>14,135</b>	<b>14,135</b>	
<b>OTHER</b>					
Rent		1,517	57,200	58,717	1400 sf @ \$13/sf X 1 mo. for Rate Review Center (RRC) in year 1; 4400 sf @ \$13/sf (3000 sf office/mtg space; 1400 sf RRC) -Yr 2; no indirect costs charged.

New Staff Position Office Furnishings		4,597	18,442	23,039	Dell Laptop (\$1588); LaserJet Printer (\$388); ATT Speakerphone (\$249), 4 Dr. File Cabinet (\$198); Bookcase (\$121); High Back Desk Chair (\$320); Desk (\$609); Connector (\$358), 48"return (\$256); 2 Side Chairs @ \$96 ea (\$192); tax (\$1644) - X 5 employees
SQL Server DBMS		15,050		15,050	For Rate Review Data base; Includes licenses
Alpha Five Application Server Licenses		930		930	To support IT expansion
Rate Review Training Center Furniture*		19,922		19,922	Conf. Table (\$2850); 8 Conf. Chairs @ \$300 each (\$2,400); 80 Stacking Chairs @ \$60 each (\$4,800); 30 Folding Tables @ \$187 ea. (\$5610); Refreshment Center (Refrig. @\$886; Microwavie @ \$144; 2 Coffee makers @ \$188; Cook top @ \$149; Sink, faucet, and cabinets @ \$889; garbage disposal @ \$198; and installation @ \$518); tax (\$1,290)
Rate Review Training Center Non-Capital Equipment*		19,211		19,211	Electric Projection Screen (\$2,763); Wireless Lavalier Microphone System (\$1,242); Lectern Microphone (\$373); DVD/VCR Combo Player (\$611); Video Projector Switcher/Scaler (\$2,200); Rack Mounting and Power Distribution (\$2479); Document Camera (\$3,844); System Connection Plate (\$920); LCD Monitors/Mount (\$3,439); tax (\$1340)
Implementation Technical Plan/Training*		4,935		4,935	Rate Review Training and Outreach Center
System Installation*		26,715		26,715	Rate Review Training & Outreach Center equipment installation, AC power and conduit pathways, installation and wiring of projection screen, LAN circuits, proper lighting (incl. design assist.)
Traveling Exhibit Board			2,000	2,000	For information dissemination at meetings/conferences, etc.
Printing			15,000	15,000	Brochures, manuals, informational pieces
Telecommunications			6,000	6,000	Telephone expenses (desk, cells, blackberries)
Copier Expenses			1,000	1,000	Pro-rated for 5 positions
Special Needs.			2,000	2,000	Translators, special equipment, etc.for hearings, educational sessions
Advertisements			10,168	10,168	For hearings, community meetings, AID web, etc
<b>Other Subtotal</b>		<b>92,877</b>	<b>111,810</b>	<b>204,687</b>	
<b>GRAND TOTAL</b>		<b>226,199</b>	<b>773,801</b>	<b>1,000,000</b>	
* See Attachment Rate Review Center Equipment detail in XYZ					
AID Agrees to Maintain Current Rate Review MOE @ \$14,500 annually.					