

Health Insurance Rate Review Grant Program  
Cycle I Quarterly Report Template

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**Submission Date:** July 27, 2011

**State:** Arkansas

**Project Title:** Arkansas Health Insurance Rate Review Grant  
Program Cycle 1

**Project Quarter Reporting Period:** Quarter 3 (April 1, 2011 - June 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

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

April 30, 2011-TBD  
July 31, 2011-TBD  
October 31, 2011-TBD

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 to OCIO. The quarterly 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 first quarterly report must be submitted between January 31, 2011 and February 28, 2011 and must be submitted electronically through the Health Insurance Oversight System (HIOS). Each state will be trained individually on the use of this system in January, 2011.

The following reporting guidelines are intended as a framework and can be modified when agreed upon by the OCIO grant project officer and the State. A complete quarterly 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: NARRATIVE REPORT FORMAT**

### **Introduction:**

This quarterly report (3rd) will update and detail the considerable progress made by the Rate Review Division of the Arkansas Insurance Department (“AID”) that has occurred since the second quarterly report was submitted on May 20, 2011.

1. On June 14, 2011, the AID Rate Review Division hosted a high level data development task force meeting attended by many in state healthcare leadership 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. (See Attachment #14)
2. On July 1, 2011, CCIIO officially notified AID that Arkansas had been determined to have an “Effective Rate Review Program” in all markets. (See Attachment #13)
3. On June 10, 2011, AID released its proposed Bulletins 6-2011 and 7-2011 for comment. The Bulletins were officially adopted on July 7, 2011 with effective dates of September 1, 2011. These two Bulletins allowed the AID to meet the applicable criteria in order to be officially designated as an “Effective Rate Review Program.” (See Attachments #8 & 9)
4. On July 8, 2011, AON Hewitt issued its final report to AID with the Phase II Rate Review Recommendations. (See Attachment #5)
5. On May 18, 2011 the Request for Bid was released by the Office of State Procurement. The bids were opened on June 21, 2011 and the winning bidder identified. The bid was awarded on July 5, 2011. On July 21, 2011, official purchase orders were issued for the Rate Review Media Center in the amount of \$120,899.97 which was below the projected budget. Implementation has begun with completion anticipated by August 20, 2011. (See Attachment #6)
6. On Friday, July 22, 2011, AID through the 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. At 10:34:18 a.m. on the same date, Grants.gov confirmed the receipt of the application and assigned “GRANT 10928395” as the AID official tracking number.

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## **Program Implementation Status:**

### **1. Accomplishments to Date:**

- Successful implementation of AON Hewitt Reports (See Attachments #4, 5, & 12). AON Hewitt's Phase I response to this RFP has given AID Rate Review a comprehensive and quality assessment of nearly all components of the current AID health insurance rate review process. This response identifies changes in the current AID rate review process, including AID regulatory reporting, needed to fully comply with the mandates of HHS/PPACA. The final Phase I report has, 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 provides 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.
- The Media Center RFP has been converted to an "Invitation for bid" (IFB) as mandated by state purchasing. Bidding was opened on June 21, 2011 with an expected award date of July 5, 2011. Completion with final installation is scheduled to be no later than August 19<sup>th</sup>, 2011. (see Attachment 6)
- Outreach program has been implemented with multiple public presentations.
- The majority of the RR grant staff positions have been filled with employees in place;
- New office space, furniture, computers, and communication equipment have been procured.
- Arkansas has been determined by HHS to have an "Effective Rate Review Program" for all markets.
- AID has issued Bulletins 6-2011 and 7-2011 that expand the rate filing requirements for individual and small employer group policies.

### **2. Challenges and Responses:**

State rules and regulations have hampered progress in employment, procurement, and the hiring process. This has resulted in considerable delays in filling the two remaining vacant staff positions:

- Rate Review Compliance
- Rate Review System Analyst

In addition, the 'Arkansas State Office of Purchasing' required we switch the Media Center RFP to a straight bid format which required a great deal of extra work to comply which caused delays in award being issued.

**3. Describe any required variations from original timeline.**

The challenges stated above, concerning state rules and regulations, have caused considerable delays across the board from the original AID grant timelines. With the reports received from AON Hewitt and the adoption of Bulletins 6-2011 and 7-2011, enhancements to the rate review process should move forward at a faster pace.

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### **Significant Activities: Undertaken and Planned**

- Within the Arkansas Insurance Department (“AID”), leadership of the three CCIIO funded projects (Premium Rate Review, Health Benefits Exchange, and Consumer Assistance Program) have begun to meet regularly for strategic sharing and planning.
- The Premium Rate Review and Exchange Planning Programs continue communication and sharing of information. The need for understandable consumer information, consumer outreach education, and consumer empowerment is shared and advocated by all three programs.
- **ARKANSAS RATE REVIEW AUTHORITY**  
Under existing law, the Arkansas Insurance Department has prior approval authority over rates for individual health policies. Ark. Code Ann. § 23-79-109(a)(1)(A). Rates may be disapproved if they are unreasonable Ark. Code Ann. §23-79-110(5). For small employer groups, the Department has the authority to review a carrier’s rating practices and its underwriting practices. The Department can review all information and documents that demonstrate that the carrier’s rating methods and practices are based upon accepted actuarial assumptions. Rates for small employers are restricted by the provisions in Ark. Code Ann. § 23-86-204. These provisions apply to employer groups with no fewer than two or more than twenty-five employees.

In the recent legislative session, the Department sought to increase its rate approval authority over small employer groups and increase the number of employees to fifty. For individual rates, the Department sought to increase the information required to be filed with a rate increase and to increase the grounds for disapproving rates. Neither of these legislative changes was passed. However, these bills were placed in an interim study committee along with all proposed legislation dealing with the Affordable Care Act.

To move the rate review program forward, the Department issued two new Bulletins providing further guidance to carriers on the requirements placed upon them for all future rate filings for all individual and small employer group policies. On July 7, 2011, the Department issued Bulletins 6-2011 and 7-2011. These two new Bulletins will allow the Department to meet all of the applicable criteria in order to be determined to have an “Effective Rate Review Program”. Bulletin 6-2011 address the filing requirements for individual policies and Bulletin 7-2011 addresses the filing requirements for small employer group policies. (See Attachments 8 & 9)

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

As stated previously, state procurement and state hiring processes have been problematic and caused considerable delays. AID is working diligently to overcome these limitations.

### **Public Access Activities:**

RR will continue to enhance current communication strategies and implement news ones during this quarter to continue implementing an effective outreach campaign with the purpose being to educate consumers with meaningful information regarding premium rates and health care costs. (See Attachment 5)

AID continues to be proactive in developing educational materials, enhancement of current website, amending Primer “101” and launching a social media campaign which will include a Facebook and Twitter page.

A Media Center IFB has been awarded and is expected to be fully equipped and operational before September 1, 2011. The Media Center will serve a ‘nerve center’ for various stakeholders including legislators, consumers, various task forces and industry officials. It will be used to conduct meetings, webinars, podcasts, and various other mechanisms that will be used to disseminate meaningful rate review information.

The AID website was studied in-depth and major improvements suggested improving the Department’s existing website and a new RR website. Rate Review received a proposal to contract and develop a new state-of-the-art consumer friendly website to provide advanced notice regarding rate increase filings and comment periods. 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 help make this information more appealing and interesting to consumers, the goal is to create a graphic-intensive site design and present the information as interactive components when possible.

### **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.”

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### **Customer 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.
- Develop email alerts for consumers to receive updates on companies' rate request filings.
- Conduct webinars on health care and rate review topics.
- Conduct a series of statewide public information and engagement meetings during the planning phase.
- Create tailored presentations and materials for consumer outreach and education for various target groups.
- Work with local partners to reach various stakeholder and consumer groups.
- Use social media such as Twitter and Facebook to reach consumers.

### **Collaborative Efforts:**

Rate Review will continue to work with the primary stakeholder groups and consumer advisory groups to reach Arkansans with new, meaningful information and materials. AID continues to participate in all NAIC working group calls and HHS conference calls pertaining to rate review.

### **Lessons Learned:**

We've learned there is a substantial lack of general health care knowledge and it will shape the development of our educational materials and continuing outreach efforts.

### **Updated Budget**

The current allocation of grant funds closely 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. A detailed operating budget is provided in Attachment #11.

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BUDGET CATEGORY	ORIGINAL BUDGET	REVISED BUDGET	VARIANCE
SALARIES AND WAGES	\$329,650.00	\$329,650.00	\$0.00
MATCH	\$90,455.00	\$90,455.00	\$0.00
EQUIPMENT	\$79,355.00	\$79,355.00	\$0.00
TRAVEL	\$2,400.00	\$2,400.00	\$0.00
OPERATING EXPENSE	\$221,332.00	\$221,332.00	\$0.00
CONTRACTUAL SERVICES	\$276,808.00	\$276,808.00	\$0.00
TOTAL	\$1,000,000.00	\$1,000,000.00	\$0.00

### Additional 3<sup>rd</sup> Quarter Reports Supporting Budget Documents

1. See enclosed Attachment #15 which contains *the most* current SF-425 covering the time period from 3.31.11 through 6.30.11.
2. See enclosed Attachment #11 which demonstrates a detailed operating budget covering the last two months of 2010 and the remaining months to date of 2011, as well as projections for the remaining months of the grant period.

# Health Insurance Rate Review Grant Program

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### **Updated Work Plan and Timeline:**

During this quarter, the Department was able to review the AON Hewitt Phase I and Phase II reports which provide a quality assessment and specific recommendations for nearly all components of the current AID health insurance rate review process, including analysis and recommendations for outreach efforts and AID regulatory reporting needed to fully comply with the mandates of HHS/PPACA. Recommendations from AON will help in the continued improvement and implementation of an effective rate review program.

A robust outreach program has been implemented and using feedback from AON and our various Stakeholder Groups, will continued to be developed. RR has implemented a robust outreach program which includes expansion of the AID website, distribution of education materials regarding the rate review process in Arkansas in face-to-face outreach efforts and on the web. A social media campaign will be launched this quarter and includes an AID Facebook page and Twitter account.

RR continues to work with various departments within the AID to synergize outreach efforts including the Consumer Services Division. RR provides content and materials to divisions to include during outreach events.

The Media Center IFB has been awarded and will be a key component of our outreach efforts. It's expected to be fully equipped and operational by August 24, 2011. (See Attachment 6)

The goal continues to be: to educate Arkansas consumers and create maximum transparency about the health insurance rate review process. We have made significant process in providing basic information to the public in face-to-face outreach and on the AID website. Our efforts will continue to be molded and improved as we make progress in our implementation efforts.

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## **Enclosures/Attachments:**

Attachment 1	AID RR Timeline
Attachment 1b	AON Timeline
Attachment 2	Milestones
Attachment 3	RFP Scope of Service
Attachment 4	AON Hewitt RFP Phase I Report
Attachment 5	AON Hewitt RFP Phase II Report
Attachment 6	Media Center IFB
Attachment 7	National NAIC Survey
Attachment 8	AID Bulletin 6-2011
Attachment 9	AID Bulletin 7-2011
Attachment 10	Proposed RR Manual Table of Contents
Attachment 11	Budget Detail
Attachment 12	RR Checklist
Attachment 13	CCIIO Letter
Attachment 14	RR Data Center Proposal
Attachment 15	SF-425

## AID Rate Review Timeline | 2011

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July 6, 2011	Scheduled In-Person presentation of AON Final Phase II report
July 1, 2011	Voluntary Letter of Intent to apply for CFDA: 93.511
June 30, 2011	Final 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 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	In-Person 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 scheduled with newly developed Consumer Advisory Group
May 18, 2011	Response from AID on Phase I Draft Report, conference call scheduled
May 17, 2011	Department wide social media outreach kick-off meeting
May 17, 2011	Rate Review Primer disseminated at SHIIP outreach event

## AID Rate Review Timeline | 2011

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May 16, 2011	Follow up 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 9, 2011	Primer “101” created

Arkansas Insurance Department (AID) - Rate Review Project  
Timeline

Activity	Responsible Party	Date	Status	Notes
<b>Initial Steps</b>				
Kickoff Meeting	Aon Hewitt / AID	2/24/2011	Complete	
Initial interviews with key State personnel	Aon Hewitt / AID	2/24/2011	Complete	
Review proposed regulatory changes	Aon Hewitt	3/4/2011	Complete	
Get final signed contract	Aon Hewitt / AID	3/15/2011	Complete	
Contract approved by legislative counsel	AID	4/15/2011	Complete	
Project Timeline	Aon Hewitt	4/18/2011	In progress	
<b>Phase I - Assessment of Current Process</b>				
Review material provided by AID (sample rate filings, etc.)	Aon Hewitt	3/15/2011-4/15/2011	In progress	
Request and complete follow-up interviews with AID, if required	Aon Hewitt / AID	4/11/2011-4/22/2011		
Hold discussions with the three domestic carriers submitting rate review filings	Aon Hewitt / AID	4/20/2011-4/22/2011		To better understand carriers' rationale for common assumptions and certain submissions formats
Write Phase I Report	Aon Hewitt	4/25/2011-4/29/2011		
Draft Phase I Report to AID for review	Aon Hewitt	5/2/2011		
Response from AID on Phase I report	AID	5/6/2011		
Revised Phase I Report to AID for review	Aon Hewitt	5/11/2011		
Response from AID on Revised Phase I report	AID	5/17/2011		
Final Phase I Report to AID	Aon Hewitt	5/20/2011		
In-Person Presentation of Final Phase I Report	Aon Hewitt / AID	TBD		
<b>Phase II - Develop Recommendations, Tools, and Processes to Enhance Rate Review</b>				
Meet with AID to discuss possible tools, processes, and training materials to implement enhancements	Aon Hewitt / AID	5/5/2011-5/13/2011 (Exact date TBD)		Aon Hewitt to bring recommendations for discussion.
Develop tools and processes to implement enhancements	Aon Hewitt	5/16/2011-6/3/2011		
Request and complete follow-up discussions with AID, if required	Aon Hewitt / AID	5/23/2011-6/3/2011		
Write Phase II Report	Aon Hewitt	5/31/2011-6/10/2011		
Draft Phase II Report to AID for review	Aon Hewitt	6/13/2011		
Response from AID on Phase II report	AID	6/17/2011		
Develop training materials	Aon Hewitt	6/20/2011-6/30/2011		
Revised Phase II Report to AID for review	Aon Hewitt	6/22/2011		
Response from AID on Revised Phase II report	AID	6/27/2011		
Final Phase II Report to AID	Aon Hewitt	6/30/2011		
In-Person Presentation of Final Phase II Report	Aon Hewitt / AID	TBD		
<b>Wrap-up</b>				
Assess ability and need to extend project, if necessary	Aon Hewitt / AID	TBD		

## Attachment 2

Objectives	Milestones	Challenges
1. Expand the scope of rate review to include the review of unreasonable rates in the small group market and allow AID to have an effective rate review program.	AID issued Bulletin 7-2011 which expands the filing requirements to small group policies and provides for prior approval of all rates for this market. On July 1, 2011, CCHIO determined that AID has an “effective rate review program” for the small group market.	This will be a new requirement and additional resources will be needed within AID to handle the additional workload.
2. Expand the scope of rate review in the individual market so that AID is determined to have an effective rate review program in this market.	Aid issued Bulletin 6-2011 which expanded the filing requirements for the individual polices. On July 1, 2011, CCHIO Determined that AID has an “effective rate review program” for the individual market.	AID will need to revamp it rate review procedures to meet these new requirements. Additional staff and resources will be needed.
3. Enhance technology and programmatic infrastructure to effectively collect, analyze, track and report health insurance rate filings and outcomes to diverse stakeholders including the general public and enrollees, insurers, health care providers and policymakers, including state legislators and the Secretary for DHHS.	The Phase 1 report form AON Hewitt provides a comprehensive assessment of all current components of the AID health insurance rate review process including all related and applicable information technology, data management, regulatory and management reporting requirements. The Phase II report which is due July 5, 2011 will provide recommendations on enhancements to the current process.	
4. Create health insurance rate review education, outreach, and training programs dedicated to information dissemination about rate approval processes and rate trends to various stakeholders including the general population and special consumer populations.		The lack of general health care knowledge will play a major role in how we tailor educational material to consumers. The AON Hewitt Phase II report will address these challenges.
5. Equip a modern, state-of-the-art rate review media center that can be used to meet the needs of all aspects of the outreach programs.	The media center purchasing process was completed in this quarter and the bids were opened on June 21, 2011. The final award should be made in early July.	The Media Center RFP was changed at the last moment to an invitation to bid. This delayed the process and created budget issues that needed to be resolved.

## AON Hewitt (RFP) Scope of Services

### PHASE I

In Phase I, the successful Respondent will conduct a comprehensive assessment of all components of the current AID health insurance rate review process (see attached exhibits). Phase I will also require the identification of all changes in the current AID rate review process, including AID regulatory reporting, needed to fully comply with the mandates of HHS/PPACA.

This assessment will include, but not be limited to, 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.

Additional topics to be considered are:

1. Determination of potential intersections of HHS/OCIIO Rate Review, Exchange, and Consumer Assistance Grants in the State of Arkansas (AID is the grantee of all three) and the most synergistic approach for mutual assistance and cooperation as well as avoidance of duplication of efforts.
2. Improvement of the current reporting and data collection systems, construction of an innovative data system which will house rates, related increases filed for use, and optimal utilization of the expanded functions of SERFF to allow accurate and timely analysis and reporting. This optimal data system will provide the best possible platform, structure and/or mechanism for the internal or external actuaries to perform timely and cost effective rate analysis.
  - Optimal automation, to the extent possible, and streamlining of the AID rate review process
  - Tracking required PPACA data, rate filing information, national & state trends, and patterns
  - Benchmarking capability and utilization of national, regional, and contiguous state trends
  - Improve data measurement and analytic capacity to generate meaningful AID 'rate review' management reports and upgrading technology and database management if required.
3. AID Standards for Approval
  - Conventional actuarial standards
  - Modified standards
  - Filing Requirements, Transparency and Full Discovery:
  - Review Method:
    - Hearings
    - Desk reviews
4. Optimizing consumer participation and public dissemination of information using web-based & interactive video technology, outreach, and public meetings and hearings.
5. Effective utilization of available HHS waiver processes.

## **AID Internal Actuarial Objectives**

1. Examine the appropriateness of data currently utilized by carriers in their rate request submissions and develop guidelines for validation.
  2. Study the market segment standards currently used in determining reasonableness of premium levels and increases, and identify additional information needed.
  3. Study significant assumptions currently being made in deriving the required premium rate, particularly in the event of small or immaterial blocks of business or the entrance into a new line of business.
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1. Identify reputable sources for trend assumptions and determine if there are other publicly available information sources to ascertain the reasonableness of the request.
  4. Search trend justifications from the carriers including intrinsic trend and renewing provider contracts.
  5. Consider potential external measures (surveys, claims data, etc) that are applied by the carriers in order to evaluate the assumptions used in the development of the premium rates.
  6. If any form of outcome based payment approaches are used by the carriers, study valuation of network payment levels and provider outcome measures.
  7. Determine the potential impact that carrier violations of the minimum MLR (beginning 1.1.2011) will have on the future AID rate review process and/or the actuarial calculations.

## **PHASE II**

Using the information gained from the Phase I assessments and the analyses thereof, Phase II will create and establish innovative and effective strategies and specific recommendations which will vastly improve the AID rate review process and meet the adopted goals and objectives.

# Arkansas Insurance Department (AID) Rate Review Project

## *Phase 1 – Assessment of Current Process*

### Executive Summary

Under the Affordable Care Act (ACA), the Arkansas Insurance Department (AID) has received Cycle I grant funding from Health and Human Services (HHS) to improve their health insurance rate review process. To this end, Aon Hewitt has completed an assessment of the current rate filing review process. In this report, we describe the current process, compare this to the ACA requirements, and recommend areas that should be improved upon, including:

- 1) **Defining “subject-to-review” and “unreasonable”** in regulation or bulletin form.
- 2) **Developing more specific requirements for the data, assumptions, and methodology description** that included in rate filings (or disapproving filings that do not have sufficient information for an actuary to review the filing).
- 3) **Creating internal training materials, a rate review manual, and electronic job aids.**
- 4) **Improving consumer outreach.**
- 5) **Develop an internal database with pertinent rate filing information.**

In Phase II, we plan to work with the AID to develop specific recommendations for these areas.

## Introduction

On March 30, 2010, the ACA was enacted, introducing sweeping changes to the nation's health care system via changes to the Public Health Service Act (PHS Act). Among these changes was a new section 2794 of the PHS Act, which directed the Secretary of HHS to establish a process for the review of unreasonable premium increases. This process was to include requiring health insurance issuers to submit preliminary justifications for the increases to HHS and the applicable state. HHS was charged to work with the National Association of Insurance Commissioners (NAIC) in developing requirements for the preliminary justification documents.

On December 23, 2010, HHS released a proposed regulation<sup>1</sup> to implement the rate increase disclosure and review disclosure requirements of the ACA. The NAIC and HHS have also been working on draft requirements for the preliminary justification documents<sup>2</sup>. HHS has also released proposed regulations and sub-regulatory guidance on other aspects of the ACA (e.g., minimum loss ratio requirements).

As part of the ACA, HHS announced initial grant awards ("Cycle I grants")<sup>3</sup> to the states to help improve the oversight of proposed health insurance premium increases, including:

- Pursuing additional legislative authority,
- Expanding the scope of health insurance premium review,
- Improving the health insurance premium review process,
- Making more information publicly available, and
- Developing and upgrading technology.

The Arkansas Insurance Department (AID) applied for and received a Cycle I grant from HHS. As part of this grant funding, the AID has retained Aon Hewitt to 1) perform a comprehensive assessment of the current health insurance premium increases; and 2) research, develop, and recommend a comprehensive plan for the complete upgrade of the existing AID system of health insurance rate review as well as all related and applicable technology. The assessment of the current process is "Phase I" of the project. "Phase II" is comprised of developing a comprehensive plan for future improvements and is expected to be largely complete by the end of June.

The report below contains Aon Hewitt's Phase I findings. This analysis is based on the proposed rate review and disclosure regulation issued by HHS on December 23, 2010, and the draft preliminary justification documents and instructions released by the Centers for Medicare & Medicaid Services (CMS, part of HHS) on March 1, 2011. There are still many open questions regarding the proposed regulation and how it will be implemented, and the preliminary justification documents are still only in draft form. Our analysis below is therefore based on the information available at this time.

<sup>1</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)

<sup>2</sup> Draft requirements for preliminary justification documents: <http://www.federalregister.gov/articles/2011/03/01/2011-4552/agency-information-collection-activities-proposed-collection-comment-request#p-2>. (March 1, 2011)

<sup>3</sup> Cycle I grant award announcement: <http://www.hhs.gov/news/press/2010pres/08/20100816a.html>. (August 16, 2010)

These findings from Aon Hewitt are based upon professional, actuarial knowledge and opinions regarding individual and group health insurance rate filings with state regulators. They are not legal opinions and we encourage AID to receive their own legal reviews.

## ACA Rate Increase Review and Disclosure Requirements

### Rate Increase Review

The ACA requires an annual review of unreasonable increases in premium for health insurance coverage. This rate review requirement was later interpreted by HHS in the proposed regulation to be an annual review of potentially unreasonable increases, since a rate increase cannot be determined to be unreasonable from an actuarial standpoint until it has been reviewed. Some high increases may be justifiable from an actuarial perspective (e.g., due to high increases in provider costs), while some lower increases may not be justifiable.

Recognizing that rate increases should be reviewed before being determined unreasonable, but not wanting to review every rate filing, HHS has proposed a two-step process:

- 1) All rate increases at or above a specific threshold will be deemed “**subject to review**”.
- 2) All rate increases that are “subject to review” will be reviewed by HHS and determined to **reasonable or unreasonable**.

The review process will take effect July 1, 2011, and the initial “subject to review” threshold will be 10%<sup>4</sup>. HHS plans to develop state-specific thresholds later, based on data for: 1) each rate increase that is “subject to review, and 2) data from states receiving “premium review grants”. The requirements apply to individual and small group rate filings only<sup>5</sup>. Grandfathered plans are exempted from these requirements. For all rate filings that are subject to review, carriers must comply with the rate increase disclosure requirements.

HHS made clear in the proposed regulation that the new review requirements do not supplant existing State laws or processes; the requirements only supplement and complement these. If a state has an “effective” process in place, HHS will defer to the state’s determination. Otherwise, the review will be done by HHS. The main factors for an “effective” rate review program according to HHS are:

- 1) Does the state **receive from the issuers data and documentation** that are sufficient to determine if rate increase is unreasonable?
- 2) Does the state effectively **review the data and documentation**?
- 3) Does the state examine the **reasonableness of the assumptions**?
- 4) Does the state apply a **standard set forth in statute or regulation** when making the determination of reasonable vs. unreasonable?

<sup>4</sup> Because this is an annual review process, this includes multiple rate increases that total 10% or more in a given year.

<sup>5</sup> Based on state definition of Small Group, not for other purposes under ACA.

If HHS does the review, they plan to review: 1) the actuarial estimates that form the basis of the rates, and 2) the methodology used to develop the rates. The determination of unreasonable will be based on whether the rate increase is “excessive”, “unjustified”, or “unfairly discriminatory”. However, HHS is soliciting comments regarding whether to include other factors (e.g., structure and competitiveness of a market).

## Rate Increase Disclosure

If a rate increase is above the “subject to review” threshold, the issuer must submit to the HHS Secretary and the applicable state a preliminary justification before implementation. There are three parts to the preliminary justification:

- Part I: Rate increase summary
- Part II: Written Explanation of the Rate Increase
- Part III: Rate filing documentation

The first two parts comprise a descriptive and quantitative analysis for consumers. They are required for all rate increases subject to review, to be submitted to state and HHS. HHS will post these documents to its website.

The third part is only required to be submitted if HHS is doing the review. In this case, HHS will post on website such information from Part III that is not “confidential” under HHS’ Freedom of Information Act. HHS will then provides the final determination of whether the requested rate increase is “unreasonable”.

## Post-Review Steps

If the applicable state is doing the review, the state must provide the determination of reasonable vs. unreasonable to the issuer and to HHS, including the rationale for the determination. If HHS is doing the review, HHS provides the determination to the issuer. In both cases, HHS will post the final determination on its website.

For rate increases determined to be unreasonable where HHS is doing the review, if the issuer decides not to implement the rate increase or to implement a lower increase, the issuer must provide a final notification to HHS. If a lower increase is to be implemented, this new rate increase will again be subject to review if it meets or exceeds the threshold (10% for 2011). If the issuer decides to proceed with implementing the unreasonable rate increase, the issuer must submit a final.

Regardless of who does the review, HHS will post the final determination and the issuer’s final justification (if applicable) on its website.

## Outstanding Legal Questions

As mentioned above, there are still outstanding questions regarding the proposed regulation. For example:

- 1) **Will deemers be allowed?** Many states currently have provisions that allow rates to be deemed approved if the state does not disapprove them within a specified time period (for example, 30 days). One carrier has heard that allowing rates to be deemed approved may not constitute an “effective” rate review process, since not all rate filings are marked as approved or disapproved.
- 2) **Do the requirements only need to be applied to renewals/closed blocks**, or do they affect new business as well? Based on conversations with AID personnel, they have indicated that they plan to apply the new requirements to both new business and renewals. However, one carrier indicated a preference for applying the requirements only to renewals.

## Other Health Care Reform Changes

The ACA will affect many aspects of health insurance, not just rate increase review and disclosure. Actuaries may cite some of these changes as explanations for requested rate increases. Below is a list of some of the ACA changes that could impact rates requested by actuaries or the rate filing review process:

- 1) Change in dependent eligibility age to 26
- 2) Grandfathered status
- 3) Prohibiting preexisting conditions
- 4) Removal of lifetime dollar limits
- 5) Limiting/removal of annual dollar limits
- 6) Restrictions on rescissions
- 7) Patient protections
- 8) Preventive health services
- 9) Minimum loss ratio requirements
- 10) Change in small group definition (other than for rate filing, but could affect rates)
- 11) Expansion of Medicaid
- 12) Exchanges
- 13) Age band and tobacco rating limits
- 14) Risk adjustment of individual and small group plans, both inside and outside the exchanges
- 15) Premium subsidies for small group (<25 employees)
- 16) Etc.

As part of the rate review process, the AID and will need to consider how to evaluate filing actuary's assessment of the impact of these factors. Some of these changes may have been implemented in other states before (e.g., age band limits) and so data may be available to evaluate the reasonability of these assumptions. However, other changes will be more difficult to evaluate, and the AID may need to rely on actuarial resources (an internal actuary or actuarial consulting resources) to evaluate the reasonability of the actuary's estimates.

## Aon Hewitt's Phase I Activities

During Phase I, Aon Hewitt performed the following tasks:

- 1) Initial Kick-off Discussion with the AID
- 2) Initial interviews with AID personnel, including:
  - a. Life and Health Compliance Officer
  - b. Health Insurance Rate Review Manager
  - c. Director of Life and Health
  - d. Director of Information Services
  - e. Chief Information Officer
- 3) Joint meetings with carriers and AID, to get carrier's views on current process. We met with the following carriers:
  - a. Golden Rule
  - b. QualChoice
  - c. Blue Cross/Blue Shield of Arkansas (BCBS of AR)

See Appendix A for the discussion guide used for the carrier meetings.
- 4) Follow-up questions sent to AID personnel
- 5) Prepared analysis of potential changes needed to SERFF (see Appendix B)
- 6) Interview with Public Information Officer

## Rate Filing Requirements, Staffing and Process

### Current Situation

Currently, both the rate filing requirements and the AID personnel resources devoted to reviewing rate filings are fairly limited in scope. Arkansas currently only requires rate filings to be submitted for individual rates and HMO (except for new form filings), though AID intends to begin requiring rate filings for small group non-HMO. By statute AID has the authority to deny rate submissions in the individual health market and for HMO filings. AID will be requiring small group non-HMO rate filings, but does not presently have the legal authority to deny these rate requests.

There are only 1-2 personnel that spend a significant amount of their time reviewing rate filings, and there are no personnel at the AID with actuarial or underwriting experience. The AID receives only a few health

rate filings each year and at the Commissioner's discretion sends some of these out to actuarial consultants for review.

## Current Rate Filing Requirements

### Individual

Prior to enactment of health care reform, individual rate filings have been required on an ongoing basis (not just in association with form filings). Rate filings are file and approve, with a 30-day review period (see Table 1 below). The AID tries to review all filings within 30 days. If more time is needed, a deemer letter is sent, extending the approval period by another 30 days.

Individual rate filings are required to be accompanied by actuarial data. The data required is outlined in AID Bulletin 4-79, and is summarized as follows:

- a) Description of the type of coverage and designation of the affected policy or contract form number.
- b) Rate change history.
- c) Estimated number of persons in Arkansas that will be affected.
- d) Percentage rate increase. If this is not level for all members, the maximum, minimum, and average rate increase need to be provided.
- e) Latest three calendar years of experience on an earned premium to incurred claim basis.
- f) Description of how the proposed rate increase relates to actual historical as well as future expected experience.

The Arkansas Insurance Code and the regulations issued by the AID do not cite any specific list of permitted rating variables or other rating restrictions for individual rates. Variables based on actuarial information may be used. There appear to be no other obvious restrictions on the rating variables that can be used for individual rate filings, though unfair discrimination in the premiums is not allowed under Arkansas statute and AID rules<sup>6</sup>, including due to marital status, physical or mental impairment, or blindness.

### Small Group and Large Group

For most purposes, including HIPAA protections, the current definition of small group in Arkansas is groups with 2-50 eligible employees<sup>7</sup>. However, for non-HMO rate filing requirements, small group is defined to be only 2-25 eligible employees in Arkansas<sup>8</sup>. Any groups with more than 25 eligible employees are considered to be large group for non-HMO rate filings. The AID is planning to write a rule to change the definition of small group to 2-50 for rate filing purposes.

For both small group and large group, carriers must maintain a rating manual onsite, detailing rates, rate development, and rating methodology. Rate filings are required to be submitted to the AID only for new product form filings<sup>9</sup>, in which case the rate filings must be accompanied by an actuarial memorandum and certified by an actuary that rates are reasonable.

<sup>6</sup> §23-66-206(14)(B), §23-66-206(14)(E), §23-66-206(14)(F), and AID Rules 28 and 37.

<sup>7</sup> §23-86-303(34)

<sup>8</sup> §23-66-202(1 2)(A)

<sup>9</sup> §23-79-1 09(a)(1 )(A)

**Table 1: Current State of Arkansas Rate Filing Requirements**

Segment	Eligibles	Rate Filing requirements <sup>10</sup>	Risk Adjustment Factor (RAF) band	Permitted case characteristics (outside RAF band)	Basic Rating Formula	Member notification of rate change
Individual	1	File and approve, accompanied by actuarial data <sup>11</sup> , description of % rate increase (incl min, max, average)	n/a	n/a	n/a	Required 30 days in advance (but must be after rate approval)
Small Group	2-25	Rate filings required only for HMO (file and approve with 60-day deemer). Must maintain rating manual; file annual actuarial certification on March 1. Rating manual and actuarial certifications not publicly disclosed.	15% (1.0-1.15), based on claims experience, health status, or duration of coverage	Geographic location, age, industry <sup>12</sup>	Rate = (Base Rate) x (Geo Factor) x (Age Factor) x (RAF)	Required 30 days in advance
Large Group	26+	Rate filings required only for HMO (file and approve with 60-day deemer). Must maintain rating manual. Rating manual not publicly disclosed.	n/a	No known restrictions	n/a	Required 30 days in advance

<sup>10</sup> For new products, filing must be accompanied by and actuarial memorandum and certified by an actuary that rates are reasonable.

<sup>11</sup> Actuarial data required for individual rate filings is outlined in AID Bulletin 4-79. If 500 or greater people in AR will be affected, need to send AR-specific experience in addition to nationwide experience.

<sup>12</sup> Industry not explicitly called out as a rating variable in regulations, but industries can be de facto excluded by not paying commissions. Gender is also not explicitly called out, but it is used by carriers in rating and is considered an acceptable rating variable.

## Current Staffing

The AID has very internal limited resources for reviewing health rate filings, as relatively few health rate filings are received each year. Rate filings are primarily reviewed by the Life and Health Compliance Officer, with oversight by the Deputy Commissioner/Director of Life and Health.

## Personnel

The following is a list of personnel currently involved in the rate review process or whose role is related to rate review and/or rate transparency:

- 1) **Insurance Commissioner** (currently Jay Bradford): Sets policy for department and has ultimate approval of regulations, rules, bulletins, and rate filings.
- 2) **Chief Deputy Commissioner** (currently Lenita Blasingame): Oversees Deputy Commissioners and assists with legislative matters.
- 3) **Deputy Commissioner/Health Insurance Rate Review Manager** (currently Lowell Nicholas): Project management for implementing health care reform.
- 4) **Deputy Commissioner/Director of Life and Health** (currently Dan Honey): Provides supervision and guidance for the Life and Health Compliance Officer. Recently, has been tasked by the Commissioner to review of every rate filing that includes a request for a rate increase.
- 5) **Deputy Commissioner/Director of Information Services** (currently James Winningham): Oversees information services division and provides advice to commissioner on technology-related matters.
- 6) **Deputy Commissioner/Legal Counsel** (currently Bob Alexander): Drafts legislative changes, rules, and bulletins.
- 7) **Director of Consumer Services** (currently Jackie Smith): Handles consumer complaints and outreach/education activities.
- 8) **Public Information Officer** (currently Sandra McGrew): Responsible for implementing transparency improvements as required under health care reform, in cooperation with the Information Services (IS) division.
- 9) **Chief Information Officer** (currently Britton Kerr): Day-to-day coordination of IT elements with the NAIC. The IS division provides direct support to AID regulatory staff, via development and support of computers/software.
- 10) **Life and Health Compliance Officer** (“Compliance Officer”, currently Rosalind Minor): Performs all technical reviews and communications regarding rate approval/disapproval. Also reviews non-health filings and spends only an estimated 10% of her time on
- 11) **Administrative Assistant** (currently Jennifer Newkirk): Logs all rate filings received by the AID, not just life and health filings.

## Outside Resources

The AID also uses outside actuarial resources at the Commissioner’s discretion. Historically, a consulting actuary might be obtained to review the rate filing if:

- 1) There is a considerable number of enrollees in Arkansas affected,
- 2) The rate increase is substantial, or
- 3) The rates are being submitted in association with a new form filing.

Recently, actuarial resources have been asked to review most of the health rate filings.

## Workload

Arkansas currently receives very few health rate filings. The AID personnel's time spent on each varies from approximately one hour to several days, depending on whether the rate filing is eligible for expedited approval, whether there is correspondence back and forth with the company, the level of involvement with outside actuaries, and whether the rates are negotiated with the carrier.

## Training/Expertise

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 on an as-needed basis.

Several personnel involved in the rate filing process have been at the AID for a long time and are experienced at their roles (in particular, the Compliance Officer, who has been at the AID for 23 years). However, none of the personnel who review rate filings has any underwriting or actuarial background.

The carriers we talked with perceive the AID personnel to be knowledgeable, as well as generally responsive and approachable.

## Current Rate Filing Review Process

Effective March 1, 2011, all rate filings in Arkansas are submitted via the System for Electronic Rate and Form Filing (SERFF), maintained by the NAIC. An administrative assistant also logs all rate filings when they arrive, as a backup. The Compliance Officer then checks each filing for:

- 1) Completeness (all required data included):
  - a. Last 3 calendar years' experience on an earned premium and incurred claims basis (nationwide and AR experience)
  - b. Rate history
  - c. Number of individuals insured in the block of business
- 2) New products only: Checks if product and rates are compliant with AR laws, regulations, and AID bulletins.

Expedited approval is granted if the rate filing meets all of the following conditions:

- 1) The average rate increase is less than 30%,
- 2) The number of Arkansas citizens affected is less than 100,
- 3) There has been no rate revision within the past 12 months,
- 4) The filing was submitted at least 60 days before the effective date, and
- 5) Policyholders will be notified at least 30 days prior to the effective date.

According to AID personnel, it is rare for a rate filing to qualify for expedited approval. AID personnel have stated that in practice they might consider granting expedited approval to more filings if there were too many of them.

If the conditions for expedited approval are not met, a projected loss ratio is calculated using the following formula<sup>13</sup>:

$$\frac{(\text{Historical Incurred Claims}) \times (1.15\%)}{(\text{Historical Premium}) \times (1 + \text{Requested Rate Increase})}$$

where the historical incurred claims are for the last 3 years of experience.

Whether the filing is approved, modified, or rejected would historically depend on the following factors:

- 1) Projected loss ratio: less than 50% is considered “unreasonable”
- 2) History of previous rate increases
- 3) Financial history of the company
- 4) Medical trend
- 5) Whether the insurer has filed a loss ratio guarantee. If the insurer complies with the loss ratio guarantee, the rates are deemed retrospectively approved by the commissioner.

At the commissioner’s discretion, rate increases are sometimes negotiated with insurance companies. Over the year preceding this report, requested rate increases greater than 10% were negotiated with the Commissioner. In addition, at the Commissioner’s request, recently the AID has been extending the deemer provision an additional 30 days for all rate filings with requested rate increases, in order to allow for additional analysis and possibly negotiation with the issuer. Also, the current commissioner requires that all rate filings with requested increases be reviewed by him before they are approved.

## Analysis of Rate Filing Review Performance

Aon Hewitt examined three rate filings submitted to the AID recently, including looking over the consulting actuary’s review of the filing (where applicable). We reviewed the following filings:

<sup>13</sup> Formula provided in e-mail from Lowell Nicholas (Health Insurance Rate Review Manager) on May 3,

SERFF Tracking Number	Date Filed	Issuer	Segment / Product	Purpose of Filing	Requested Rate Change	Actuary Reviewing Filing	Final Disposition
n/a	4/23/2009	BCBS of AR	Individual PPO	Rate Increase for Closed Block	+27.3%	Milliman	Approved +11.0%
AMMS-126323074	11/24/2009	Golden Rule	Individual Major Medical	Rate Increase for Closed Block	+7.0%	n/a	Approved +7.0%
UHL-127132858	4/25/2011	UnitedHealthcare of AR	Small Group HMO	Changing base rate, area factors, and trend	-4.3%	n/a	Approved -4.3%

2011, in response to a question posed to Rosalind Minor (Life and Health Compliance Officer).

### BCBS of AR, 4/23/2009 Individual Rate Filing

This was a complex rate filing, submitted for a block of some previously closed forms, two newly closed forms, and two open forms. Analysis of closed block individual rate filings can be extremely difficult, as the required rate increase is influenced by underwriting wear-off (durational factors), anti-selection, and whether the carrier included statutory active life reserves (contract reserves) in their initial rating of the policies. Unfortunately, the carrier included very little detail in their actuarial memorandum about the assumptions and methodology. The memorandum did not include the trend factors or any mention of the durational model that was used to project the experience. They included a factor for “rating cell mix changes” that was not described at all, and this terminology could be used to represent a wide variety of factors. There was also no explanation for why the carrier needed a loss ratio of 72.5% for this block, though the AID rules do not require a breakdown of the retention (1 minus target loss ratio) into components such as administrative costs, profit, commissions, and premium tax/assessments.

The AID extended the deemer period by 30 days via a letter issued on 5/20/2009 (within the original 30-day deemer period). The AID then appropriately requested comparative data from the Finance department, using NAIC data. Some of the trends in this data looked unusual (e.g., 1% increase in industry premium per member in 2007). The AID may want to consider using other sources for comparative data.

The AID also appropriately sought an actuarial review for this filing, though it appears that the actuarial consultants did not begin asking their questions until May 29, so there may have been a delay in bringing them into the process. It took multiple rounds of questions from the actuarial consultants (Milliman) to understand the assumptions and methodology. The responses given by the carrier were sometimes difficult to understand or did not appear to be answering the questions completely. However, Milliman’s review of the filing and appeared thorough and competent. After Milliman’s review, the AID negotiated a rate increase of 11%, which was approved on July 15, 2009. We were not able to locate a second deemer extension letter extending the deemer period another 30 days after the initial letter on 5/20/2009. The carrier refused to submit a revised rate filing with an actuarial certification, since the final rates were not the work of their actuaries.

This rate filing took nearly 3 months to review, which is an unusually long period of time. However, it appears that this was partly caused by a very incomplete methodology and assumptions description provided by the carrier. Also, as mentioned above, this was a very complicated filing.

### Golden Rule, 11/24/2009 Individual Rate Filing

Although this rate filing was also for a closed block of individual policyholders, it was much more straightforward. Golden Rule met all the requirements for expedited approval (including having a loss ratio guarantee in place for this block), so under AID Bulletin 4-79, the filing was automatically eligible for approval after the AID checked that the conditions were satisfied. There is no documentation showing that these conditions were checked, but the rate filing does appear to satisfy these conditions, and the filing was approved within 7 days (on 12/1/2009). Thus, the AID appeared to follow the procedures of Bulletin 4-79 for this filing. Presumably because the filing was eligible for expedited approval, the carrier provided little explanation of assumptions and methodology.

## UnitedHealthcare of AR, 4/25/2011 Small Group HMO Rate Filing

The rate filing requirements for small group and large group HMO in AR are fairly minimal. Carriers need only file new factors before using them, though the rates must be approved by the AID before they are used. There are no specific data requirements for HMO filings. Hence, the filing contained very little information regarding assumptions and methodology. It also appeared that the carrier was only filing factors that changed, so other factors used for rating were not included. The carrier also did not include a comparison of the factors versus the previous filing or a description of the rating formula. Therefore, it would be difficult to assess the impact of the changes on specific policyholders (e.g., in a certain area) without comparing against a previous filings with these factors. Also, it would not be possible to calculate a rate for a specific policyholder using this rate filing, since it appears to be missing some factors (for example, age factors). If a policyholder complained to the AID about rates, the carrier's rate calculation could not be readily checked by the AID.

The AID does appear to have followed the very limited regulations for the HMO product when reviewing this rate filing.

## Aon Hewitt's Assessment of AID Rate Filing Review Process

### Fulfilling HHS' Requirements

The AID has expressed that they would like to be able to perform rate filing review without HHS involvement. To allow this to happen, the rate filing process needs to be deemed "effective" by HHS. The following is a discussion of the AID's current process in light of HHS requirements for an effective rate review program.

### Standard for "Unreasonable" Rate Increases

HHS will consider whether a given state applies a standard set forth in statute or regulation when making the determination of whether a requested rate increase is unreasonable. Currently, the AID does not have a standard defined for determining that rates are "unreasonable", as is the case with most states (though some states have minimum loss ratio requirements). There is currently a standard for a "reasonable" projected loss ratio (50%) that is part of the process of determining whether to approve an individual rate filing. However, if a filing meets this standard, it is not clear if the filing might still be considered "unreasonable" or under what conditions this would occur. Also, this standard is well below the minimum loss ratio requirements of the ACA, so in practice every filing that is in compliance with the ACA would be considered reasonable automatically. This would most likely not be considered an effective standard for reasonability by HHS.

Additionally, the AID currently negotiates some rates and initially disapproves filings with rate increases now. This is not disallowed under the ACA, but the determination of "unreasonable" cannot be negotiated, and the standard for "unreasonable" must be spelled out in statute or regulation. Otherwise, HHS will likely not consider the process to be "effective".

The rate review process has also generally been subject to the discretion of the Commissioner who has been in office at the time. The ACA does not say anything about using the Commissioner's discretion to impact the approval/disapproval of rate filings, though arguably this can contribute to carrier dissatisfaction (one carrier expressed frustration over recent changes to the process, in particular that

rates are now subject to negotiation). The Commissioner's discretion should not be applied to the determination of "unreasonable" for specific rate filings if the AID wants to have an effective rate review process.

If the AID desires to allow the Commissioner's perspective to influence the process, the standards for "subject to review" or "unreasonable" could be set by the Commissioner then in office via rule. This standard would then be applied to all filings in the same way. Note that this procedure would not necessarily prevent the Commissioner from using his or her discretion to disapprove filings, as this is a separate issue from the determination of "unreasonable". The AID should consult with their legal counsel on this issue.

Other rate review procedures (for example, when to use outside actuarial resources) should also be established within the AID and handled consistently across all health rate filings. These procedures could be modified by each Commissioner, as long as they are applied consistently.

### Data and Documentation

HHS will also consider whether the state receives data and documentation that are sufficient to determine if a requested rate increase is unreasonable. Currently, rate filings are now required for all individual and HMO rate changes in Arkansas, and the AID expects to begin requiring rate filings for small group non-HMO. The filings are file and approve with a 30-day deemer. It is not clear in the HHS regulation whether deemers will be allowed for an "effective" rate review program (see outstanding legal questions above).

Experience and a description of the rate development are collected from the carrier as part of the rate filing. Also, rate filings include an actuarial certification. Under actuarial standards of practice, the description of the rate development must be sufficient for another actuary qualified in the same practice area to make an objective appraisal of the actuary's works as presented in the actuary's report<sup>14</sup>. However, according to AID personnel, rate filings vary widely by carrier in terms of the quality of this description. Also, rate filings that include a loss ratio guarantee provide very little information.

Currently, carriers are asked to provide the historical loss ratio, but they are not asked to provide the projected loss ratio using the current rates ("on-rate" loss ratio) or using the proposed rates. The AID does use a projected loss ratio formula when reviewing filings, as described above<sup>15</sup>. However, this formula has the following problems:

- 1) It does not account for rate increases requested during the historical period.** Note that this can be fairly complex when rate increases impact groups or individuals at different renewal dates throughout the year ("anniversary" renewal instead of a "focal" renewal that hits all members at once).
- 2) It does not account for the fact that there is typically a gap between the end of the historical period and the projection period.**

<sup>14</sup> Actuarial Standard of Practice No. 41, "Actuarial Communications", Section 3.3.3, March 2002; <http://www.actuarialstandardsboard.org/pdf/asops/asop041120.pdf> .

<sup>15</sup> 
$$\frac{(\text{Historical Premium} - \text{Incurred Claims}) \times (1 + 15\%) - (\text{Historical Premium}) \times (1 + \text{Requested Rate Increase})}{\text{Historical Premium}}$$

- 3) A flat 15% factor is used to trend claims forward** regardless of: a) current national (or regional) annual claims cost trends, and b) the period of time between the midpoint of the historical period and the midpoint of the projection period.

The AID's current projected loss ratio formula may be causing it to approve rate increases that in reality are associated with projected rate increases less than 50%.

Another potential issue is that issuers do not currently distinguish grandfathered vs. non-grandfathered plans. The ACA only requires non-grandfathered plans to comply with an effective rate review process. However, if the AID does proceed with its stated intent to review both grandfathered and non-grandfathered plans, the fact that issuers do not distinguish between these will not be a problem.

For small group non-HMO, filings not currently required. The AID has the authority to make rules for small group non-HMO and plans to draft a rule requiring rate filings for small group non-HMO. This would need to occur in order for the AID to have an effective rate review process for small group non-HMO.

### Review of Data and Documentation

Another criterion for an effective rate review program is that the state effectively reviews the data and documentation that are provided by the issuer. AID personnel have stated that they do review the data and documentation, unless the rate filing gets expedited review (uncommon). However, completed checklists are not maintained for rate filings, demonstrating what was reviewed, so it is not possible to verify that the right items are being checked.

Currently only a small proportion of rate filings are not reviewed by an actuary, though as noted above, external actuarial consultants are used to review these filings, since there are no current internal personnel with underwriting or actuarial expertise. The actuarial consultants that are used by the AID are perceived by carriers to be asking the right questions and to have the appropriate expertise.

However, internal training and documentation for how to review a rate filing are minimal. There is no rate filing review manual, and there are no job aids. A checklist exists for reviewing form filings, but not rate filings. Bulletin 4-79 is used informally as a guide for what to check in each filing.

Two carriers commented that the AID is reasonable to deal with. All three carriers we spoke with noted that AID personnel are normally prompt in getting back to them. However, one of the carriers noted that this has changed recently, and filings are not being approved within 30 days. They noted that deemers are extended beyond the initial 30 days more frequently now, which was confirmed by AID personnel. Both the carrier and AID personnel noted that the current Commissioner has been more actively involved in reviewing and negotiating rate filings, which has caused the process to slow down to some extent.

### Examining Reasonability of Assumptions

The final requirement for an effective rate review program is that the state examines the reasonableness of the assumptions. In reviewing individual health rate filings the AID uses the following checks:

- 1) Projected loss ratio: less than 50% is considered "unreasonable"
- 2) History of previous rate increases

- 3) Financial history of the company
- 4) Medical trend
- 5) Whether the insurer has filed a loss ratio guarantee.

The AID does not have the actuarial expertise to check more complex assumptions, such as the effect of changes under health care reform and the impact of a diminishing risk pool. However, the AID could (and does) send filings out to consultants for review when the filings are complex. Due to all of the upcoming health care reform changes, the impending transition to reviewing Small Group non-HMO rate filings, and the current conservative standard for “subject to review”, the AID will likely need to send more rate filings out to actuarial consultants or hire internal actuarial resources, at least initially.

## Interaction of Rate Filing Review and State Exchange

The AID proposed a bill to develop a state exchange in Arkansas, but this bill was not approved by the legislature. Since the legislature does not meet again until 2013, this means that the exchange will need to be developed by an outside entity, likely a non-profit group. Therefore, all rate filings that are “subject-to-review” will need to be reviewed by the AID and not by the exchange.

## Other Process-Related Comments

Generally, the carriers seem to be providing the bare minimum data required in the filings. For at least one very complex rate filing, it appears that a significant amount of time (and perhaps money on consulting resources) was spent clarifying the intent, methodology, and assumptions in the filing. While actuaries should be providing this information under actuarial standards of practice, some actuaries are also under a significant amount of pressure from their employers to provide as little information as possible. To make the rate filing review process less time-consuming and expensive, the AID should consider doing one or more of the following:

- 1) **Spell out more extensive and specific rate filing requirements via regulation or bulletin.** These requirements could be developed in a way that does not make them onerous, but does require the actuaries to provide what is needed for another actuary to review the filing.
- 2) For any rate filings that do not provide sufficient information for a review of the filing, **ask the carrier to send the information.** The letter with the request should indicate that the 30-day review period does not start until this data was received (a regulation and/or bulletin may need to be released to allow the AID to do this). A checklist could be used by the Compliance Officer to ensure that this information is included before the filing is sent to outside actuaries for review.
- 3) **Disapprove any rate filings that do not contain sufficient data for a review.**

## Assessment of Staffing

Adding Small Group non-HMO filings will almost certainly increase the workload, especially in the beginning, as carriers become accustomed to the new requirements. One compliance officer who also works on non-health filings (and no actuarial resources internally) will most likely not be enough resources, especially given all of the changes with health care reform that could affect filings and given

current strict standards for expedited review. The individual market is expected to roughly double in membership when exchanges are opened in 2014<sup>16</sup>, which may cause the number of individual carriers or the frequency of rate filings to increase.

Below are some options for dealing with the increased rate filing review demands:

- 1) Make expedited review easier to achieve,
- 2) Increased automation and job aids,
- 3) Hire more staff, particularly with actuarial or underwriting expertise, or
- 4) Farm out more of rate filings to actuarial consultants initially, then possibly cut back on usage of consultants if and when internal resources have been hired.

## Assessment of Training

The AID rate filing compliance officer has a long tenure at the department. Currently, she seems to understand the process well, but little is documented. Additionally, internal staff does not have actuarial/underwriting expertise to review complex filings

AID staff can attend outside seminars periodically, most commonly those held by the NAIC. However, AID personnel have commented that they would like assistance in identifying outside vendors offering more pertinent seminars.

Below are some improvements that can be made:

- 1) Create training materials to explain basic rate filings concepts
- 2) Create rate filing review rate manual to spell out expectations of review process, give guidance, and delineate when actuarial resources need to be used
- 3) Create job aids, including checklists of what to look for
  - a. Require that checklist is filled out and maintained for each filing (e.g., in paper file or scanned into a database)

The documents listed above should be updated and modified on an ongoing basis, as circumstances change.

## Transparency and Consumer Relations

### Current Situation

#### Transparency

As noted above, the 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

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<sup>16</sup> "America Under the Affordable Care Act," December 2010, Urban Institute and Robert Wood Johnson Foundation. Matthew Buettgens, Bowen Garrett, and John Holahan.

to approving or disapproving a rate filing. Current law requires a 30-day public notice from the carriers for rate increases prior to implementation.

After the approval or disapproval of a rate filing, publicly releasable filing information is posted on the AID website. The disposition letter that is posted states the percentage rate increase, but the language is complex and may be hard for the public to understand. Rate filing detail, including actuarial formulas and assumptions, cannot be publicly disclosed due to ACA.23-61-103(d)(4).

The AID is currently exploring statutory and/or regulatory changes to improve and clarify transparency, including what specifically constitutes “actuarial formulas and assumptions”.

### Consumer Complaints/Inquiries

According to the AID Director of Consumer Services, there are very few complaints or inquiries each year from consumers regarding health insurance rates. AID personnel have expressed concern that questions from consumers might increase significantly under health care reform, particularly once the exchange is operational in 2014.

### Consumer Outreach

#### Historical activities

Prior to health care reform, the AID did not have any consumer outreach activities related to health insurance rates. Because rate filings have historically been treated confidential until they are deemed closed, there have been no public announcements and requests for comments on proposed rate increases, the AID does not hold town hall meetings to discuss rate increases, and there have historically been no consumer education seminars or tutorial materials such as videos or Power Point presentation.

The Life and Health Division does have a website, which appears mostly geared toward people working in the health insurance industry. It is very functional in appearance and not very consumer friendly. The terms on the website are not defined, and many of the terms would be unfamiliar to consumers.

#### Changes Under Cycle I Grant

Using rate review grant funding, the AID has hired a Public Information Officer to develop and implement a Communication Action Plan. The goals of this project are to improve consumer knowledge and involvement in the rate approval process. The Public Information Officer has developed a Communication Action Plan, met with consumer groups, and begun planning for improvements to the website in cooperation with the IT department. Additionally, a new section has been added to the website for the Health Insurance Premium Rate Review Division. This site contains basic educational information, such as a definition of “health insurance premium”, how to reduce insurance premiums, etc.

### Aon Hewitt’s Assessment of Transparency and Consumer Relations

If the AID wants 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. As noted above, the AID plans to clarify what constitutes “actuarial formulas and assumptions”. The AID could then redact confidential information from filings or request the actuary to submit separate public vs. confidential

rate filings, as is currently done in the State of Washington. This would allow the AID to post filings on the website prior to approval, provide press releases announcing pending rate increases, invite consumers to comment, and possibly hold town hall meetings to hear consumer opinions. However, one carrier did note that public forums such as town hall meetings would make the process much more cumbersome for them.

Although there have not been many consumer complaints and inquiries historically regarding health insurance premiums, the AID should anticipate this changing after health care reform is enacted. The AID should consider proactive education activities to help handle these inquiries later. For example, consumer questions regarding how to obtain coverage via an exchange could be answered by pointing consumers to an education pamphlet or web page that explains exchanges and how to access them. Although this requires up-front investment, it will save the AID time and expense later.

More general consumer outreach could be improved via an enhanced website. Oregon in particular is a good example of a state that has a very consumer-friendly website, with a consumer guide, links to resources for finding coverage or federally funded clinics, a basic primer on health insurance, and links to resources to help improve health. The AID should consider this for members who have access to and familiarity with the Internet. However, other approaches may need to be used for residents who do not use the Internet much, due to lack of good Internet coverage in rural areas, unfamiliarity with the Internet, and for those who simply prefer more traditional approaches.

## Information Technology and Database Management

### Data for Reporting

The AID needs to have the ability to run reports summarizing the information in all health rate filings, in order to provide data to HHS and the public. Currently, the AID does not store much rate-related data in a database format that can be easily accessed for reporting purposes or by consumers. There is a basic master ledger document that is used to track all rate filings internally, mostly as a back-up to SERFF. This master ledger only contains a few basic fields, such as the date received, fees paid, analyst assigned to do the review, etc.

All rate filings are now required to be submitted via SERFF, as of March 1, 2011, so information can be pulled out of SERFF for each filing. However, this information is not currently in a format that the AID can readily run reports from. For example, it would not be possible for the AID to run a report on the average projected loss ratio for all health filings in a given year. SERFF stores most of the rate filing information as file attachments, so the AID would need to open each one of these attachments, which would be too cumbersome for reporting purposes.

It was relayed to us from AID that SERFF originally committed to make the changes needed so that all required data was available in order to meet HHS' needs for rate review. However, it is not clear whether this will be in a format that can be used to readily run reports, and it also appears that SERFF is significantly behind in making these changes (still in the planning phase). As a result, the AID should consider the following approaches, depending on whether SERFF makes changes in time and whether they meet the AID's needs:

**1) Press SERFF to make the modifications needed to store all data elements as separate fields.** If this is accomplished in time, the AID would then need to be able to run reports from these data elements. If the AID's reporting needs are extensive and frequent, or if these data elements are needed for other rate filings needs (e.g., automated job aids to help with rate filing review), the AID may want to pull relevant data down from SERFF periodically (e.g., weekly, for health filings only) for use internally.

2) If SERFF can only store data as files (e.g., disclosure documents), the AID may want to **create a way to extract the data from each file into database format** for use internally.

3) The AID may want to make its own **comprehensive internal database**, to store data from SERFF (obtained through method #1 or 2 above), as well as additional fields that are not in SERFF. For example, the HHS preliminary justification does not include any information on the impact of plan design changes. Some carriers may implement benefit reductions on their plans in an effort to ensure that they fall below the "subject-to-review" threshold for rate filings (10% for HHS in 2011). The AID may wish to separate the effect of true underlying cost trend vs. the effect of plan design changes by creating its own data fields.

At this time, it appears that SERFF will only be able to store the required data as files (#2 above). Therefore, in order to facilitate reporting to HHS and allow for some basic automation in the rate filing process, we recommend that the AID start developing some sort of database internally now, populating it manually at first. Then data could be downloaded directly from SERFF if and when this becomes possible. This downloading could be done by writing a procedure to automatically extract data elements from a standard Excel file submitted by the actuary and load them into the database.

## Incorporating Other Data

The AID should also consider incorporating other data sources into the process: internal to AID and also from external sources. For example, for at least one of the rate filings, the Director of Life and Health requested from the Finance department an analysis of the annual statement and recent financial trends from the NAIC database. Some of this data could be incorporated into an internal database and be accessed during the rate filing review process. However, the value of data often lies in how it is interpreted; the commentary from the Finance department was also useful and cannot be captured easily in a database or formula. The use of data should be combined with a critical analysis of the data from someone who understands it. Further, it would be helpful to incorporate data from outside of AID; such as developing regional and national rate trends from HHS and cost trends from sources such as Standard & Poors and the Centers for Medicare & Medicaid Services.

## Automating the Rate Filing Review Process

The AID has expressed interest in automating some aspects of rate filing review. The AID currently has no job aids for rate filing review other than Bulletin 4-79. There are many aspects of rate filing review that could be improved via electronic job aids, such as:

- 1) **Formulas to check the total annual rate increase.** Carriers sometimes file more than once a year. If the AID sets an annual "subject-to-review" threshold, the AID would need to combine the rate increases from these filings. If members experience rate increases on an anniversary basis

(upon renewal at different times during the year, not all at the same time), this can actually be somewhat complex to calculate for each renewal date.

- 2) **Formulas to check the actuary's calculation** of projected experience from the historical experience. Errors found in the actuary's calculation or assumptions can sometimes cause a large impact on the rate increase.
- 3) **Basic checks on assumptions for trend, loss ratio, etc.** Error messages could indicate to the Compliance Officer when assumptions are unusual.
- 4) **Electronic checklist of items to be checked by the Compliance Officer** before sending it on to actuarial consultants (where applicable).

Because some rate filings can be extremely complex, some human analysis will need to be part of the process. However, the process can be greatly improved with the assistance of some electronic job aids.

## IT Capabilities and Resources

As noted above, we recommend that the AID begin developing an internal database that could be used for HHS reporting and basic automation of some aspects of the rate filing process. In Phase II, we plan to do a deeper assessment of: 1) the current state of the data systems, and 2) whether the AID's IT department can carry out these activities on their own or whether they will need outside resources to make the necessary enhancements.

## Conclusions

The AID currently receives very filings, and the requirements for these filings are fairly minimal. There are also few resources available for training or job aids. In order to comply with the ACA and improve the current process, communications, and information technology, the AID should consider the following:

- 1) **Develop standards for filings that are "subject-to-review" and "unreasonable"**. The determination of "unreasonable" will likely need to involve some subjective judgment (e.g., by an actuary), but the AID should at least provide a general outline of how a filing is determined to be "unreasonable".
- 2) Consider **developing more specific requirements for the data, assumptions, and methodology description** that need to be included in rate filings. This should help to minimize resources spent on reviewing filings, including internal staff time and external actuarial resources. Alternatives to developing specific requirements include disapproving filings that do not include enough documentation and/or developing a list of data elements to check for each filing.
- 3) **Create internal training materials, a rate review manual, and electronic job aids** to help with the rate filing review process.
- 4) **Improve consumer outreach**, including educational documents, website layout and content, The release of least portions of rate filings publicly available before they are closed, and possibly press releases and/or town hall meetings to discuss rate requests.

- 5) **Develop an internal database with pertinent rate filing information** that will either be loaded with information manually by AID personnel or electronically from SERFF. This database will be used for reporting to HHS and for helping with rate filing review.

## Next Steps

In Phase II of this project, we plan to present specific recommendations to the AID for consideration. We will then work with the AID to agree upon the changes to be made. Next, we will create internal training materials, a rate review manual, and job aids. We will also work with the Information Technology division, the Public Information Officer, and Internal Legal Counsel to help provide feedback and recommendations for their work. Finally, we plan to present our Phase II results both in person and in written form to the AID.

Laura Peck, FSA, MAAA	
Richard Rush, FSA, MAAA	(date)

# Arkansas Insurance Department

## *Health Insurance Rate Review Process*

### *Phase I Discussions with Carriers*

#### *Discussion Guide (April 26, 2011)*

## Introduction

The Arkansas Insurance Department (AID) has obtained Cycle I grant funding under the Patient Protection and Affordable Care Act (PPACA) to enhance current state processes for reviewing health insurance premium increases. Using part of this funding, the AID has retained Aon Hewitt to 1) perform a comprehensive assessment of the current health insurance premium increases; and 2) research, develop, and recommend a comprehensive plan for the complete upgrade of the existing AID system of health insurance rate review as well as all related and applicable technology. The assessment of the current process is “Phase I” of the project. “Phase II” is comprised of developing the comprehensive plan for future improvements and is expected to be complete in a few months.

For each of these two phases, Aon Hewitt plans to obtain carrier input, primarily via conference calls. The purpose of these calls is to get feedback from the carriers regarding the current process (Phase I) and proposed changes to the process (Phase II). We feel that carrier input will be valuable in helping to develop effective recommendations that allow the AID to review rate filings without the need for assistance from the United States Department of Health and Human Services (HHS).

During Phase I, these calls will consist of discussions of the current process. To assist with this discussion, we have included below a discussion guide for the Phase I calls.

## Aon Hewitt Participants

The following Aon Hewitt actuaries will be leading these calls:

- **Richard C. Rush, FSA, MAAA:** Rick is a senior vice president in Aon Hewitt’s Health and Benefits practice in Denver, CO. Rick has over 25 years of employee benefits actuarial experience, including executive positions with insurance companies, actuarial consulting firms, and the human resources responsibilities of a *Fortune* 500 company. His insurance company and related consulting experience includes chief executive and chief actuary responsibilities for health insurers and regional HMOs, and a federal court-appointed rehabilitator and liquidator of two separate insolvent HMOs..
- **Laura L. Peck, FSA, MAAA:** Laura is an actuarial consultant at Aon Hewitt in Newport Beach, CA. She has over 12 years of health care actuarial experience. Prior to joining Aon Hewitt, Laura interned at the California Department of Health and Human Services, worked in consulting for two years, and

## Appendix B

worked at a health insurance carrier for eight years. Laura experience submitting rate filings for individual, small group, and large group—both HMO and PPO.

### Discussion Topics for Phase I

Below is a list of sample questions for discussion. If you file rates in other states, please feel free to reference your experiences in these states.

- 1) What changes, if any, do you plan to make to your rate filing process nationwide in response to PPACA? For example, are you developing a standard plain language summary that will be used as a template in all states? Do you plan to automatically submit additional justifications when requesting rate increases of 10% or more? Is there any other rate filing standardization being done nationwide as part of PPACA?
- 2) Have there been any technological issues with filing rates? Are you accustomed to filing via SERFF, and does this process work well for you? Do you have any technological concerns about SERFF? E.g., trouble with submitting filings, system downtime, etc.
- 3) Are the current data requirements for Arkansas health rate filings reasonable and appropriate in your view? What, if any, changes would you suggest to the data requirements for rate filings?
- 4) If the AID responds to a rate filing with additional questions, are they asking the right questions in your view?
- 5) If rate filings are sent back as not approved, why are they typically disapproved? What actions have you taken after a disapproval? E.g., re-submit with additional data or a lower rate increase, etc.
- 6) When communicating with the AID regarding rate filings, does the staff seem to have the right level of training, knowledge, and experience to understand the complexities of rate development (both in the past and for future rate filings that may be impacted by health care reform changes)? Have there been any challenges with explaining the rationale for rate changes?
- 7) Does the AID respond to rate filings or questions from carriers regarding rates in a timely manner?
- 8) As the AID looks to begin reviewing small group rate filings as required under PPACA, are there any suggestions that you have? What data requirements would you suggest for small group rate filings?

### In Closing

We thank you for participating in this process and look forward to working with you again during Phase II.

# Arkansas Insurance Department

## *Health Insurance Rate Review Process*

### *Potential Changes Needed to SERFF*

*May 6, 2011*

## Introduction

The following is a discussion of potential changes that may be needed to SERFF, in order to enable the Arkansas Insurance Department (AID) to conduct an effective rate review process that complies with the draft HHS rate review regulations<sup>17</sup> and also to facilitate enhancements to Arkansas' rate review process.

We have used the following documents as the basis for this list:

- 1) Draft HHS rate review regulations (12/21/2010)
- 2) Proposed HHS Preliminary Justification (Disclosure) Form and Instructions (3/1/2011)<sup>18</sup>.
- 3) Current fields available in SERFF

The discussion below is a preliminary draft based on current information. We expect it to change as additional guidance becomes available from HHS and/or the NAIC and as we develop our recommendations for changes to the AID's rate review process.

## HHS Preliminary Disclosure Requirements

An issuer with a filing that is "subject to review" is required to submit a preliminary justification. HHS has proposed that the preliminary disclosure be composed of the following three parts:

- Part I: Rate increase summary ("Rate Summary Form")
- Part II: Written Explanation of the Rate Increase ("Consumer Template")
- Part III: Rate filing documentation

Together, Parts I and II would provide a descriptive and quantitative analysis for consumers. Part III would only be required when HHS is doing the review.

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<sup>17</sup> Interim Final Rule on Rate Increase Disclosure and Review, released by the Department of Health and Human Services (HHS) on 12/21/2010.

<sup>18</sup> Published by the Centers for Medicare and Medicaid Services (CMS) on March 1, 2011

# Comments Regarding HHS Disclosure Forms

## Usefulness of Information for Consumers

While we would agree that this information may be useful for states to collect and use as part of its review process, much of the material appears to be of limited value to consumers. For example, it's not clear that a trend of x% for lab and radiology would mean much for consumers. Simply listing off percentages by service category may simply add to confusion and cause consumers to focus too much on the wrong issues. Consumers may think that high "trends" indicate poor provider contracts when they may actually indicate that the block was underpriced at inception. On the other hand, a low trend may not indicate good utilization or unit cost management, but rather aggressive plan design changes on the part of the carrier ("cost-shift" to consumers).

## Storage of Disclosure Information in SERFF System

Currently, SERFF primarily stores documents and captures basic information regarding a rate filing (name of actuary submitting filing, status of filing, etc.). It does not capture detailed information from each filing. To allow HHS to perform rate filing reviews where needed, SERFF will need to be modified to store the disclosure information. This can be done in one or both of the following ways:

- 1) Have SERFF store the disclosure documents as files** on the SERFF system. For example, they would be stored as Excel, Word, or Adobe pdf documents, etc. This would allow HHS (and the states) to retrieve the information, but it would not allow for any high-level reporting.
- 2) Have SERFF store each piece of data from the disclosure documents as a separate field** within SERFF. For example, separate fields for base period inpatient member months, base period outpatient member months, etc. While this could potentially require much more modification work within SERFF, it would for more reporting capabilities for HHS and the states.

HHS mentioned in the proposed regulation that an analysis of data from the states' filings would be used to determine future state-specific "subject to review" thresholds. Having a national database with detailed rate filing information in a format that users can query from would help to facilitate this analysis.

The field-by-field approach suggested above would only work well for Part I of the Preliminary Disclosure, the Rate Summary Form. Many of the components of Part II are also in Part I. It is not clear whether HHS intends that at least some of the fields in Part II will be auto-populated from Part I in some way. While some of the information in Part II could be captured in field format, based on the instructions it appears that many elements could not be captured as easily in fields (e.g., "Provide a brief, non-technical description of why the issuer is requesting this rate increase.").

For Part III, it is anticipated that responses from carriers will vary widely, and this information cannot be easily captured in field format unless HHS provides more specific guidance re: what carriers need to provide (e.g., components of loss ratio exhibit).

### Additional Fields

HHS and/or Arkansas may want to ask SERFF to add additional fields, beyond those included in HHS' preliminary justification. Below is a discussion of additional fields that may be useful.

### Trends

We would suggest at a minimum that HHS (or Arkansas) supplement these requirements by breaking down the total trend into cost "drivers". For example:

- 1) Unit cost changes
- 2) Utilization changes (including "mix" changes)
- 3) Impact of plan design changes
- 4) Impact of health care reform
- 5) Underpricing in previous rate filing
- 6) Changes in target retention (admin and profit) assumption
- 7) Other factors (to be delineated and described by the filing actuary)

These trend drivers would not need to be broken down by service category; they could be reported only for the total trend. In addition, we would suggest that all trends in the consumer information be presented on an annualized basis, to allow for consistency in reporting for each filing and to facilitate comparisons across filings and carriers.

### Loss Ratios

Loss ratios are an integral part of PPACA, they are commonly used in rate filings, and they are referred to in Arkansas' current data requirements for rate filings. Therefore, we would suggest that more loss ratio information be included in the preliminary justification (or required by Arkansas). For example:

- 1) Historical loss ratio for each of the last three years of experience
- 2) Projected loss ratio using current rates
- 3) Projected (target) loss ratio using proposed rates

### Inclusion of Fields in Initial Rate Filing

Arkansas may choose to review at least some rate filings that do not exceed the "subject to review" reporting threshold. For example, the AID currently reviews rate filings associated with new forms. In order to allow for aggregate reporting of all rate filings (e.g., average inpatient trend) and to allow for an effective review of these filings, the AID may wish to consider requiring that at least some of the data elements in the preliminary disclosure are included in the initial rate filing.

### Complete List of Suggested Fields to Add to SERFF

Based on the discussion above, our preliminary analysis suggests that the following fields should be included in SERFF. Note that the HHS regulation and preliminary justification forms have not been finalized yet. This list is based on information available at this time and may change when HHS releases additional or revised information.

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

- 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**
- 4) Base period total allowed
  - a. Inpatient
  - b. Outpatient
  - c. Professional
  - d. Prescription drugs
  - e. Other
  - f. Capitation
  - g. Total (sum of a:f)**
  - h. Total PMPM**
- 5) Base period net claims
  - a. Inpatient
  - b. Outpatient
  - c. Professional
  - d. Prescription drugs
  - e. Other
  - f. Capitation
  - g. Total (sum of a:f)**
  - h. Total PMPM**
- 6) Base period – total rate PMPM
- 7) Current rate start date
- 8) Current rate end date
- 9) Current rate overall medical trend
  - a. Inpatient
  - b. Outpatient
  - c. Professional
  - d. Prescription drugs
  - e. Other
  - f. Capitation
  - g. Total**
- 10) Drivers of total medical trend
  - a. Unit cost changes

- b. Utilization changes (including “mix” changes)
  - c. Impact of plan design changes
  - d. Impact of health care reform
  - e. Underpricing in previous rate filing
  - f. Changes in target retention (admin and profit) assumption
  - g. Other factors (to be delineated and described by the filing actuary)
- 11) Current rate member’s cost sharing
- a. Inpatient
  - b. Outpatient
  - c. Professional
  - d. Prescription drugs
  - e. Other
  - f. Capitation
  - g. Total**
- 12) Current rate projected allowed PMPM**
- 13) Current rate net claims PMPM**
- 14) Current rate administrative costs PMPM
- 15) Current rate underwriting gain/loss PMPM
- 16) Current rate – total rate PMPM**
- 17) Future rate start date
- 18) Future rate end date
- 19) Future rate overall medical trend
- a. Inpatient
  - b. Outpatient
  - c. Professional
  - d. Prescription drugs
  - e. Other
  - f. Capitation
  - g. Total (sum of a:f)
- 20) Future rate total allowed
- a. Inpatient
  - b. Outpatient
  - c. Professional
  - d. Prescription drugs
  - e. Other
  - f. Capitation
  - g. Total (sum of a:f)
- 21) Future rate net claims
- a. Inpatient
  - b. Outpatient
  - c. Professional
  - d. Prescription drugs
  - e. Other
  - f. Capitation
  - g. Total (sum of a:f)
- 22) Future rate allowed PMPM**
- 23) Future rate net claims PMPM**
- 24) Future rate administrative costs PMPM
- 25) Future rate underwriting gain/loss PMPM
- 26) Future rate – total rate PMPM**
- 27) Historical loss ratio for each of last 3 years

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- 28) Projected loss ratio using current rates
- 29) Projected (target) loss ratio using proposed rates
- 30) Reason for the rate increases (brief, to limit that field size will allow)



# Arkansas Insurance Department (AID) Rate Review Project

*Aon Hewitt Progress Report*

*For Rate Review Grant Program, Quarter 2*

*Revised May 6, 2011*

## Phase I Activities Completed

Aon Hewitt has completed the following Phase I activities:

- 1) Initial interviews with AID personnel, including:
  - a. Life and Health Compliance Officer
  - b. Health Insurance Rate Review Manager
  - c. Director of Life and Health
  - d. Director of Information Services
  - e. Chief Information Officer
- 2) Joint meetings with carriers and AID, to get carrier's views on current process
- 3) Follow-up questions sent to AID personnel; responses received
- 4) Outline of Phase I report sent to AID, including:
  - a. Assessment of current rate filing review process, as compared to the requirements under HHS' proposed rate review regulation
  - b. Analysis of staffing level, as well as expertise of current staff
  - c. Assessment of training resources at the AID (materials, job aids, ability to attend outside seminars, etc.)
- 5) Write-up of proposed changes to SERFF, including:
  - a. Analysis of the data required in the proposed HHS disclosure forms
  - b. Suggestions for additional fields not included in the HHS disclosure forms
  - c. Proposed list of all fields that would need to be added

## Phase I Activities Remaining

- 1) Assessment of AID website, information technology, database management, core reporting capabilities
- 2) Analysis of historic rate review performance
- 3) Review of filing and processing of public contacts and requests
- 4) Assessment of level of consumer service and outreach
- 5) Determination of potential intersections of HHS/OCIIO Rate Review, Exchange, and Consumer Assistance Grants
- 6) Consideration of improvement of the current reporting and data collection systems, construction of an innovative data system which will house rates, related increases filed for use, and optimal utilization of the expanded functions of SERFF to allow accurate and timely analysis and reporting
- 7) Consideration of optimizing consumer participation and public dissemination of information using web-based & interactive video technology, outreach, and public meetings and hearings
- 8) Complete draft Phase I report
- 9) Revisions to Phase I report based on AID feedback

## Upcoming Phase II Activities

- 1) Draft recommendations for improving the AID rate review process
- 2) Work with AID personnel to agree upon planned changes
- 3) Develop training materials for AID personnel involved in the rate review process
- 4) Develop rate filing review manual
- 5) Develop job aids, including checklists



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**

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

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

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

## Job Aids

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

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

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

### Cumulative Annual Rate Change Calculator

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

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

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

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

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

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

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

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

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



**Figure 3: Medical Loss Ratio Tool**

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

### Annual Trend Assumption Calculator

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

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

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

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

**Figure 4: Annual Trend Assumption Calculator**

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

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

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

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

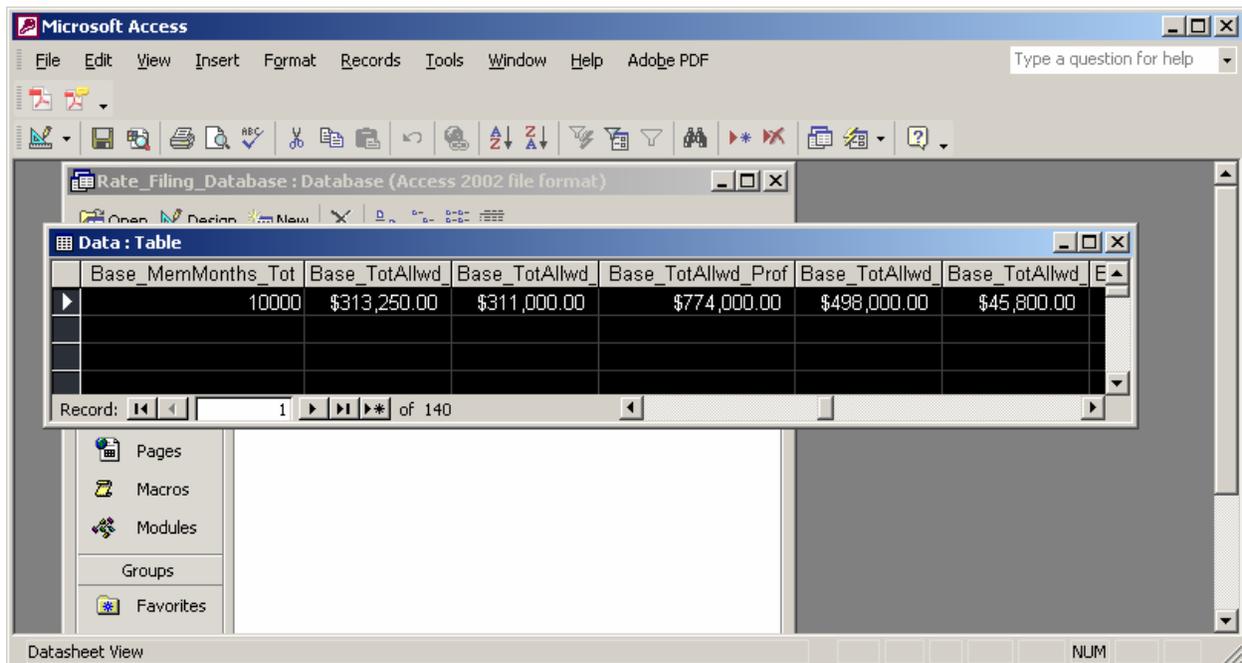
## Information Technology

### 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

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Internal Training Analysis

For the Arkansas Insurance Department Premium Rate Review  
Process

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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)
<b>Oregon</b>	1	5	5	-5	<b>8</b>
<b>Colorado</b>	-3	-4	-4	-8	<b>-10</b>
<b>S. Carolina</b>	-1	4	4	-11	<b>-12</b>
<b>Arkansas</b>	-4	-8	0	-6	<b>-18</b>
<b>California</b>	-8	-5	0	-8	<b>-21</b>
<b>Indiana</b>	-1	-5	-7	-10	<b>-33</b>

## Summary of the Best-in-Class Websites

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

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

**Navigation**

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

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

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

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

**Presentation**

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

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

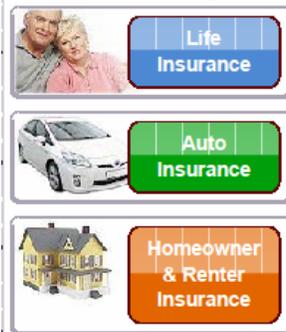
Oregon uses bolded headings and each paragraph is two or three sentences. Oregon also uses bullets and easy-to-skim questions and answers throughout its site:

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

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

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

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



**Trust**

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

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

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

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

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

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

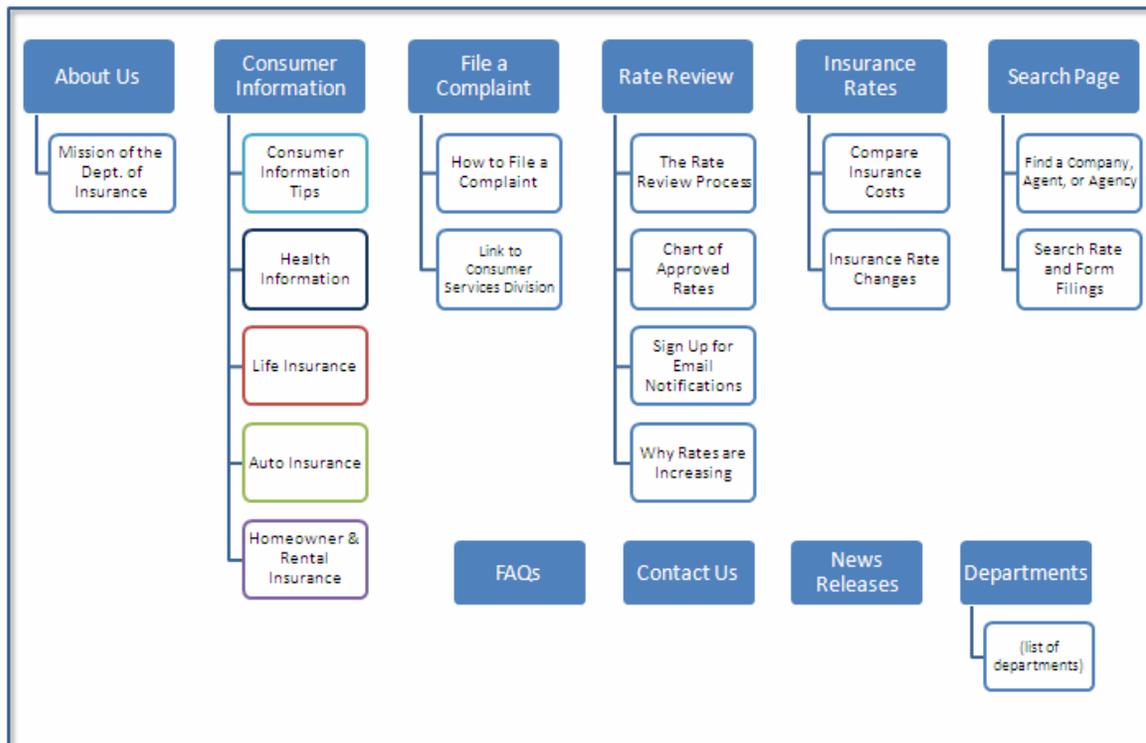
Following are our recommendations to assist the Department in redesigning the website.

### Site Map

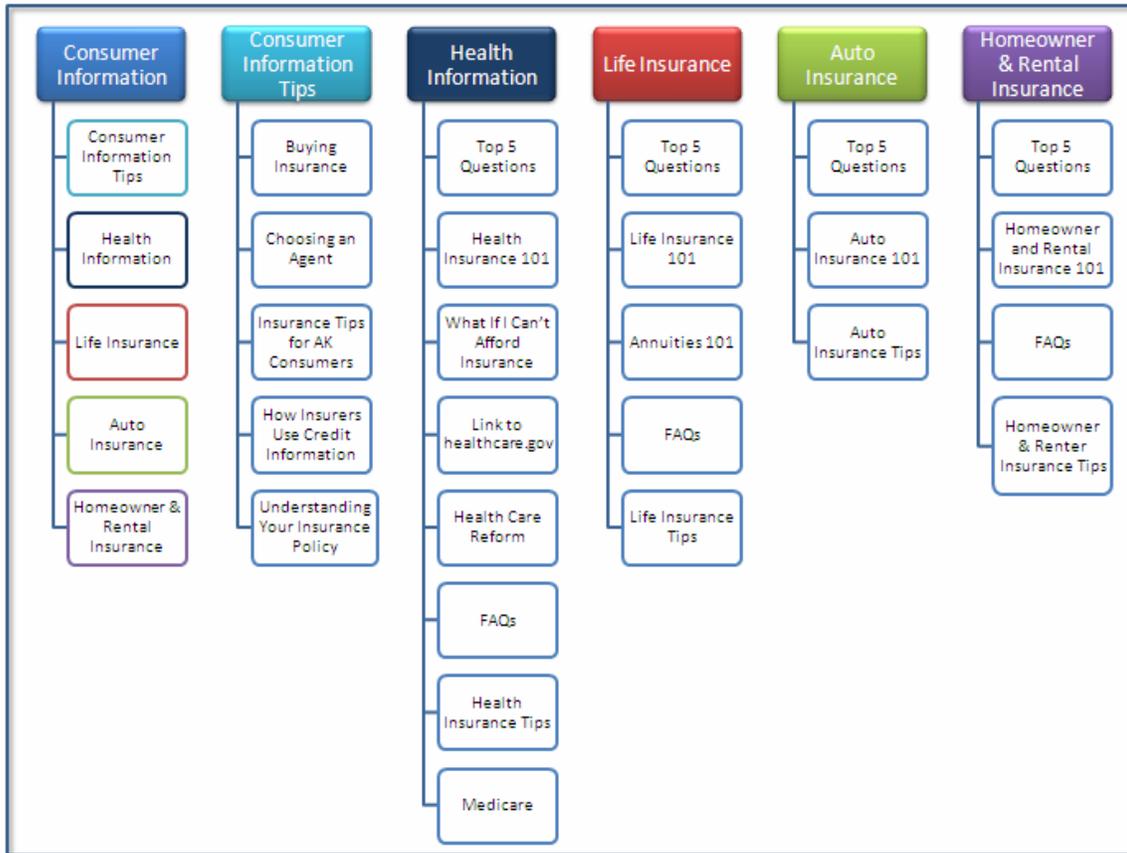
The first step to organizing the Department’s website is to identify the main sections of the site and group related information together. Inside each main section, the content can be broken into sub-categories to help the user find the exact information she is looking for.

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

### The Arkansas Insurance Department Homepage



The Arkansas Insurance Department Consumer Information Tab



## Content

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

### Phase 1

Essential Information	Recommendation
Mission of the Dept. of Insurance	<ul style="list-style-type: none"> <li>Draft content with information about the Department of Insurance and its purpose</li> </ul>
Insurance Rates and the Rate Review Process	<ul style="list-style-type: none"> <li>Create a link on the homepage titled <b>Insurance Rates and the Rate Review Process</b></li> </ul>
<ul style="list-style-type: none"> <li>The rate review process</li> </ul>	<ul style="list-style-type: none"> <li>Draft content about the rate review process</li> <li>Create a website similar to <i>www.oregonhealthrates.org</i></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 <i>www.oregonhealthrates.org</i> 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 2006	February 2006	February 2006	March 2006	March 2006	April 2006	April/May 2006 (April 16 – May 15)	May/June 2006	July 2006	July 1, 2006
Rollout Program Design	Rollout Communication Strategy	Pre-Announcement	Training	Announcement	Announcement	BEA Rollout	Health Management Education	Reinforcement and Measurement	Effective Date
PEBTF Board	PEBTF/Aon planning team	To eight DIs: To all employees	To all key communicators	To all employees	All employees	To all employees	To all employees	To all employees	All employees
<p>Board Approval (1/24)</p>	<p>Written Communication Strategy (2/16)</p> <p>Create an Identity</p> <p>Other Unions Briefing (2/24)</p>	<p>Union District Briefing (start 2/24)</p> <p>HR Regional Agency Briefing</p> <p>Employee Advisory Group</p>	<p>Train the trainer (8/8) (PEBTF all-union regional union reps)</p> <p>Questions and Answers</p> <p>Announcement (3/16) (Overview of Health Management Program and Healthy Incentives, surgery reduction/benefit management)</p> <p>Press Release To PEBTF (3/1)</p> <p>Post on EOC Intranet site (comparable union sites??)</p>	<p>Self-aider (Health Management and Incentives) (April 6)</p> <p>e-mail and Pop-up Reminders about surgery/obesity management</p> <p>Posters/Table Tents (Health Management Program)</p>	<p>Newsletter (Introduction from Health, Mark, Union representative, general overview, what's changed/improving, when focus on obesity management)</p> <p>Surgery Evolution (to be pre-certified by 4/1 and surgery scheduled on or before 7/1)</p> <p>Posters/Table Tents (Obesity Management)</p> <p>Event Sign</p> <p>Employee and Spouse Meeting Invitation</p>	<p>Posters/Table Tents (Meeting reminder)</p> <p>Employee and Spouse Meeting (April 6 – May 1)</p> <p>CD Announcement Penn Dot, Corrections and other non-disk based employees (April 6)</p> <p>Health Risk Assessment</p> <p>Promotional Item</p>	<p>Health Management Highlights Brochure (obesity meeting)</p> <p>Feedback Questionnaire</p> <p>Benefit Service Reps</p> <p>Pedometer to encourage walking</p> <p>e-mail and Pop-up Reminders</p>	<p>Contribution waiver/holder Letter</p> <p>Questions and Answers</p> <p>Signed Wallet Card (Program numbers with address)</p> <p>Benefit Service Reps</p> <p>Employee Self-service (Postal material, provide links to various web/desk items)</p> <p>e-mail and Pop-up Reminders</p>	<p>Contributions 1) Pay Period 7/2 – 7/15 pay date 7/20 2) Pay Period 7/16 – 7/19 pay date 7/20 3) Pay Period 7/20 – 7/22 pay date 7/25</p> <p>Waivers Expanded Disease Management</p> <p>Obesity Management</p> <p>Chiropractic Centers of Excellence</p> <p>Local Newsletters (Articles and links for union, PEBTF, Aon, newsletters, HR results, success stories, current disease management, answers to questions received through call center/other)</p> <p>Posters/Table Tents (Health Management Program)</p>

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



## 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.

State of Arkansas  
Office of State Procurement  
1509 West Seventh Street, Room 300  
Little Rock, AR 72201-4222

**INVITATION FOR BID**

IFB Number: SP-11-0281	Buyer: Jaime Kaufman
Commodity: Audio/Visual Equipment Agency: Arkansas Insurance Department	Bid Opening Date: June 21, 2011
Date: May 18, 2011	Bid Opening Time: 1:00pm CST

BIDS WILL BE ACCEPTED UNTIL THE TIME AND DATE SPECIFIED ABOVE. THE BID ENVELOPE, INCLUDING THE OUTSIDE OF OVERNIGHT PACKAGES, **MUST** BE SEALED AND SHOULD BE PROPERLY MARKED WITH THE Bid NUMBER, DATE AND HOUR OF BID OPENING AND VENDOR'S RETURN ADDRESS. IT IS NOT NECESSARY TO RETURN "NO BIDS" TO THE OFFICE OF STATE PROCUREMENT.

**Vendors are responsible for delivery of their bid documents to the Office of State Procurement prior to the scheduled time for opening of the particular bid. When appropriate, vendors should consult with delivery providers to determine whether the bid documents will be delivered to the OSP office street address prior to the scheduled time for bid opening. Delivery providers, USPS, UPS, and FedEx deliver mail to our street address on a schedule determined by each individual provider. These providers will deliver to our offices based solely on our street address.**

MAILING ADDRESSES: Office of State Procurement 1509 West Seventh Street, Room 300 Little Rock, AR 72201-4222	BID OPENING LOCATION: Office of State Procurement 1509 West Seventh Street, Room 300 Little Rock, AR 72201-4222
TELEPHONE NUMBER: 501-324-9316	

Company Name: \_\_\_\_\_

Name (type or print): \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Signature: \_\_\_\_\_

USE INK ONLY; UNSIGNED BIDS WILL NOT BE CONSIDERED

Identification: \_\_\_\_\_

Federal Employer ID Number

Social Security Number

**FAILURE TO PROVIDE TAXPAYER IDENTIFICATION NUMBER MAY RESULT IN BID REJECTION**

Business Designation (check one):  
 Individual       Sole Proprietorship       Public Service Corp  
 Partnership       Government/ Nonprofit

GENERAL DESCRIPTION:	Audio/Visual Equipment
TYPE OF CONTRACT:	Term
BUYER:	Jaime Kaufman
AGENCY P.R. NUMBER	1000551254

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:

\_\_\_\_\_ African American    \_\_\_\_\_ Hispanic American    \_\_\_\_\_ American Indian  
\_\_\_\_\_ Native American    \_\_\_\_\_ Asian    \_\_\_\_\_ 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

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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/prointent.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**.

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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 —mustll or —shallll or —willll 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).

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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 (—AIDII) is seeking bids for equipping its AID Rate Review Meeting Room (—MRII) 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 artII 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 8'6II. 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 be 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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- 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. (Littlite1 8G- 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, 1 080p/24Hz-compatible HDMI video output, 1 080p 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 —FII 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.

STATE OF ARKANSAS  
INVITATION FOR BID

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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>	\$	
<hr/>		
Optional Warranty Year 2	\$	Per Year
Optional Warranty Year 3	\$	Per Year

STATE OF ARKANSAS  
INVITATION FOR BID

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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.

STATE OF ARKANSAS  
INVITATION FOR BID

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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.

STATE OF ARKANSAS  
INVITATION FOR BID

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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.

# HIPR (Health Insurance Premium Review) Cycle II Survey Results Overview



Date: 5/17/2011 8:28 AM PST  
Responses: Completes  
Filter: No filter applied

In order to determine whether SERFF should be leveraged to meet the Health Insurance Premium Review Cycle II requirements, we ask that you please take a few moments to complete our short survey and submit it no later than Friday, May 13, 2011. Your participation is greatly appreciated. If you have any questions, please contact Stacie Donner, Business Analyst, SERFF, [sdonner@naic.org](mailto:sdonner@naic.org), 816-783-8485 or Jon Sink, Business Analyst, SERFF, [jsink@naic.org](mailto:jsink@naic.org), 816-783-8819

## 2. Is your state going to apply for the Cycle II Premium Review Grant?

Yes		13	39%
No		2	6%
Undecided		18	55%
Total		33	100%

## 3. Has your state developed functionality outside of SERFF to collect additional data related to improving rate review processes?

Yes		13	39%
No		13	39%
Not yet, but we're planning to		7	21%
Total		33	100%

## 4. If the response to Question 3 was no, do you have a need to collect additional data that you would be interested in collecting via SERFF

Yes		14	42%
No		19	58%
Total		33	100%

## 7. Does your state need to improve the tracking of the rate review process?

Yes		8	24%
No		9	27%
Not sure		16	48%
Total		33	100%

# 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.

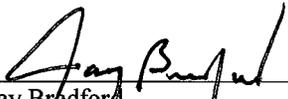
In reviewing all rate filings under this Bulletin, the Arkansas Insurance Department will review the following to the extent applicable to the filing under review:

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

# 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:

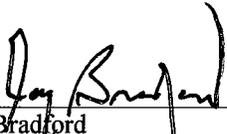
- (1) Each small employer carrier shall file annually on June 1 with the Commissioner its schedule of rates or methodology for determining rates. No schedule of rates, or amendment thereto, may be used in conjunction with any small group accident and health policy until either a copy of the schedule 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
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  - 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
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- 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
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  - 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
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**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
  
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  - a. Loss Ratio Exhibit:
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- 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.

**e 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	\$ 242,580.00	\$ 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	1.0669	\$ 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	3.66%	\$ 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**

Claims Components	Impact on Rate	Percent
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	\$ (1.92)	-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%

## 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.
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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.

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- 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.
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  - 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)
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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	1.0669	\$ 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	3.66%	\$ 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**

Claims Components	Impact on Rate	Percent
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	\$ (1.92)	-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%

**TABLE OF CONTENTS**  
**ARKANSAS RATE REVIEW MANUAL**

**Introduction**

- Objective of rate filings and why they need to be reviewed **Background**
- Components of rate development
  - Losses
  - Premiums
  - Expenses/Loads
  - Loss Ratio
  - Plan Design
  - Demographic factors
  - Trend
  - Underwriting
- Regulations regarding rate justification and review process
  - State v Fed
  - Compliance with HHS “Effective Rate Review” regulations
  - Role of NAIC
  - Arkansas specific
    - Individual
      - New Product
      - Renewal

. Group

- New Product
- Renewal

○ Federal - Impact of PPACA

□ Reviewing Filings – High level

○ Actuarial Memorandum

○ Experience history

○ Projection

○ Requested rate actions

**Individual Rate Review**

- Individual Checklist – Requirements (with detailed discussions)
- Individual Review Process

**Group Rate Review**

- Group Checklist – Requirements (with detailed discussions)
- Group Review Process

**Appendices**

- Relevant laws and regulations
- Sample filings with review notes
- Relevant Actuarial Standards of Practice



Salary	170,332	329,650	159,318
Fringe Benefits	34,292	88,624	54,332
Travel	14,135	14,135	0
Other	-	13,168	13,168
Rental	39,804	58,717	18,913
Professional Services/Contracts	299,488	276,808	(22,680)
Supplies and Other Office Expenses	199,115	124,493	(74,622)
Capital	-	94,405	94,405
Total	757,166	1,000,000	242,834

	ACTUAL									BUDGET			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					
Monthly Totals	16,987	4,120	42,516	42,260	32,169	29,106	35,835	152,062	273,672	128,438	757,166	1,000,000	242,834		
Regular Salary	8,184	8,990	14,133	16,151	16,151	16,151	18,388	30,937	20,624	20,624	170,332	329,650	159,318		
FICA & Medicare	598	660	1,049	1,193	1,193	1,193	1,364	2,302	1,535	1,535	12,621	44,508	31,887		
Agency Cost of ARCAP	28	28	40	43	43	43	43	43	43	43	396	400	4		
Employee Retirement	1,020	1,120	1,773	2,012	2,012	2,012	2,291	3,852	2,568	2,568	21,230	23,400	2,170		
Unemployment Comp	-	7	-	-	31	-	-	-	-	-	38	9,984	9,946		
Workers Comp	-	4	-	-	-	-	-	4	-	-	8	10,332	10,324		
Total Fringe Benefits	1,646	1,818	2,862	3,248	3,279	3,248	3,698	6,201	4,146	4,146	34,292	88,624	54,332		
Actuarial Consultants	7,138	(7,138)	-	-	-	-	-	99,800	99,800	-	199,600	205,000	5,400		
SERFF	-	-	18,808	-	-	-	-	-	-	8,400	27,208	18,808	(8,400)		
Data Center	-	-	-	7,434	209	1,603	2,991	-	-	53,000	65,238	50,000	(15,238)		
Temporary Staffing	-	-	-	-	-	512	2,970	2,492	1,469	-	7,443	3,000	(4,443)		
Total Professional/Contract Services	7,138	(7,138)	18,808	7,434	209	2,115	5,961	102,292	101,269	61,400	299,488	276,808	(22,680)		
Binding Copying & Collating	-	-	-	29	-	-	-	25	25	25	104	2,200	2,096		
Printing	-	-	-	-	-	-	68	-	-	16,000	16,068	15,000	(1,068)		
Postage	20	-	-	-	-	50	-	25	25	25	145	150	5		
Telecom Wired (Landline)	-	210	294	178	116	113	120	113	113	113	1,370	1,500	130		
Network Services (Cellular)	-	-	707	434	313	419	378	400	400	400	3,451	4,500	1,049		
Freight	-	-	-	32	5	13	-	25	25	25	125	250	125		
Office Supplies	-	-	659	1,137	3,239	(232)	785	250	250	250	6,338	4,910	(1,428)		
Low Value Assets	-	-	-	8,523	2,676	1,991	821	-	135,000	-	149,011	90,887	(58,124)		
Software Licenses	-	-	-	-	1,002	246	-	-	-	-	1,248	930	(318)		
Subscriptions, Publications & Dues	-	-	-	-	145	-	355	125	125	125	875	1,000	125		





**Arkansas Insurance Department (AID)  
Rate Review Checklist**

**Individual Rate Filings**

Company Name  
Segment (Indiv, Small Group, Large Group)  
Product (HMO, PPO, etc.)  
SERFF Tracking Number  
Current Rate Filing Effective Date  
Requested Rate Increase

**ABC Insurance Company**  
**Individual**  
**HMO**  
**123456**  
**9/1/2011**  
**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		
10	Includes latest 3 years of experience? (for existing forms)		
11	Includes statement re: how the experience is driving the rate increase?		
12	Includes actuarial certification that the proposed rate or rate revision does not discriminate unfairly between policyholders?		
13	Did an officer of the insurer certify the completeness and accuracy of the data?		
14	If there are other rate filings in the past year, pull the rate change history from the Rate Review Database.		
15	Use the Cumulative Annual Rate Change tool to determine if the filing exceeds the "Subject to Review" threshold.		
<b>Individual Rate Filings NOT Exceeding the Subject to Review Threshold (Bulletin 4-79)</b>			
14	Does the filing qualify for expedited approval? (if answers to a-f below are all Yes)		
a)	Average rate increase < 30%?		
b)	# of AR citizens affected < 100?		
c)	No rate revision for this product in the last 12 months?		
d)	Rates filed at least 60 days before effective date?		
e)	Policyholders will be notified at least 30 days in advance?		
f)	Carrier stated in writing that the filing is being made for expedited approval in compliance with Bulletin 4-79		
15	If qualifies for expedited approval, stamp one copy approved and return to carrier.		
16	If does not qualify for expedited approval, notify carrier that the filing will be subject to standard review procedures.		
<b>Individual Rate Filings Exceeding the Subject to Review Threshold</b>			
17	Includes a complete Rate Summary Worksheet (HHS Preliminary Justification - Exhibit 1)?		
18	Includes a complete written description justifying the rate increase (HHS Preliminary Justification - Exhibit 2)?		
19	Includes all data elements in the HHS Preliminary Justification - Exhibit 3?		
20	Includes the target Medical Loss Ratio as calculated under federal guidelines, including the actual data elements used in the calculation?		
21	Post rate filing on website at least 30 days before approval (list date posted to the right ---->)		
22	Target Loss Ratio - does it appear that this will fall within the federal guidelines, or will rebates likely be triggered?		
23	Is the assumed annual trend between the <b>base</b> (historical) period and the <b>current</b> period no more than 1% over benchmarks?		
24	If all data elements included and the above tests are passed, send rate filing to actuaries for review (with copy of this checklist). (list date sent to the right ---->)		
25	Ask Finance department for a review of the annual statement, capital and surplus levels, and recent financial trends.		
26	Were consumers given the opportunity to provide feedback (e.g., by posting rate filing on website and allowing comments on website for at least 30 days?)		



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

**Arkansas Insurance Department  
Rate Review Data Center Overview**

**Insurance Department Rate Review Database Overview**

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The Arkansas Insurance Department Rate Review Division will build or contract to building a comprehensive Data Center for **Insurance Rate Review** that will combine health system data from Arkansas commercial sources to achieve these objectives:

1. protect consumers from unreasonable, unjustified and/or excessive rate increases;
2. to enhance existing systems to enable us to capture required data, aggregate data, report critical;
3. to review trends and rating practices in the individual as well as the small and large group health insurance market to help develop policy initiatives and make recommendations aimed at ensuring health insurance rates charged within the state are fair and reasonable;
4. gain insight into Arkansas's health insurance systems by identifying variations in insurance rates;
5. promote transparency across health insurance providers and reimbursement systems; and
6. guide development of new rate review models for considered implementation;

With this information, the Insurance Department APCD will support evidence-based analyses to build recommendations for rate changes and adjustments for commercial insurance providers across Arkansas.

**Data Sources**

The Insurance Department APCD will include medical claims, pharmaceutical claims and eligibility member data from the following insurance providers:

- SERFF
- All Payer Claims Database (APCD)
- AR Department of Health
- AR Department of Health & Human Services
- AHRQ, MEPS, and all other applicable federal sources
- State of Arkansas Employee Benefit Division
- AR Carriers
  - ✓ Arkansas Blue Cross and Blue Shield
  - ✓ QualChoice
  - ✓ UnitedHealth Group
- Arkansas Hospital Association
- Arkansas Medical Association
- Arkansas Pharmacy Association

**Arkansas Insurance Department  
Rate Review Data Center Overview**

**Insurance Department Database Solution Overview**

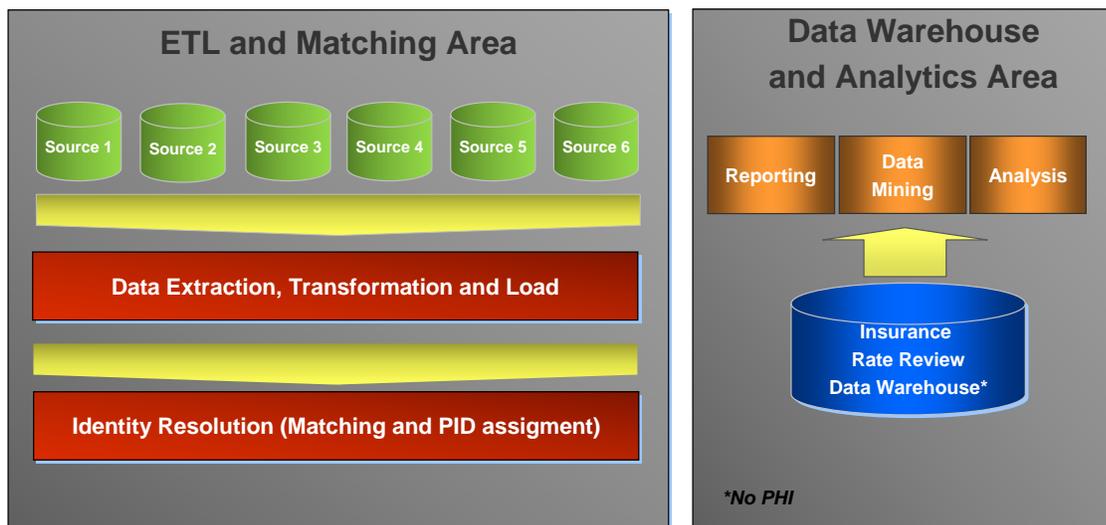
The Insurance Department data center infrastructure will contain two primary areas (housed on separate servers).

Area 1 - ETL and Matching Area: This area will be used for ETL and matching environment where all source data will be stored, transformed for inclusion in the data warehouse and assigned an identifier representing the individual on the record. All PHI will be kept in this data area and not transferred to the analytical environment.

Area 2 - Data Warehouse and Analytics Area: This area will contain the APCD data warehouse and analytical tools used for rate review evaluation and other required analysis and reporting. Source data will be housed on the APCD data warehouse with identifiers representing individuals. No individual PHI will be available to analysis.

Personal health information (PHI) from each source will be processed through custom extract, transform and load (ETL) and matching processes to produce a personal identifier (PID) representing each individual. PIDs are appended to corresponding analytical data to create the Insurance Department APCD. This process protects the anonymity of all individuals on the data warehouse. See Figure 1 for the Insurance Department APCD data transformation and matching process.

**Figure 1: Insurance Department APCD Overall Process Flow**



**Arkansas Insurance Department  
Rate Review Data Center Overview**

**Insurance Department Database Process Flow Descriptions**

1. Commercial provider data is loaded onto the data environment, evaluated and prepared for inclusion on the APCD in source specific ETL processes.
2. Transformed data is sent to the Identity Resolution engine to be grouped with other source data.
3. The Identity Resolution Engine assigns personal identifiers (PIDs) to represent unique individuals based on name, address, SSN, date of birth and/or other PHI. PIDs are carried forward to the APCD, eliminating all visibility to individual identifying information on each record.
4. PIDs are appended to their corresponding analytical data, replacing the original PHI.
5. All analytical data is combined, rolling up all data to create claims detail level and aggregated data for each individual (unique PID).
6. Transformed data are loaded to the analytic environment, creating the APCD.
7. The APCD is created.

**Data Warehouse Implementation Process**

The development of the Insurance Department Database will follow traditional data warehouse build processes. The following is the proposed project task list.

**Project Initiation – 2 months**

- Establish costs
- Identify Project Team
- Create project plan
  - Project overview
  - Risk Assessment
  - Communication plan
  - Work breakdown structure
- Execute DUAs

**Envisioning and Discovery –2 month**

- Identify Business Requirements
- Establish source data and usage requirements
- Establish user access requirements
- Authorize Data Access - HIPAA certification
- Determine integration requirements within and across sources
- Identify daily operations and support requirements
- Identify analysis and reporting requirements
- Establish data transfer protocols

## **Arkansas Insurance Department**

### **Rate Review Data Center Overview**

- Establish data warehouse updates and frequency
- Acquire source data
- Execute Source Evaluation
- Select data warehouse software
- Identify Build Tools
- Identify and order hardware/software
- Develop data and process flow protocols
- Update project plan
- Publish Envisioning document
  - Build and update process overview
  - Updated project plan
    - Risk Assessment
    - Communication Plan
    - Work breakdown structure
    - Initial project timeline

### **Planning and Design – 2 months**

- Develop project design
- Establish technical requirements:
  - ETL processing
  - Aggregated data calculations
  - Integration
  - Reporting and Analysis
  - Hardware/Software
  - Back-up protocols
  - Operations and Support
- Develop logical and physical data models
- Finalize Timeline
- Update project plan
- Develop and publish project design document

### **Development and Stabilization – 3 to 6 months**

- Set-up Hardware
- Install Software
- Develop and execute ETL Processing
- Develop and execute matching processes (assignment of IDs)
- Develop data warehouse load scripts
- Develop aggregation scripts
- Build data warehouse
  - Load primary tables

**Arkansas Insurance Department  
Rate Review Data Center Overview**

- Build aggregation Tables
- Build scripts and views for auditing, reporting and analysis
- Develop reporting and analysis
- Develop update process
- User acceptance testing
- Partner sign-off

**Deployment/Implementation – 1 month**

- Execute User Training
- Move data warehouse and analytical processes into production
- Project Closure
- Ongoing Maintenance and Support

**Data Warehouse Management**

The Insurance Department Data Team will be responsible for the build, maintenance, archiving and storage of all data used in the Insurance Department APCD. Data warehouse updates will be scheduled periodically as source claims and fee schedule data becomes available to ensure the most recent data is available for rate review and analysis. Source data files will be archived after being processed through the ETL processes and loaded into the Insurance Department APCD. Archived data is stored in a secure location off-site.

**Server and equipment**

Suggested Insurance Department APCD Data Center infrastructure includes:

<b>Equipment</b>	<b>Estimated Cost</b>
ETL and Matching Servers – PowerEdge R710 2U Server and operating system (Windows Server Enterprise 2008)	\$13,500
Data warehouse and Analytical Tool Server - PowerEdge R710 2U Server and operating system (Windows Server Enterprise 2008)	\$13,500
Storage – 4TB per server	\$32,000 (\$16,000 each)
Back-up Equipment – PowerVault TL 2000 back-up drive, software and tape media (used for both servers)	\$12,000
Data Warehouse Software: SQL Server 2008 Qty: 2 (one for ETL Matching server and one for data warehouse and analytical Tool server)	\$2500 (\$1250 each)
Analytical Software: SAS Analytical Suite Server License	\$5000 (\$4000 renewal fee)

**Data Warehouse Team Structure**

**Arkansas Insurance Department  
Rate Review Data Center Overview**

**Implementation Data Team**

<b>Team Role</b>	<b>Role</b>	<b>% FTE</b>
Project Leader	Provides oversight to data warehouse design and build process. Interface with Insurance Department Stakeholders.	50%
Project Manager	Manages deliverables, timelines and budgets for to data warehouse design and build process. Interface with Insurance Department Stakeholders.	75%
DBA	Administers, manages, designs, documents, and evaluates the data warehouse management system; performs technical, analytical and professional services involving program/member services, evaluation and problem resolution.	50%
Programmer	Builds all programmatic transformation processes per the technical requirements.	50%
Research Associate	Interprets data warehouse business requirements and helps develop and execute technical requirements. Designs source data evaluation, data mapping, data resolution. Executes design and development plans provided by the DBA.	100%
Data Processor	Designs and executes all data processing, ETL processes, matching processes and data warehouse loads per the data warehouse technical requirements.	75%
Technical Writer	Provides documentation creation and support for the Implementation team.	35%
Analyst	Design and develop analytical tool interface with the data warehouse.	15%
Network/IT support	Installs and supports data warehouse infrastructure.	25%

**Ongoing Support Team**

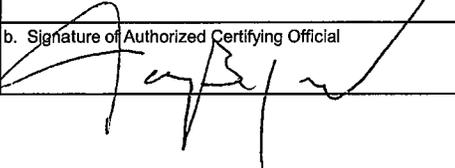
<b>Team Role</b>	<b>Role</b>	<b>% FTE</b>
Project Leader	Provides oversight to data warehouse update and enhancement processes. Interface with Insurance Department Stakeholders.	20%
Project Manager	Manages deliverables, timelines and budgets for to data warehouse update and enhancement processes. Interface with Insurance Department Stakeholders.	35%
DBA	Administers, manages, designs, documents, and evaluates the data warehouse management system; performs technical, analytical and	15%

**Arkansas Insurance Department  
Rate Review Data Center Overview**

	professional services involving program/member services, evaluation and problem resolution.	
Programmer	Builds all programmatic transformation processes per the technical requirements for data warehouse changes and enhancements.	10%
Research Associate	Interprets data warehouse business requirements and helps develop and execute technical requirements for data warehouse updates, changes and enhancements. Designs source data evaluation, data mapping, data resolution for new data sources. Executes updates plans provided by the DBA.	60%
Data Processor	Designs and executes all data processing, ETL processes, matching processes and data warehouse loads per the data warehouse technical requirements for update processes. Manages archival and back-up processes.	75%
Technical Writer	Provides documentation creation and support for the ongoing support team.	10%
Network/IT support	Installs and supports data warehouse infrastructure.	10%

**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>1IPRPR100015-01-00</b>		Page <b>1</b>	of  pages		
3. Recipient Organization (Name and complete address including Zip code) <b>ARKANSAS INSURANCE DEPARTMENT 1200 WEST THIRD STREET, LITTLE ROCK, AR 72201</b>							
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>09/30/2011</b>		9. Reporting Period End Date (Month, Day, Year) <b>06/30/2011</b>			
10. Transactions				Cumulative			
<i>(Use lines a-c for single or multiple grant reporting)</i>							
<b>Federal Cash (To report multiple grants, also use FFR Attachment):</b>							
a. Cash Receipts				238,766.00			
b. Cash Disbursements				197,926.00			
c. Cash on Hand (line a minus b)				40,840.00			
<i>(Use lines d-o for single grant reporting)</i>							
<b>Federal Expenditures and Unobligated Balance:</b>							
d. Total Federal funds authorized				1,000,000.00			
e. Federal share of expenditures				197,926.00			
f. Federal share of unliquidated obligations				329,567.00			
g. Total Federal share (sum of lines e and f)				527,493.00			
h. Unobligated balance of Federal funds (line d minus g)				472,507.00			
<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)							
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 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 <b>JAY BRADFORD STATE INSURANCE COMMISSIONER</b>				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>7/22/11</b>			

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.