

State of Arkansas
DEPARTMENT OF INSURANCE
1200 W. Third St, Little Rock, Arkansas 72201-1904
REQUEST FOR PROPOSAL

RFP Number: ID-11-1001	Buyer: Arkansas Insurance Department Lowell Nicholas
Premium Rate Review Grant Professional Services 1200 W. Third, Little Rock, AR 72201	Proposal Opening Date: January 21, 2011
Date: December 3, 2010	Proposal Opening Time: 1:00 PM CST

PROPOSALS WILL BE ACCEPTED UNTIL THE TIME AND DATE SPECIFIED ABOVE. THE PROPOSAL ENVELOPE INCLUDING THE OUTSIDE OF OVERNIGHT PACKAGES **MUST** BE SEALED AND SHOULD BE PROPERLY MARKED WITH THE PROPOSAL NUMBER, DATE AND HOUR OF PROPOSAL 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 proposal documents to the Arkansas Insurance Department prior to the scheduled time for opening of the particular proposal. When appropriate, vendors should consult with delivery providers to determine whether the proposal documents will be delivered to the Arkansas Insurance Department office street address prior to the scheduled time for proposal opening. Delivery providers, USPS, UPS, and FedEx deliver mail to our street address, 1200 W. Third Street, Little Rock, AR 72201-1904, on a schedule determined by each individual provider. These providers will deliver to our offices based solely on our street address.**

MAILING ADDRESSES: Lowell Nicholas Department of Insurance 1200 W. Third Street Little Rock, AR 72201-1904 TELEPHONE NUMBER: 501-371-2621	PROPOSAL OPENING LOCATION: Department of Insurance 1200 W. Third Street Little Rock, AR 72201-1904
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Company Name: _____

Name (type or print): _____

Title: _____

Address: _____

Telephone Number: _____

Fax Number: _____

E-Mail Address: _____

Signature: _____

USE INK ONLY; UNSIGNED PROPOSALS WILL NOT BE CONSIDERED

Identification: _____

Federal Employer ID Number _____ Social Security Number _____

FAILURE TO PROVIDE TAXPAYER IDENTIFICATION NO. MAY RESULT IN PROPOSAL REJECTION

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

GENERAL DESCRIPTION:	Premium Rate Review Grant Professional Services
TYPE OF CONTRACT:	Term
BUYER:	Arkansas Department of Insurance Lowell Nicholas

1. **MINORITY BUSINESS POLICY:** Minority participation is encouraged in this and in 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 _____
Arkansas Certification number _____
2. **EQUAL EMPLOYMENT OPPORTUNITY POLICY:** In compliance with Act 2157 of 2005, the Arkansas Insurance Department (AID) 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: Lowell.nicholas@arkansas.gov or as a hard copy accompanying the solicitation response. The Arkansas Insurance Department will maintain a file of all vendor EO policies submitted in response to solicitations issued by the Arkansas Insurance Department (AID). The submission is a one-time requirement, but vendors are responsible for providing updates or changes to their respective policies, and for 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.
3. **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>.
4. **ALTERATION OF ORIGINAL SOLICITATION DOCUMENTS:** The original written or electronic language of the RFP documents shall not be changed or altered except by approved written addendum issued by the Arkansas Insurance Department (AID). 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/Respondent'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.
5. **REQUIREMENT OF AMENDMENT:** THIS PROPOSAL MAY BE MODIFIED ONLY BY ADDENDUMS WRITTEN AND AUTHORIZED BY THE ARKANSAS INSURANCE DEPARTMENT (AID). Vendors are cautioned to ensure they have received or obtained and responded to any and all addendums to the proposal prior to submission. There will be no addendums to a bid 72 hours prior to the proposal 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.
6. **DELIVERY OF RESPONSE DOCUMENTS:** In accordance with the Arkansas Procurement Law and Regulations, it is the responsibility of vendors to submit proposals at the place, and on or before the date and time, set in the solicitation documents. Proposal documents received at the Arkansas Insurance Department (AID) after the date and time designated for proposal opening are considered late proposals and shall not be considered. Proposal documents arriving late, which are to be returned and are not clearly marked, may be opened to determine for which RFP the submission is intended.
7. **ADDITIONAL TERMS AND CONDITIONS:** The Arkansas Insurance Department (AID) objects to, and shall not consider, any additional terms or conditions submitted by a respondent, including any appearing in documents attached as part of his response. In signing and submitting his proposal, a respondent agrees that any additional terms or conditions, whether submitted intentionally or inadvertently, shall have no force or effect. Failure to comply with terms and conditions, including those specifying information that must be submitted with a proposal, shall be grounds for rejecting a proposal.
8. **ANTICIPATION TO AWARD:** After complete evaluation of the proposal, 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 timeframe in which vendors and agencies are aware of the anticipated award. The proposal

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 Arkansas Insurance Department (AID) reserves the right to waive the policy of Anticipation to Award when it is in the best interest of the State. Vendors are responsible for viewing the Anticipation to Award section of the OSP web site at: http://www.arkansas.gov/dfa/procurement/pro_intent.php.

9. **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 Arkansas Insurance Department (AID) at the time of the RFP 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.
10. **VISA ACCEPTANCE:** Awarded Respondents 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.
11. **EO-98-04 GOVERNOR'S EXECUTIVE ORDER:** Bidders should complete the Disclosure Forms posted with this proposal.

SECTION I GENERAL INFORMATION

1.0 INTRODUCTION

Vendors are invited to submit proposals for 'Premium Rate Review Grant Professional Services' to Arkansas Insurance Department (AID), an agency of the State of Arkansas..

1.1 ISSUING AGENCY

The Arkansas Insurance Department (AID), an agency of the State of Arkansas, has issued this Request for Proposal (RFP) and will be the sole point of contact in the State for this selection process. Vendor questions regarding this RFP and related matters should be made through the Arkansas Insurance Department's buyer; Lowell Nicholas at 501 371-2632 or Lowell.nicholas@arkansas.gov

The Arkansas Insurance Department (AID) has received \$1 million in HHS federal planning grant funds for Premium Rate Review for the period of August 16, 2010 through September 30, 2011.

1.2 CAUTION TO VENDORS

- 1.2.1 During the time between the proposal opening and contract award, any contact concerning this RFP will be initiated by the issuing office or requesting entity and not the vendor. Specifically, the person(s) named herein will initiate all contact.

Vendors **must** submit **one (1) signed original technical proposal**, on or before the date specified on page one of this RFP. Vendors **must** also submit **one (1) original "Official Proposal Price Sheet"**. **Do not include any pricing from the Official Proposal Price Sheet on the technical proposal, including the CD or flash drive. Pricing from the Official Price Sheet(s) must be separately sealed from the technical proposal response and clearly marked as pricing information.** The vendor should submit six (6) complete copies (marked copy) of the signed RFP technical proposal response, and one (1) electronic version of the technical proposal response, preferably in MS Word/Excel format, on CD or flash drive. **Do not include any pricing from the Official Proposal Price Sheet on the technical proposal copies, including the CD or flash drive. Pricing from the Official Proposal Price Sheet must be separately sealed from the technical proposal response and clearly marked as pricing.** Failure to submit the required number of copies with the proposal may be cause for rejection. If

the Arkansas Insurance Department requests additional copies of the proposal, they **must** be delivered within twenty-four (24) hours of request.

1.2.2 For a proposal to be considered, an official authorized to bind the vendor to a resultant contract **must** have signed the proposal.

1.2.3 All official documents and correspondence shall be included as part of the resultant contract.

1.2.4 The Arkansas Insurance Department (AID) reserves the right to award a contract or reject a proposal for any or all line items of a proposal received as a result of this RFP, if it is in the best interest of the State to do so. Proposals will be rejected for one or more reasons not limited to the following:

- a. Failure of the vendor to submit his proposal(s) on or before the deadline established by the issuing office.
- b. Failure of the vendor to respond to a requirement for oral/written clarification, presentation, or demonstration.
- c. Failure to sign the Official RFP Document.
- d. Failure to complete the Official Proposal Price Sheet and include them sealed separately from the rest of the proposal.
- e. Any wording by the offeror in their response to this RFP, or in subsequent correspondence, which conflicts with or takes exception to a requirement in the RFP.
- f. Failure of any proposed service to meet or exceed specifications.

1.3 RFP FORMAT

Any statement in this document that contains the word “must” or “shall” or “will” means that compliance with the intent of the statement is mandatory, and failure by the respondent to satisfy that intent will cause the proposal to be rejected. It is recommended that offerors respond to each item or paragraph of the RFP in sequence. Items not needing a specific vendor statement may be responded to by concurrence or acknowledgement; no response will be interpreted as an affirmative response or agreement to the State conditions. Reference to handbooks or other technical materials as part of a response must not constitute the entire response and respondent must identify the specific page and paragraph being referenced.

1.4 ACCOUNTING PROVISIONS

The Respondent 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.

1.5 PROPRIETARY INFORMATION

Proprietary information submitted in response to this (RFP) will be processed in accordance with applicable State of Arkansas procurement procedures. Proposals and documents pertaining to the (RFP) become the property of the State and shall be open to public inspection subsequent to bid opening. It is the responsibility of the Vendor to identify all proprietary information. The respondent must submit one complete copy of the proposal from which any proprietary information has been removed, i.e., a redacted copy. The redacted copy should reflect the same pagination as the original, show the empty space from which information was redacted, and should be submitted on a CD or flash drive. Except for the redacted information, the redacted copy must be identical to the original hard copy. The vendor is responsible for ensuring the redacted copy on CD/flash drive is protected against restoration of redacted data. The redacted copy will be open to public inspection under the Freedom of Information Act (FOIA) without further notice to the vendor. If you do not send a redacted copy your entire proposal will be open to public inspection with the exception of financial data (other than pricing). If the State of Arkansas deems redacted information to be subject to the FOIA the respondent will be contacted prior to sending out the information.

1.6 RESERVATION

This RFP does not commit the Arkansas Insurance Department (AID) to award a contract, to pay costs incurred in the preparation of a proposal in response to this request, or to procure or contract for data collection. The State reserves the right to accept or reject, in part or in its entirety, any or all proposals received as a result of the RFP, if it is in the best interest of the State to do so.

1.7 CLARIFICATION OF RFP

If additional information is necessary to enable respondents to better interpret the information contained in the RFP, written questions will be accepted until the close of business on December 14, 2010. Vendor questions submitted in writing will be consolidated and responded to by the Arkansas Insurance Department (AID). The consolidated written Arkansas Insurance Department (AID) response will be posted on the OSP website on or before the close of business on December 21, 2010. 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 Lowell Nicholas at Lowell.nicholas@arkansas.gov.

PROPOSAL EVALUATION AND SELECTION

Responses will be reviewed by the Arkansas Insurance Department (AID) to ensure that all mandatory requirements have been met. An evaluation committee, determined by the Arkansas Insurance Department (AID), will evaluate and score the technical response. The overall approach to the evaluation will be to determine how effectively an offeror's response fulfills the needs of the agency. An independent panel will review qualified proposals and make its award recommendations to the Arkansas Insurance Department (AID) for final approval. The contract award will be awarded to the respondent whose proposal receives the highest cumulative point total.

1.8 CONTRACT INFORMATION

1.8.1 The State of Arkansas may not contract with another party:

- a. 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.
- b. Upon default, to pay all sums to become due under a contract.
- c. To pay damages, legal expenses or other costs and expenses of any party.
- d. To continue a contract once the equipment has been repossessed.
- e. To conduct litigation in a place other than Pulaski County, Arkansas.
- f. To agree to any provision of a contract which violates the laws or constitution of the State of Arkansas.

1.8.2 A party wishing to contract with the State of Arkansas should:

- a. Remove any language from its contract which grants to it any remedies other than:
 - i. The right to possession.
 - ii. The right to accrued payments.
 - iii. The right to expenses of de-installation.
 - iv. The right to expenses of repair to return the equipment to normal working order, normal wear and tear excluded.
 - v. The right to recover only amounts due at the time of repossession and any unamortized nonrecurring cost as allowed by Arkansas Law.
- b. Include in its contract that the laws of the State of Arkansas govern the contract.
- c. Acknowledge that contracts become effective when awarded by the State Procurement Official.

1.9 DEFINITION OF TERMS

The Arkansas Insurance Department (AID) has made every effort to use industry-accepted terminology in this RFP and will attempt to further clarify any point of item in question as indicated in "Clarification of RFP". The words "offeror," "respondent," "vendor" are used as synonyms in this document. The word "successful vendor" refers to the service provider selected for contract award. The word "Agency" or "Department" refers to the Arkansas Department of Insurance.

1.10 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.

1.11 AWARD RESPONSIBILITY

The Arkansas Insurance Department (AID) will be responsible for award and administration of any resulting contract.

1.12 INDEPENDENT PRICE DETERMINATION

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

- 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 office of the Attorney General, all bidders shall understand that this paragraph may be used as a basis for litigation.

1.13 SUBCONTRACTORS

The service provider is fully responsible for all work performed under the contract.

The service provider may, with the consent of Arkansas Insurance Department (AID), enter into written subcontracts for performance of certain of its functions under the contract. Subcontracts must be approved in writing by the Arkansas Insurance Department (AID) prior to the effective date of any subcontract. The contract will maintain the duties of performance associated with the contract. The service provider must notify the Arkansas Insurance Department (AID) immediately regarding a claim that is filed by a Subcontractor against the Service Provider.

1.14 PUBLICITY

News release(s) by a vendor pertaining to this RFP or any portion of the project shall not be made without prior written approval of the Arkansas Insurance Department (AID). Failure to comply with this requirement is deemed to be a valid reason for disqualification of the vendor's proposal. The Arkansas Insurance Department (AID) will not initiate any publicity relating to this procurement action before the contract award is completed.

1.15 CONFIDENTIALITY

The vendor shall be bound to confidentiality of any information that its employees may become aware of during the course of performance of contracted tasks. Consistent and/or uncorrected breaches of confidentiality may constitute grounds for cancellation of the contract.

1.16 CANCELLATION

In the event the Arkansas Insurance Department (AID) no longer needs the service or commodity specified in the contract or purchase order due to program changes, changes in laws, rules, or regulations, or relocation of offices, the Arkansas Insurance Department (AID) may cancel the contract or purchase order by giving the Respondent written notice of such cancellation 30 days prior to the date of cancellation. Funding for this contract is contingent upon availability and appropriation of grant funds.

1.17 NEGOTIATIONS

As provided in this request for proposal and under regulations, discussions may be conducted with responsible vendor(s) who submit proposal(s) determined to be reasonably susceptible of being selected for award for the purpose of obtaining clarification of proposal response and negotiation for best and final offers.

1.18 CONTRACT PAYMENT

In consideration of the contract agreement provisions and RFP requirements, the Arkansas Insurance Department (AID) agrees to pay the Respondent on a monthly reimbursement basis after expenditures have occurred. The successful vendor must submit proof of progress/expenditures when requesting reimbursements in the form of invoices, receipts and/or a spreadsheet outlining each line item of the reimbursement form (Standard DWS form). Award recipient must submit a reimbursement request for payment for the services delivered no later than 15 days after the affected month. The payment for services can be expected to be distributed after review of a submitted reimbursement request within 10 working days.

SECTION 2: ADMINISTRATIVE OVERVIEW

2.0

BACKGROUND

The Patient Protection and Affordable Care Act (ACA), was signed into law March 23, 2010. Section 2794 of ACA requires full evaluation of the premium rate increases proposed by health insurance carriers. To support this legislative mandate, the U.S. Department of Health and Human Services awarded \$46 million to forty-five states and the District of Columbia to enhance current state processes for reviewing health insurance premium increases.

The Arkansas Insurance Department ("AID"), on behalf of the State of Arkansas, was awarded \$1 million in Cycle I grant funds on August 16, 2010, to improve the review of proposed health insurance premium increases, take action against insurers seeking unreasonable rate increases, and ensure that consumers receive value for their premium dollars.

Cycle I funding will continue through September 30, 2011. HHS contemplates additional Rate Review funding via Cycle II awards in mid 2011 to those states that have demonstrated substantial progress in their stated goals and objectives and the implementation thereof.

PURPOSE

- 2.1 This Request for Proposal (RFP) will enable the Arkansas Insurance Department to select a highly qualified vendor who will assess, 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.

This RFP will consist of two phases. Phase I of the RFP will require 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 & management reporting requirements, and statewide outreach.

Phase II will require a clear analysis of the information derived from Phase I and a subsequent submission to AID of detailed findings, recommendations, and a focused plan of implementation. The Phase II final submitted recommendations must be specific, innovative, and compatible with state and federal regulations. These recommendations should demonstrate superior strategies that will directly impact the success of AID in all aspects of health insurance rate review.

Phase I & II must be bid as one unit. Any deviation will cause that bid to be deemed non-responsive.

Additionally, AID seeks to qualitatively automate future health insurance rate review processes and increase rate review capabilities to the extent possible. AID will require a significant improvement in the current reporting and data collection methodology, including an effective data system which will house rates, related increases filed for use, and leveraging & optimal utilization of the new capabilities of 'THE SYSTEM FOR ELECTRONIC RATE AND FORM FILING' (SERFF) to allow accurate and timely analysis and multi-query reporting to all applicable parties. 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 health insurance rate review analysis in the future.

AID will endeavor to create maximum transparency to the public in the health insurance rate review process. This will include, but not be limited to, AID website, outreach, public relations, education, and public hearings on relevant requests for rate increases.

- 2.3 Respondents submitting proposals must view this as a one-time funding opportunity. **Allocated budget must be submitted in a separate sealed envelope with each proposal.** The proposal must demonstrate an understanding of the nature of this project and the outcomes expected to be produced. The proposal must demonstrate actuarial and related information technology experience as well as the ability to gather quantitative and qualitative data as it relates to the Rate Review process. Proven ability to work with the public, advocacy groups, advisory groups, and providers will be helpful.

2.4 **CONTRACT PERIOD.** The term of this contract is for approximately three months, February 11, 2011 – April 30, 2011. The contract may be mutually renewed for increments of three (3) month terms or a portion thereof, if additional grant funds become available.

2.5 **ANTICIPATED PROCUREMENT TIMELINE**

Vendor questions submitted in writing will be consolidated and responded to by the Arkansas Insurance Department (AID) by December 21, 2010. The consolidated written Arkansas Insurance Department (AID) response will be posted on the OSP and AID websites on or before the close of business on December 21, 2010.

December 3, 2010	Request For Proposal (RFP) Release Date
December 14, 2010	Vendor Questions for Clarification Deadline by 4:30 p.m. CDT to Lowell.nicholas@arkansas.gov
December 21, 2010	Answers to Vendor's Questions Posted http://www.arkansas.gov/dfa/procurement/bids/index.php
January 20, 2011	Proposal Submission Deadline
January 28, 2011*	Anticipated Award
February 11, 2011*	Final Award

* *Approximate dates*

SECTION 3: SCOPE OF WORK

Each Respondent will be evaluated based on the response to each element of the scope of work below.

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.
4. Identify reputable sources for trend assumptions and determine if there are other publicly available information sources to ascertain the reasonableness of the request.
5. Search trend justifications from the carriers including intrinsic trend and renewing provider contracts.
6. 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.
7. If any form of outcome based payment approaches are used by the carriers, study valuation of network payment levels and provider outcome measures.
8. Determine the potential impact that carrier violations of the minimum MLR (effective 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.

PHASE II MUST BE COMPLETED AND THE COMBINED RESULTS OF PHASES I & II, SUBMITTED IN FINAL FORM TO AID ON OR BEFORE APRIL 11, 2011.

SECTION 4: PROPOSAL SUBMISSION REQUIREMENTS

EXPERIENCE

The respondent's proposal must be able to demonstrate the following **minimum** experience and qualifications to perform the work outlined in this Request for Proposals:

- At least five (5) years as an established organization
- Proven experience of similar work requested, such as research-based assessments
- Proven experience executing multiple research assessments within a specified time-frame
- Proven experience of data aggregation and developing an overall, comprehensive evaluation of the findings & recommendations moving toward evidence-based policy recommendations and decisions.

Overview of technical requirements

- i. Describe the vendor's familiarity with the rate review requirements provided in the Affordable Care Act and the Arkansas health insurance rate filing requirements.
- ii. Describe the vendor's knowledge of and familiarity with **Arkansas'** health insurance market.
- iii. Describe the vendor's knowledge of or experience with the review of health insurance rate filings to determine compliance with both state and federal regulations. Indicate whether the

- work cited was completed for insurers or regulators. Include a description of the firm's experience with the System for Electronic Rate and Form Filing (SERFF), if any.
- iv. Describe the vendor's actuarial experience with regard to individual health insurance, including any experience with the setting of rates. Indicate whether the work cited was completed for insurers or regulators.
 - v. Describe the vendor's actuarial experience with regard to small employer health insurance, including any experience with the setting of rates in compliance with small employer health insurance rating regulations and inflation trends in that environment. Indicate whether the work cited was completed for insurers or regulators.
 - vi. Describe the vendor's actuarial experience with regard to large group rate setting. Indicate whether the work cited was completed for insurers or regulators.
 - vii. Describe the vendor's experience preparing testimony or testifying in public hearings regarding health insurance rate filings. Indicate whether the work was completed for insurers or regulators.
 - viii. Describe the vendor's ability to provide actuarial assistance and expertise in the development of a comprehensive system for tracking, monitoring and analyzing rates and rating practices in the Arkansas health insurance market. Include a description of the firm's experience and involvement at all stages of the system development, from developing project requirements through implementation.
 - ix. Describe the vendor's ability to access and utilize relevant data other than AID supplied data for use in rate filing reviews and market analysis.
 - x. Describe the vendor's ability to evaluate and provide actuarial assistance to ensure that rates are appropriate for the populations covered and the benefits provided, including any experience with establishing the actuarial value of rating factors and benefit design or benefit changes.
 - xi. Describe the vendor's ability to provide actuarial assistance in the development of a system for enhancing consumer access to pertinent rate filing information.

SECTION 5: PROPOSAL EVALUATION CRITERIA

Submission of a proposal implies vendor acceptance of the evaluation technique and recognition that objective judgments must be made by the Evaluation Committee during the assignment of rating points.

Proposals will be evaluated in three (3) phases. The first phase will determine if the mandatory requirements and minimum qualifications of this Request for Proposals have been agreed to and/or met. Failure to comply will deem a proposal non-responsive. Any proposal that is incomplete may be rejected by the State. However, the State may waive minor irregularities. This phase is to be completed by the Arkansas Insurance Department.

The second phase will be based on the evaluation of the technical proposals. An evaluation team appointed by the Arkansas Insurance Department will score the written proposals.

The third phase will be the opening of the cost proposal by the Arkansas Insurance Department. The awarding of points will be determined by the following formula:

$a/b \times c = d$ (Dividing lowest price (a) by the next lowest price (b) and multiplying by the total points for cost (c) will equal the number of cost points awarded (d).)

The effect of the formula is to insure that the lowest proposal receives the maximum number of points and each of the other proposals receive proportionately fewer points based on proposed bid price.

The proposals will be evaluated and awarded points based on a comparative formula of relative weighting as detailed below:

<i>Criteria</i>	<i>Weight</i>
Project Design	60
Organizational Staffing Capacity	10
Organizational Experience	20
Organizational Financial Capacity (Cost)	10
TOTAL POINTS	100

PROJECT DESIGN

Quality of work plan submitted: provides a clear definition of the steps to be taken in the design and delivery of the plan to be provided. For example, clearly describe the utilization of sources of information in developing the best strategies.

- Expertise in recommending appropriate research methods based on objectives, and intended outcomes
- Ability to develop questions and/or similar probing mechanisms to elicit responses that will prove most advantageous for meeting the objective
- Ability to make strategic communications recommendations based on research findings
- Feasibility of timeline for completion of project within specified project period. Includes performance and outcome measures to ensure that scope of project is completed.

ORGANIZATIONAL STAFFING CAPACITY

Organization and staffing: includes identification of all staff and/or subcontractor proposed as members of the project team and the duties, responsibilities, and concentration of effort, which applies to each. Attach resumes, curricula vitae, or statements of prior experience and qualification.

- Resumes
- Qualifications of staff assigned to the project

ORGANIZATIONAL EXPERIENCE

Relevant experience/background, capability, and qualifications of Respondent: includes relevant documentation that demonstrates that the Respondent meets the qualifications described above.

ORGANIZATIONAL FINANCIAL CAPACITY

Suitability of cost proposal: includes a description of the business background of the Respondent and all subcontractors.

COST AND COMPENSATION

The reimbursement rate discount will include the services and requirements described in this request for proposals including all administrative costs and overhead

COST PROPOSAL / BUDGET NARRATIVE

Explain how the requested funding amount reflects the Respondent’s goals and design to accomplish the proposed project. The budget submission should include a three month budget with monthly breakdowns. In addition, a budget narrative should also be included which contains specific line item costs allocations. Each budget must illustrate the exact formula used to derive each dollar amount listed. The budget narrative must be a detailed description of each line item. It must state how the line item will be used and what purchases will be included in each individual line item.

The proposal must provide cost information as required to support the reasonableness of the proposal.

*****COST PROPOSAL MUST BE SUBMITTED UNDER SEPARATE COVER. ANY REFERENCE TO COST(S) INCLUDED WITH THE TECHNICAL/BUSINESS PROPOSAL WILL RESULT IN OFFEROR’S PROPOSAL BEING REJECTED. THE TECHNICAL/BUSINESS PROPOSAL WILL BE EVALUATED PRIOR TO THE PROPOSAL PRICING SHEET BEING REVIEWED.*****

STANDARD TERMS & CONDITIONS

1. **GENERAL:** Any special terms and conditions included in the request for proposal 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.
2. **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.
3. **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.
4. **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. 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.
5. **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.
6. **BRAND NAME REFERENCES:** Any catalog brand name or manufacturer's reference used in the bid 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. 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 bid.
7. **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. 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.
8. **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.
9. **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.
10. **AMENDMENTS:** The bid cannot be altered or amended after the bid opening except as permitted by regulation.
11. **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.

12. 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.

13. LENGTH OF CONTRACT: The request for proposal will show the period of time the term contract will be in effect.

14. DELIVERY ON FIRM CONTRACTS: The solicitation 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 Arkansas Insurance Department 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.

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

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

17. 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 Respondent. The Respondent must give written notice to the Arkansas Insurance Department 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.

18. 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.

19. INVOICING: The Respondent 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 solicitation, (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.

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

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

22. ASSIGNMENT: Any contract entered into pursuant to this request for proposal is not assignable nor the duties there under delegable by either party without the written consent of the other party of the contract.

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

24. 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 Respondent 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 Respondent may file a claim with the Arkansas Claims Commission. If the Respondent has provided services and there are no longer funds legally available to pay for the services, the Respondent may file a claim.

25. 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 there under 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.

26. 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.

27. ANTITRUST ASSIGNMENT: As part of the consideration for entering into any contract pursuant to this request for proposal, the bidder named on the front of this request for proposal, 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.

28. 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 Respondent, 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.

EXHIBITS

1. AID Grant Abstract
2. AID Current Rate Review Process
3. AID Full Narrative
4. AID Healthcare.gov RR Summary
5. Arkansas Statutory Regulations
6. AID Forms
7. AID Databases
8. AID Mandatory SERFF Filings (Bulletin No. 9-2010)
9. SERFF Information Summary
10. NAIC 'Draft' Rate Filing Disclosure Forms
11. AID Redacted Sample Filing
12. HHS Rate Review Program Timeline
13. HHS Reporting 'Mockup'
14. HHS 'Draft' Template for Data Dictionary
15. HHS Table A-D Summary
16. HHS Table A-B 'Mockup'
17. Arkansas carriers "Individual"
18. Arkansas carriers "Small Groups"
19. Aid Organizational Chart

Grants to States for Health Insurance Premium Review – Cycle 1 Arkansas Project Abstract

The U.S. Patient Protection and Affordable Care Act (PPACA) provides Arkansans with long-overdue opportunities for improved access to health care services. Insurance reform is the dominant theme of the PPACA. The Arkansas Insurance Department (AID) has responsibility to serve and protect the public by equitable enforcement of the state's laws and regulations affecting the insurance industry. During this time of health care reform, there is an urgency to transform health insurance rate approval and cost monitoring requirements and processes to insure transparency and consumer protection against unreasonable, unjust, or excessive health insurance rate increases.

With strong commitment and capable change leadership by Governor Mike Beebe and Arkansas Insurance Commissioner Jay Bradford, Arkansas stands ready to expand and enhance the health insurance rate approval processes in Arkansas. Jay Bradford will serve as project director for this Premium Review – Cycle 1 grant. Under his leadership, Arkansas Insurance Department plans to: 1) expand its legal authority for health insurance rate review and approval/disapproval; 2) enhance expertise for health rate reviews; 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 DHHS Secretary; and 4) create a health insurance rate review education, outreach, and training program dedicated to information dissemination about rate approval processes and rate trends to diverse stakeholders including the general public and special consumer populations, policymakers, health insurers, health care providers, and the business community.

The proposed funding of one million dollars will be used to: 1) enhance staff and technical expertise/efficiency for rate reviews through actuarial/information technology consultation and process improvements; 2) increase AID rate review staff by five positions; 3) create and staff an active consumer-driven Advisory Council to assist with implementing meaningful methods to improve consumer knowledge and involvement in rate approval processes; and 4) equip a modern, state-of-the-art Rate Review Center at AID that will serve as the “nerve center” for health insurance rate review information exchange with the general public and professional health industry groups.

The AID plans to obtain broad rule-making authority for all insurance rate matters and to immediately expand prior approval authority for small groups. This will include amending the definition of small group from “2-25” to “2-100”. Actuarial and information technology consultation made possible by the Cycle 1 funding will be used to evaluate needed process improvements and then plan and implement strategic improvements. These improvements are expected to result in more in-depth and comprehensive rate review requirements with transparent processes, routine trend analyses, and active public and industry reporting. The ultimate goal is consumer protection and improved health care access.

AID Current Rate Review Process

(1) Life and Health Division Process:

All individual rate filings, including rates that accompany new form filings and rate revisions (increases) on existing filings, are filed with the Life and Health Division (LHD) for review and approval. Currently, filings are received via mail or NAIC's System for Rate and Form filings (SERFF). Pursuant to AID Bulletin 9-2010, effective March 1, 2011 LHD will accept filings through SERFF only. Filings received by mail are scanned and uploaded to SERFF by the LHD Administrative Secretary. Scanned filings and SERFF filings are reviewed by the LHD Administrative Secretary and assigned to the appropriate Compliance Officer for review and approval. The Compliance Officer performs an initial review to assure that the filing contains the required information needed to complete the review process. If additional information is needed, the Compliance Officer request such information from the insurer. If the filing contains all the required information and request for an initial rate/rate increase are not excessive and reasonable in relation to the benefits provided, it is approved by the Compliance Officer. For those rates in question, the Deputy Commissioner for LHD will contract with a consulting actuary and consult with the Commissioner prior to approval of the rate.

(2) Staffing & Resources:

Currently the LHD staff involved in the rate review process for individual major medical health insurance includes the Administrative Secretary, LHD Compliance Officer, and Deputy Commissioner. Consulting Actuaries are contracted on an as needed basis. Resources used by LHD include investigators of the Consumer Services Division, market regulation examiners from the Finance Division, and attorneys in the Legal Division. Information Technology (IT) resources include internet access to the SERFF form and filing system, personal computers, the use of software to communicate internally and externally with industry and outside sources as well as IT technical support. Educational opportunities provided by the National Association of Insurance Commissioner (NAIC), and other organizations are used on an as needed basis. Additional equipment is purchased to further enhance the ability of the staff to function at its highest level of service to the Department, Industry and Consumers.

(3) Current Level of Resources and Capacity for Rate Review (IT and System Capacity)

The Life and Health Division (LHD) of the Arkansas Insurance Department utilizes the SERFF system to track and house all form, rate and other related filings submitted to the division. SERFF makes the assignment of multiple reviewers possible. Communication between the Department and the insurer's filer is maintained within the SERFF system which facilitates the process to bring the filings into compliance with statutory requirements and/or provide any additional information or changes needed to complete the reviewing process. SERFF provides a full record of the process on each filing submitted and the final disposition on the completed filing. SERFF provides certain reporting and data that assist the Compliance Officer in the evaluation of the filing and in responding to inquires for information.

Arkansas Health Insurance Premium Review – Cycle 1 Narrative

Governor Mike Beebe and Arkansas Insurance Department (AID) Commissioner Jay Bradford take seriously AID's responsibility to "serve and protect the public interest by the equitable enforcement of the state's laws and regulations affecting the insurance industry". Under the effective leadership of Commissioner Bradford, AID is committed to expanding and strengthening its ability to support health care reform through meaningful and transparent processes that align health insurance rate review, approval, analyses, reporting and public notification processes with the agency's mission of "consumer protection through insurer solvency and market conduct regulation, and fraud prosecution and deterrence". Specifically, AID seeks funding through the Health Insurance Premium Review-Cycle 1 program to protect consumers from unreasonable, unjustified, or excessive rate increases through: 1) expanded legal authority for health rate review and approval/disapproval; 2) expanded expertise for health rate reviews; 3) enhanced technology and programmatic infrastructure to effectively collect, analyze, and report health insurance rate filings and outcomes to diverse stakeholders including the general public, health care insurers, health care providers, and policymakers including state legislators and the Department of Health and Human Services (HHS) Secretary; and 4) creation of a health insurance education, outreach, and training unit dedicated to information dissemination about health insurance rate approval processes and rate trends to diverse stakeholders including the general public and special consumer populations, policymakers, health insurers, health care providers, and the business community.

Jay Bradford was appointed Arkansas Insurance Commissioner by Governor Mike Beebe in January 2009. Commissioner Bradford worked in the insurance industry for more than forty years and also served as an Arkansas State Senator and State Representative for 24 years—having been elected as both Speaker of the House and President Pro-Tempore of the Senate. In addition to his insurance background and political savvy, Commissioner Bradford is nationally recognized for his work in health care and consumer advocacy. He sponsored the

state law mandating that 100% of Arkansas's tobacco settlement dollars be spent for healthcare. He sponsored Arkansas's breast care legislation that resulted in millions of dollars becoming available for breast cancer prevention and treatment. And, he sponsored the Arkansas Mental Health Parity Act.

Prior to being appointed AID Commissioner, Bradford served two years as Director of the Arkansas Department of Human Services' Division of Behavioral Health Services. Commissioner Bradford is an effective change agent and leader. Major accomplishments during his first two years at AID have included increasing consumer recovery from nine million to sixteen million dollars as a result of consumer complaints, and negotiating a lower rate increase for Arkansas's largest health insurance carrier--from a requested 28% to an approved 11%. As a collaborative, passionate, and action-oriented leader, Commissioner Bradford sits in the right place at the right time to help Arkansas successfully transition to a new, consumer-friendly health care delivery and financing system. He will serve as project director for Arkansas's Health Insurance Premium Review - Cycle 1 project.

Providing agency leadership at Commissioner Bradford's side is Chief Deputy Commissioner Lenita Blasingame, an experienced and nationally recognized insurance professional with a 44 year tenure at AID. She was named Deputy Commissioner in 2000 and Chief Deputy Commissioner in 2006. She was appointed Insurance Commissioner by Governor Mike Beebe on January 2, 2009 to fulfill the previous Commissioner's unexpired term. After the appointment of Commissioner Bradford, she returned to her position as Chief Deputy Commissioner where her duties include oversight responsibility for several key support divisions pertinent to this Cycle 1 application including Consumer Services and Administrative Support Divisions of Accounting and Human Resources. She is skilled in legislative matters and drafting rules and bulletins. She is active in the National Association of Insurance Commissioners (NAIC) and a member of the Association of Insurance Compliance Professionals and Insurance Regulatory Examiner's Society. Ms. Blasingame will serve as interim assistant project director

responsible for grant management and reporting until the new position of Deputy Commissioner/Health Insurance Rate Review Manager is filled (see Goal 2.1, narrative p. 11).

Current AID Health Insurance Rate Review Capacity and Processes. *Relevant statutory and regulatory authority for the Arkansas rate review process is presented as an attachment (Statutory and Regulatory Authority).* Under ACA §23-79-109(a)(1)(A), “No basic insurance policy, or annuity contract form, or applications form...or printed rider or endorsement form or form of renewal certificate shall be issued, delivered, or used...unless the form has been filed with and approved by the Insurance Commissioner and, in the case of individual accident and health contracts, the rates have been filed with and approved by the commissioner”. As noted, AID currently has prior approval authority for rates only in the individual health market.

Health insurance products regulated by AID are PPO, small group, large group, and individual. Health insurance market companies regulated by AID are HMO, domestic, and foreign insurance companies that have obtained a Certificate of Authority to operate in Arkansas and maintain the license for Accident and Health Insurance. The AID has no prior approval authority over group health rates.

Rating rules for health products in the small group market are rating bands with actuarial justification (see ACA §23-86-204). The case characteristics used may be geographic location and age. The AID Bulletin 4-79 (see attachment) outlines data to be included in the actuarial memorandum. Bulletin 12-81(9) (see attachment) outlines the projected loss ratio.

Each small employer carrier (defined as 2-25 employees in Arkansas) is required to maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation which demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles. On March 1 annually, each small employer carrier files with the Insurance Commissioner an actuarial certification that the carrier is in compliance with AID regulations and that the rating methods of the carrier are

actuarially sound. A small employer carrier is required to make this information and documentation available to the Commissioner upon request. However, the information is not currently subject to disclosure by the Commissioner to persons outside the AID, except as agreed to by the carrier or ordered by a court of competent jurisdiction.

The data required for rate filings are outlined under AID Bulletin 4-79. When an insurance company files a new health insurance product, the filing must be accompanied by an actuarial memorandum and certified by an actuary. The rates must be reasonable in relation to the premium charged. Under ACA 23-61-103(d)(4) (see attachment) the actuarial formulas and assumptions certified by a qualified actuary are confidential and privileged when submitted to comply with a rate or form filing requirement of the department; therefore, the attached sample filing (see attachment – sample filing) is redacted.

All individual health insurance rate filings must be accompanied by actuarial data which is provided by the insurance company. Initial rate filings for new business rely on certification of reasonableness of rates by the company actuary. The AID's current position is that a projected loss ratio less than 50% is not a reasonable relationship between benefits and premiums. Individual companies must, at the time of their rate filings, furnish AID the approximate number of persons in Arkansas affected by the proposed rates. If that number is 500 or greater (considered a credible number), the company is requested to send the experience for Arkansas in addition to their Nationwide experience. The past three calendar years of experience is considered by AID Life and Health Division staff in calculations to determine the loss ratio. These latest three years of incurred claims are averaged and multiplied at 15% to allow for inflation. Then the latest three years of earned premium are averaged and multiplied by the percentage of rate increase. The adjusted earned premiums are then divided by the adjusted incurred claims to get the projected loss ratio. If the loss ratio remains above the required 50%, the rate increase may be approved subject to the Commissioner's discretion.

For individual carriers, a description of the type of coverage and a designation of the policy or contract form number affected by the proposed rate is required with a separate filing for each policy or contract form number. If the proposed rate is for a contract or policy form not currently approved for use in Arkansas, such form should accompany the filing. If the proposed rate is a revision for a form currently approved, a description of the percentage rate increase is required; if not a level increase, this statement should include the maximum, minimum, and average rate increase. A statement as to how the proposed rate applies to anticipated experience or, if the rate is a revision for a form currently approved, a statement as to how the proposed rate applies to actual experience and anticipated experience is required. The actuarial certification must indicate that, in the belief of the actuary, the proposed rate or rate revision does not discriminate unfairly between policyholders. The completeness and accuracy of the data furnished in the filing is to be certified by an officer of the insurer.

There is an expedited approval process for an individual accident and health insurance policy if the average rate increase is less than 30%, the number of Arkansas citizens affected is less than 100, there has been no rate revision for the insurance product within the past 12 months, the effective date of the proposed rate revision will be no earlier than the next policy anniversary following 60 days after the date of the filing, and notice of the rate revision will be given to the policyholder at least 30 days prior to the first due date of the revised premium.

The AID rate review process is managed by an AID Life and Health Compliance Officer who reviews the actuarial data provided by the insurance company (see Bulletin 4-79) and evaluates the rates based on this data. Approximately 99% of all rate and form filings are electronically submitted to the Life and Health Division through the NAIC System for Electronic Rate and Form Filing (SERFF).

When a new individual health product is submitted for approval, accompanied by an actuarial memorandum and data used to develop the proposed rates, the product and rates are reviewed by the Compliance Officer for compliance with Arkansas laws, regulations and AID

bulletins. If the Compliance Officer has a question on the rates or product, she will consult with the Insurance Deputy Commissioner/Director Life and Health Division. The Compliance Officer also reviews for approval any request for a rate increase on already approved individual products. The information that must accompany the actuarial memorandum for approved products includes the last three calendar years' experience on an earned premium and incurred claims basis (nationwide & Arkansas experience) and the history of the rates and the number of individuals insured on the block of business. A consulting actuary may be obtained when a considerable number of enrollees in Arkansas could be affected by a substantial rate increase on a block of individual health business.

Grounds for rate approval, modification and rejection are factors such as: The loss ratio of earned premium and incurred claims, the history of previous rate increases, the financial history of the company, and medical trend. Rates for new individual health products or modifications of existing rates must be prospectively submitted and reviewed for approval. Under ACA 23-79-110(5)(A) (see attachment), rates on a particular policy form will be deemed approved retrospectively upon filing with the commissioner if the insurer has filed a loss ratio guarantee with the commissioner and complied with the terms of the loss ratio guarantee. Benefits will continue to be deemed reasonable in relation to the premium so long as the insurer complies with the terms of the loss ratio guarantee which must be submitted in writing, signed by an officer of the insurer, and must contain information as listed in ACA 23-79-110 (5) (A).

Over the past year, at the discretion of the Commissioner, Arkansas has been negotiating with those insurance companies that have been requesting rate increases greater than 10% on their individual health insurance products. The Commissioner negotiated a lower rate for an Arkansas domestic with the largest state market share, affecting approximately 90,000 policyholders. The AID does not have prior approval authority over group rates, and therefore has not negotiated with companies to prevent or reduce rate increases in the group market.

Current Resources and Capacity for Reviewing Health Insurance Rates:

Information Technology and Systems. The AID reviews and processes Arkansas SERFF filings (99% of Arkansas health rate proposals) remotely via a web browser interface. The AID Information Services Division provides the technical expertise for interface with SERFF, and SERFF filings can be downloaded to the AID electronically for online use or printing.

Approximately one percent (1%) of Arkansas life and health insurance rate and form filings are received as paper filings. These are reviewed in hard-copy format. All filings are manually logged within the Division of Life and Health as a backup. (See Goal 3, narrative p. 12 for proposed system enhancements.)

The AID Deputy Commissioner/Director of Information Systems (IS) is James Winningham. His responsibilities include day-to-day coordination of IT elements with the NAIC. The IS Division uses virtual machine technology and provides direct support to AID regulatory staff in their development and day-to-day use of computer workstations and software. The IS Division also supports the public and industry use of AID online services provided through the AID web site.

Publicly-releasable filing information is made available on the AID web site following approval or disapproval of a rate request. The disposition letter which states the percentage of rate increase is included in what is available for the public to view, however the language in these letters is often complex and not readily understandable for the lay public. The AID does not currently announce rate increases via news releases, however all press releases generated by the Department are placed on its website and available for viewing for a period of four years. Thus, an enhanced web site could be a tool for consumers and researchers to see the history of increases for particular companies. Other current public information dissemination practices by AID are limited. Needed improvements (see Goal 4, narrative p. 13) will be effected through Cycle 1 funding.

Current Resources and Capacity for Reviewing Health Insurance Rates: Budget

and Staffing. The AID is a dedicated funding agency, meaning that it derives none of its operating revenue from premium tax collections nor general revenue. The agency is funded by fees and assessments imposed on entities regulated by the Department. The AID annual operating budget is approximately \$10.6 million. A total of \$196,138,029 was collected by AID in state fiscal year 2009, with \$143,798,712 million being premium taxes.

Health rates are reviewed within the AID Life and Health Division. The Deputy Commissioner/Director of Life and Health is Dan Honey. In addition to rate review, Mr. Honey also oversees the Seniors Health Insurance Information Program (SHIIP). An attorney, Honey has served as deputy to the Arkansas State Treasurer, General Counsel for Arkansas Workers' Compensation Commission, Senior Counsel for Fortis Health (now Assurant Health) of Milwaukee, and Associate Counsel for the Centennial Life Insurance Company in Kansas City. During his tenure with both Fortis and Centennial, he spent the majority of his time dealing with complex state and federal health insurance regulatory matters.

The Life and Health Compliance Officer, Rosalind Minor, performs all technical reviews and communications regarding rate approval/disapproval for those rates the AID has legal authority over. A 23 year AID employee, Ms. Minor has also served as Senior Rate and Form Analyst, Rate and Form Analyst, and investigator in the Consumer Services Division.

Arkansas receives 100 plus rate filings annually, some of which may include health products other than major medical. Since Arkansas does not currently regulate group rates, there is no count on the group side. A rate filing that does not present any problems takes approximately one hour. Rate filings requiring repeated correspondence with the company could take several days of back and forth communication with the company. Last year, Ms. Minor spent approximately 10% of her time reviewing 22 individual major medical filings.

Based on total Compliance Officer position costs of \$75,000, rate review costs are calculated at \$7,500 (0.10 FTE). The Deputy Commissioner/Director for Life and Health spends

approximately five percent of his time (position cost of \$141,000) providing supervision and guidance to the Compliance Officer. Based on these costs, the estimated AID cost for rate review (\$7,500) and supervision (\$7,000) is approximately \$14,500 annually. The AID does not have any current actuarial contracts. *Maintenance of AID current rate review effort will be honored and AID will not use any Cycle 1 funds to supplant these dollars.*

One rate review concern has been the lack of AID actuarial capacity for initial rate reviews. Currently, when a company (in the individual market where AID has authority) files rates for a new product, the company will include an actuarial certification that the rates are reasonable in relation to the benefits provided. Because AID lacks the staff time and expertise to question such company certification, it is generally AID's practice to take the company's certification at face value and approve the initial rate. It is not uncommon to have situations where a company will undercharge on a new product rate in order to be more competitive in the market. Then, after a few years' claims experience, the company will begin to lose money on that block of business because the claims are more than the premium revenue.

Consumer Protections. Rate filing detail is not publicly disclosed in Arkansas pursuant to ACA.23-61-103(A)(4) (see attachment). However, Arkansas is in the process of placing rate information not subject to this statute on the AID website and is interested in exploring statutory and regulatory authority changes to make overall rate filing and review processes more transparent to the public and other stakeholders (see Goal 1.2, narrative p. 11). Access to public records of governmental agencies, including the AID, is regulated by Arkansas's Freedom of Information Act (ACA 25-19-101 through 25-19-109) (see attachment).

At present, consumers are not provided with prior notice of rate request filings. There is not a process for public comment on proposed changes, nor are rate change summaries currently provided in plain language for consumers. Insurance companies, however, are required to give enrollees a minimum of 30 days notice from the date of approval before implementing a new rate. The AID will be working to reform these consumer

notification/participation practices in support of transparency as mandated by the Patient Protection and Affordable Care Act (PPACA) and championed by Arkansas's Insurance Commissioner (See Goal 2.4, narrative p.12 and Goal 4, narrative p.13).

Consumer inquiries and complaints related to health insurance rates are addressed by the AID Consumer Services Division (CSD). For 2008 and 2009, 378 health insurance complaints and inquiries were filed; only 12 (3%) were for rate issues. Dispositions of those 12 were: 5-company in compliance; 2-compromised settlement/resolution; 1-company position upheld, 1-advised complainant; 1-contract provision/legal issue; 1-no jurisdiction; and 1-information furnished/expanded.

Examination and Oversight. There have been no actions taken by AID against insurance companies pursuant to health insurance rates over the past two years. One company self-reported having sold a product for which they had inadvertently failed to obtain approval. The AID worked with the company to make refunds to approximately 150 affected consumers.

Challenges. As noted above, AID has identified challenges to overcome as it provides leadership to: 1) protect the public through efficient, modern, and transparent health insurance rate setting, and 2) effect more comprehensive health insurance reform. In summary, current rate review challenges include: limited AID legal authority for health rate increase approvals; legal restrictions on release of "confidential" insurance company information to the public; lack of AID actuarial expertise; lack of fully integrated and interoperable data systems that can enhance health rate data management, tracking, analyses and reporting to diverse stakeholders including consumers and the HHS Secretary; and limited agency experience in reaching out to diverse consumers and stakeholders in an effort to increase their knowledge so they are better able to meaningfully participate in the rate approval process.

Another challenge will be to sustain energy, focus, urgency, creativity, and coordination/integration of activities among multiple AID Divisions and external constituencies (particularly state agencies, health reform advocates, insurance industry, and consumers)

during times of ambiguity and sweeping change. However, these change management attributes will be critical to achieving informed and acceptable health insurance reform with a model that best serves Arkansas citizens.

Proposed Rate Review Enhancements. Under this Cycle 1 program, AID plans to expand and enhance existing rate review and approval practices and transparency. The ultimate outcome of improvements in communicating, analyzing, reporting and tracking rate increase requests and actions is expected to be increased consumer participation and protection. A specific work plan with goals, activities, and milestones is included as an attachment. Additional needed resources are reflected in the budget narrative.

Goal 1: Expand AID authority for prior approval of health insurance rates and rate increases. 1.1: The AID will seek expanded authority during the 2011 Arkansas General Assembly to review and approve small groups. *This will include changing the definition of small group from 2-25 to 2-100.* 1.2: AID will also seek statutory authority for broad rulemaking regarding all insurance rate matters in order to achieve needed consumer protections.

Goal 2: Increase AID expertise to effectively review health insurance rate requests. 2.1: Create and fill an AID Deputy Commissioner/Health Insurance Rate Review Manager (See Challenges Section above). This full-time position will serve as assistant project director for this Cycle 1 effort and will report to the Commissioner (project director). *The successful candidate will have a doctoral degree and demonstrated leadership and management skills, including health industry experience as a health care provider and with patient insurance processing, and experience working with government agencies. With committed, visible, accountable and accessible leadership, this Cycle 1 project will manage resources with the urgency and skill needed to effect timely changes and lay a foundation for future reforms.* 2.2: Create and fill a position of Health Insurance Rate Review Compliance Officer to meet the increased demand created by expanding rate reviews to small groups. *This reviewer will have experience with an actuary and primary responsibility for rate reviews, and*

will assist with internal and external training on rate review processes. 2.3: Contract with consulting health actuaries to: a) assist in formulating an enhanced rate review process, and b) provide consultation for complex rate review cases (see attachment –rate review cost estimate). It is anticipated that this consultation will result in AID requiring more comprehensive supporting documentation and actuarial attestations, including requirements that companies separately report and justify administrative expenses in order to assess for compliance with increased medical loss ratio regulations. A further expectation is that AID will have enhanced capacity to assess an insurance company's overall finances (profits/investment income) when making rate change determinations. 2.4: Develop and implement processes for consumer input prior to insurance rate increase approval. The AID Life and Health Division, Advisory Council (Goal 4.1 below), and Partners for Inclusive Communities (Goal 4.2) will work collaboratively to develop meaningful and inclusive processes for consumer input into rate review processes,

Goal 3: Expand and enhance AID capacity for efficiently collecting, storing, analyzing, tracking, and reporting complete and comprehensive rate review data using interoperable systems. 3.1: AID will require that all health insurance rate review requests be submitted electronically in 2011. AID Life and Health Division will provide technical assistance to companies transitioning from paper submission. 3.2: AID will work with NAIC to augment existing SERFF capabilities to meet rate review and reporting requirements (see attachment – NAIC proposal). 3.3: AID will coordinate technology improvements with the Governor's Health Reform Information Technology leadership team. 3.4: AID will develop and host an insurance rate review data base on a Department server using virtual machine technology and the SQL Server database management system. Because this data base will contain data downloaded from SERFF along with data entered by insurance companies and consumers through the AID web site, it will enable grant-required reporting and manage data elements for analyses not currently supported through SERFF. System design will prevent disparities between information residing in SERFF and the AID rate review database. A separate virtual server will be

configured to host the web services necessary to provide public visibility into rate review. 3.5: Augment existing AID web-site publication capabilities with additional applications, data manipulation capabilities, data reporting capabilities, data tables, and programmatic and communications interfaces necessary to better inform and receive information from diverse constituencies including insurance companies and consumers. 3.6: Determine AID internal capability versus need for contracted academic/research Data Center or consultant to perform at least annual analyses/reporting of Arkansas insurance cost and rate trends. 3.7: Using technology and expertise enhancements listed above, AID will report rate review process and outcomes data and trend analyses as well as other required individual and aggregate data requirements to the HHS Secretary.

Goal 4: Create and implement a robust and coordinated Rate Review Education, Outreach, and Training program that effectively provides user friendly and timely access to rates, rate filing processes, requests, outcomes, complaints, and other related information to constituencies both internal and external to AID. 4.1: Create and support the *Transparency in Health Insurance Rate Determinations Advisory Council* (Advisory Council) that serves as an informed advocacy group charged with insuring transparency in health insurance rate review processes, actions, and communications including rate trends, and complaints, and how these affect the consumer. *The Advisory Council will be appointed by the Commissioner and include consumers (including consumers from the disability or long-term care communities), insurance companies, health care providers, key state agency and health care reform leadership, and legislators. Consumer positions will comprise the majority.* 4.2: Create and implement diverse communication products and methods for specific constituencies that include: expanding AID web site to detail health insurance rates, rate filings, complaints, and pertinent processes in a manner that is understandable to the public; media/press releases; policy briefings; accessible 1-800 consumer inquiry, complaint, or fraud report telephone service; advertisements in statewide newspapers/magazines; webinars; accessible public

meetings, hearings and seminars held at AID and locations across the state; newsletters; specific stakeholder and institutional presentations; and/or other communication strategies advocated by the Advisory Council. *One method for informing persons with disabilities and long-term care needs will be through the University of Arkansas for Medical Sciences' Partners for Inclusive Communities. With a mission to support individuals with disabilities and their families to fully and meaningfully participate in community life, effect systems change, prevent disabilities and promote healthy lifestyles, Partners will seek consumer input through focus groups, review public education materials for public understanding, and disseminate health insurance rate and review information through their extensive network of individuals, advocacy boards and groups, and community partners. AID will maintain a small pool of funds to assist with accessibility issues for consumers or family members wanting to learn more or comment on insurance rate issues.*

4.3: Provide technical training for constituencies including, but not limited to, members of the Advisory Council, AID employees, insurers, staff members of sister agencies, legislators or legislative research staff, and other stakeholders on processes for rate review. *This would include hosting Train the Trainers seminars where AID would access and host meaningful instruction and classes in "rate filings and rate review" for internal and external constituencies as offered by NAIC or any credible educational institutions having this expertise.*

4.4: Educate and update broad constituencies including, but not limited to, Advisory Council, AID employees, insurers, enrollees, general public, advocacy organizations, staff members of sister agencies, legislators, legislative research staff, health related organizations, institutions of higher education, and other stakeholders about general processes of rate review and specifics of ongoing rate trends in Arkansas and the Nation by benefit category, claims paid, price inflation, risk, complaints, and other dynamic factors. *This education and outreach is expected to have broad impact in effecting transparency and needed changes. For example, AID legislative education would advance appropriate AID rate review authority, and education of specific disability rights groups would promote their increased engagement in meaningful rate*

review approval processes. 4.5: Designate and transform a 1400 square foot “hearing room” space on the first floor of the AID office building into a modern Health Insurance Rate Review Center for public and professional training, education, and information dissemination activities including public hearings. The AID Insurance Rate Review Center will serve as the “nerve center” for education and outreach efforts. Training methodologies will include classes, seminars, and interactive webinars or interactive video conferences augmented by power point presentations, course syllabi, video clips, and manuals.

Reporting to the Secretary on Rate Increase Patterns.

The AID attests that it will comply with the Cycle 1 Special Terms and Conditions requirements for reporting trends in premium rating areas as well as reporting individual carrier and aggregate data to the DHHS Secretary. The AID will comply with all reporting requirements outlined in statute.

Optional Data Center Funding

An evaluation of internal capacity versus need to obtain academic and research experts for data collection and analyses describing cost and rate trends will be conducted by January 1, 2011. Potential contractors would include the University of Arkansas for Medical Sciences College of Public Health. See 3.6 above.

The Arkansas AID looks forward to this Cycle 1 opportunity to expand and enhance our rate review authority, expertise, processes, and consumer involvement and protection.

Arkansas (summary as just exhibited in healthcare.gov)

- **Current Authority**
 - **Individual Market:** Individual: All rates are subject to the prior approval of the Department (ACA §23-79-109(a)(1)(A)). Actuarial certification must comply with the 50 percent minimum loss ratio.
 - **Small Group Market:** Small Group Market: All carriers must file actuarial certification that rates comply with rating reforms (age and geography) and rate bands (ACA §23-86-204).
- **Additional Legislative Authority:** Arkansas currently has prior approval over individual market rates. The State will seek authority to review small group rates.
- **Expand the Scope of Health Insurance Premium Review:** The State intends to expand to review small group rates.
- **Improve the Health Insurance Premium Review Process:** Currently Arkansas conducts prospective review of individual coverage and intervenes for rate increases above 10%. The State will work with consultants to develop a more thorough review process for filings. New staff will be added to conduct reviews.
- **Make More Information Publicly Available:** Currently the State discloses approval vs. disapproval via publishing its disposition letters on the web and requires 30 days public notice on rate increases prior to implementation, however no details are published. Using grant funding, they will create and staff a consumer driven Advisory council, to improve transparency and communications to all stakeholders via an expanded website as well as create a Rate Review Center for consumers and issuers.

23-86-204. Restrictions relating to premium rates.

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

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%). This subdivision (a)(1) shall not apply to a class of business if all of the following apply:

(A) The class of business is one for which the carrier does not reject, and never has rejected, small employers included within the definition of employers eligible for the class of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claim experience or health status;

(B) The carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit plan into or out of the class of business; and

(C) The class of business is currently available for purchase;

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent (25%) of the index rate;

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

(A)(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period.

(ii) In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate;

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

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

(4) In the case of health benefit plans issued prior to January 1, 1992, a premium rate for a rating period may exceed the ranges described in subsection (a)(1) or (2) of this section for a period of five (5) years following January 1, 1992. In such a case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

(A)(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period.

(ii) In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate; and

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

(b)(1) Nothing in this section is intended to affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status, or duration of coverage in the determination of premium rates.

(2) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

(c)(1) A small employer carrier shall not involuntarily transfer a small employer into or out of a class of business.

(2) A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration since issue.

23-79-109. Filing and approval of forms.

(a)(1)(A) No basic insurance policy, or annuity contract form, or application form when written application is required and is to be made a part of the policy or contract, or printed rider or endorsement form or form of renewal certificate, shall be issued, delivered, or used as to a subject of insurance resident, located, or to be performed in this state unless the form has been filed with and approved by the Insurance Commissioner and, in the case of individual accident and health contracts, the rates have been filed with and approved by the commissioner.

(B) This subsection shall not apply to:

(i) Policy or coverage forms for large commercial risks, as defined in subsection (g) of this section;

(ii) Commercial umbrella policy or coverage forms;

(iii) Excess umbrella policy or coverage forms;

(iv) Excess of loss policy or coverage forms;

(v) Public officials' liability policy or coverage forms;

(vi) Fiduciary liability policy or coverage forms;

(vii) Directors' and officers' liability policy or coverage forms;

(viii) Kidnap and ransom policy or coverage forms;

(ix) Political risk policy or coverage forms;

(x) Expropriation coverage policy or coverage forms;

(xi) Mortgage pool insurance policy or coverage forms;

(xii) Railroad protective liability policy or coverage forms;

(xiii) Equity loan programs, second mortgage coverage, policy or coverage forms;

(xiv) Highly protected risk forms;

(xv) Surety bonds;

(xvi) Policies, orders, endorsements, or forms of unique character designed for, and used with relation to, insurance upon a particular subject, or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life and accident and health insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder; or

(xvii) Policies, contracts, riders, endorsements, and certificates issued by surplus lines insurers.

23-79-110. Forms — Grounds for disapproval.

The Insurance Commissioner shall disapprove any form filed under § 23-79-109, or withdraw any previous approval, only if the form:

- (1) Is in any respect in violation of or does not comply with this code;
- (2) Contains or incorporates by reference, when the incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions that deceptively affect the risk purported to be assumed in the general coverage of the contract;
- (3) Has any title, heading, or other indication of its provisions that is misleading;
- (4) Is printed or otherwise reproduced in such manner as to render any provision of the form substantially illegible or not easily legible to persons of normal vision;
- (5)(A) Is an individual accident and health contract in which the benefits are unreasonable in relation to the premium charge. Rates on a particular policy form will be deemed approved upon filing with the commissioner if the insurer has filed a loss ratio guarantee with the commissioner and complied with the terms of the loss ratio guarantee. Benefits will continue to be deemed reasonable in relation to the premium so long as the insurer complies with the terms of the loss ratio guarantee. This loss ratio guarantee must be in writing, signed by an officer of the insurer, and must contain at least the following:
 - (i) A recitation of the anticipated target loss ratio standards contained in the original actuarial memorandum filed with the policy form when it was originally approved;
 - (ii) A guarantee that the actual Arkansas loss ratios for the experience period in which the new rates take effect, and for each experience period thereafter until new rates are filed, will meet or exceed the loss ratio standards referred to in subdivision (a)(5)(A)(i) of this section. If the annual earned premium volume in Arkansas under the particular policy form is less than one million dollars (\$1,000,000) and therefore not actuarially credible, the loss ratio guarantee will be based on the actual nationwide loss ratio for the policy form. If the aggregate earned premium for all states is less than one million dollars (\$1,000,000), the experience period will be extended until the end of the calendar year in which one million dollars (\$1,000,000) of earned premium is attained;
 - (iii) A guarantee that the actual Arkansas, or national, if applicable, loss ratio results for the year at issue will be independently audited at the insurer's expense. This audit must be done in the second quarter of the year following the end of the experience period and the audited results must be reported to the commissioner not later than the date for filing the applicable accident and health policy experience exhibit;
 - (iv)(a) A guarantee that affected Arkansas policyholders will be issued a proportional refund, based on premium earned of the amount necessary to bring the actual aggregate loss ratio up to the loss ratio standards referred to in subdivision

(a)(5)(A)(i) of this section. If nationwide loss ratios are used, then the total amount refunded in Arkansas will equal the dollar amount necessary to achieve the loss ratio standards multiplied by the total premium earned in Arkansas on the policy form and divided by the total premium earned in all states on the policy form.

(b) The refund must be made to all Arkansas policyholders who are insured under the applicable policy form as of the last day of the experience period and whose refund would equal ten dollars (\$10.00) or more.

(c) The refund will include statutory interest from the end of the experience period until the date of payment.

(d) Payment must be made during the third quarter of the year following the experience period for which a refund is determined to be due; and

(v) A guarantee that refunds of less than ten dollars (\$10.00) will be aggregated by the insurer and paid to the State Insurance Department.

23-61-103. Insurance Commissioner — Powers and duties.

(a) The Insurance Commissioner shall enforce the provisions of the Arkansas Insurance Code and shall execute the duties imposed upon him or her by the Arkansas Insurance Code.

(b) The commissioner shall have the powers and authority expressly conferred upon him or her by or reasonably implied from the provisions of the Arkansas Insurance Code.

(c) The commissioner is authorized to enter into regulatory cooperation and coordination agreements with other governmental regulatory agencies within and outside of this state with respect to the regulation of the business of insurance, including, but not limited to:

- (1) Licensing of insurance companies;
- (2) Licensing of producers;
- (3) Regulation of premium rates and policy forms;
- (4) Regulation of insurer solvency and insurance receiverships; and
- (5) Other matters relating to the effective regulation of the business of insurance.

(d)(1) The commissioner may conduct such examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as he or she may deem proper to determine whether any person has violated any provision of the Arkansas Insurance Code or to secure information useful in the lawful administration of any such provision. The cost of these additional examinations or investigations shall be borne by the state.

(2) Notwithstanding any other provision of law, active investigatory or examination files as maintained by the State Insurance Department shall be deemed confidential and privileged and shall not be made open to the public until:

(A) The matter under investigation or examination is deemed closed by the commissioner; or

(B) Referred to any law enforcement authority and made subject to public disclosure by the authority.

(3) At such time that any matter investigated or examined has been set for an administrative hearing pursuant to § 23-61-304 or § 25-15-208, investigation or examination information shall be made available as provided in § 25-15-208.

(4) Unless otherwise exempted by subdivision (d)(5) of this section, actuarial formulas and assumptions certified by a qualified actuary are confidential and privileged when submitted to comply with a rate or form filing requirement of the department, including, but not limited to, any actuarial report:

(A) Required, submitted, or attached to any filing made to the department under § 23-67-211, for rate and form filings of an insurer, or to those submitted under § 23-63-216 for annual statements of an insurer; or

(B) Submitted to the department to comply with any form and rate filing requirement imposed by statute or rule upon licensed insurers, health maintenance organizations, fraternal benefit societies, and hospital and medical service corporations.

**The Arkansas Freedom of Information Act
(FOIA)**

25-19-101. Title.

This chapter shall be known and cited as the "Freedom of Information Act of 1967".

History. Acts 1967, No. 93, § 1.

A.S.A. 1947, § 12-2801.

25-19-102. Legislative intent.

It is vital in a democratic society that public business be performed in an open and public manner so that the electors shall be advised of the performance of public officials and of the decisions that are reached in public activity and in making public policy. Toward this end, this chapter is adopted, making it possible for them or their representatives to learn and to report fully the activities of their public officials.

History. Acts 1967, No. 93, § 2.

A.S.A. 1947, § 12-2802.

25-19-103. Definitions.

As used in this chapter:

(1)(A) "Custodian", with respect to any public record, means the person having administrative control of that record.

(B) "Custodian" does not mean a person who holds public records solely for the purposes of storage, safekeeping, or data processing for others;

(2) "Format" means the organization, arrangement, and form of electronic information for use, viewing, or storage;

(3) "Medium" means the physical form or material on which records and information may be stored or represented and may include, but is not limited to, paper, microfilm, microform, computer disks and diskettes, optical disks, and magnetic tapes;

(4) "Public meetings" means the meetings of any bureau, commission, or agency of the state or any political subdivision of the state, including municipalities and counties, boards of education, and all other boards, bureaus, commissions, or organizations in the State of Arkansas, except grand juries, supported wholly or in part by public funds or expending public funds;

(5)(A) "Public records" means writings, recorded sounds, films, tapes, electronic or computer-based information, or data compilations in any medium required by law to be kept or otherwise kept and that constitute a record of the performance or lack of performance of official functions that are or should be carried out by a public official or employee, a governmental agency, or any other agency wholly or partially supported by public funds or expending public funds. All records maintained in public offices or by public employees within the scope of their employment shall be presumed to be public records.

(B) "Public records" does not mean software acquired by purchase, lease, or license; and

(6)(A) "Public water system" means all facilities composing a system for the collection, treatment, and delivery of water to the general public, including, but not limited to, reservoirs, pipelines, reclamation facilities, processing facilities, and distribution facilities.

(B) This subdivision (6) shall expire on July 1, 2007.

History. Acts 1967, No. 93, § 3; 1977, No. 652, § 1; 1981, No. 608, § 1; 1985, No. 468, § 1; Acts 2001, No. 1653, § 1; 2003, No. 763, § 1; 2005, No. 259, § 1.

A.S.A. 1947, § 12-2803.

25-19-104. Penalty.

Any person who negligently violates any of the provisions of this chapter shall be guilty of a Class C misdemeanor.

History. Acts 1967, No. 93, § 7; Acts 1987, No. 49, § 3; 2005, No. 1994, § 413.

A.S.A. 1947, § 12-2807.

25-19-105. Examination and copying of public records.

(a)(1)(A) Except as otherwise specifically provided by this section or by laws specifically enacted to provide otherwise, all public records shall be open to inspection and copying by any citizen of the State of Arkansas during the regular business hours of the custodian of the records.

(B)(i) However, access to inspect and copy public records of the Department of Correction and the Department of Community Correction shall be denied to:

(a) A person who at the time of the request has pleaded guilty to or been found guilty of a felony and is incarcerated in a correctional facility; and

(b) The representative of a person under subdivision **(a)(1)(B)(i)(a)** of this section unless the representative is the person's attorney who is requesting information that is subject to disclosure under this section.

(ii) Access to inspect and copy public records of the Department of Correction and the Department of Community Correction shall be denied to a person under subdivision **(a)(1)(B)(i)(a)** of this section regardless of whether the records are in the possession of the Department of Correction, the Department of Community Correction, or another agency of the state.

(2)(A) A citizen may make a request to the custodian to inspect, copy, or receive copies of public records.

(B) The request may be made in person, by telephone, by mail, by facsimile transmission, by electronic mail, or by other electronic means provided by the custodian.

(C) The request shall be sufficiently specific to enable the custodian to locate the records with reasonable effort.

(3) If the person to whom the request is directed is not the custodian of the records, the person shall so notify the requester and identify the custodian, if known to or readily ascertainable by the person.

(b) It is the specific intent of this section that the following shall not be deemed to be made open to the public under the provisions of this chapter:

(1) State income tax records;

(2) Medical records, adoption records, and education records as defined in the Family Educational Rights and Privacy Act of 1974, 20 U.S.C. § 1232g, unless their disclosure is consistent with the provisions of that act;

(3) The site files and records maintained by the Arkansas Historic Preservation Program of the Department of Arkansas Heritage and the Arkansas Archeological Survey;

(4) Grand jury minutes;

(5) Unpublished drafts of judicial or quasi-judicial opinions and decisions;

(6) Undisclosed investigations by law enforcement agencies of suspected criminal activity;

(7) Unpublished memoranda, working papers, and correspondence of the Governor, members of the General Assembly, Supreme Court Justices, Court of Appeals Judges, and the Attorney General;

(8) Documents that are protected from disclosure by order or rule of court;

(9)(A) Files that if disclosed would give advantage to competitors or bidders and records maintained by the Arkansas Economic Development Commission related to any business entity's planning, site location, expansion, operations, or product development and marketing, unless approval for release of those records is granted by the business entity.

(B) However, this exemption shall not be applicable to any records of expenditures or grants made or administered by the commission and otherwise disclosable under the provisions of this chapter;

(10)(A) The identities of law enforcement officers currently working undercover with their agencies and identified in the Arkansas Minimum Standards Office as undercover officers.

(B) Records of the number of undercover officers and agency lists are not exempt from this chapter;

(11) Records containing measures, procedures, instructions, or related data used to cause a computer or a computer system or network, including telecommunication networks or applications thereon, to perform security functions, including, but not limited to, passwords, personal identification numbers, transaction authorization mechanisms, and other means of

preventing access to computers, computer systems or networks, or any data residing therein;

(12) Personnel records to the extent that disclosure would constitute a clearly unwarranted invasion of personal privacy;

(13) Home addresses of nonelected state employees, nonelected municipal employees, and nonelected county employees contained in employer records, except that the custodian of the records shall verify an employee's city or county of residence or address on record upon request;

(14) Materials, information, examinations, and answers to examinations utilized by boards and commissions for purposes of testing applicants for licensure by state boards or commissions;

(15) Military service discharge records or DD Form 214, the Certificate of Release or Discharge from Active Duty of the United States Department of Defense, filed with the county recorder as provided under § 14-2-102, for veterans discharged from service less than seventy (70) years from the current date; and

(16)(A) Records, including analyses, investigations, studies, reports, recommendations, requests for proposals, drawings, diagrams, blueprints, and plans, containing information relating to security for any public water system.

(B) The records shall include:

(i) Risk and vulnerability assessments;

(ii) Plans and proposals for preventing and mitigating security risks;

(iii) Emergency response and recovery records;

(iv) Security plans and procedures; and

(v) Any other records containing information that if disclosed might jeopardize or compromise efforts to secure and protect the public water system.

(C) This subdivision (b)(16) shall expire on July 1, 2007.

(c)(1) Notwithstanding subdivision (b)(12) of this section, all employee evaluation or job performance records, including preliminary notes and other materials, shall be open to public inspection only upon final administrative resolution of any suspension or termination proceeding at which the records form a basis for the decision to suspend or terminate the employee and if there is a compelling public interest in their disclosure.

(2) Any personnel or evaluation records exempt from disclosure under this chapter shall nonetheless be made available to the person about whom the records are maintained or to that person's designated representative.

(3)(A) Upon receiving a request for the examination or copying of personnel or evaluation records, the custodian of the records shall determine within twenty-four (24) hours of the receipt of the request whether the records are exempt from disclosure and make efforts to the fullest extent possible to notify the person making the request and the subject of the records of that decision.

(B)(i) If the subject of the records cannot be contacted in person or by telephone within the twenty-four-hour period, the custodian shall send written notice via overnight mail to the subject of the records at his or her last known address. Either the custodian, requester, or the subject of the records may immediately seek an opinion from the Attorney General, who, within three (3) working days of receipt of the request, shall issue an opinion stating whether the decision is consistent with this chapter.

(ii) In the event of a review by the Attorney General, the custodian shall not disclose the records until the Attorney General has issued his or her opinion.

(C) However, nothing in this subsection shall be construed to prevent the requester or the subject of the records from seeking judicial review of the custodian's decision or the decision of the Attorney General.

(d)(1) Reasonable access to public records and reasonable comforts and facilities for the full exercise of the right to inspect and copy those records shall not be denied to any citizen.

(2)(A) Upon request and payment of a fee as provided in subdivision (d)(3) of this section, the custodian shall furnish copies of public records if the custodian has the necessary duplicating equipment.

(B) A citizen may request a copy of a public record in any medium in which the record is readily available or in any format to which it is readily convertible with the custodian's existing software.

(C) A custodian is not required to compile information or create a record in response to a request made under this section.

(3)(A)(i) Except as provided in § 25-19-109 or by law, any fee for copies shall not exceed the actual costs of reproduction, including the costs of the medium of reproduction, supplies, equipment, and maintenance, but not including existing agency personnel time associated with searching for, retrieving, reviewing, or copying the records.

(ii) The custodian may also charge the actual costs of mailing or transmitting the record by facsimile or other electronic means.

(iii) If the estimated fee exceeds twenty-five dollars (\$25.00), the custodian may require the requester to pay that fee in advance.

(iv) Copies may be furnished without charge or at a reduced charge if the custodian determines that the records have been requested primarily for noncommercial purposes and that waiver or reduction of the fee is in the public interest.

(B) The custodian shall provide an itemized breakdown of charges under subdivision (d)(3)(A) of this section.

(e) If a public record is in active use or storage and therefore not available at the time a citizen asks to examine it, the custodian shall certify this fact in writing to the applicant and set a date and hour within three (3) working days at which time the record will be available for the exercise of the right given by this chapter.

(0(1) No request to inspect, copy, or obtain copies of public records shall be denied on the ground that information exempt from disclosure is commingled with nonexempt information.

(2) Any reasonably segregable portion of a record shall be provided after deletion of the exempt information.

(3) The amount of information deleted shall be indicated on the released portion of the record and, if technically feasible, at the place in the record where the deletion was made.

(4) If it is necessary to separate exempt from nonexempt information in order to permit a citizen to inspect, copy, or obtain copies of public records, the custodian shall bear the cost of the separation.

(g) Any computer hardware or software acquired by an entity subject to § 25-19-103(5)(A) after July 1, 2001, shall be in full compliance with the requirements of this section and shall not impede public access to records in electronic form.

(h) Notwithstanding any Arkansas law to the contrary, at the conclusion of any investigation conducted by a state agency in pursuit of civil penalties against the subject of the investigation, any settlement agreement entered into by a state agency shall be deemed a public document for the purposes of this chapter. However, the provisions of this subsection shall not apply to any investigation or settlement agreement involving any state tax covered by the Arkansas Tax Procedure Act, § 26-18-101 et seq.

History. Acts 1967, No. 93, § 4; 1977, No. 652, § 2; Acts 1987, No. 49, § 1; 1989 (3rd Ex. Sess.), No. 8, § 1; 1993, No. 895, § 1; 1997, No. 540, § 52; 1997, No. 873, § 1; 1997, No. 1335, § 1; 1999, No. 1093, § 1; 2001, No. 1259, § 1; 2001, No. 1336, § 1; 2001, No. 1653, § 2; 2003, No. 213, § 1; 2003, No. 275, § 2; 2003, No. 763, § 2; 2003, No. 1214, § 1; 2005, No. 259, § 2; 2005, No. 2003, § 1.

A.S.A. 1947, § 12-2804.

25-19-106. Open public meetings.

(a) Except as otherwise specifically provided by law, all meetings, formal or informal, special or regular, of the governing bodies of all municipalities, counties, townships, and school districts and all boards, bureaus, commissions, or organizations of the State of Arkansas, except grand juries, supported wholly or in part by public funds or expending public funds, shall be public meetings.

(b)(1) The time and place of each regular meeting shall be furnished to anyone who requests the information.

(2) In the event of emergency or special meetings, the person calling the meeting shall notify the representatives of the newspapers, radio stations, and television stations, if any, located in the county in which the meeting is to be held and any news media located elsewhere that cover regular

meetings of the governing body and that have requested to be so notified of emergency or special meetings of the time, place, and date of the meeting. Notification shall be made at least two (2) hours before the meeting takes place in order that the public shall have representatives at the meeting.

(c)(1) Executive sessions will be permitted only for the purpose of considering employment, appointment, promotion, demotion, disciplining, or resignation of any public officer or employee. The specific purpose of the executive session shall be announced in public before going into executive session.

(2)(A) Only the person holding the top administrative position in the public agency, department, or office involved, the immediate supervisor of the employee involved, and the employee may be present at the executive session when so requested by the governing body, board, commission, or other public body holding the executive session.

(B) Any person being interviewed for the top administrative position in the public agency, department, or office involved may be present at the executive session when so requested by the governing board, commission, or other public body holding the executive session.

(3) Executive sessions must never be called for the purpose of defeating the reason or the spirit of this chapter.

(4) No resolution, ordinance, rule, contract, regulation, or motion considered or arrived at in executive session will be legal unless, following the executive session, the public body reconvenes in public session and presents and votes on the resolution, ordinance, rule, contract, regulation, or motion.

(5)(A) Boards and commissions of this state may meet in executive session for purposes of preparing examination materials and answers to examination materials that are administered to applicants for licensure from state agencies.

(B) Boards and commissions are excluded from this chapter for the administering of examinations to applicants for licensure.

(6)(A) Subject to the provisions of subdivision (c)(4) of this section, any public agency may meet in executive session for the purpose of considering, evaluating, or discussing matters pertaining to public water system security as described in § 25-19-105(b)(16).

(B) This subdivision (c)(6) shall expire on July 1, 2007.

History. Acts 1967, No. 93, § 5; 1975 (Extended Sess., 1976), No. 1201, § 1; 1985, No. 843, § 1; reen. Acts 1987, No. 1001, § 1; 1999, No. 1589, § 1; 2001, No. 1259, § 2; 2003, No. 763, § 3; 2005, No. 259, § 3.

A.S.A. 1947, § 12-2805.

25-19-107. Appeal from denial of rights - Attorney's fees.

(a) Any citizen denied the rights granted to him or her by this chapter may appeal immediately from the denial to the Pulaski County Circuit Court or to the circuit court of the residence of the aggrieved party, if an agency of the state is involved, or to any of the circuit courts of the appropriate judicial districts when an agency of a county, municipality, township, or school district, or a private organization supported by or expending public funds, is involved.

(b) Upon written application of the person denied the rights provided for in this chapter, or any interested party, it shall be mandatory upon the circuit court having jurisdiction to fix and assess a day the petition is to be heard within seven (7) days of the date of the application of the petitioner, and to hear and determine the case.

(c) Those who refuse to comply with the orders of the court shall be found guilty of contempt of court.

(d) In any action to enforce the rights granted by this chapter, or in any appeal therefrom, the court shall assess against the defendant reasonable attorney's fees and other litigation expenses reasonably incurred by a plaintiff who has substantially prevailed unless the court finds that the position of the defendant was substantially justified or that other circumstances make an award of these expenses unjust. However, no expenses shall be assessed against the State of Arkansas or any of its agencies or departments. If the defendant has substantially prevailed in the action, the court may assess expenses against the plaintiff only upon a finding that the action was initiated primarily for frivolous or dilatory purposes.

History. Acts 1967, No. 93, § 6; Acts 1987, No. 49, § 2.

A.S.A. 1947, § 12-2806.

25-19-108. Information for public guidance.

(a) Each state agency, board, and commission shall prepare and make available:

(1) A description of its organization, including central and field offices, the general course and method of its operations, and the established locations, including, but not limited to, telephone numbers and street, mailing, electronic mail, and Internet addresses and the methods by which the public may obtain access to public records;

(2) A list and general description of its records, including computer databases;

(3)(A) Its regulations, rules of procedure, any formally proposed changes, and all other written statements of policy or interpretations formulated, adopted, or used by the agency, board, or commission in the discharge of its functions.

(B)(i) Rules, regulations, and opinions used in this section shall refer only to substantive and material items that directly affect procedure and decision-making.

(ii) Personnel policies, procedures, and internal policies shall not be subject to the provisions of this section.

(iii) Surveys, polls, and fact-gathering for decision-making shall not be subject to the provisions of this section.

(iv) Statistical data furnished to a state agency shall be posted only after the agency has concluded its final compilation and result.

(4) All documents composing an administrative adjudication decision in a contested matter, except the parts of the decision that are expressly confidential under state or federal law; and

(5) Copies of all records, regardless of medium or format, released under § 25-19-105 which, because of the nature of their subject matter, the agency, board, or commission determines have become or are likely to become the subject of frequent requests for substantially the same records.

(b)(1) All materials made available by a state agency, board, or commission pursuant to subsection (a) of this section and created after July 1, 2003, shall be made publicly accessible, without charge, in electronic form via the Internet.

(2) It shall be a sufficient response to a request to inspect or copy the materials that they are available on the Internet at a specified location, unless the requester specifies another medium or format under § 25-19-105 (d)(2)(B).

History. Acts 2001, No. 1653, § 3.

25-19-109. Special requests for electronic information.

(a)(1) At his or her discretion, a custodian may agree to summarize, compile, or tailor electronic data in a particular manner or medium and may agree to provide the data in an electronic format to which it is not readily convertible.

(2) Where the cost and time involved in complying with the requests are relatively minimal, custodians should agree to provide the data as requested.

(b)(1) If the custodian agrees to a request, the custodian may charge the actual, verifiable costs of personnel time exceeding two (2) hours associated with the tasks, in addition to copying costs authorized by § 25-19-105(d)(3).

(2) The charge for personnel time shall not exceed the salary of the lowest paid employee or contractor who, in the discretion of the custodian, has the necessary skill and training to respond to the request.

(c) The custodian shall provide an itemized breakdown of charges under subsection (b) of this section.

History. Acts 2001, No. 1653, § 4.

23-61-103

Powers and duties; delegation of powers

Former Citations 66-2107; 66-2110

(a) The Insurance Commissioner shall enforce the provisions of the Arkansas Insurance Code and shall execute the duties imposed upon him or her by the Arkansas Insurance Code.

(b) The commissioner shall have the powers and authority expressly conferred upon him or her by or reasonably implied from the provisions of the Arkansas Insurance Code.

(c) The commissioner is authorized to enter into regulatory cooperation and coordination agreements with other governmental regulatory agencies within and outside of this state with respect to the regulation of the business of insurance, including, but not limited to:

- (1) Licensing of insurance companies;
- (2) Licensing of producers;
- (3) Regulation of premium rates and policy forms;
- (4) Regulation of insurer solvency and insurance receiverships; and
- (5) Other matters relating to the effective regulation of the business of insurance.

(d)(1) The commissioner may conduct such examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as he or she may deem proper to determine whether any person has violated any provision of the Arkansas Insurance Code or to secure information useful in the lawful administration of any such provision. The cost of these additional examinations or investigations shall be borne by the state.

(2) Notwithstanding any other provision of law, active investigatory or examination files as maintained by the State Insurance Department shall be deemed confidential and privileged and shall not be made open to the public until:

(A) The matter under investigation or examination is deemed closed by the commissioner; or

(B) Referred to any law enforcement authority and made subject to public disclosure by the authority.

(3) At such time that any matter investigated or examined has been set for an administrative hearing pursuant to § 23-61-304 or § 25-15-208, investigation or examination information shall be made available as provided in § 25-15-208.

(4) Unless otherwise exempted by subdivision (d)(5) of this section, actuarial formulas and assumptions certified by a qualified actuary are confidential and privileged when submitted to comply with a rate or form filing requirement of the department, including, but not limited to, any actuarial report:

(A) Required, submitted, or attached to any filing made to the department under § 23-67-211, for rate and form filings of an insurer, or to those submitted under § 23-63-216 for annual statements of an insurer; or

(B) Submitted to the department to comply with any form and rate filing requirement imposed by statute or rule upon licensed insurers, health maintenance organizations, fraternal benefit societies, and hospital and medical service corporations.

(5)(A) Subdivisions (d)(2) and (d)(4) of this section do not prohibit release by the commissioner of active investigatory or examination files:

(i) At the discretion of the commissioner, to a person or persons that the commissioner determines to be aggrieved or affected by the examination or investigation; or

(ii) To state, federal, or local law enforcement or regulatory agencies or private organizations established for tracking or preventing insurance violations, or to the National Association of Insurance Commissioners.

(B) This section shall have no effect on or application to any of the filings gathered or compiled in compliance with § 23-63-1201 et seq.

Text of subsection (d)(6) effective until 90 days after legislature adjourns

(6) Release of active investigatory or examination files as provided in subdivision (d)(4) of this section does not abrogate or modify the confidential nature of investigatory or examination files as provided in subdivision (d)(2) of this section.

Text of subsection (d)(6) effective 90 days after legislature adjourns

(6) Release of active investigatory or examination files under subdivision (d)(5) of this section does not abrogate or modify the confidential nature of investigatory or examination files under subdivision (d)(2) of this section.

(e)(1) The commissioner may delegate to any assistant, deputy, examiner, or employee of the department the exercise or discharge in the commissioner's name of any power, duty, or function, whether ministerial, discretionary, or of whatever character which may be vested by the Arkansas Insurance Code in the commissioner.

(2) The commissioner shall be responsible for the official acts of his or her deputy, assistant, examiner, or employee acting in the commissioner's name and by his or her authority.

Text of subsection (f) effective 90 days after legislature adjourns

(f)(1)(A) To the extent not otherwise governed by the Trade Practices Act, Section 23-66-201 et seq., Section 23-65-101 et seq., or a law or rule providing specific injunctive powers to the commissioner, if it appears to the commissioner upon sufficient grounds or evidence that any person has engaged in or is about to engage in any act or practice constituting a violation of an insurance law, rule, or order of this state, the commissioner may summarily order the person to cease and desist from the act or practice.

(B)(i) Upon the entry of the cease and desist order under subdivision (f)(1)(A) of this section, the commissioner shall promptly notify the person who is the subject of the order:

(a) That the order has been entered; and

(b) Of his or her right to a hearing concerning the order.

(ii) The notification shall include a copy of the order or a detailed statement of the reasons for the order.

(2)(A) A hearing shall be held under Section 23-61-301 et seq. on the written request of the person aggrieved by the cease and desist order under subdivision (f)(1)(A) of this section if the request is received by the commissioner within thirty (30) days of the date of the entry of the order or if ordered by the commissioner.

(B) If no hearing is requested and none is ordered by the commissioner, the order shall remain in effect until it is modified or vacated by the commissioner.

(C) If a hearing is requested or ordered, the commissioner after notice and opportunity for hearing:

(i) May affirm, modify, or vacate the order; and

(ii) Shall conduct the hearing within ten (10) days of the date a hearing is requested or ordered by the commissioner.

(3)(A) After issuance of an order under this subsection, the commissioner may apply to the Pulaski County Circuit Court to temporarily or permanently enjoin the act or practice and to enforce compliance with the insurance laws of this state.

(B) However, without issuing such an order, the commissioner may apply directly to the Pulaski County Circuit Court for relief.

(4) Upon a proper showing, a permanent or temporary injunction, restraining order, or writ of mandamus shall be granted.

(5)(A) The commissioner may also seek and the appropriate court shall grant, upon proper showing, any other ancillary relief that may be in the public interest.

(B) The relief may include:

(i) The appointment of a receiver, temporary receiver, or conservator;

(ii) A declaratory judgment;

(iii) An accounting;

(iv) A disgorgement of profits;

(v) The assessment of a fine not to exceed the total amount of money, property, or other value received in connection with an insurance law violation; or

(vi) Any other relief appropriate to protect the public interest.

(6) The commissioner is not required to post a bond as a condition for obtaining relief under this subsection.

(7) This subsection does not prohibit or restrict the informal disposition of a proceeding or allegations that might give rise to a proceeding by stipulation, settlement, consent, or default in lieu of a formal or informal hearing on the allegations or in lieu of the sanctions authorized by this subsection.

History	Acts 1959, No. 148, ss 22, 25; A.S.A 1947, ss 66-2107, 66-2110; Acts 1997, No. 956, s 1; 1999, No. 453, s 1; 2001, No. 1239, s 2, eff. 4-2-2001; 2009, SB 806, s 5, eff. 90 days after legislature adjourns; 2009, HB 2112, s 1, eff. 90 days after legislature adjourns.
Cited By	Rule and Regulation 53 s 1; Rule and Regulation 68 s 4; Bulletin 3-99; Bulletin 6-99; Bulletin 8-2001; Bulletin 6-2009; Order 91-12; Order 91-30; Order 95-31; Opinion 2007-004



**ARKANSAS
INSURANCE
DEPARTMENT**

400 University Tower Building ■ Little Rock, Arkansas 72204

W. H. L. Woodyard III
Insurance Commissioner

April 23, 1979

Ph. 501 371-1325

BULLETIN NO. 4-79
(SUPERSEDES BULLETIN NO. 3-74)

RE: INDIVIDUAL DISABILITY INSURANCE RATE FILINGS

Ark. Stat. Ann. §66-3209 provides that no rates for individual disability insurance policies may be used on policy forms issued in this State unless such rates have been filed with and approved by the Insurance Commissioner. Insurers making premium rate filings in compliance with this Act shall furnish the following data:

- (a) A description of the type of coverage and a designation of the policy or contract form number affected by the proposed rate. A separate filing must be made for each policy or contract form number. If the proposed rate is for a contract or policy form not currently approved for use in Arkansas, such form should accompany the filing.
- (b) If the proposed rate is a rate revision for a policy or contract form currently approved for use in Arkansas, a statement of the history of the rates.
- (c) A statement of the approximate number of persons in Arkansas affected by the proposed rates.
- (d) If the proposed rate is a rate revision for a policy or contract form currently approved, a description of the percentage rate increase; if not a level increase this statement should include the maximum, minimum and average rate increase.
- (e) If the proposed rate is a rate revision for a policy or contract form currently approved, a description of the latest three calendar years experience on an earned premium to incurred claim basis for the policy or contract form.
- (f) A statement as to how the proposed rate applies to anticipated experience or, if the proposed rate is a rate revision for a policy or contract form currently approved, a statement as to how the proposed rate applies to actual experience and anticipated experience.

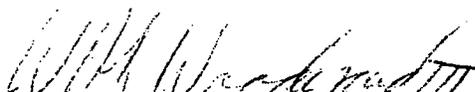
- (g) An actuarial certification indicating that, in the belief of the actuary, the proposed rate or rate revision does not discriminate unfairly between policyholders.

The completeness and accuracy of the data furnished in a filing should be certified to by an officer of the insurer. Two copies of the filing should be submitted to the Department.

A proposed rate revision for an individual disability insurance policy currently approved in the State of Arkansas will receive expedited approval by the Insurance Department if the following conditions are met:

- (a) The average rate increase is less than thirty percent;
- (b) The number of Arkansas citizens affected is less than one hundred;
- (c) No rate revision for the insurance product has become effective within the past twelve months;
- (d) The effective date of the proposed rate revision will be no earlier than the next policy anniversary following sixty days after the date of the filing;
- (e) Notice of the rate revision will be given to the policyholder at least thirty days prior to the first due date of the revised premium.

An insurer wishing to have a rate revision considered for expedited approval shall state in writing that the filing is being made for expedited approval in compliance with this bulletin. Upon receipt of a filing made for expedited approval the Department will, after it has been determined that the requisite conditions are met and the appropriate data furnished, stamp one copy of the filing approved and return it to the insurer. If the filing is found not to meet the conditions set forth in this paragraph, the Department will notify the insurer that the proposed rate revision will be subject to standard review procedures.


W. H. L. Woodyard, III
Insurance Commissioner



**ARKANSAS
INSURANCE
DEPARTMENT**

400 University Tower Building ■ Little Rock, Arkansas 72204

W. H. L. Woodyard III
Insurance Commissioner

July 31, 1981

Ph. 501 371-1325

BULLETIN NO. 12-81

TO: ALL AUTHORIZED LIFE & DISABILITY INSURERS
LICENSED IN THE STATE OF ARKANSAS

FROM: INSURANCE COMMISSIONER OF THE STATE OF ARKANSAS

RE: PROCEDURES FOR RATE AND FORM FILINGS
LIFE AND DISABILITY INSURANCE

- (1) A separate cover letter must be submitted for each form.
- (2) Two copies of both the cover letter and form must be submitted.
- (3) A self-addressed, postage paid envelope must be furnished for the return of the company's copy of the filing.
- (4) Two copies of the application must accompany the filing of the policy form.
- (5) While Arkansas does not have a policy filing fee, the appropriate fee must be paid on a retaliatory basis.
- (6) Act 258 of 1979, Readability, became effective July 19, 1981. Filings submitted without the proper certification required by Bulletin 14-79 will not be reviewed and will be returned to the company.
- (7) All life policy filings must be accompanied by a "detailed statement of method" of the non-forfeiture values, including formulas and specimen calculations. (Life only)
- (8) Even though Rule and Regulation 18 Revised does not state that the Outline of Coverage is to be submitted to the Department, our position is that it must accompany the form filing and must be reviewed by us. (Disability only)

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- (9) All individual health insurance rate filings must be accompanied by the actuarial data. The Department's position is that a projected loss ratio less than 50% is not a reasonable relationship between benefits and premiums. Single trip accident insurance is the only exception. (Disability only)



W. H. L. Woodyard III
Insurance Commissioner

Exhibit 6

1. AID AC CFRF	COMPANIES' FINANCIAL REGULATION FEE	ACCOUNTING
2. AID AC EST-Q	ESTIMATED INSURANCE PREMIUM TAX	ACCOUNTING
3. AID AC FBS	ANNUAL REPORT OF FEES OF ALL FRATERNAL BENEFIT SOCIETIES	ACCOUNTING
4. AID AC FPRF-Q	ESTIMATED FIRE PROTECTION PREMIUM TAX	ACCOUNTING
5. AID AC FMAA-T	ANNUAL REPORT OF PREMIUMS AND TAXES OF ALL FARMERS MUTUAL AID ASSOC	ACCOUNTING
6. AID AC FPRF	ANNUAL REPORT OF PREMIUMS AND TAXES OF AUTHORIZED AND FORMERLY AUTHORIZED P&C INSURERS FOR THE FIRE PROTECTION PREMIUM TAX FUND	ACCOUNTING
7. AID AC HMO-T	ANNUAL REPORT OF PREMIUMS, CO-PAYMENTS, TAXES AND FEES OF ALL OF HEALTH MAINTENANCE ORGANIZATIONS	ACCOUNTING
8. AID AC HM-T	ANNUAL REPORT OF PREMIUM TAXES HOSPITAL/MEDICAL SERVICE CORP	ACCOUNTING
9. AID AC LD-T	ANNUAL REPORT OF PREMIUMS, TAXES AND FEES OF ALL LIFE AND ACCIDENT AND HEALTH INSURANCE COMPANIES	ACCOUNTING
10. AID AC LD-T(D)	ANNUAL REPORT OF PREMIUMS, TAXES AND FEES OF ALL ARKANSAS DOMESTIC LIFE AND ACCIDENT AND HEALTH INSURANCE COMPANIES	ACCOUNTING
11. AID AC PC-T	ANNUAL REPORT OF PREMIUMS, TAXES AND FEES OF ALL PROPERTY & CASUALTY INSURANCE COMPANIES	ACCOUNTING
12. AID AC PC-T(D)	ANNUAL REPORT OF PREMIUMS, TAXES AND FEES OF ALL ARKANSAS DOMESTIC PROPERTY & CASUALTY INSURANCE COMPANIES	ACCOUNTING
13. AID AC RRG-T	ANNUAL REPORT OF PREMIUMS, TAXES AND FEES OF ALL REGISTERED RISK RETENTION GROUPS	ACCOUNTING
14. AID AC SL-2	AFFIDAVIT OF SURPLUS LINE BROKER	ACCOUNTING
15. AIC AC SL-4	ANNUAL STATEMENT OF SURPLUS LINE BROKER	ACCOUNTING
16. AID AC SLI-T	ANNUAL CONTINUATION FEE	ACCOUNTING
17. AID AC TI-T	ANNUAL REPORT OF PREMIUMS, TAXES AND FEES OF ALL TITLE AND AVIATION TITLE INSURANCE COMPANIES	ACCOUNTING
18. SCHEDULE WC	now collected by the ARKANSAS WORKERS' COMPENSATION COMMISSION	
19. AID AD SPEAKER	SPEAKER REQUEST FORM	ADMINISTRATION
20. AID CS COMPLAINT	CONSUMER COMPLAINT FORM	CONSUMER SERVICES

21. AID CS PROVIDER	HEALTH CARE PROVIDER COMPLAINT FORM	CONSUMER SERVICES
22. AID CI FRAUD	UNIFORM SUSPECTED INSURANCE FRAUD REPORTING FORM	CRIMINAL INVESTIGATION
23. AID FI CP	ASSIGNMENT AND PLEDGE OF CERTIFICATE OF DEPOSIT	FINANCE
24. AID FI EMLF	DEPOSIT AGREEMENT FOR EMPLOYEE LEASING FIRMS/GROUPS	FINANCE
25. AID FI NB/CP	NOTARY BOND SURETY CORP SECURITY DEPOSIT CERTIFICATE OF PLEDGE	FINANCE
26. AID FI NB/SUR	NOTARY BOND SURETY CORP SECURITY DEPOSIT-CERTIFICATE OF DEPOSIT	FINANCE
27. AID FI NB/SUR	NOTARY BOND SURETY CORP SECURITY DEPOSIT	FINANCE
28. AID FI RDC	RESERVE DEPOSIT CHECK FOR LICENSED LIFE &/OR ANNUITY COMPANIES	FINANCE
29. AID FI SEC/HMO-1	DEPOSIT AGREEMENT FOR HEALTH MAINTENANCE ORGANIZATION (HMO)	FINANCE
30. AID FI SEC/LD-1	DEPOSIT AGREEMENT FOR LIFE AND/OR DISABILITY INSURANCE	FINANCE
31. AID FI SEC/MC	DEPOSIT AGREEMENT FOR AUTOMOBILE CLUB OR ASSOCIATION	FINANCE
32. AID FI SEC/PC-1	DEPOSIT AGREEMENT FOR ALL KINDS OF INSURANCE OTHER THAN LIFE, DISABILITY OR SURETY	FINANCE
33. AID FI SEC/RP	REGISTERED POLICIES DEPOSIT FOR LIFE INSURANCE &/OR ANNUITY CONTRACTS	FINANCE
34. AID FI SEC/SPL-1	DEPOSIT AGREEMENT FOR SURPLUS LINES INSURANCE CARRIER	FINANCE
35. AID FI SEC/SUR-1	DEPOSIT AGREEMENT FOR SURETY INSURANCE ONLY	FINANCE
36. AID FI SEC/SVD-1	SPECIAL VOLUNTARY DEPOSIT AGREEMENT	FINANCE
37. AID FI SEC/SVD-2	SPECIAL VOLUNTARY DEPOSIT AGREEMENT FOR ALL POLICYHOLDERS & CREDITORS	FINANCE
38. AID FI SEC/SVD-3	SPECIAL VOLUNTARY DEPOSIT AGREEMENT	FINANCE
39. AID FI F1	APPLICATION FOR A PREPAID FUNERAL BENEFITS LICENSE	FINANCE-PREPAID
40. AID FI F2	APPLICATION FOR RENEWAL OF A PREPAID FUNERAL BENEFITS LICENSE	FINANCE-PREPAID
41. AID FI F3	AGREEMENT TO HOLD, INVEST AND ADMINISTER PREPAID FUNERAL BENEFITS TRUST	FINANCE-PREPAID
42. AID FI F4	CERTIFICATION OF NET WORTH BY APPLICANT FOR INITIAL LICENSE OR RENEWED LICENSE	FINANCE-PREPAID

43. AID FI F5	APPLICANT'S AFFIDAVIT OF NO EXISTING PREPAID CONTRACTS	FINANCE-PREPAID
44. AID FI F6	APPLICATION FOR CHANGE OF OWNERSHIP OF PREPAID FUNERAL BENEFITS CONTRACTS AND TRUST FUNDS	FINANCE-PREPAID
45. AID FI F7	ASSIGNMENT AND ACCEPTANCE OF PREPAID FUNERAL BENEFITS CONTRACTS AND TRUST FUNDS	FINANCE-PREPAID
46. AID FI F8	TRANSFeree'S CERTIFICATION OF NET WORTH IN A CHANGE OF OWNERSHIP TRANSACTION	FINANCE-PREPAID
47. AID FI F9	APPLICATION TO TRANSFER TRUST FUNDS	FINANCE-PREPAID
48. AID FI CA	CUSTODIAL AGREEMENT	FINANCE-PREPAID
49. AID FI C1	SELLER'S AFFIDAVIT OF CONTRACT PERFORMANCE: REQUEST TO WITHDRAW FUNDS OR PROCEEDS	FINANCE-PREPAID
50. AID FI C2	SELLER'S AFFIDAVIT FOR CANCELLATION AND REFUND OF PREPAID FUNERAL BENEFITS CONTRACT PROCEEDS	FINANCE-PREPAID
51. AID FI C3	AFFIDAVIT AND REQUEST OF PURCHASER TO CANCEL A PREPAID FUNERAL BENEFITS CONTRACT	FINANCE-PREPAID
52. AID-LI-AC	ADDRESS CHANGE FORM	LICENSE
53. AID-LI-ADJ	ADJUSTER LICENSE APPLICATION	LICENSE
54. AID-LI-ANF	ASSUMED BUSINESS NAME	LICENSE
55. AID-LI-ARF-RBE	REPLACEMENT LICENSE RENEWAL FOR BUSINESS ENTITIES	LICENSE
56. AID-LI-ARF-RP	REPLACEMENT LICENSE RENEWAL FOR PRODUCERS	LICENSE
57. AID-LI-I48	AGENT APPOINTMENT	LICENSE
58. AID-LI-I48-A	AMEND AGENCY APPOINTMENT	LICENSE
59. AID-LI-I48-AGENCY	AGENCY APPOINTMENT	LICENSE
60. AID-LI-I71	APPOINTMENT TERMINATION	LICENSE
61. AID-LI-MGA40	MANAGING GENERAL AGENT LICENSE APPLICATION	LICENSE
62. AID-LI-MGA41	MANAGING GENERAL AGENT COMPANY APPOINTMENT	LICENSE
63. AID-LI-MGA42	MANAGING GENERAL AGENT TERMINATION OF APPOINTMENT	LICENSE

64. AID-LI-MGA43	MANAGING GENERAL AGENT BOND	LICENSE
65. AID-LI-MGA45	MANAGING GENERAL AGENT CONTRACT	LICENSE
66. AID-LI-CAR	RENTAL CAR COMPANY APPLICATION	LICENSE
67. AID-LI-RP	RESIDENT PRODUCER LICENSE APPLICATION	LICENSE
68. AID-LI-SELF	SELF-FUNDED, TRUSTS, METS AND MEWAS	LICENSE
69. AID-LI-SLB	SURPLUS LINES BROKER/PRODUCER LICENSE APPLICATION	LICENSE
70. AID-LI-SLBB	SURPLUS LINES BROKER/PRODUCER BOND	LICENSE
71. AID-LI-SLBE	SURPLUS LINES PRODUCER FOR BUSINESS ENTITY APPLICATION	LICENSE
72. AID-LI-TA	TITLE AGENT	LICENSE
73. AID-LI-TAGY	TITLE AGENCY	LICENSE
74. AID-LI-ARF-TI-AGY-R	TITLE AGENCY REPLACEMENT RENEWAL FORM	LICENSE
75. AID-LI-AGY-ADD-TI	TITLE AGENCY PRODUCER ADDITION	LICENSE
76. AID-LI-AGY-TERM-TI	TITLE AGENCY PRODUCER TERMINATION	LICENSE
77. AID-LI-TPA	THIRD PARTY ADMINISTRATOR	LICENSE
78. AID-LI-TPA-BOND	THIRD PARTY ADMINISTRATOR BOND	LICENSE
79. AID-LI-UBE	UNIFORM BUSINESS ENTITY	LICENSE
80. AID-LI-AGY-ADD	BUSINESS ENTITY PRODUCER ADDITION	LICENSE
81. AID-LI-UBE-TERM	BUSINESS ENTITY PRODUCER TERMINATION	LICENSE
82. AID-LI-LSBI	LIFE SETTLEMENT BROKER INDIVIDUAL APPLICATION	LICENSE
83. AID-LI-LSBE	LIFE SETTLEMENT BROKER BUSINESS ENTITY APPLICATION	LICENSE
84. AID-LI-LSPN	LIFE SETTLEMENT PRODUCER NOTICE FORM	LICENSE
85. AID-LH-LSP	LIFE SETTLEMENT PROVIDER APPLICATION	LIFE & HEALTH

86. AID-LH-LSPA	LIFE SETTLEMENT PROVIDER ANNUAL REPORT	LIFE & HEALTH
87. APCGF-1	MANDATORY PROPERTY & CASUALTY GUARANTY FUND INFORMATION SHEET	LIQUIDATION
88. AR-3	PHYSICIANS REPORT OF INJURY AND TREATMENT	PUBLIC EMPLOYEE CLAIMS
89. AR-D	DEATH & PERMANENT TOTAL DISABILITY ACCEPTANCE/UPDATE	PUBLIC EMPLOYEE CLAIMS
90. AR-N	EMPLOYEE'S NOTICE OF INJURY	PUBLIC EMPLOYEE CLAIMS
91. AR-S	SUPPLEMENTAL REPORT	PUBLIC EMPLOYEE CLAIMS
92. AR-V	VERIFICATION OF PERMANENT TOTAL DISABILITY	PUBLIC EMPLOYEE CLAIMS
93. AR-W	WAGE STATEMENT IMMEDIATELY PRECEDING INJURY DATE	PUBLIC EMPLOYEE CLAIMS
94. IA-1	WORKERS COMPENSATION -FIRST REPORT OF INJURY OR ILLNESS	PUBLIC EMPLOYEE CLAIMS
95. MILEAGE	MILEAGE REIMBURSEMENT FORM	PUBLIC EMPLOYEE CLAIMS
96. PECD1	EMPLOYEE'S REPORT OF ACCIDENT-PUBLIC EMPLOYEE CLAIMS DIVISION	PUBLIC EMPLOYEE CLAIMS
97. PECD2	INFORMATION REQUESTED BY PUBLIC EMPLOYEE CLAIMS DIVISION	PUBLIC EMPLOYEE CLAIMS
98. AID PC ADVMAIL	ADVISORY ORGANIZATION--UPDATED CONTACT INFORMATION	PROPERTY & CASUALTY
99. AID PC APCS	AUTOMOBILE PREMIUM COMPARISON SURVEY	PROPERTY & CASUALTY
100. AID PC ARRUA	ARRUA FORM	PROPERTY & CASUALTY
101. AID PC EC	EARTHQUAKE COVERAGE REPORT	PROPERTY & CASUALTY
102. PEO-P	PROFESSIONAL EMPLOYER ORGANIZATION (PEO) APPLICATION	PROPERTY & CASUALTY
103. PEO-G	GROUP PEO APPLICATION	PROPERTY & CASUALTY
104. PEO-E	PEO EXEMPT APPLICATION	PROPERTY & CASUALTY
105. ESAO-A1	EMPLOYER ASSURANCE SERVICE ORGANIZATION APPLICATION	PROPERTY & CASUALTY
106. PEO-C	CHANGE OF CONTROL OF A PEO FORM	PROPERTY & CASUALTY
107. PEO-PR	PEO RENEWAL APPLICATION	PROPERTY & CASUALTY

108.	PEO-GR	GROUP PEO RENEWAL APPLICATION	PROPERTY & CASUALTY
109.	PC EL-Quarterly RPT	PEO QUARTERLY REPORT	PROPERTY & CASUALTY
110.	AID PC F-1	FORM FILING ABSTRACT	PROPERTY & CASUALTY
111.	AID PC FEE1	FEE SCHEDULE FOR PROPERTY & CASUALTY INSURERS	PROPERTY & CASUALTY
112.	AID PC FEE2	MISCELLANEOUS FEE SCHEDULE	PROPERTY & CASUALTY
113.	AID PC H-1	HOMEOWNERS ABSTRACT	PROPERTY & CASUALTY
114.	AID PC HPCS	HOMEOWNERS PREMIUM COMPARISON SURVEY	PROPERTY & CASUALTY
115.	AID PC MHPCS	MOBILEHOMEOWNERS PREMIUM COMPARISON SURVEY	PROPERTY & CASUALTY
116.	AID PC PG RENEW	PURCHASING GROUP RENEWAL REGISTRATION FORM	PROPERTY & CASUALTY
117.	AID PC PGAPP	PURCHASING GROUP-NOTICE AND REGISTRATION	PROPERTY & CASUALTY
118.	AID PC PGMAIL	PURCHASING GROUP--UPDATED CONTACT INFORMATION	PROPERTY & CASUALTY
119.	AID PC PGRENEW	PURCHASING GROUP RENEWAL REGISTRATION FORM	PROPERTY & CASUALTY
120.	AID PC RF-1	RATE FILING ABSTRACT	PROPERTY & CASUALTY
121.	AID PC RF-2	INSURER RATE FILING	PROPERTY & CASUALTY
122.	AID PC RF-WC	WORKERS' COMPENSATION ABSTRACT	PROPERTY & CASUALTY
123.	AID PC RRFT	PROPERTY & CASUALTY TRANSMITTAL DOCUMENT	PROPERTY & CASUALTY
124.	AID PC SELF	REPORT OF INDEPENDENTLY-PROCURED INSURANCE TAX	PROPERTY & CASUALTY
125.	AID PC SLMAIL	SURPLUS LINES--UPDATED CONTACT INFORMATION	PROPERTY & CASUALTY
126.	AID PC SL-3	DISCLOSURE TO SURPLUS LINE INSURED	PROPERTY & CASUALTY
127.	AID RM ADD VEHICLE	REQUEST TO ADD VEHICLES TO STATE MASTER VEHICLE POLICY	RISK MANAGEMENT
128.	AID PS ADD VEHICLE	REQUEST TO ADD VEHICLES TO THE SCHOOL VEHICLE POLICY	RISK MANAGEMENT

SHIIP uses an online database to track the people we help called SHIPTalk.org. We also have an access database the AID IS folks built for us to track phone calls, emails, etc. SHIIP and AID were required to sign a data use agreement detailing our access to the information and how we can use it. If you're interested in tying in SHIIP records we need to review the agreement and see what is allowed.

Insurance Department Data of Potential Interest to HIT

September 15, 2010

The information currently maintained by the Insurance Department is information brought together to support insurance regulation. As the role of the Department evolves in light of the Affordable Care Act, new types of information will be added. So far the new information that has been identified as a result of the Rate Review and Ombudsman grant programs is information that will be built upon the current base of Department information. We'll learn more about the Health Insurance Exchange information as we go through the planning stage.

Health Insurance Company Licensing –

Finance Division
LION Database

Health Insurance Producer Licensing, CE, Appointments –

Licensing Division
LION Database

Health Insurance Rate and Form Filings –

Life & Health Division
SERFF (NAIC), L&H
Master Ledger

Health Insurance Consumer Complaints –

Consumer Services Division
Complaints Database

Public Employee Workers Comp Claims with Pharmacy –
Benefits Management

Public Employee Claims Div
Various PECD Databases

Seniors Health Information –

**Seniors Health Insurance
Information Program (SHIIP)**
SHIIP Web Page

Health Insurance Fraud Reporting –

Criminal Investigations Div
CID Web Page

Receivership Worker's Comp Insurance Claims –

Liquidation Division
Electronic claims (payment)
information, National
Liquidation Application (NAIC)

Rate Review Grant Project Data –

Life & Health Division
SERFF (NAIC), Rate Review
Database

Ombudsman Grant Project Data –

Ombudsman Staff
Ombudsman Database

Arkansas Insurance Department

Mike Beebe
Governor



Jay Bradford
Commissioner

BULLETIN NO. 9-2010

TO: ALL ENTITIES MAKING RATE AND FORM FILINGS WITH THE LIFE AND HEALTH, PROPERTY AND CASUALTY DIVISIONS AND OTHER INTERESTED PARTIES

FROM: ARKANSAS INSURANCE DEPARTMENT

SUBJECT: MANDATORY SERFF FILINGS

DATE: NOVEMBER 2, 2010

Effective March 1, 2011, the Arkansas Insurance Department (AID) will no longer accept paper filings. All filings submitted on or after March 1, 2011 must be filed via the System for Electronic Rate and Form Filing ("SERFF"). Additionally, AID mandates the use of Electronic Funds Transfer (EFT) of filing fees as EFT will further expedite disposition of filings.

SERFF enables the submission of rate and form filings electronically and facilitates electronic storage, management, analysis, and communication regarding filings. It improves the efficiency of the rate and form filing and approval processes and reduces the time and cost involved in making filings.

Insurers, rating organizations, and authorized filers may sign up for SERFF by contacting the SERFF Marketing Team at 816-783-8787 or via email at serffmktg@naic.org. More information about SERFF, including the SERFF vs Industry Manual, may be found on the SERFF website at www.serff.com. Formal training is offered to allow insurers to more fully utilize SERFF. Training information is available at www.serff.com/services_support/training.htm.

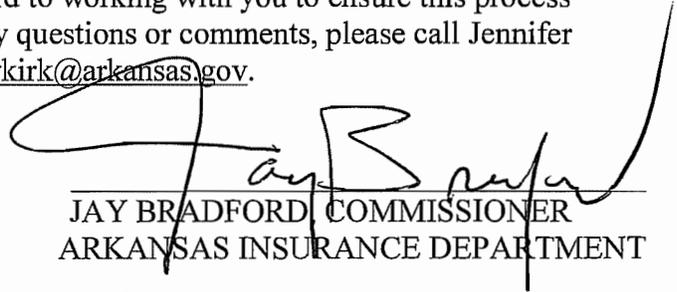
Additionally, AID mandates the use of Electronic Funds Transfer (EFT) of filing fees, as EFT will further expedite filings.

Should your organization believe that it will be unable to comply with this requirement by March 1, 2011; you must provide written notice to the Commissioner no later than December 15, 2010. Such notice must specify the reasons why compliance with this requirement constitutes a hardship for you organization.

Pursuant to A.C.A. §23-73-102(b), Farm Mutual Insurance Associations are not subject to the definition of insurer set forth in §23-60-102(2) and thus exempt from the requirements of this bulletin. Additionally, Surplus Lines writers are exempt from the requirements of this bulletin,

as they are not required to file rates or forms pursuant to A.C.A. §23-67-203(10) and A.C.A. §23-79-109(a)(1)(B)(xvii).

We thank for your cooperation and look forward to working with you to ensure this process works as smoothly as possible. If you have any questions or comments, please call Jennifer Newkirk at 501-371-2765, or email her at jnewkirk@arkansas.gov.



JAY BRADFORD, COMMISSIONER
ARKANSAS INSURANCE DEPARTMENT

November 2, 2010
DATE

The System for Electronic Rate and Form Filing (SERFF)

SERFF is a smart Internet application designed to provide an efficient process for rate and form filing. The SERFF application provides for the submission of electronic rate and form filings and facilitates electronic storage, management analysis, and communication regarding filings and their disposition. The system is designed to improve the accuracy of rate and form filings, speed approval processes, and reduce the time and cost associated with the regulatory filing process. Using SERFF, insurance companies submit rate and form filings to the State Departments of Insurance for approval of newly developed products as well as rate or other changes to existing products.

Increased SERFF functionality is being provided in order to enable compliance with Section 1003 of the Affordable Care Act of 2010. (P.L. 111-148). Modifications to SERFF will allow for improved data collection and reporting requirements related to the required review of health insurance premiums by the states. Specific changes will address requirements defined in Sections V.A.1(c) (1) and V.A.1(c) (2) of the Department of Health and Human Services (HHS), *Grants to States for Health Insurance Premium Review – Cycle I: Initial Announcement, Invitation to Apply for FY 2010* and such other related requirements issued by HHS subsequent to this agreement. Specific enhancements will include but not be limited to:

- a) State-maintained indicator for rate filing requests meeting the Department of Health and Human Services' (HHS) threshold for "unreasonable." This will allow the states to track filings that were determined to meet the HHS definition of "unreasonable".
- b) Addition of field to indicate product types such as PPO, POS, HSA, HMO, etc.
- c) Addition of product, policy, market segment and block information for the filings.
- d) Enhancements to SERFF to provide Health Insurance Premium Review (HIPR) data on a filing basis, including information regarding percent rate change requested and approved, number of affected insureds and policy holders, new and prior annual dollar rate, total projected and prior earned premium rate on an annual basis, and total prior year and projected incurred claims.
- e) Changes to the State Application Programming Interface (API) to accommodate retrieval of the data elements added above and to allow for updates of appropriate data elements via the State API. This will allow the states to access all of the data collected in SERFF via the use of web services. The states can then use this information for their own analysis and trending.
- f) Support the ability to satisfy reporting requirements within the format of the HHS issued uniform template for data reporting.



The following three sections apply to those premium increases that meet the “unreasonable” test under Section 2794 of the Public Health Service Act. Health insurance issuers are required to submit the information required under these three sections and a complete rate filing which includes a justification for the premium increase to the Secretary and the relevant state prior to the implementation of the increase.

Section I - Rate Filing Disclosure Form

A: Issuer Information and Type of Plan

1. Name of the Health Insurance Issuer	
2. NAIC Company Code	
3. Name of State in which the Rate was Filed	
4. Type of Plan (Individual, Small Group, Large Group, or Conversion)	
5. SERFF Tracking Number(s) for Filing	
6. State Tracking Number	
7. Policy Form Number(s)	
8. Plan Name(s)	
9. Product Type (HMO, PPO, etc...)	
10. Brief Description of Deductible, Copayment and Coinsurance	
11. Open or Closed Block of Business	

B: Rate Request

1. Proposed Effective Date	
2. Number of Covered Persons in this State	
3. Number of Covered Persons Under the Plan(s) Nationwide	
4. Proposed Average Rate Increase/Decrease* [show as % and Average Per Member Per Month (PMPM) increase/decrease from one year earlier]	%
	Increase/decrease from PMPM to PMPM
5. Minimum Rate Increase/Decrease for any Individual* [show as % and Average Per Member Per Month (PMPM)]	%
	Increase/decrease from

increase/decrease from one year earlier]	PMPM to	PMPM
6. Maximum Rate Increase/Decrease for any Individual* [show as % and Average Per Member Per Month (PMPM) increase/decrease from one year earlier]	%	
	Increase/decrease from	
	PMPM to	PMPM

**The average rate does not mean that the premium will increase/decrease by this amount. Premiums are affected by many factors, including ages of the people covered, whether family members are covered and the date the policy renews. The "Minimum/Maximum Rate Increase for any Individual" is to capture the minimum/maximum premium increase for any individual within this block of business.*

C: Components of the Average Rate Increase/Decrease and Basis for Rate Request

Break down the "Proposed Average Rate Increase/Decrease" into the following components of rate changes (in percentage):

1. Medical** Utilization Changes	%
2. Medical** Price Changes	%
3. Medical** Benefit Changes Required by Law	%
4. Medical** Benefit Changes Not Required by Law	%
5. Changes to Administration Costs	%
6. Insufficiency of Prior Rates (continuing losses that need to be covered by additional rate – not a recovery of previous losses, but a projection of continued shortfall from target)	%
7. Other Reasons for the Rate Request	%
8. Provide a Simple Calculation of how the Average Rate Increase/Decrease is derived based on the above components of rate changes	

***Medical includes Prescription Drug*

D: Earned Premiums, Incurred Claims, and Underwriting Gain/Loss Per Member Per Month (PMPM) for the 12-Month Experience Period for the Plans Included in this filing filed with this State and for Nationwide if the Plans are Available in Other States

1. (a). Reported 12-Month Period: From (month/year) to (month/year)
- (b). Member Months:

	This State	Nationwide
2. Earned Premiums Excluding Federal and State Taxes and Licensing or Regulatory Fees	PMPM	PMPM
3. Reimbursement for Clinical Services Provided to Enrollees	PMPM	PMPM

4. Activities That Improve Health Care Quality	PMPM	PMPM
5. Federal and State Taxes and Licensing or Regulatory Fees	PMPM	PMPM
6. Administrative Costs Allocated or Assigned to the Plans Reported in this Filing, Excluding Items 4 and 5 Above and by the Following Categories:		
a) Total annual compensation of the ten highest paid officers or employees,	PMPM	PMPM
b) Total annual compensation for staff other than ten highest paid officers or employees,	PMPM	PMPM
c) Agents and brokers fees and commissions, and	PMPM	PMPM
d) Other General and Administrative Expenses	PMPM	PMPM
e) Total = a+b+c+d	PMPM	PMPM
7. Underwriting Gain/Loss (Line 2 – (Lines 3 + 4 + 6))	PMPM	PMPM

E: Projected Results of the Proposed Rates

A health insurance premium is made up of items 3 through 7 listed in D. If the requested rate change is implemented, the issuer projects the following changes:

	This State	Nationwide
1. Reimbursement for Clinical Services Provided to Enrollees as a Percentage of Premiums:	Will change from % (Section I.D.3 as a percentage of Section I.D.2) to %	Will change from % (Section I.D. 3 as a percentage of Section I.D. 2) to %
2. Activities That Improve Health Care Quality as a Percentage of Premiums:	Will change from % (Section I.D.4 as a percentage of Section I.D. 2) to %	Will change from % (Section I.D. 4 as a percentage of Section I.D. 2) to %
3. Federal and State Taxes and	Will change from %	Will change from %

Licensing or Regulatory Fees as a Percentage of Premiums:	(Section I.D.5 as a percentage of Section I.D. 2) to %	(Section I.D. 5 as a percentage of Section I.D. 2) to %
4. Administrative Costs as a Percentage of Premiums:	Will change from % (Section I.D.6 as a percentage of Section I.D. 2) to %	Will change from % (Section I.D.6 as a percentage of Section I.D.2) to %
5. Underwriting Gain/Loss as a Percentage of Premiums:	Will change from % (Section I.D.7 as a percentage of Section I.D. 2) to %	Will change from % (Section I.D.7 as a percentage of Section I.D. 2) to %

F: List the Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years

Calendar Year	Requested This State	Implemented This State	Implemented Nationwide
	%	%	%
	%	%	%
	%	%	%

Section II - Summary of the Rate Filing

A: Issuer Information and Type of Plan

Provide the description of the issuer, type of plan, SERFF tracking numbers(s) if applicable, policy form number(s), and plan design.

B: Rate Request

Provide a brief description of the carrier's rate-making methodology, including identification of the data used and the kinds of the assumptions and projections made, and the rating requirements specifically required by this State. If this State's data is not credible, describe how a larger set of data is used and how the credibility factors are applied in order to derive the rate projection. List the average number of covered persons during the experience period for this state and for nationwide, and the average proposed rate change. Provide the description of the calculation for the average rate increase/decrease and the minimum/maximum rate change for any individual, including built-in trend factors, duration factors, age, geography, family size, industry, health status and other rating factors used to calculate the average rate

increase/decrease or the minimum/maximum rate change. Include a detailed description of how the average rate increase/decrease and the minimum/maximum rate change are translated into the increase/decrease per member per month (PMPM). Provide an illustrative example if necessary. List the rating requirements (such as adjusted community rating) and citations of the rating requirements specifically required by this state.

C: Component of the Average Rate Increase and Basis for Rate Request

Provide a detailed description of each component of rate changes listed in C of the Rate Filing Disclosure Form and the calculation of the overall average rate increase/decrease derived from these components. . List benefits changes required by law, and not required by law, including changes to deductible, copayment, coinsurance and essential health benefits defined under Section 1302(b) of the Patient Protection and Affordable Care Act. Provide reasons for the benefits changes not required by law.

D: Earned Premiums, Incurred Claims, and Underwriting Gain Loss Per Member Per Month (PMPM) for the 12-Month Experience Period for the Plans Included in this filing filed with this State and for Nationwide if the Plans are Available in Other States

Provide each item listed in D of the Rate Filing Disclosure Form for the 12-month experience period from this state and nationwide. List and explain in detail all adjustments in earned premiums, such as state assessments, collections or receipts for risk adjustment and risk corridors, and payments of reinsurance. List all activities that improve health care quality.

E: Projected Results of the Proposed Rates

Include detailed calculations of each item listed in E of the Rate Filing Disclosure Form. Provide all justifications of any adjustments used to calculate these projected results.

F: List the Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years

Show rate changes on an annual basis by calendar year. Provide an explanation of how these calendar-year rate changes were translated from past rate filings.

G: Additional Comments

Provide additional comments from an officer on the reasons for the rate change including the following topics:

1. Whether certain benefits have been reduced or enhanced in order to steer members away from less effective or less cost-effective services,
2. Any efforts toward cost containment and quality improvement, especially those inaugurated since the insurer's last rate filing, and
3. How rate changes can vary depending on rating factors, with examples.

Section III – Documentation and Justification Required for a Rate Filing

Each rate filing must include the following information and documents:

1. A description of the health insurance issuer's rate-making methodology, including a description of the benefit plan and any changes to the benefit plan design, identification of the data used and the kinds of assumptions and projections made, and the rating requirements specifically required by this State. If this State's data is not credible, describe how a larger set of data is used and how the credibility factors are applied in order to derive the rate projection.
2. The number of covered persons for the plans included in this filing. These numbers must be shown for each month of the experience period and the prior two (12-month) periods by plan and in aggregate if two or more plans are included in the rate filing.
3. Earned premiums for each month of the experience period and the prior two (12-month) periods by plan and in aggregate if two or more plans are included in the rate filing.
4. Incurred claims for clinical services provided to enrollees as referenced in Section 2718 of the Public Health Service Act for the plans included in this rate filing for each month of the experience period and the prior two (12-month) periods, and breakdown by the following categories:
 - a) Inpatient Hospital,
 - b) Outpatient Hospital,
 - c) Physician Services,
 - d) Pharmacy,
 - e) Laboratory,
 - f) Imaging,
 - g) Emergency Room, and
 - h) Others
5. A breakdown of the health insurance issuer's expenses allocated or assigned to the plans included in this rate filing for the experience period and the prior two (12-month) periods at least as detailed as the categories listed below. Provide the documentation and justification of the assignment or allocation of the expense to the plans included in this rate filing.
 - a) Activities that improve health care quality as referenced in Section 2718 of the Public Health Service Act ,

- b) Federal and state taxes and licensing or regulatory fees as referenced in Section 2718 of the Public Health Service Act ,
 - c) Total annual compensation of the ten highest paid officers or employees,
 - d) Total annual compensation for staff other than ten highest paid officers or employees,
 - e) Agents and brokers fees and commissions, and
 - f) Other General and Administrative Expenses.
6. A detailed calculation and documentation of the proposed rate change including but not limited to the following:
- a) Earned premiums for the experience period, premiums adjusted to the current rate level, and the projected earned premiums.
 - b) Incurred claims for the experience period, and the projected claims.
 - c) Trend factors and detailed development.
 - d) Impacts on claims due to benefit changes.
 - e) Projected breakdown of the expenses as a dollar amount and as a percentage of projected earned premiums by the following categories:
 - Activities that improve health care quality as referenced in Section 2718 of the Public Health Service Act ,
 - Federal and state taxes and licensing or regulatory fees as referenced in Section 2718 of the Public Health Service Act ,
 - Total annual compensation of the ten highest paid officers or employees,
 - Total annual compensation for staff other than ten highest paid officers or employees,
 - Agents and brokers fees and commissions,
 - Other General and Administrative Expenses,
 - Any credit from forecasted investment earnings on claim reserves or other similar liabilities, and
 - A reasonable provision for projected profit, contribution to surplus, contingency charges, or risk charges. For the purposes of this section, “projected profit, contribution to surplus, contingency charges, or risk charges” means the portion

of the “projected earned premiums” not associated directly with the “claims” or “expenses.”

- f) Factors used to derive the projected rate change and the specific rate for any individual, employee, or employer including built-in trend factors, duration factors (such as durational loss ratio), age, geography, family size, industry, health status and other applicable rating factors.
 - g) Documentation and justification for the credibility factors used in the rate projection if the experience of the plans included in the rate filing is not credible.
 - h) Changes to the rating factors from prior rate filing to this rate filing and the impacts on the rate projection. Health insurance issuer must provide a justification for the changes to the rating factors. For example, if the age factors are modified from the prior rate filing, the issuer must show that the revenues projected before and after changing the age factors are the same.
 - i) Base rates and plan relativities if two or more plans are included in the rate filing. For the purposes of this section, base rate means the rate for any plan prior to the adjustment for any rating factors. The plan relativities mean the relative values of the benefit plan.
 - j) Description of the methodology used to adjust the base rate to obtain the premium rate for a specific individual or group, including the minimum and maximum rate change for any individuals or covered persons, the range of rate change by the distribution of members or groups. The methodology must be detailed enough to allow the reviewer to replicate the calculation of premium rates if given the necessary data.
7. Provide the documentation and calculations of the overall average rate increase and each component of rate change as described in C of the Rate Filing Disclosure Form. Efforts should be made to break down the medical utilization and price changes consistent with the data required under this section and into the following categories: inpatient hospital, outpatient hospital, physician, pharmacy, laboratory, imaging, emergency room, and other.
8. A certification by a member of the American Academy of Actuaries that rates for the plans included in this filing are reasonable in relation to the benefits provided.
9. The requirements of subsections (2) through (7) may be modified by the health insurance issuer if a reasonable explanation is provided. For example, if the rate filing involves capitation contracts that would make it difficult to breakdown the categories as required by subsection (4), the issuer may modify the categories for the purposes of reporting.

10. Since the rate filing cannot be understood without a wider understanding of the company, a link referencing a website from which the health insurance issuer's most recent Annual Statement may be accessed. The following pages or Exhibits from the most recent Annual Statement provide information that can be helpful in understanding the insurer's financial position:

- Assets
- Liabilities, Capital, and Surplus
- Statement of Revenue and Expenses
- Analysis of Operations by Line of Business
- Underwriting and Investment Exhibit—Analysis of Expenses
- Exhibit of Net Investment Income
- Exhibit of Capital Gains (Losses)
- Enrollment by Product Type for Health Business Only (Exhibit 1 of the Health Annual Statement Blank)
- Summary of Transactions with Providers (Exhibit 7 of the Health Annual Statement Blank).
- Notes to Financial Statements
- General Interrogatories
- Five-Year Historical Data
- Exhibit of Premiums, Enrollment, and Utilization
- Management's Discussion and Analysis
- Accident and Health Policy Experience Exhibit
- Supplemental Compensation Exhibit
- Supplemental Health Care Exhibit (now being developed by E Committee)

(Note: The data included in the Annual Statement is companywide information and reported on a calendar year basis. The data submitted in the rate filing is information assigned or allocated to the plans referenced in the rate filing and may not be on a calendar year basis.)

Definition and Glossary of Terms: *Some items mentioned throughout these three sections are yet to be determined. (For example, what kind of activities can be classified as activities that improve health quality?) It is recommended that a link to the Definition and Glossary of Terms be included.*

Actuarial Memorandum - Arkansas
October 19, 2009

Managed Care Major Medical Plans A3601-A3606

1. Purpose of Filing

This actuarial memorandum is intended to describe the proposed rate change for Plans A3601-A3606 and demonstrate compliance with minimum loss ratio standards and may not be suitable for other purposes.

2. General Description

Plans A3601-A3604 were first issued in October/November, 1997. Plans A3605-A3606 were introduced starting late in 1999. Plans A3605-A3606 are not available in all states. Sales in all states have been discontinued.

Deductibles range from \$500 to \$10,000. After the deductible is satisfied, a stop-loss applies. This amount varies by plan and, in many cases, by in-network vs. out-of-network, ranging from \$2,500 for the A3602 to \$20,000 for the A3606 out-of-network charges. Other major differences between the plans are:

Plan	Coinsurance	Pharmacy Co-pay	Office Visit Co-pay
A3601	80% in / 80% out	\$10 in / \$20 out	\$15 in / \$15 in
A3602	50% in / 50% out	\$10 in / \$20 out	\$15 in / \$15 out
A3603	90% in / 70% out	\$10 in / \$20 out	\$15 in / \$30 out
A3604	80% in / 60% out	\$10 in / \$20 out	\$15 in / \$30 out
A3605	70% in / 50% out	see below	\$20 in / s.t. deduct. out
A3606	50% in / 50% out	s.t. deduct.	\$20 in / s.t. deduct. out

The pharmacy co-pay only applies to deductibles less than \$2,500 and the office visit co-pay only applies to deductibles less than \$5,000. The pharmacy co-pay on the A3605 is \$15 for in-network generic prescriptions, \$30 or 50% of the cost for in-network brand-name prescriptions, after a separate \$100 prescription drug deductible. Out-of-network prescriptions on the A3605 are subject to the deductible and coinsurance.

xxxx changed the pharmacy co-pays and office visit co-pays on Plans A3601-A3604 to reflect higher costs. These changes were effective starting April 1, 2001.

In network, the pharmacy co-pay is now:

- \$10 or 20 percent of the cost (whichever is greater) for generic drugs
- \$20 or 30 percent of the costs (whichever is greater) for brand drugs on the formulary
- \$30 or 50 percent of the costs (whichever is greater) for brand drugs not on the formulary

Outside the network, the co-pay is \$40 or 50 percent of the costs, whichever is greater.

On PPO plans, the doctor's office visit co-pay, in network, is now:

- \$20 at in-network providers
- \$40 at out-of-network providers

For non-PPO plans, the office visit co-pay is now \$20.

xxx also implemented additional benefit changes on these plans, effective April 1, 2002 in most states.

Plans A3601-A3604:

In network, the pharmacy co-pay is:

- \$15 or 20 percent of the cost (whichever is greater) for generic drugs
- \$25 or 30 percent of the costs (whichever is greater) for brand drugs on the formulary
- \$35 or 50 percent of the costs (whichever is greater) for brand drugs not on the formulary

Outside the network, the co-pay is \$45 or 50 percent of the costs, whichever is greater.

On PPO plans, the doctor's office visit co-pay, in network, is:

- \$30 at in-network providers
- \$50 at out-of-network providers

For non-PPO plans, the office visit co-pay is \$30.

Previously, these plans all had the same deductible for in-network and out-of-network benefits. This has changed, using an additional \$500 deductible for out-of-network charges and accumulating the in-network and out-of-network deductibles separately. This change became effective January 1, 2003.

Plan A3605:

In network, the pharmacy co-pay is:

- \$20 or 30 percent of the cost (whichever is greater) for generic drugs
- \$35 or 50 percent of the costs (whichever is greater) for brand drugs

Outside the network, benefits continue to be subject to the deductible and coinsurance.

Plans A3605-A3606:

Doctor's office visits:

- \$35 co-pay at in-network providers
- subject to the deductible and coinsurance at out-of-network providers

Premiums for these plans are based on the insured's sex (except in MN, MT, and ND), attained age, and smoking status. In addition, substandard rates and elimination endorsements are used for certain health conditions, subject to statutory restrictions. These plans may be non-renewed on a state basis only.

3. Policy Experience and Proposed Rate Changes

Due to the fact that Plans A3601-A3606 were priced on the same basis, these plans were pooled for purposes of this rate increase calculation.

The proposed rate increase is calculated in Exhibit A.

Earned premiums and incurred claims by plan and state are shown in Exhibit B.

The assumed annual medical trend is 21%. This consists of such items as inflation in the cost of services, increases in utilization, and deductible leveraging.

We analyzed 19-months of experience, January 1, 2008 to July 31, 2009, for rate adequacy and reasonableness. Incurred claims reflect PPO savings, net of PPO fees. The completion factors used for claims were 1.0001 for 2007 claims, 1.0035 for 2008 claims and 1.3012 for 2009 claims, with actual claims paid through July 31, 2009.

The incurred loss ratio during the experience period is 74.0%. Restated to current rate levels this incurred loss ratio is 64.3%. The restated loss ratio was then projected using trend from the mid-point of the experience period (October 15, 2008) to the mid-point of the rate effective period (assumed to be July 1, 2010, due to the effect of modes, rate guarantees, and expected implementation dates). This produced a trended loss ratio of 89.1% for the rate effective period.

The lifetime target loss ratio is 60% for these plans. After adjusting the lifetime target loss ratio to the average duration, the Durationally Adjusted Loss Ratio for the rating period is 72.3%. The maximum rate increase that can be justified was calculated by comparing the projected loss ratio during the rating period with the Durationally Adjusted Loss Ratio. As shown in Exhibit A, the rate increase needed to meet pricing is 23.1%. We are requesting a rate increase of 10.0%

The past and current loss ratios exceed the minimum required loss ratio. The future and lifetime loss ratios are expected to exceed the minimum required loss ratio.

This rate increase will affect renewal policies equally. This increase will affect everything except the outpatient accident benefit and routine pregnancy benefit.

4. Policy Counts and Average Premiums

In Force counts and annualized premium are shown in Exhibit C, for your state and nationally.

5. Rate Increase History

Exhibit E shows nationwide rate increase history. Exhibit D summarizes the rate increase history for your state.

6. Rate Sheets and Effective Date

The appropriate rate sheets are attached to this memorandum.

The proposed effective date of the rate increase is listed in the cover letter. The rate increase will apply to all policies on their first premium due date on or after the effective date of the rerate.

7. Actuarial Certification

I, xxx, am a Fellow in the Society of Actuaries and a Member of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Based on the assumptions outlined herein, I certify that, to the best of my knowledge and judgment, this rate submission is in compliance with the laws and regulations of the State, that the benefits are reasonable in relation to the premiums, that the rates are not excessive, inadequate or unfairly discriminatory, and that the memorandum was prepared to comply with the current standards of practice as promoted by the Actuarial Standards Board.



Exhibit A
Rate Increase Calculation

Plans A3601-06

National Experience

Calendar Year	Earned Premium Current Experience	Incurred Claims	Loss Ratio
1997	36,291	9,956	27.4%
1998	4,894,591	2,479,396	50.7%
1999	15,540,824	10,410,437	67.0%
2000	41,814,737	27,564,298	65.9%
2001	94,354,917	65,112,579	69.0%
2002	97,072,427	67,200,483	69.2%
2003	66,258,339	45,762,832	69.1%
2004	45,246,040	32,473,285	71.8%
2005	30,928,548	21,331,107	69.0%
2006	21,546,975	15,601,858	72.4%
2007	16,460,447	12,174,354	74.0%
2008	13,020,752	9,478,707	72.8%
1-7/2009	6,305,875	4,826,850	76.5%
Total	453,480,763	314,426,142	69.3%

Restated to the Current Rate Level

2008	15,749,839	9,478,707	60.2%
1-7/2009	6,500,158	4,826,850	74.3%
Total	22,249,997	14,305,557	64.3%

Durationally Adjusted Loss Ratio for Rating Period	72.3%
Lifetime Target Loss Ratio	60.0%
Average 2007 Rate Increase Granted	21.6%
Amount of 2007 National Rate Increase Reflected in 2007 Earned Premium	0.3%
Amount of 2007 National Rate Increase Reflected in 2008 Earned Premium	17.2%
Amount of 2007 National Rate Increase Reflected in 7-2009 Earned Premium	21.6%
Average 2008 Rate Increase Granted	17.1%
Amount of 2008 National Rate Increase Reflected in 2008 Earned Premium	0.4%
Amount of 2008 National Rate Increase Reflected in 7-2009 Earned Premium	13.6%
Annual Trend Assumption	21.0%
Midpoint of Current Experience Period	10/15/2008
Midpoint of Projected Rating Period	7/1/2010
Cumulative Trend	38.5%
Trended Loss Ratio	89.1%
Rate Increase to Meet the Target Loss Ratio	23.1%
Requested Rate Increase	18.0%


Exhibit B

Earned Premium and Incurred Claims by State, Calendar Year, and Plan Through 7/31/09

State	Calendar Year	State Specific			National		
		Earned Premium	Incurred Claims	Loss Ratio	Earned Premium	Incurred Claims	Loss Ratio
AR	1997	-	-	0.0%	36,291	9,956	27.4%
	1998	-	187	0.0%	4,894,591	2,479,396	50.7%
	1999	3,186	563	17.7%	15,540,824	10,410,437	67.0%
	2000	-	163	0.0%	41,814,737	27,564,298	65.9%
	2001	220,721	63,902	29.0%	94,354,917	65,112,579	69.0%
	2002	548,852	412,118	75.1%	97,072,427	67,200,483	69.2%
	2003	391,787	173,641	44.3%	66,258,339	45,762,832	69.1%
	2004	276,311	55,456	20.1%	45,246,040	32,473,285	71.8%
	2005	229,482	124,335	54.2%	30,928,548	21,331,107	69.0%
	2006	194,015	45,070	23.2%	21,546,975	15,601,858	72.4%
	2007	154,815	22,386	14.5%	16,460,447	12,174,354	74.0%
	2008	128,216	17,699	13.8%	13,020,752	9,478,707	72.8%
	2009	56,306	2,937	5.2%	6,305,875	4,826,850	76.5%
	Total	2,203,691	918,456	41.7%	453,480,763	314,426,142	69.3%



Exhibit C
In Force and Annualized Premium as of 7/31/09

National and State-Specific Data

State	Plan Code	State-Specific Data (based on issue state)			State-Specific Data (based on resident state)			National Data		
		Policy Count	Annualized Premium	Average Annualized Premium	Policy Count	Annualized Premium	Average Annualized Premium	Policy Count	Annualized Premium	Average Annualized Premium
AR	A3601	-	-	-	-	-	-	154	1,381,671	8,972
AR	A3602	-	-	-	-	-	-	21	200,628	9,554
AR	A3603	-	-	-	-	-	-	187	1,725,755	9,229
AR	A3604	6	51,484	8,581	6	51,484	8,581	645	5,341,996	8,282
AR	A3605	1	21,058	21,058	1	21,058	21,058	135	1,142,792	8,465
AR	A3606	2	15,795	7,898	2	15,795	7,898	32	230,551	7,205
		9	88,338	9,815	9	88,338	9,815	1,174	10,023,392	8,538



Exhibit D

Summary of Your State's Rate Increases

State	Plan	Issue Years	Date	Increase
AR	A3601 - A3606	10/1/97-11/31/01	8/28/2000	Original Approval
AR	A3601 - A3606		5/1/2001	20.0%
AR	A3601 - A3606		12/1/2001	28.9% avg
AR	A3601 - A3606		12/1/2002	23.1% avg
AR	A3601 - A3606		12/1/2003	21.5% avg
AR	A3601 - A3606		12/1/2004	28.0%
AR	A3601 - A3606		12/1/2005	20.0%
AR	A3601 - A3606		12/1/2006	15.0%
AR	A3601 - A3606		12/1/2007	20.0%
AR	A3601 - A3606		12/1/2008	19.5%

Exhibit E
National Rate Increase History

Plan	Issue Years	Date	Timing	Increase
A3601-A3606	10/1/97-11/31/01	8/28/2000		AR Original Approval
A3601-A3604	10/1/98-9/30/01	4/27/1998		AZ Original Approval
A3605-A3606	4/15/00-9/30/01	10/18/1999		AZ Original Approval
A3601-A3604	10/1/97-10/31/01	3/5/1997		CO Original Approval
A3605-A3606	1/1/00-10/31/01	12/15/1999		CO Original Approval
A3601-A3604	8/1/98-4/30/02	4/7/1998		GA Original Approval
A3605-A3606	1/15/01-4/30/02	11/30/2000		GA Original Approval
A3601-A3604	10/1/97-2/28/02	2/20/1997		IA Original Approval
A3605-A3606	8/15/00-2/28/02	7/7/2000		IA Original Approval
A3601-A3604	6/1/99-9/30/01	3/26/1999		IL Original Approval
A3605-A3606	3/1/00-9/30/01	1/7/2000		IL Original Approval
A3601-A3604	1/1/00-5/31/02	10/26/1999		IN Original Approval
A3605-A3606	6/15/00-5/31/02	4/19/2000		IN Original Approval
A3601-A3604	4/15/99-5/31/01	1/5/1999		KS Original Approval
A3601-A3604	6/1/99-5/31/02	3/19/1999		LA Original Approval
A3601-A3606	1/1/00-9/30/01	10/14/1999		MI Original Approval
A3601-A3604	4/15/99-4/5/01	1/27/1999		MN Original Approval
A3601-A3606	2/1/01-4/5/01	12/20/2000		MN Original Approval
A3601-A3604	4/15/99-9/25/01	11/16/1998		MS Original Approval
A3605-A3606	3/1/00-9/25/01	1/4/2000		MS Original Approval
A3601-A3604	12/1/98-5/15/02	10/5/1998		MT Original Approval
A3601-A3604	5/1/99-12/13/02	10/5/1998		NC Original Approval
A3605-A3606	5/15/00-12/13/02	4/6/2000		NC Original Approval
A3601-A3604	10/1/97-Present	4/17/1997		ND Original Approval
A3605-A3606	7/1/00-Present	5/16/2000		ND Original Approval
A3601-A3604	10/1/97-11/31/01	1/15/1997		NE Original Approval
A3605-A3606	1/1/00-11/31/01	10/20/1999		NE Original Approval
A3601-A3606	2/15/00-5/31/02	12/30/1999		NM Original Approval
A3601-A3606	10/15/00-3/31/02	9/6/2000		OH Original Approval
A3601-A3604	4/15/99-2/28/02	1/12/1999		OK Original Approval
A3601-A3604	11/1/98-2/28/02	9/3/1998		SC Original Approval
A3605-A3606	4/1/01-2/28/02	1/19/2001		SC Original Approval
A3601-A3604	4/8/98-4/13/02	2/13/1998		SD Original Approval
A3601-A3606	1/15/00-2/28/02	12/8/1999		TN Original Approval
A3601-A3604	1/1/99-5/15/03	9/17/1998		TX Original Approval
A3605-A3606	5/15/00-5/15/03	4/5/2000		TX Original Approval
A3601-A3604	12/1/98-9/30/01	10/1/1998		VA Original Approval
A3601-A3604	10/1/97-2/28/02	2/6/1997		WI Original Approval
A3605-A3606	3/1/00-2/28/02	1/10/2000		WI Original Approval
A3601-A3604	10/1/98-11/31/01	6/25/1998		WY Original Approval

Exhibit E
National Rate Increase History

Plan	Issue Years	Date	Timing	Increase	
A3601-A3604		6/1/1998	Premium Due Date	NE IA WI	9.0% 9.0% 9.0% Area factor changed resulting in an additional 4.5%
A3601-A3604		7/1/1998	Premium Due Date	ND	9.0%
A3840, A3845		7/1/1998	Premium Due Date	ND	9.0%
A3601-A3604		8/1/1998	Premium Due Date	CO	9.0%
Average A3601-A3604		8/11/1998	Premium Due Date	All Avg	9.6% Based on the average of the state implementation dates, amounts, and payment modes.

Exhibit E
National Rate Increase History

Plan	Issue Years	Date	Timing	Increase	
A3601-A3604		3/1/1999	Premium Due Date	NE	12.9%
A3601-A3604		4/1/1999	Premium Due Date	IA	8.9%
				SD	12.9%
A3860, A3865		4/1/1999	Premium Due Date	SD	12.0%
A3601-A3604		5/1/1999	Premium Due Date	CO	12.9%
				WI	8.9%
A3601-A3604		6/1/1999	Premium Due Date	ND	12.9%
				SC	12.0%
A3845, A3845		6/1/1999	Premium Due Date	ND	12.9%
A3601-A3604		12/1/1999	Premium Due Date	AZ	11.2%
				GA	12.0%
				MT	12.0%
				VA	12.0%
				WY	12.0%
A3601-A3604		1/1/2000	Premium Due Date	TX	12.0%
Average A3601-A3604		6/16/1999	Premium Due Date	All Avg	11.7% Based on the average of the state implementation dates, amounts, and payment modes.

Exhibit E
National Rate Increase History

Plan	Issue Years	Date	Timing	Increase
A3601, A3602, A3604		4/1/2000	Premium Due Date	NE 7.0%
A3601, A3602, A3604		5/1/2000	Premium Due Date	CO 20.0%
				IA 11.0%
				LA 11.0%
				MS 11.0%
				WI 11.0%
A3601, A3602, A3604		6/1/2000	Premium Due Date	IL 11.0%
				KS 11.0%
				MN 7.0%
				ND 7.0%
				OK 11.0%
				SC 7.0%
				SD 8.5%
A3601, A3602, A3604		8/1/2000	Premium Due Date	NC 11.0%
A3601, A3602, A3604		9/1/2000	Premium Due Date	AZ 7.0%
				GA 7.0%
				MT 7.0%
				VA 7.0%
				WY 7.0%
A3601, A3602, A3604		10/1/2000	Premium Due Date	TX 7.0%
A3601, A3602, A3604		12/1/2000	Premium Due Date	IN 11.0%
				MI 7.0%
				NM 7.0%
				TN 7.0%
A3603		4/1/2000	Premium Due Date	NE 11.0%
A3603		5/1/2000	Premium Due Date	CO 20.0%
				IA 15.0%
				LA 15.0%
				MS 15.0%
				WI 15.0%
A3603		6/1/2000	Premium Due Date	IL 15.0%
				KS 15.0%
				MN 11.0%
				ND 11.0%
				OK 15.0%
				SC 11.0%
				SD 8.5%

Exhibit E
National Rate Increase History

Plan	Issue Years	Date	Timing	Increase	
A3603		8/1/2000	Premium Due Date	NC	15.0%
A3603		9/1/2000	Premium Due Date	AZ	11.0%
				GA	11.0%
				MT	11.0%
				VA	11.0%
				WY	11.0%
A3603		10/1/2000	Premium Due Date	TX	11.0%
A3603		12/1/2000	Premium Due Date	IN	15.0%
				MI	11.0%
				NM	11.0%
				TN	11.0%
A3605-A3606		9/1/2000	Premium Due Date	AZ	7.0%
A3605-A3606		10/1/2000	Premium Due Date	CO	20.0%
				NE	7.0%
A3605-A3606		12/1/2000	Premium Due Date	IL	7.0%
				MI	7.0%
				MS	11.0%
				NM	7.0%
				TN	7.0%
				WI	11.0%
A3840, A3845		6/1/2000	Premium Due Date	ND	7.0%
A3860, A3865		6/1/2000	Premium Due Date	SD	8.5%
Average A3601-A3606		6/10/2000	Premium Due Date	All Avg	13.3% Based on the average of the state implementation dates, amounts, and payment modes.

Exhibit E
National Rate Increase History

Plan	Issue Years	Date	Timing	Increase	
A3601-A3606		3/1/2001	Premium Due Date	NE AZ IA MT OK	20.0% 25.0% 20.0% 20.0% 20.0%
A3601-A3604		3/1/2001	Premium Due Date	IL MS	20.0% 18.0%
A3601-A3606		4/1/2001	Premium Due Date	CO GA LA SC TX WY	35.0% 20.0% 20.0% 30.0% 20.0% 20.0%
A3601-A3604		4/1/2001	Premium Due Date	WI	30.0%
A3601-A3606		5/1/2001	Premium Due Date	AR OH	20.0% 20.0%
A3601-A3606		6/1/2001	Premium Due Date	IN MI NC ND NM SD TN VA	20.0% 20.0% 25.0% 20.0% 20.0% 20.0% 20.0% 25.0%
A3605-A3606		6/1/2001	Premium Due Date	IL WI	20.0% 30.0%
A3601-A3606		7/1/2001	Premium Due Date	KS	20.0%
A3605-A3606		12/1/2001	Premium Due Date	MS	18.0%
A3601-A3606		4/1/2002	Premium Due Date	MN	20.0%
A3860, A3865		6/1/2001	Premium Due Date	SD	20.0%
A3840, A3845		6/1/2001	Premium Due Date	ND	25.0%
Average A3601-A3606		5/6/2001	Premium Due Date	All Avg	25.5% Based on the average of the state implementation dates, amounts, and payment modes.

Exhibit E
National Rate Increase History

Plan	Issue Years	Date	Timing	Increase		
A3601-A3606		10/1/2001	Premium Due Date	AZ	31.5%	
				IL	31.5%	
		11/1/2001	Premium Due Date	CO	31.5%	
				12/1/2001	Premium Due Date	AR
		GA	29.3%			
		IA	29.3%			
		MT	28.6%			
		NE	29.3%			
		OH	29.5%			
		OK	29.1%			
		SC	29.5%			
		SD	29.6%			
		TX	29.5%			
		WI	30.7%			
		WY	28.6%			
		1/1/2002	Premium Due Date	LA	29.3%	
				NC	30.0%	
				NM	29.5%	
		3/1/2002	Premium Due Date	MS	29.2%	
4/1/2002	Premium Due Date	IN	27.0%			
6/1/2002	Premium Due Date	ND	27.9%			
7/1/2002	Premium Due Date	KS	35.0%			
		MI	38.7%			
8/1/2002	Premium Due Date	TN	39.6%			
9/1/2002	Premium Due Date	VA	28.1%			
A3860, A3865		12/1/2001	Premium Due Date	SD	20.0%	
A3840, A3845		6/1/2002	Premium Due Date	ND	25.0%	
Average A3601-A3606		12/18/2001	Premium Due Date	All Avg	30.6% Based on the average of the state implementation dates, amounts, and payment modes.	

Exhibit E
National Rate Increase History

Plan	Issue Years	Date	Timing	Increase		
A3601-A3606		10/1/2002	Premium Due Date	AZ	23.1%	
				IL	23.1%	
		11/1/2002	Premium Due Date	CO	23.1%	
				12/1/2002	Premium Due Date	AR
		GA	23.1%			
		IA	17.1%			
		MT	23.1%			
		NE	13.1%			
		OH	23.1%			
		OK	23.1%			
		SC	23.1%			
		SD	23.1%			
		TX	49.9%			
		WI	23.1%			
		WY	23.1%			
		1/1/2003	Premium Due Date	LA	23.1%	
				NC	33.1%	
NM	23.1%					
2/1/2003	Premium Due Date	IN	23.1%			
6/1/2003	Premium Due Date	MS	23.1%			
		ND	15.8%			
7/1/2003	Premium Due Date	MI	23.1%			
8/1/2003	Premium Due Date	KS	34.0%			
		TN	23.1%			
9/1/2003	Premium Due Date	MN	15.0%			
A3860, A3865		12/1/2002	Premium Due Date	SD	18.3%	
A3840, A3845		6/1/2003	Premium Due Date	ND	16.0%	
Average A3601-A3606		12/31/2002	Premium Due Date	All Avg	31.0% Based on the average of the state implementation dates, amounts, and payment modes.	

Exhibit E
National Rate Increase History

Plan	Issue Years	Date	Timing	Increase	
A3601-A3606		10/1/2003	Premium Due Date	AZ	21.5% Avg
				IL	21.5% Avg
		12/1/2003	Premium Due Date	AR	21.5% Avg
				GA	21.5% Avg
				IA	21.5% Avg
				IN	21.5% Avg
				LA	21.5% Avg
				NC	19.5% Avg
				NE	21.5% Avg
				NM	16.6% Avg
				OH	16.6% Avg
				OK	26.6% Avg
				SC	21.5% Avg
				SD	21.5% Avg
				WI	21.5% Avg
WY	26.6% Avg				
12/4/2003	Premium Due Date	TX	21.5% Avg		
1/1/2004	Premium Due Date	CO	21.5% Avg		
		MT	21.5% Avg		
8/1/2004	Premium Due Date	KS	29.0%		
		ND	25.0% Avg		
9/1/2004	Premium Due Date	MI	40.0% Avg		
10/1/2004	Premium Due Date	TN	40.0% Avg		
12/1/2004	Premium Due Date	MS	36.0%		
		VA	30.5% Avg		
A3840, A3845		8/1/2004	Premium Due Date	ND	25.0% Avg
Average A3601-A3606		12/25/2003	Premium Due Date	All Avg	21.0% Based on the average of the state implementation dates, amounts, and payment modes.

Exhibit E
National Rate Increase History

Plan	Issue Years	Date	Timing	Increase	
A3601-A3606		10/1/2004	Premium Due Date	AZ	28.0%
				IL	28.0%
				IN	28.0%
				LA	28.0%
				NE	33.0%
				OK	36.0%
				TX	28.0%
		WY	28.0%		
		11/1/2004	Premium Due Date	IA	24.0%
				OH	28.0%
				SC	28.0%
				WI	28.0%
		12/1/2004	Premium Due Date	AR	28.0%
CO	18.0%				
GA	28.0%				
MT	28.0%				
NC	25.0%				
1/1/2005	Premium Due Date	NM	28.0%		
Average A3601-A3606		11/1/2004	Premium Due Date	All Avg	22.6% Based on the average of the state implementation dates, amounts, and payment modes.

Exhibit E
National Rate Increase History

Plan	Issue Years	Date	Timing	Increase	
A3601-A3606		4/1/2005	Premium Due Date	AZ	23.0%
				IL	23.0%
				LA	23.0%
				NE	23.0%
				OK	25.0%
				TX	23.0%
				WY	23.0%
		5/1/2005	Premium Due Date	MI	30.0%
				OH	25.0%
				SC	23.0%
		6/1/2005	Premium Due Date	WI	23.0%
				CO	23.0%
		7/1/2005	Premium Due Date	GA	23.0%
				MN	25.2%
8/1/2005	Premium Due Date	SD	23.0%		
		KS	30.0%		
Average	A3601-A3606	5/2/2005	Premium Due Date	ND	15.0%
				All Avg	17.0%

Exhibit E
National Rate Increase History

Plan	Issue Years	Date	Timing	Increase	
A3601-A3606		10/1/2005	Premium Due Date	IN	15.0%
				LA	10.0%
				OK	15.0%
		11/1/2005	Premium Due Date	IA	3.5%
				OH	15.0%
		12/1/2005	Premium Due Date	AR	20.0%
				CO	9.0%
				MS	22.0%
				MT	15.0%
				TN	17.0%
WI	10.0%				
1/1/2006	Premium Due Date	NC	15.0%		
		NM	17.0%		
Average A3601-A3606		12/9/2005	Premium Due Date	All Avg	6.2% Based on the average of the state implementation dates, amounts, and payment modes.

Exhibit E
National Rate Increase History

Plan	Issue Years	Date	Timing	Increase	
A3601-A3606		4/1/2006	Premium Due Date	AZ	9.0%
				IL	9.0%
				LA	9.0%
				NE	15.0%
				OK	12.0%
				TX	9.0%
				WY	9.0%
		5/1/2006	Premium Due Date	GA	9.0%
				MI	9.0%
				OH	9.0%
				VA	27.0%
		6/1/2006	Premium Due Date	CO	15.0%
				MT	9.0%
SC	9.0%				
WI	9.0%				
8/1/2006	Premium Due Date	KS	23.0%		
		ND	9.0%		
10/1/2006	Premium Due Date	SD	30.0%		
12/1/2006	Premium Due Date	MN	15.5%		
Average A3601-A3606		6/10/2006	Premium Due Date	All Avg	8.8% Based on the average of the state implementation dates, amounts, and payment modes.

Exhibit E
National Rate Increase History

Plan	Issue Years	Date	Timing	Increase	
A3601-A3606		12/1/2006	Premium Due Date	AR	15.0%
		12/1/2006		AZ	17.0%
		12/1/2006		GA	15.0%
		12/1/2006		IA	12.0%
		12/1/2006		LA	15.0%
		12/1/2006		NE	15.0%
		12/1/2006		TN	15.0%
		12/1/2006		TX	17.0%
		12/1/2006		WI	15.0%
		12/1/2006		WY	15.0%
		1/1/2007	Premium Due Date	NC	15.0%
		1/1/2007		NM	20.0%
		1/1/2007		OH	30.0%
		1/1/2007		IN	15.0%
		1/1/2007		OK	30.0%
		1/1/2007		SC	21.0%
		1/1/2007		MI	15.0%
		2/1/2007	Premium Due Date	IL	15.0%
		3/1/2007	Premium Due Date	CO	14.0%
		6/1/2007	Premium Due Date	MS	18.0%
6/1/2007		MT	23.0%		
7/1/2007	Premium Due Date	SD	20.0%		
9/1/2007	Premium Due Date	KS	30.0%		
Average A3601-A3606		1/1/2007	Premium Due Date	All Avg	16.6% Based on the average of the state implementation dates, amounts, and payment modes.

Exhibit E
National Rate Increase History

Plan	Issue Years	Date	Timing	Increase			
A3601-A3606		12/1/2007	Premium Due Date	AR	20.0%		
		12/1/2007		GA	20.0%		
		12/1/2007		IN	20.0%		
		12/1/2007		LA	20.0%		
		12/1/2007		ND	15.0%		
		12/1/2007		TX	25.0%		
		12/1/2007		WI	20.0%		
		12/1/2007		WY	20.0%		
		1/1/2008	Premium Due Date	IA	7.5%		
		1/1/2008		NC	15.0%		
		1/1/2008		NE	25.0%		
		2/1/2008	Premium Due Date	AZ	20.0%		
		2/1/2008		OH	16.6%		
		2/1/2008		OK	25.0%		
		2/1/2008		TN	10.0%		
		3/1/2008	Premium Due Date	CO	18.0%		
		3/1/2008		NM	20.0%		
		4/1/2008	Premium Due Date	SC	20.0%		
		4/1/2008		MN	27.6%		
		7/1/2008	Premium Due Date	MI	20.0%		
		9/1/2008	Premium Due Date	IL	30.0%		
		9/1/2008		SD	35.0%		
		9/1/2008		OK	18.0%		
		11/1/2008	Premium Due Date	MS	18.0%		
		Average A3601-A3606		2/17/2008	Premium Due Date	All Avg	21.6% Based on the average of the state implementation dates, amounts, and payment modes.

Exhibit E
National Rate Increase History

Plan	Issue Years	Date	Timing	Increase
A3601-A3606		12/1/2008	Premium Due Date	AR 19.5%
		12/1/2008		WY 15.0%
		1/1/2009	Premium Due Date	GA 21.5%
		1/1/2009		NC 15.0%
		1/1/2009		CO 19.5%
		1/1/2009		SC 19.5%
		1/1/2009		AZ 19.5%
		1/1/2009		LA 21.5%
		1/1/2009		TX 21.5%
		1/1/2009		MI 21.5%
		1/1/2009		IN 15.0%
		1/1/2009		TN 10.0%
		1/1/2009		IA 7.5%
		2/1/2009	Premium Due Date	WI 21.5%
		2/1/2009		ND 15.0%
		2/1/2009		OH 15.0%
		2/1/2009		NE 15.0%
		3/1/2009	Premium Due Date	OK 15.0%
		3/1/2009		MT 21.5%
		4/1/2009	Premium Due Date	IL 19.5%
4/1/2009		MN 13.1%		
7/1/2009	Premium Due Date	NM 8.3%		
Average A3601-A3606			Premium Due Date	17.1% Based on the average of the state implementation dates, amounts, and payment modes.

Grants to States for Health Insurance Premium Review Program – Cycle I

TIMELINE

August 9, 2010– September 30, 2011

<u>ACTIVITY</u>	<u>TIMELINE</u>
<i>Grant award</i>	August 9, 2010
<i>Grant period begins</i>	August 9, 2010
<i>Accept award package</i>	September 16, 2010
<i>Notify OCIO of Fiscal Agent/Officer Responsible for completing the SF-269a-short form and SF-425</i>	September 30, 2010
<i>Revised Budget and SF-424A (when applicable or requested)</i>	Due within 60 days of award
<i>Required Data Center Information</i>	October 31, 2010
<i>“Meet and Greet” with HHS grant project officers</i>	November 2010; conference calls to be scheduled by OCIO staff
<i>3 Quarterly Programmatic Progress Reports</i>	Due 30 days after the end of each Federal fiscal quarter
<i><u>First</u> Programmatic Progress Report Due:</i>	January 31, 2011
<i>Monitoring Call to Discuss First Progress Report:</i>	February/March 2011
<i><u>Second</u> Programmatic Progress Report Due:</i>	April 30, 2011
<i>Monitoring Call to Discuss Second Progress Report:</i>	May/June 2011
<i><u>Third</u> Programmatic Progress Report Due:</i>	July 31, 2011
<i>Monitoring Call to Discuss Third Progress Report:</i>	August/September 2011

Please note the Health Insurance Premium Review Program Grant Program will also schedule technical assistance calls *before* each of the quarterly report due dates as necessary.

Response to OCIO requests for additional Information for the evaluation of the grants

Ongoing and as requested by OCIO

Guidance Call for Preparation of the Final Report

To be scheduled by the OCIO Project Officer approximately 60 days before end of grant year

Final Programmatic Progress Report

Due 90 days after the conclusion of the grant project period on December 31, 2011

Federal Financial Report (FFR SF425)

Due on a quarterly basis within 30 days after the end of the quarter. For additional guidance refer to the Payment Management System available at <http://www.dpm.psc.gov>

First FFR SF 425 Report Due:

Due no later than January 31, 2011

Second FFR SF 425 Report Due:

Due no later than April 30, 2010

Third FFR SF 425 Report Due:

Due no later than July 31, 2011

Final Financial Status Report (FSR 269a-short form:)

Due within 90 days after the grant project period end date; due by December 31, 2011.

No Cost Extension Request

Should the State require a no cost extension, a written request to the Project Officer and grants management contact must be received no later than 30 days prior to the project period end date.



Rate Review Grants Reporting for Cycle 1: System Prototype Mockups

October 19, 2010

HIOS Login Page

Health Insurance Oversight System

Friday, September 03, 2010

Sign-In

* Indicates required fields.

User Name:*
Password:*

[Forgot Password?](#)

Type the letters you see in the image into the Word Verification field below. If you are unable to read the image pictured below, please click the Play Audio Code link for audio verification

Word Verification * Please enter the letters you see in the image. If you use the Audio Verification, type the pronounced numbers and the first letter of each word.



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Health Insurance Oversight System

Tuesday, August 24, 2010

Premium Review Grant Homepage

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Quarter Submitted:

Thank you for your submission.

The file State Report.xls has been accepted and is pending process. The submission will not be completed until the file is successfully processed. If any errors occur during processing, you will be notified of the error via email. When the submission is successfully processed, you will receive a confirmation via email. Please contact the helpdesk for further assistance. The upload file size is 200 kilobytes.

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Quarter Submitted: Q1 2011

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Documents Uploaded:

- Narrative 1.doc
- Narrative 2.pdf
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Thank you for your submission. The files Narrative 1.doc, Narrative 2.pdf, and Narrative 3.txt have been uploaded.

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Health Insurance Oversight System

Tuesday, August 24, 2010

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Review and Attest Submitted Data Page – Summary Information

Health Insurance Oversight System

Tuesday, August 24, 2010

Review and Attest Submitted Data

First Name Last Name

Submission Period: Q1 2011

Apply

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Print

Data Submission

State: WA
Date Time/Submitted for Review: 8/24/2010: 5:00:00 PM
Submitter: N/A
Submission Type: SERFF Import
Submission ID: ID001
Submission Status: Not Attested
File Name: N/A
Number of Filings: 40

View Submission Data

Click on this button to view the full data contained in the submission

Attestation: I certify that the data is complete and accurate

Narratives

Number of Documents: 3

Date/Time Submitted:
8/25/2010 3:00:00 PM
8/25/2010 4:00:00 PM
8/25/2010 5:00:00 PM

Submitter:
State User 1
State User 1
State User 1

File Name:
[Narrative 1.doc](#)
[Narrative 2.pdf](#)
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Review and Attest Submitted Data Page – Submission Data Attested

Health Insurance Oversight System

Tuesday, August 24, 2010

Review and Attest Submitted Data

First Name Last Name

Submission Period:

-
-
-
-
-
-

State Abbreviation	SERFF Tracking Number	Policy Form ID	Rate Filing ID	Issuer ID	NAIC Company ID Number	Reviewed by State Y/N	State Review Includes Actuary Y/N	Insurance Company Name	Insurance Product Name	New Policy (Y/N)
WA	RGAC-126531127	MM2000-C-IN-FLIC	RGAC-126531127	22222	53901	Y	Y	Regence Blue Shield	MM2000-C-IN-FLIC	Y
WA	RGAC-126531127	ERS2000-OR-FLIC	RGAC-126531127	22222	53901	Y	N	Regence Blue Shield	ERS2000-OR-FLIC	N
WA	PACF-123456789	PA2000-WA-FLIC	PACF-123456789		70781	Y	N	PacificCare Life and Health Insurance Co	PA2000-WA-FLIC	N
WA	PACF-123456789	PA2000-OR-FLIC	PACF-123456789		70781	Y	Y	PacificCare Life and Health Insurance Co	PA2000-OR-FLIC	N
WA	PRIN-223870909	PR2000-LF-FLIC	PRIN-223870909	33333	61272	Y	N	Principal Life Insurance Company	PR2000-LF-FLIC	N
WA	COMM-987555989	CO2000-HP-FLIC	COMM-987555989		47048	Y	N	Community Health Plan of Washington	CO2000-HP-FLIC	Y
WA	UDHC-128894447	UH2000-IN-FLIC	UDHC-128894447	44444	79411	Y	Y	UnitedHealthcare Insurance Company	UH2000-IN-FLIC	N
WA	KPSH-198784333	KP2000-OR-FLIC	KPSH-198784333		53871	Y	N	KPS Health Plans	KP2000-OR-FLIC	N
WA	KAIS-555888333	KA2000-OR-FLIC	KAIS-555888333	55555	95541	Y	Y	Kaiser Foundation Healthplan of the NW	KA2000-OR-FLIC	N
WA	GRPH-765765765	GR2000-IN-FLIC	GRPH-765765765		47051	Y	N	Group Health Options, Inc.	GR2000-IN-FLIC	Y
WA	GRPH-765765765	GR2000-OR-FLIC	GRPH-765765765		47051	Y	N	Group Health Options, Inc.	GR2000-OR-FLIC	N
WA	GRPH-765765765	GR2000-WA-FLIC	GRPH-765765765		47051	Y	Y	Group Health Options, Inc.	GR2000-WA-FLIC	N
WA	AETH-567332111	AE2000-OR-FLIC	AETH-567332111	66666	60051	Y	N	Aetna Life Insurance Company	AE2000-OR-FLIC	N
WA	METR-789432345	MT2000-WA-FLIC	METR-789432345		65971	Y	Y	Metropolitan Life Insurance Company	MT2000-WA-FLIC	Y
WA	LFWS-283748489	LF2000-IN-FLIC	LFWS-283748489	77777	52633	Y	N	LifeWise Health Plan of WA	LF2000-IN-FLIC	N
WA	AMER-987654321	AM2000-OR-FLIC	AMER-987654321		97179	Y	Y	American Medical Security Ins CO	AM2000-OR-FLIC	N
WA	TMIN-128389565	TM2000-IN-FLIC	TMIN-128389565	88888	69477	Y	N	Time Insurance Company	TM2000-IN-FLIC	Y
WA	TMIN-128389565	TM2000-OR-FLIC	TMIN-128389565	88888	69477	Y	Y	Time Insurance Company	TM2000-OR-FLIC	N

Attestation: I certify that the data is complete and accurate
 Attested by: State User 1 on 9/1/2010 4:00:00 PM

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Review and Attest Submitted Data Page – Summary Information – Narrative Only

Health Insurance Oversight System

Tuesday, August 24, 2010

Review and Attest Submitted Data

First Name Last Name

Submission Period: Q1 2011

Apply

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Data Submission

No Data is Available

Narratives

Number of Documents:

3

Date/Time Submitted:

8/25/2010 3:00:00 PM
8/25/2010 4:00:00 PM
8/25/2010 5:00:00 PM

Submitter:

State User 1
State User 1
State User 1

File Name:

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Exhibit 14

	1	22	7	8	6	24	2	3	4	5	9	10	11
	State Abbreviation	SERFF Tracking Number	Policy Form ID	Rate Filing ID	Issuer ID	NAIC Company ID Number	Reviewed by State Y/N	State Review Includes Actuary Y/N	Insurance Company Name	Insurance Product Name	New Policy (Y/N)	Market Segment	Comprehensive Medical Coverage Type
Example Data	XX	HAMM-987654321	ANL-ZXMT	HAMM-987654321	23456	88888	Y	Y	Company B	Freedom Major Medical	N	Large Group	HMO
	XX	HAMM-987654321	ANL-ZXM92	HAMM-987654321	23456	88888	Y	Y	Company B	Freedom Major Medical	N	Large Group	HMO
	XX	HAMM-987654321	ANL-ZX95	HAMM-987654321	23456	88888	Y	Y	Company B	Freedom Premium	Y	Small Group	PPO
	XX	HAMM-987654321	ANL-ZX95	HAMM-987654321	23456	88888	Y	Y	Company B	Freedom Major Medical	Y	Large Group	HMO
Required?	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
HHS Definition		The tracking number assigned by the NAIC SERFF system assigned to the rate filing.	The policy ID of the insurance product as sold by the insurance company.	The rate filing ID of the insurance product as sold by the insurance company	The unique identifier as assigned by the HHS HIOS system.	The company identifier assigned by the NAIC system to identify the insurer.	A yes/no flag used to identify whether the rate change was reviewed by the State. This value will be "no" for States that collect information but do not currently review rates and for States that "deem" rates approved.	A yes/no flag that demonstrates if the State review process includes a review by an actuary.	The name of the insurance company.	The "street" name of the insurance product as sold by the insurance company.	A yes/no flag that demonstrates if the policy is a New issue that has never been issued before.	Allowable values for market segment are: Large group, Small group, Individual, Conversion.	Allowable values for comprehensive medical coverage type are: HMO, PPO, POS, FFS, EPO, Other - (please note details)
Additional Information			Policy Form ID plus Product equate to the unique identifier for the records to be reported.	SERFF Tr Num will be repeated here.			Per HHS, states should use their own standards as to what constitutes an actuarial review. They are not requiring that the reviewer be an accredited actuary.			The HHS product ID may also be utilized in reporting to better identify products.			

12	13	14	15	16	17	18	19	20	21	23	25	26
Block Status	Rate Effective Date	% Change Requested	% Change Approved	Change Period	Number Affected Insureds	Number Affected Policy Holders	Member Months	Annual \$ for New Rate	Annual \$ for Prior Rate	SERFF Rate Filing Type	Description of trend factors	Benefit Adjusted Y/N
Open	9/8/2010	2.25	1.9	Annual	12,500	8,300	115,000	72-560	65-472	Rate	Trend based on historical experience and expected contracting changes	N
Open	9/8/2010	2.25	1.9	Annual	12,500	8,300	115,000	72-560	65-472	Rate	Trend based on historical experience and expected contracting changes	N
Open	9/8/2010	2.25	1.9	Annual	7,200	6,700	72,000	72-560	65-472	Rate	Trend based on historical experience and expected contracting changes	N
Open	9/8/2010	2.25	1.9	Annual	12,500	8,300	115,000	72-560	65-472	Rate	Trend based on historical experience and expected contracting changes	N
Yes	Yes	Yes	Yes	Yes	Conditional	Conditional	Yes	Yes	Yes	No	No	Yes
Demonstrates if the rate for the policy is "open", "closed". An open policy is one that is available for sale to new enrollees.	Date that the rate is effective for the policyholders.	The percentage of change approved can be a positive or negative number. Demonstrated as a range of min- max.	The percentage of change requested can be a positive or negative number. Demonstrated as a range of min- max.	Demonstrates the time for which the premium change is effective. Allowable values are: Annual, Semi-annual, Quarterly, Other - (Please note details)	Total number of enrolled individuals affected by the rate change. This may be null for States that only collect policy holder counts.	Total number of policy holders affected by the rate change. This may be null for States that only collect the number of enrolled individuals.	The member months used for the purpose of the rate development.	The dollar amount of the New Annual Rate. Demonstrated as a range of min- max.	The dollar amount of the Prior Annual Rate. Demonstrated as a range of min- max.	The rate filing type as used in the NAIC SERFF system.	Text description of trend factors and rating factors used in developing the rate. Max 1000 characters	A yes/no flag used to identify if the benefits were adjusted or changed for the period.
							We are contemplating adding a flag that indicates whether or not the member months are representative of the actual experience for this group of policyholders.			NAIC will provide current Filing Mode values to HHS, as they indicated that might be the information they are wanting here.	HHS indicated that a short description was desired and there was tentative agreement to limit to 1,000 characters.	

27	28	29	30	31	32	33	34	35	36	37	38	39
Deductible Increase Y/N	Benefit Increase Y/N	Benefit Decrease Y/N	Cost Sharing Y/N	Coinsurance Y/N	Primary Care Copayment Amount	Specialist Care Copayment Amount	Inpatient Hospital Copayment Amount	Outpatient Hospital Copayment Amount	Generic Pharmacy Copayment Amount	Brand Pharmacy Copayment Amount	Total Earned Premium Amount - Prior year	Total Incurred Claims Amount - Prior year
N	N	N	N	N	10-25	25-35	100-250	100-250	10-15	20-25	31,057,844	22,408,525
N	N	N	N	N	10-25	25-35	100-250	100-250	10-15	20-25	31,057,844	22,408,525
N	N	N	N	N	10-25	20-25	150-250	150-250	10-15	25-35	26,451,233	17,584,225
N	N	N	N	N	10-25	25-35	100-250	100-250	10-15	20-25	31,057,844	22,408,525
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
A yes/no flag used to identify if the deductible amount was increased.	A yes/no flag used to identify if the services benefits were increased.	A yes/no flag used to identify if the services benefits were decreased.	A yes/no flag used to identify if there are cost sharing requirements for the rate.	A yes/no flag used to identify if there are coinsurance requirements for the rate.	The copayment required at the primary care doctors office that coincides with the rate. Demonstrated as a range of min- max.	The copayment required at specialty care doctors office that coincides with the rate. Demonstrated as a range of min- max.	The copayment required for inpatient hospitalization that coincides with the rate. Demonstrated as a range of min- max.	The copayment required for outpatient hospitalization that coincides with the rate. Demonstrated as a range of min- max.	The copayment required for generic drugs at the pharmacy that coincides with the rate. Demonstrated as a range of min- max.	The copayment required for brand name drugs at the pharmacy that coincides with the rate. Demonstrated as a range of min- max.	The total dollar amount collected for the purpose of premium payments.	The total dollar amount paid for services incurred.
											This should be reported as prior experience year, which may or may not be a calendar year.	This should be reported as prior experience year, which may or may not be a calendar year.

40	41	43	44	45	46	47	48	49	50	51	52
Disposition of Rate Review	Prospective Rate % Attributed to Claims and Capitation	Prospective Rate % Attributed to Admin	Prospective Rate % Attributed to Broker Commissions	Prospective Rate % Attributed to Premium Taxes	Prospective Rate % Attributed to Assessment Fees	Prospective Rate % Attributed to Federal Taxes	Prospective Rate % Attributed to Reserves	Medical Price % Change	Medical Utilization % Change	Medical Trend % Insufficient Prior Rate	Overall Medical Trend % Increase
Approved	0.213	0	0	0	0	0	0	0	0.15	0.03	0.18
Approved	0.213	0	0	0	0	0	0	0	0.15	0.03	0.18
Approved	0.213	0	0	0	0	0	0	0	0.15	0.03	0.18
Approved	0.213	0	0	0	0	0	0	0	0.15	0.03	0.18
No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
The disposition of the rate review, e.g. "approved," "denied", "deferred",	The prospective percent of the rate increase attributed to historical Claims and Capitation	The prospective percent of the rate increase attributed to historical Admin increase	The prospective percent of the rate increase attributed to historical Claims and Capitation increase	The prospective percent of the rate increase attributed to historical Premium tax increase	The prospective percent of the rate increase attributed to historical assessment fee increase	The prospective percent of the rate increase attributed to historical Federal tax increase	The prospective percent of the rate increase attributed to historical reserves increase	The medical price percentage of change used to develop the rate	The medical utilization percentage of change used to develop the rate. Using current standards, not future MLR definition.	The percentage of historical insufficient prior rate used as a factor to develop the current rate	The prospective total of the Medical Price % Change, Medical Utilization % Change, and the Medical Trend % Insufficient Prior Rate

Tables A, B, C, and D

Date: 10/13/2010

Table A Summary

For all counts, the filing will be counted once for each company included. A filing that lists three companies will add three to this total. A filing submission that includes multiple products for a single company will only be counted once.

Field A1 HHS Definition- <i>Number of Submitted Rate Filings</i> – the total number of comprehensive major medical filings submitted to the State for the time period.	
Definition	Method
The filing was received during the reporting period.	For electronic filings, this will be the date of submission. For paper filings, the date will be determined according to state guidelines regarding receipt of paper submissions.
The filing was made for a comprehensive major medical line of business.	The filing was made under a Sub-TOI identified as health insurance coverage affected by the PPACA, regardless of whether the company identified it as being PPACA related (checking either or both of the grandfathered and non-grandfathered immediate market reforms fields when submitting.)
The filing is rate related.	The identification of filings that are rate related will be based on a flag controlled by the state.

Other Assumptions

- The filing will be counted as submitted regardless of any subsequent action taken by either state or industry, including being withdrawn.
- The filing must meet the above qualifications at the time of the report to be included. The data submissions are assumed to be “point in time” reports.
- States using administrative staff to perform cursory checks of the filing for completeness etc, will be able to train those staff to identify and set the flag to indicate the filing is rate related.
- The filing to be reported are rate related, which included combination filings such as Rate/Form.

Field A2 HHS Definition- <i>The number of policy rate filings requesting increase in premiums</i> – the number of filings in which any increase is identified for any reason. This includes effective increases created by a level rate with a benefit decrease as well as informational filings that indicate an increase.	
Definition	Method
This should include any filing that	The identification of filings that are rate related

includes a rate increase request for any segment of the population, regardless of whether the overall rate impact is neutral or a decrease.	will be based on a flag controlled by the state. As the intent is to capture any initial rate increase request, this flag must be set early in the filing review as subsequent action by the state or company could result in a neutral or decreased rate.
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Other Assumptions

- The filing will be counted regardless of any subsequent action, including being withdrawn.
- The filing must meet the above qualifications at the time of the report to be included. The data submissions are assumed to be “point in time” reports.

Field A3 HHS Definition - <i>Number of filings reviewed for approval, denial, etc</i> - the total number of filings for which the State reviewed and issued determination, regardless of whether or not the state has approval authority. (In other words, file and use states that conducted a review of the filing would still count it here.)	
Definition	Method
This should include any filing that was counted in A and which the state reviewed, regardless of the final Disposition.	This would be based on the sending of a Disposition that qualifies for HHS reporting.
Field A4 HHS Definition – <i>Number of filings approved</i> - the total number of filings that were reviewed, as counted in A3, and were approved or the company is permitted to market.	
Field A5 HHS Definition – <i>Number of filings denied</i> – the total number of filings that were reviewed and denied for the time period.	
Field A6 HHS Definition – <i>Number of filings deferred</i> - the total number of filings that were withdrawn or rejected for lack of adequacy for the time period.	

Other Assumptions

- The filing must meet the above qualifications at the time of the report to be included. The data submissions are assumed to be “point in time” reports.
- Because fields A3, A4, A5, and A6 all require a Disposition, the state specific Disposition Statuses will be mapped to A4, A5, and A6.
- A3 is expected to be the sum of A4, A5, and A6

Definitions for Tables B, C, and D

The purpose of tables B, C, and D is to assist States that are conducting reviews to illustrate by market segment and product type the number of potentially affected subscribers and covered individuals.

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

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

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

Field 1 HHS Definition: <i>Plan Year</i> – obsolete, please ignore.
Field 2 HHS Definition: <i>Product Type</i> – A breakdown of filings by product type, using the product types as defined on the Rate Review Disclosure Form. A filing may be counted several times if more than one product type applies.
Field 3 HHS Definition: <i>Number of Policy Holders</i> – the total number of subscribers, if available.
Field 4 HHS Definition: <i>Number of Covered Lives</i> – the total number of members covered, if available.

Other Assumptions

- Tables B, C, and D are representations of filings by market type, with each further broken down into product types.
- A table for each market type/product type combination will be reported per participating state.
- Filings counted in tables B, C, and D are closed PPACA eligible filings with a qualified HHS within the quarter’s date range.
- The numbers report in Tables B, C, and D will not map back to the Table A numbers due to multi-product filings.

TABLE A

Missouri	Quarter 1 8/15/10-12/31/10	Quarter 2 1/1/11-3/31/11	Quarter 3 4/1/11-6/30/11	Quarter 4 7/1/11-8/14/11	Annual Total 8/15/10-8/14/11
Number of Submitted Rate Filings	75	91	113	102	381
Number of Policy Rate Filings Requesting Increase in Premiums	45	74	81	79	279
Number of Filings Reviewed for Approval/Denial, etc.	87	82	89	111	369
Number of Filings Approved	64	67	70	90	291
Number of Filings Denied	5	8	7	5	25
Number of Filings Deferred	18	7	12	16	53

* The table below represents an example of Tables B, C, or D.

TABLE B - Individual / TABLE C - Small Group / TABLE D - Large Group					
Missouri	Quarter 1 8/15/10-12/31/10	Quarter 2 1/1/11-3/31/11	Quarter 3 4/1/11-6/30/11	Quarter 4 7/1/11-8/14/11	Annual Total 8/15/10-8/14/11
<i>Plan Year (Please Ignore)</i>					
Product Type	PPO				
Number of Policy Holders	24,589	29,450	19,556	27,958	101,553
Number of Covered Lives	28,975	31,647	22,569	29,641	112,832
Product Type	HMO				
Number of Policy Holders	26,980	25,942	25,153	20,564	98,639
Number of Covered Lives	28,643	28,564	26,869	24,350	108,426
Product Type	EPO				
Number of Policy Holders	12,589	15,364	10,564	13,565	52,082
Number of Covered Lives	13,650	19,536	14,358	15,306	62,850
Product Type	POS				
Number of Policy Holders	18,352	15,805	15,764	14,056	63,977
Number of Covered Lives	20,538	18,053	18,635	19,235	76,461
Product Type	HSA				
Number of Policy Holders	9,832	10,543	8,056	11,989	40,420
Number of Covered Lives	11,335	12,688	9,005	12,582	45,610
Product Type	HDHP				
Number of Policy Holders	12,652	10,245	10,988	11,685	45,570
Number of Covered Lives	15,635	12,568	11,446	13,954	53,603
Product Type	FFS				
Number of Policy Holders	958	1,003	2,856	841	5,658
Number of Covered Lives	1,065	1,268	3,265	1,174	6,772
Product Type	Other				
Number of Policy Holders	0	45	3	15	63
Number of Covered Lives	0	45	5	25	75

View companies offering plans in 72120:

INDIVIDUALS

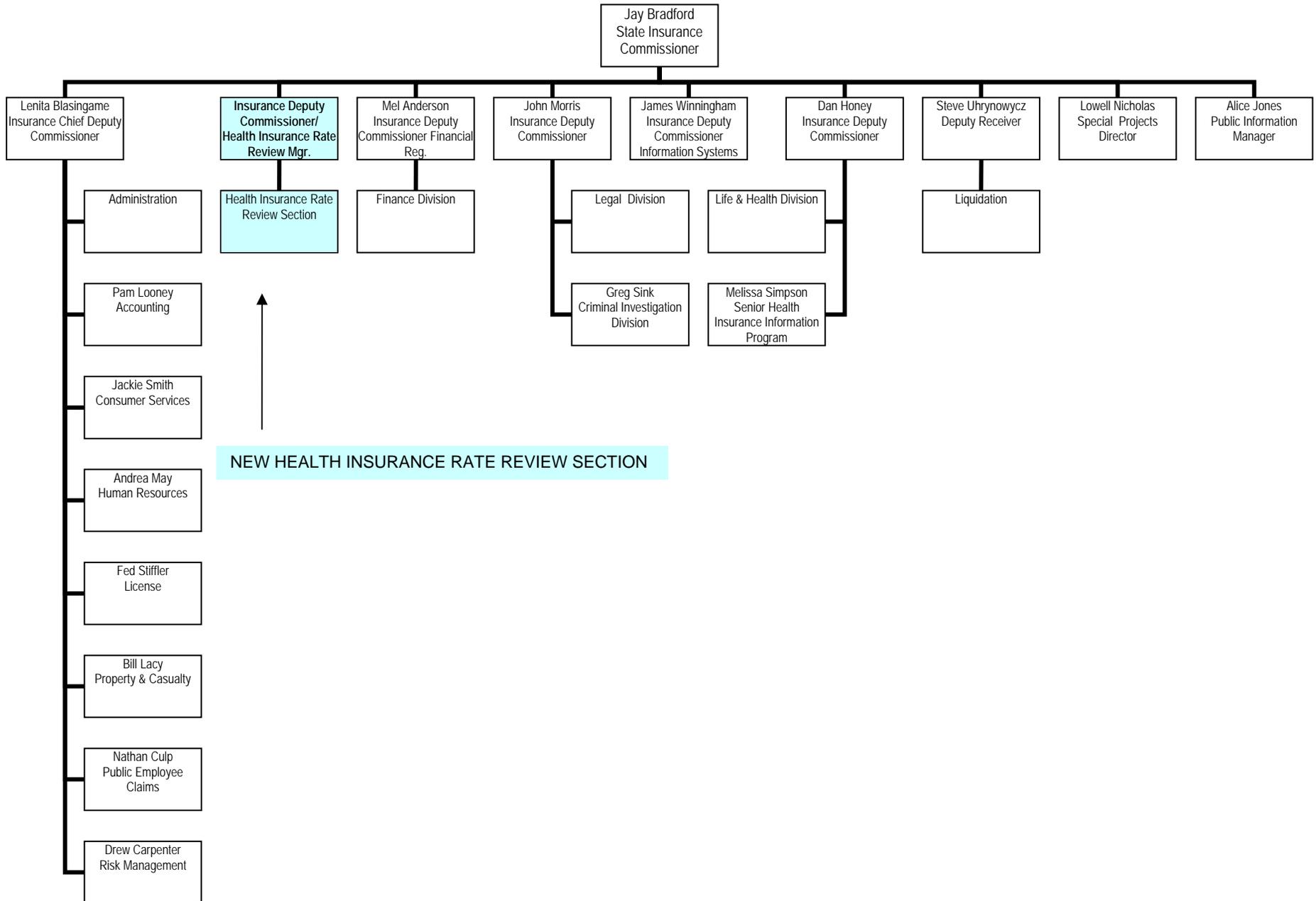
Celtic Insurance Company	3 Plan(s) Available
Aetna Life Insurance Company	1 Plan(s) Available
QCA Health Plan, Inc.	2 Plan(s) Available
John Alden Life Insurance Company	2 Plan(s) Available
Golden Rule Insurance Company	6 Plan(s) Available
Time Insurance Company	2 Plan(s) Available
Madison National Life	1 Plan(s) Available
Humana Insurance Company	5 Plan(s) Available
Standard Security Life	1 Plan(s) Available
World Insurance Company	1 Plan(s) Available
Freedom Life Insurance	4 Plan(s) Available
Arkansas Blue Cross and Blue Shield	4 Plan(s) Available
Mercy Health Plans	1 Plan(s) Available
Independence American Ins Co	1 Plan(s) Available
American Republic Insurance Company	8 Plan(s) Available

View companies offering plans in 72120:

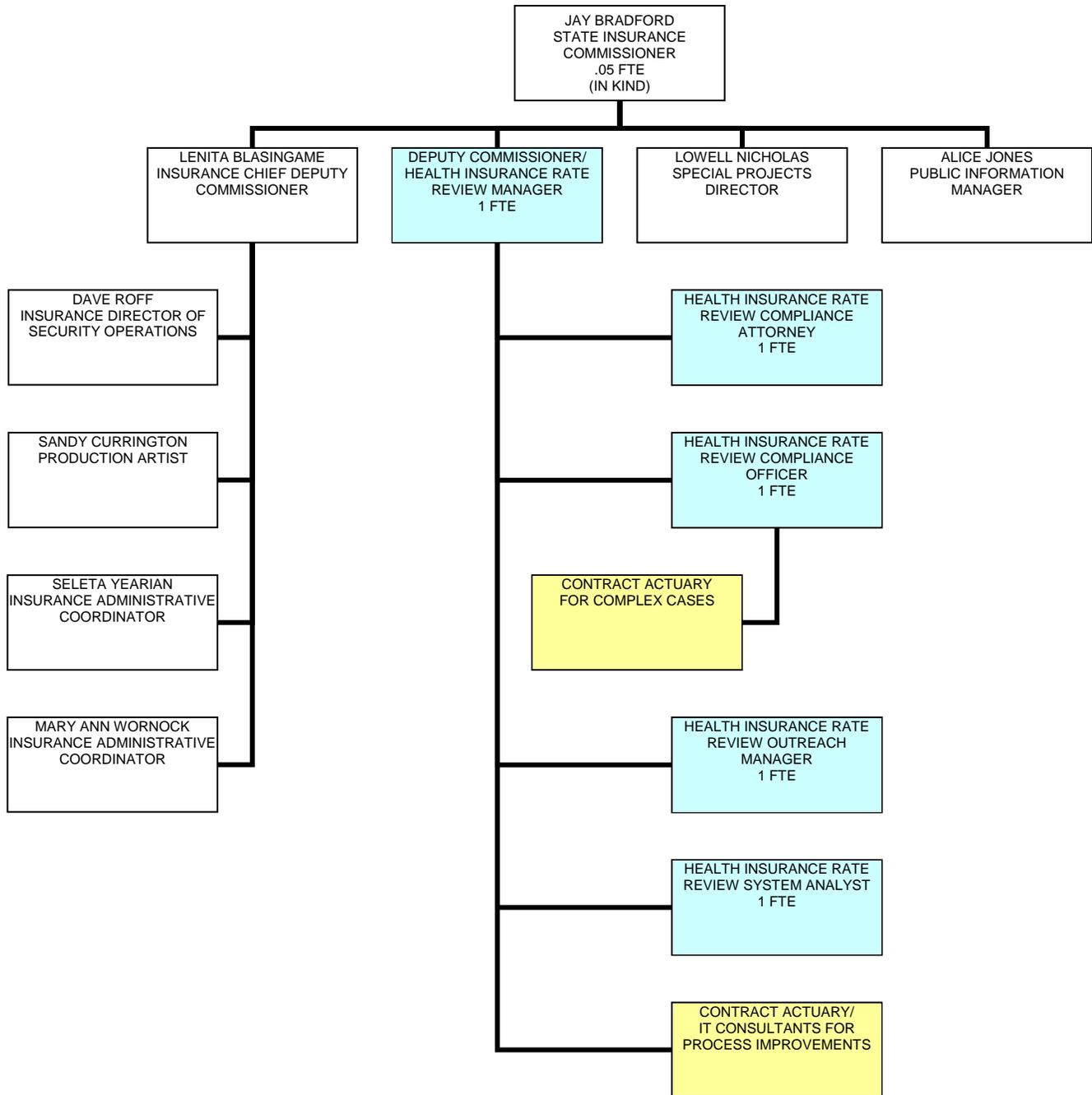
SMALL GROUPS

Trustmark Life Insurance Company	3 Plan(s) Available
Standard Security Life	1 Plan(s) Available
John Alden Life Insurance Company	2 Plan(s) Available
HMO Partners, Inc.	3 Plan(s) Available
Arkansas Blue Cross and Blue Shield	3 Plan(s) Available
Mercy Health Plans	1 Plan(s) Available
Principal Life Insurance Company	2 Plan(s) Available
UnitedHealthcare Insurance Company	2 Plan(s) Available
UnitedHealthcare of Arkansas, Inc.	1 Plan(s) Available
QCA Health Plan, Inc.	4 Plan(s) Available
Time Insurance Company	1 Plan(s) Available
Federated Mutual Insurance Company	1 Plan(s) Available
Union Security Insurance Company	2 Plan(s) Available
Humana Insurance Company	11 Plan(s) Available
Madison National Life	1 Plan(s) Available
Aetna Life Insurance Company	2 Plan(s) Available

ARKANSAS INSURANCE DEPARTMENT PREMIUM RATE REVIEW CYCLE 1



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



NEW HEALTH INSURANCE RATE REVIEW SECTION

CONTRACT EMPLOYEES