Health Insurance Rate Review Grant Program
Cycle I Quarterly Report Template

Submission Date: **May 20, 2011**

State: **Arkansas**

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

Project Quarter Reporting Period: **Quarter 2 (01/01/2011-3/31/2011)**

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

Reporting Period:

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

Timeframe for Delivery: January 31, 2011-February, 28, 2011
April 30, 2011-TBD
July 31, 2011-TBD
October 31, 2011-TBD

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

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

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

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

PART I: NARRATIVE REPORT FORMAT

Introduction:

This quarterly report (2nd) will update and detail the considerable progress made by the Rate Review Division of the Arkansas Insurance Department ("AID") that has occurred since the first quarterly report was submitted on February 23, 2011.

First and foremost, our principal goal is to have an "effective rate review process" which will meet or exceed all applicable HHS/CCIIO guidelines and standards. CCIIO will rule by July 1, 2011, whether a state has an "effective rate review process" for the individual and small group markets. The key requirements are: a) does the state have authority (by law, regulation, bulletin) to require a carrier to file a rate increase request with the state regulator? b) does the state have sufficient resources to review the rate increase request? and c) does the state review the rate increase request in accordance with the federal regulations? The ultimate goal of AID is optimal consumer protection and improved health care access.

Specific goals and objectives remaining are 1) expansion of AID legal authority for health insurance 'rate review' ("RR") and approval/disapproval; 2) enhanced expertise for health rate reviews; 3) enhanced 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) creation of health insurance rate review education, outreach, and training programs 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. Considerable progress has been made on all the goals detailed herein.

The grant funding is currently being used to: 1) enhance staff and technical expertise/efficiency for rate reviews through actuarial/information technology, consultation and process improvements and automation to the extent possible; 2) increase the size of the AID rate review staff; 3) create 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, legislators, state agencies, stakeholders, and professional health industry groups. The Rate Review Media Center will greatly improve AID's ability to train and upgrade internal staff as well as house RR "Public Hearings" (see attachment 6 – Media IFB).

As a result of the 'Request for Proposal' (RFP) being awarded to AON Hewitt in March of 2011, a comprehensive assessment of AID's Rate Review Process was received on May 13, 2011. This report is attached in its entirety (Attachment 2- RFP Scope of Service) & (Attachment 3 – AON Hewitt RFP Phase I Report). The information from this report has already greatly enhanced our knowledge and efforts.

Program Implementation Status:

1. **Accomplishments to Date**:

   - Successful implementation of AON Hewitt RFP
     AON Hewitt's Phase I response to this RFP has given AID Rate Review a comprehensive and quality assessment of nearly all components of the current AID health insurance rate review process. This response identifies changes in the current AID rate review process, including AID regulatory reporting, needed to fully comply with the mandates of HHS/PPACA. The final Phase I response will, in great detail, assess 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.
   - The Media Center RFP has been converted to an "Invitation for bid" (IFB) as mandated by state purchasing. Completion with final installation is scheduled to be no later than August 19th, 2011. (see Attachment 6)
   - Outreach program has been fully implemented with multiple public presentations.
   - The majority of the RR grant staff positions have been filled with employees in place;
   - New office space, furniture, computers, and communication equipment have been procured.

2. **Challenges and Responses**:

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

   - Rate Review Compliance
   - Rate Review System Analyst

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

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

   The challenges stated above, concerning state rules and regulations, have caused considerable delays across the board from the original AID grant timelines. AID will take whatever steps necessary to make up this lost time.

Significant Activities: Undertaken and Planned

- Within the Arkansas Insurance Department ("AID"), leadership of the three CCIIO-funded projects (Premium Rate Review, Health Benefits Exchange, and Consumer Assistance Program) have begun to meet regularly for strategic sharing and planning.

- The Premium Rate Review and Exchange Planning Programs have moved into newly renovated connecting space which allows for greater on-going communication and sharing of information between these programs. The need for understandable consumer information, consumer outreach education, and consumer empowerment is shared and advocated by all three programs.

- ARKANSAS RATE REVIEW AUTHORITY
  Under existing law, the Arkansas Insurance Department has prior approval authority over rates for individual health policies. Ark. Code Ann. § 23-79-109(a)(1)(A). Rates may be disapproved if they are unreasonable Ark. Code Ann. §23-79-110(5). For small employer groups, the Department has the authority to review a carrier's rating practices and its underwriting practices. The Department can review all information and documents that demonstrate that the carrier's rating methods and practices are based upon accepted actuarial assumptions. Rates for small employers are restricted by the provisions in Ark. Code Ann. § 23-86-204. These provisions apply to employer groups with no fewer than two nor more than twenty-five employees.

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

  At this time, the Department is considering the adoption of an administrative rule to address these issues. The Department has broad rule making authority including the authority to adopt any rule necessary for the state to be in compliance with any federal law. Ark. Code Ann. § 23-61-108(b).

  We are currently working with our rate review consultants on proposed language for this rule. Our goal will be to adopt a rule that will allow the Department to be determined to have an effective rate program. The rule will address additionally filing requirements as well as which material will be considered confidential. Any material that is not confidential will be made public through our expanded website capabilities. Our goal is to have filed this rule by June 1, 2011 and have effective by August 1, 2011.

Table 1: Current State of Arkansas Rate Filing Requirements

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

[10] For new products, filing must be accompanied by and actuarial memorandum and certified by an actuary that rates are reasonable.
[11] Actuarial data required for individual rate filings is outlined in AID Bulletin 4-79. If 500 or greater people in AR will be affected, need to send AR-specific experience in addition to nationwide experience.
[12] Industry not explicitly called out as a rating variable in regulations, but industries can be de facto excluded by not paying commissions. Gender is also not explicitly called out, but it is used by carriers in rating and is considered an acceptable rating variable.

Operational/Policy Developments/Issues

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

AID sought to increase its rate approval authority over small employer groups and increase the number of employees to fifty. For individual rates, the Department sought to increase the information required to be filed with a rate increase and to increase the grounds for disapproving rates. Neither of these legislative changes was passed. As a result, these bills were placed in an interim study committee. The Department has broad rule making authority, including the authority to adopt any rule necessary for the state to be in compliance with any federal law, and is considering the adoption of an administrative rule to address these issues.

Public Access Activities:

The Arkansas Insurance Department is in the implementation phase of the statewide stakeholder engagement outreach campaign. Our goal remains to improve consumer knowledge and involvement in the rate approval process in Arkansas while providing transparency.

The Public Information Officer has developed a Communication Action Plan, met with consumer groups, and has implemented improvements to the website in cooperation with the Information Technology department.

A new section has been added to the website for the Health Insurance Premium Rate Review Division. To enhance transparency and educate Arkansas consumers about the rate review process and how it impacts them, AID RR created a Rate Review '101' Primer which is posted on the AID website and has been distributed to consumers during face-to-face outreach events. The Primer contains basic educational information, such as a definition of "health insurance premium", how to reduce insurance premiums, etc. This is a "living document" and will continue to be refined as we develop various aspects of our outreach plan.

Using feedback received from our consultants on current and future outreach plans, RR held a "white boarding" session with the IT department to discuss making the AID website more interactive and user-friendly for consumers. The department is in the process of providing consumer friendly updates to the current AID website including allowing consumers to comment on proposed rate increases and signing up to be notified by email when a company files a rate increase.

Although there have not been many consumer complaints and inquiries historically regarding health insurance premiums, we have seen higher inquiry numbers in recent weeks and anticipate more inquires once rate review provisions of the health care reform is enacted and become more public.

AID is proactive in developing education activities to help handle these inquiries later with more enhancements to the website, a pamphlet, and amendments to the Primer.

AID is also in the process of launching a social media campaign which will include a Facebook page and Twitter account for the AID.

A Media Center IFB has been issued and will play a major role in our future outreach. The Media Center will serve a 'nerve center' for various stakeholders including legislators, consumers, various task forces and industry officials. It will be used to conduct meetings, webinars, podcasts, various other mechanisms that will ultimately be used to reach the consumer with information.

Strategies Undertaken:

- To create an active consumer-driven Advisory Council to assist with implementing meaningful methods to improve consumer knowledge and involvement in the rate approval processes.
- To work with the SERFF team to enhance the AID website to make rate review filings current, accessible, and understandable to the public.
- To identify the appropriate target market for its outreach efforts.
- To develop needed outreach strategies to reach applicable stakeholder groups.
- AID has established partnerships with various stakeholder groups to gain public input into the premium rate review education planning process.
- To develop a Rate Review 'Primer' which will explain the rate review process to consumers in "plain language."
- To develop tailored presentations and materials for consumer outreach and education for various target groups.
- To work with local partners to reach various consumer groups.
- To use social media as a method to reach consumers with information; Twitter and Facebook
- In planning phase to conduct a series of statewide public information and engagement meetings.

Strategies Planned:

- To issue press releases and public service announcements regarding outreach efforts.
- To develop print materials to post in municipal, county, state offices and for handouts during speaking engagements.
- 1-800 consumer inquiry service.
- To develop e-mail alerts for consumers to receive updates on companies' rate request filings.
- To conduct webinars and podcasts on health care and rate review topics.

The barriers and challenges the AID anticipates is taking complex information on rate review and making it easy for the general consumer to understand and present it in a way that will make the consumer benefit from the information we provide.

As mentioned, AID has developed a Rate Review '101' Primer. RR will continue to refine the Primer and provide information that will be helpful to the consumer gain a better understanding of their health care costs and how rate increases affect their budgets.

Collaborative Efforts:

AID RR has reached out to other states with advanced outreach plans to generate and supplement ideas including discussions on the use of social media as a mechanism to reach consumers. Conversations continue with various stakeholder groups, including state agency groups, consumer advocates, the Governor's office, legislators and key divisions within the AID. AID continues to participate in all NAIC working group calls and HHS conference calls pertaining to rate review.

Lessons Learned:

We are learning that the substantial lack of general health care knowledge will play a major role in how we tailor educational materials to consumers. We need to use terms and information the public will not only understand, but also care about. What does this mean to them and their family? These are the questions we are getting from consumer advocates and task forces that have been helpful in providing framework for aspects of our outreach plan.

Updated Budget

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

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

Updated Work Plan and Timeline:

During this second quarter, AON Hewitt was awarded RFP ID-11-1001 and has issued its Phase I report which provides a quality assessment of nearly all components of the current AID health insurance rate review process, including AID regulatory reporting needed to fully comply with the mandates of HHS/PPACA. A lengthy series of meetings and conference calls between our staff and AON Hewitt enabled this phase of the RFP to be completed.

Using feedback from AON and our various Advisory Groups, RR has implemented a robust outreach program which includes expansion of the AID website, distribution of education materials regarding the rate review process in Arkansas in face-to-face outreach efforts and on the web. A social media campaign will be launched and includes an AID Facebook page and Twitter account. RR has conducted a number of public presentations and is using the consultants and Advisory Groups comments to continue to amend and tailor the information to consumers.

RR is working with various departments within the AID to synergize outreach efforts including the Consumer Services Division. RR has provided content and materials to divisions to include during outreach events.

The Media Center IFB has been issued and will be a key component of our outreach efforts. The first on-site visit has been scheduled.

a) Phase I of the AON Hewitt RFP has been completed with 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.
b) Phase II will provide 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.

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

Enclosures/Attachments:

Attachment 1	AID RR Timeline
Attachment 1b	AON Timeline
Attachment 2	Milestones
Attachment 3	RFP Scope of Service
Attachment 4	AON Hewitt RFP Phase I Report
Attachment 5	AON Progress Report
Attachment 6	Media Center IFB
Attachment 7	National NAIC Survey
Attachment 8	AID Bulletins by year
Attachment 9	Proposed RR Manual Table of Contents

Attachment 1

AID Rate Review Timeline | 2011

July 6, 2011	Scheduled In-Person presentation of AON Final Phase II report
July 1, 2011	Voluntary Letter of Intent to apply for CFDA: 93.511
June 30, 2011	Final AON Phase II Report to AID
June 27, 2011	Response from AID on Revised Phase II Report
June 22, 2011	Revised Phase II report submitted for review
June 21, 2011	Media Center IFB bid opening date
June 20, 2011	AON develops training materials
June 17, 2011	Response from AID on Phase II Report
June 15, 2011	Draft Phase II Report to AID
June 10, 2011	Develop tools and processes to implement enhancements
June 8, 2011	AON to meet with AID to discuss possible tools, processes, and training materials to implement enhancements.
June 2, 2011	In-Person Presentation of Final Phase I report
May 31, 2011	Anticipated date for posting of remaining two staff positions
May 27, 2011	Final Phase I Report to AID
May 26, 2011	Anticipated launch of Facebook and Twitter
May 26, 2011	On-site visit for Media Center
May 18, 2011	First meeting scheduled with newly developed Consumer Advisory Group
May 18, 2011	Response from AID on Phase I Draft Report, conference call scheduled
May 17, 2011	Department wide social media outreach kick-off meeting
May 17, 2011	Rate Review Primer disseminated at SHIIP outreach event

May 16, 2011	Follow up call with AON on RR communication strategy with AON supplementary suggestions and ideas on enhancements to implementation of outreach plan.
May 13, 2011	Phase I Draft Report from AON
May 12, 2011	Media Center IFB issued
May 11, 2011	Conference call with AON on RR communication strategy
May 9, 2011	Remainder of supplies and additional office furniture ordered
May 9, 2011	Temp position filled
May 3, 2011	Additional computer equipment ordered to facilitate outreach plan
May 3, 2011	Additional staff positions posted.
May 2, 2011	Social media outreach meeting with Chief Deputy Commissioner And Director of Information Technology
April 20, 2011	First post contract call with AON to discuss work plan and timeline
April 15, 2011	AON contract approved and finalized
April 5, 2011	Second stakeholder meeting to update group on progress and seek feedback
March 21, 2011	Rate Review website created, went live
March 15, 2011	Engaged in face to face outreach with consumers; handed out print materials and answered questions regarding rate review
March 9, 2011	Primer “101” created

Arkansas Insurance Department (AID) - Rate Review Project

Timeline

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

Attachment 2
MILESTONES

Objectives	Progress	Challenges, Responses & Variations
1. Expand AID's legal authority for health insurance 'rate review' ("RR") and approval/disapproval.	AID is currently working with our consultants on proposed language to adopt a rule to expand our scope of authority to include small employer groups.	In the recent legislative session, the Department sought to increase its rate approval authority over small employer groups and increase the number of employees to fifty. For individual rates, the Department sought to increase the information required to be filed with a rate increase and to increase the grounds for disapproving rates. Neither of these legislative changes was passed. However, these bills were placed in an interim study committee along with all proposed legislation dealing with the Affordable Care Act. At this time, the Department is considering the adoption of an administrative rule to address these issues.
2. Enhance expertise for health rate reviews.	Phase I of the AON Hewitt report provides a comprehensive outline of current AID personnel and resources used for rate review and is in the process of making enhancement recommendations in Phase II.	State rules and regulations have hampered progress in employment, procurement, and the hiring process. This has resulted in considerable delays in filling remaining vacant staff positions including a Rate Review Compliance Officer.
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.	Phase I of the AON Hewitt report provides a comprehensive assessment of all current components of the AID health insurance rate review process including all related and applicable information technology, data management, regulatory and management reporting requirements. The next phase will include recommendations on enhancements.	

MILESTONES

Objectives	Progress	Challenges, Responses & Variations
4. Create health insurance rate review education, outreach, and training programs 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 outreach program has been fully implemented with multiple public presentations. Educational materials have been developed, posted on AID website and distributed to diverse stakeholders including the general public. A social media campaign will be launched soon to provide another avenue for consumers to have access to AID and helpful information.	The substantial lack of general health care knowledge will play a major role in how we tailor educational materials to consumers. RR is working with consultants and IT Department to develop a more consumer friendly website and materials.
5. 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.	AID has established partnerships with various stakeholder groups including our primary Stakeholder group and newly developed Consumer Advisory Group to gain public input into the premium rate review education planning process. Meetings have been conducted and feedback from these groups has provided a framework for aspects of our outreach plan.	
6. 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, legislators, state agencies, stakeholders, and professional health industry groups.	The Media Center RFP has been converted to an "Invitation for bid" (IFB) as mandated by state purchasing and completion with final installation no later than August 19th, 2011. An on-site visit is scheduled July 26th, 2011.	The 'Arkansas State Office of Purchasing' required that we switch the Media Center RFP to a straight bid format which required a great deal of extra work to comply and delayed progress.

Attachment 3

AON Hewitt (RFP) Scope of Services

PHASE I

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

This assessment will include, but not be limited to, AID personnel, AID resources, legislation and regulations, internal and external actuarial functions and procedures, scope of use of external actuarial services, operating standards and guidelines, the AID web site, information technology, database management, core reporting capabilities, historic rate review performance, filing and processing of public contacts and requests, level of consumer service, current and future use of SERFF capacities, management reporting, training of internal rate review personnel, outreach, and process transparency.

Additional topics to be considered are:

1. Determination of potential intersections of HHS/OCIIO Rate Review, Exchange, and Consumer Assistance Grants in the State of Arkansas (AID is the grantee of all three) and the most synergistic approach for mutual assistance and cooperation as well as avoidance of duplication of efforts.

2. Improvement of the current reporting and data collection systems, construction of an innovative data system which will house rates, related increases filed for use, and optimal utilization of the expanded functions of SERFF to allow accurate and timely analysis and reporting. This optimal data system will provide the best possible platform, structure and/or mechanism for the internal or external actuaries to perform timely and cost effective rate analysis.
   - Optimal automation, to the extent possible, and streamlining of the AID rate review process
   - Tracking required PPACA data, rate filing information, national & state trends, and patterns
   - Benchmarking capability and utilization of national, regional, and contiguous state trends
   - Improve data measurement and analytic capacity to generate meaningful AID ‘rate review’ management reports and upgrading technology and database management if required.

3. AID Standards for Approval
   - Conventional actuarial standards
   - Modified standards
   - Filing Requirements, Transparency and Full Discovery:
   - Review Method:
     - Hearings
     - Desk reviews

4. Optimizing consumer participation and public dissemination of information using web-based & interactive video technology, outreach, and public meetings and hearings.

5. Effective utilization of available HHS waiver processes.

AID Internal Actuarial Objectives

1. Examine the appropriateness of data currently utilized by carriers in their rate request submissions and develop guidelines for validation.

2. Study the market segment standards currently used in determining reasonableness of premium levels and increases, and identify additional information needed.

3. Study significant assumptions currently being made in deriving the required premium rate, particularly in the event of small or immaterial blocks of business or the entrance into a new line of business.

1. Identify reputable sources for trend assumptions and determine if there are other publicly available information sources to ascertain the reasonableness of the request.

4. Search trend justifications from the carriers including intrinsic trend and renewing provider contracts.

5. Consider potential external measures (surveys, claims data, etc) that are applied by the carriers in order to evaluate the assumptions used in the development of the premium rates.

6. If any form of outcome based payment approaches are used by the carriers, study valuation of network payment levels and provider outcome measures.

7. Determine the potential impact that carrier violations of the minimum MLR (beginning 1.1.2011) will have on the future AID rate review process and/or the actuarial calculations.

PHASE II

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

Arkansas Insurance Department (AID)

Rate Review Project

Phase 1 – Assessment of Current Process

Executive Summary

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

1) **Defining "subject-to-review" and "unreasonable"** in regulation or bulletin form.

2) **Developing more specific requirements for the data, assumptions, and methodology description** that included in rate filings (or disapproving filings that do not have sufficient information for an actuary to review the filing).

3) **Creating internal training materials, a rate review manual, and electronic job aids**.

4) **Improving consumer outreach**.

5) **Develop an internal database with pertinent rate filing information**.

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

Introduction

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

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

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

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

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

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

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[1] Proposed HHS rule on rate increase disclosure and review: http://www.gpo.gov/fdsys/pkg/FR-2010-12-23/pdf/2010-32143.pdf. (December 23, 2010)
[2] Draft requirements for preliminary justification documents: http://www.federalregister.gov/articles/2011/03/01/2011-4552/agency-information-collection-activities-proposed-collection-comment-request#p-2. (March 1, 2011)
[3] Cycle I grant award announcement: http://www.hhs.gov/news/press/2010pres/08/20100816a.html. (August 16, 2010)

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

ACA Rate Increase Review and Disclosure Requirements

Rate Increase Review

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

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

1) All rate increases at or above a specific threshold will be deemed **"subject to review".**

2) All rate increases that are "subject to review" will be reviewed by HHS and determined to **reasonable or unreasonable**.

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

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

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

[4] Because this is an annual review process, this includes multiple rate increases that total 10% or more in a given year.
[5] Based on state definition of Small Group, not for other purposes under ACA.

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

Rate Increase Disclosure

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

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

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

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

Post-Review Steps

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

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

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

Outstanding Legal Questions

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

1) **Will deemers be allowed?** Many states currently have provisions that allow rates to be deemed approved if the state does not disapprove them within a specified time period (for example, 30 days). One carrier has heard that allowing rates to be deemed approved may not constitute an "effective" rate review process, since not all rate filings are marked as approved or disapproved.

2) **Do the requirements only need to be applied to renewals/closed blocks**, or do they affect new business as well? Based on conversations with AID personnel, they have indicated that they plan to apply the new requirements to both new business and renewals. However, one carrier indicated a preference for applying the requirements only to renewals.

Other Health Care Reform Changes

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

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

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

Aon Hewitt's Phase I Activities

During Phase I, Aon Hewitt performed the following tasks:

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

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

Rate Filing Requirements, Staffing and Process

Current Situation

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

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

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

Current Rate Filing Requirements

Individual

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

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

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

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

Small Group and Large Group

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

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

[6] §23-66-206(14)(B), §23-66-206(14)(E), §23-66-206(14)(F), and AID Rules 28 and 37.
[7] §23-86-303(34)
[8] §23-66-202(12)(A)
[9] §23-79-109(a)(1)(A)

Table 1: Current State of Arkansas Rate Filing Requirements

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

[10] For new products, filing must be accompanied by and actuarial memorandum and certified by an actuary that rates are reasonable.
[11] Actuarial data required for individual rate filings is outlined in AID Bulletin 4-79. If 500 or greater people in AR will be affected, need to send AR-specific experience in addition to nationwide experience.
[12] Industry not explicitly called out as a rating variable in regulations, but industries can be de facto excluded by not paying commissions. Gender is also not explicitly called out, but it is used by carriers in rating and is considered an acceptable rating variable.

Current Staffing

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

Personnel

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

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

Outside Resources

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

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

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

Workload

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

Training/Expertise

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

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

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

Current Rate Filing Review Process

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

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

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

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

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

If the conditions for expedited approval are not met, a projected loss ratio is calculated using the following formula[13]:

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

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

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

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

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

Analysis of Rate Filing Review Performance

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

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

[13] Formula provided in e-mail from Lowell Nicholas (Health Insurance Rate Review Manager) on May 3, 2011, in response to a question posed to Rosalind Minor (Life and Health Compliance Officer).

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

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

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

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

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

Golden Rule, 11/24/2009 Individual Rate Filing

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

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

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

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

Aon Hewitt's Assessment of AID Rate Filing Review Process

Fulfilling HHS' Requirements

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

Standard for "Unreasonable" Rate Increases

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

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

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

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

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

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

Data and Documentation

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

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

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

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

2) **It does not account for the fact that there is typically a gap between the end of the historical period and the projection period.**

[14] Actuarial Standard of Practice No. 41, "Actuarial Communications", Section 3.3.3, March 2002; http://www.actuarialstandardsboard.org/pdf/asops/asop041_120.pdf .

[15] $$\frac{(\text{Historical Incurred Claims}) \times (1 + 15\%)}{(\text{Historical Premium}) \times (1 + \text{Requested Rate Increase})}$$

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

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

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

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

Review of Data and Documentation

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

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

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

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

Examining Reasonability of Assumptions

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

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

3) Financial history of the company

4) Medical trend

5) Whether the insurer has filed a loss ratio guarantee.

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

Interaction of Rate Filing Review and State Exchange

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

Other Process-Related Comments

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

1) **Spell out more extensive and specific rate filing requirements via regulation or bulletin**. These requirements could be developed in a way that does not make them onerous, but does require the actuaries to provide what is needed for another actuary to review the filing.

2) For any rate filings that do not provide sufficient information for a review of the filing, **ask the carrier to send the information**. The letter with the request should indicate that the 30-day review period does not start until this data was received (a regulation and/or bulletin may need to be released to allow the AID to do this). A checklist could be used by the Compliance Officer to ensure that this information is included before the filing is sent to outside actuaries for review.

3) **Disapprove any rate filings that do not contain sufficient data for a review**.

Assessment of Staffing

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

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

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

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

Assessment of Training

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

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

Below are some improvements that can be made:

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

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

Transparency and Consumer Relations

Current Situation

Transparency

As noted above, the AID has not historically made rate filing information available to the public until it is deemed closed by the commissioner. Therefore, the AID has not historically sought consumer input prior

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

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

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

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

Consumer Complaints/Inquiries

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

Consumer Outreach

Historical activities

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

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

Changes Under Cycle I Grant

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

Aon Hewitt's Assessment of Transparency and Consumer Relations

If the AID wants to improve transparency and the ability for the public to provide input prior to approving rates, the practice of holding rate filings confidential before they are deemed closed will need to be changed to allow the AID to provide information about proposed rate filings to the public. As noted above, the AID plans to clarify what constitutes "actuarial formulas and assumptions". The AID could then redact confidential information from filings or request the actuary to submit separate public vs. confidential

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

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

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

Information Technology and Database Management

Data for Reporting

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

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

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

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

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

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

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

Incorporating Other Data

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

Automating the Rate Filing Review Process

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

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

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

2) **Formulas to check the actuary's calculation** of projected experience from the historical experience. Errors found in the actuary's calculation or assumptions can sometimes cause a large impact on the rate increase.

3) **Basic checks on assumptions for trend, loss ratio, etc.** Error messages could indicate to the Compliance Officer when assumptions are unusual.

4) **Electronic checklist of items to be checked by the Compliance Officer** before sending it on to actuarial consultants (where applicable).

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

IT Capabilities and Resources

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

Conclusions

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

1) **Develop standards for filings that are "subject-to-review" and "unreasonable".** The determination of "unreasonable" will likely need to involve some subjective judgment (e.g., by an actuary), but the AID should at least provide a general outline of how a filing is determined to be "unreasonable".

2) Consider **developing more specific requirements for the data, assumptions, and methodology description** that need to be included in rate filings. This should help to minimize resources spent on reviewing filings, including internal staff time and external actuarial resources. Alternatives to developing specific requirements include disapproving filings that do not include enough documentation and/or developing a list of data elements to check for each filing.

3) **Create internal training materials, a rate review manual, and electronic job aids** to help with the rate filing review process.

4) **Improve consumer outreach**, including educational documents, website layout and content, The release of least portions of rate filings publicly available before they are closed, and possibly press releases and/or town hall meetings to discuss rate requests.

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

Next Steps

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

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

Arkansas Insurance Department

Health Insurance Rate Review Process

Phase I Discussions with Carriers

Discussion Guide (April 26, 2011)

Introduction

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

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

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

Aon Hewitt Participants

The following Aon Hewitt actuaries will be leading these calls:

- **Richard G. Rush, FSA, MAAA:** Rick is a senior vice president in Aon Hewitt's Health and Benefits practice in Denver, CO. Rick has over 25 years of employee benefits actuarial experience, including executive positions with insurance companies, actuarial consulting firms, and the human resources responsibilities of a *Fortune* 500 company. His insurance company and related consulting experience includes chief executive and chief actuary responsibilities for health insurers and regional HMOs, and a federal court-appointed rehabilitator and liquidator of two separate insolvent HMOs..

- **Laura L. Peck, FSA, MAAA:** Laura is an actuarial consultant at Aon Hewitt in Newport Beach, CA. She has over 12 years of health care actuarial experience. Prior to joining Aon Hewitt, Laura interned at the California Department of Health and Human Services, worked in consulting for two years, and

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

Discussion Topics for Phase I

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

1) What changes, if any, do you plan to make to your rate filing process nationwide in response to PPACA? For example, are you developing a standard plain language summary that will be used as a template in all states? Do you plan to automatically submit additional justifications when requesting rate increases of 10% or more? Is there any other rate filing standardization being done nationwide as part of PPACA?

2) Have there been any technological issues with filing rates? Are you accustomed to filing via SERFF, and does this process work well for you? Do you have any technological concerns about SERFF? E.g., trouble with submitting filings, system downtime, etc.

3) Are the current data requirements for Arkansas health rate filings reasonable and appropriate in your view? What, if any, changes would you suggest to the data requirements for rate filings?

4) If the AID responds to a rate filing with additional questions, are they asking the right questions in your view?

5) If rate filings are sent back as not approved, why are they typically disapproved? What actions have you taken after a disapproval? E.g., re-submit with additional data or a lower rate increase, etc.

6) When communicating with the AID regarding rate filings, does the staff seem to have the right level of training, knowledge, and experience to understand the complexities of rate development (both in the past and for future rate filings that may be impacted by health care reform changes)? Have there been any challenges with explaining the rationale for rate changes?

7) Does the AID respond to rate filings or questions from carriers regarding rates in a timely manner?

8) As the AID looks to begin reviewing small group rate filings as required under PPACA, are there any suggestions that you have? What data requirements would you suggest for small group rate filings?

In Closing

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

Arkansas Insurance Department

Health Insurance Rate Review Process

Potential Changes Needed to SERFF

May 6, 2011

Introduction

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

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

1) Draft HHS rate review regulations (12/21/2010)

2) Proposed HHS Preliminary Justification (Disclosure) Form and Instructions (3/1/2011)[18].

3) Current fields available in SERFF

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

HHS Preliminary Disclosure Requirements

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

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

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

[17] Interim Final Rule on Rate Increase Disclosure and Review, released by the Department of Health and Human Services (HHS) on 12/21/2010.
[18] Published by the Centers for Medicare and Medicaid Services (CMS) on March 1, 2011

Comments Regarding HHS Disclosure Forms

Usefulness of Information for Consumers

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

Storage of Disclosure Information in SERFF System

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

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

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

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

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

Additional Fields

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

Trends

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

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

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

Loss Ratios

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

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

Inclusion of Fields in Initial Rate Filing

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

Complete List of Suggested Fields to Add to SERFF

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

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

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

b. Utilization changes (including “mix” changes)
c. Impact of plan design changes
d. Impact of health care reform
e. Underpricing in previous rate filing
f. Changes in target retention (admin and profit) assumption
g. Other factors (to be delineated and described by the filing actuary)

11) Current rate member’s cost sharing
a. Inpatient
b. Outpatient
c. Professional
d. Prescription drugs
e. Other
f. Capitation
g. Total

12) Current rate projected allowed PMPM
13) ***Current rate net claims PMPM***
14) Current rate administrative costs PMPM
15) Current rate underwriting gain/loss PMPM
16) Current rate – total rate PMPM
17) Future rate start date
18) Future rate end date
19) Future rate overall medical trend
a. Inpatient
b. Outpatient
c. Professional
d. Prescription drugs
e. Other
f. Capitation
g. Total (sum of a:f)

20) Future rate total allowed
a. Inpatient
b. Outpatient
c. Professional
d. Prescription drugs
e. Other
f. Capitation
g. Total (sum of a:f)

21) Future rate net claims
a. Inpatient
b. Outpatient
c. Professional
d. Prescription drugs
e. Other
f. Capitation
g. Total (sum of a:f)

22) Future rate allowed PMPM
23) ***Future rate net claims PMPM***
24) Future rate administrative costs PMPM
25) Future rate underwriting gain/loss PMPM
26) ***Future rate – total rate PMPM***
27) Historical loss ratio for each of last 3 years

Appendix B

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

Arkansas Insurance Department (AID)

Rate Review Project

Aon Hewitt Progress Report

For Rate Review Grant Program, Quarter 2

Revised May 6, 2011

Phase I Activities Completed

Aon Hewitt has completed the following Phase I activities:

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

Phase I Activities Remaining

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

Upcoming Phase II Activities

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

Attachment 6

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

INVITATION FOR BID

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

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

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

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

Company Name: _____

Name (type or print): _____

Title: _____

Address: _____

Telephone Number: _____

Fax Number: _____

E-Mail Address: _____

Signature: _____
USE INK ONLY; UNSIGNED BIDS WILL NOT BE CONSIDERED

Identification:

*	*
Federal Employer ID Number	Social Security Number

FAILURE TO PROVIDE TAXPAYER IDENTIFICATION NUMBER MAY RESULT IN BID REJECTION

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

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

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DELIVERY OF RESPONSE DOCUMENTS

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

MINORITY BUSINESS POLICY

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

Check minority type:

_____ African American	_____ Hispanic American	_____ American Indian
_____ Native American	_____ Asian	_____ Pacific Islander

AR Certification number_____

CURRENCY

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

LANGUAGE

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

REQUIREMENT OF ADDENDUM

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

ALTERATION OF ORIGINAL IFB DOCUMENTS

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

ADDITIONAL TERMS AND CONDITIONS

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

ACT 157 of 2007 EMPLOYMENT OF ILLEGAL IMMIGRANTS

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

EO-98-04 GOVERNOR'S EXECUTIVE ORDER:

Required to be completed by the successful bidder prior to award

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EQUAL EMPLOYMENT OPPORTUNITY POLICY

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

ANTICIPATION OF AWARD

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

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

PAST PERFORMANCE

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

VISA ACCEPTANCE

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

OUTSTANDING TAX LIABILITY

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

AWARDING INSTRUCTIONS

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

DELIVERY

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

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SECTION 1: GENERAL INFORMATION

INTRODUCTION

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

ISSUING OFFICE

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

MANDATORY SITE VISIT

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

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

IFB FORMAT

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

ACCOUNTING PROVISIONS

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

PERFORMANCE BOND

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

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

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

CLARIFICATION OF IFB

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

CONTRACT INFORMATION

A. The State of Arkansas may not contract with another party:
   1. To indemnify and defend that party for any liability and damages. However, the State Procurement Official may agree to hold the other party harmless from any loss or claim resulting directly from and attributable to the State's use or possession of equipment or software and reimburse that party for the loss caused solely by the State's uses or possession.
   2. Upon default, to pay all sums to become due under a contract.
   3. To pay damages, legal expenses or other costs and expenses of any party.
   4. To continue a contract once the equipment has been repossessed.
   5. To conduct litigation in a place other than Pulaski County, Arkansas
   6. To agree to any provision of a contract which violates the laws or constitution of the State of Arkansas.

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

DEFINITION OF TERMS

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

CONDITIONS OF CONTRACT

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

TERM OF CONTRACT

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

VENDOR REQUIREMENTS

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

STATEMENT OF LIABILITY

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

AWARD RESPONSIBILITY

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

INDEPENDENT PRICE DETERMINATION

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

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

SUBCONTRACTORS

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

PUBLICITY

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

ANTICIPATED PROCUREMENT TIMELINE

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

*approximate dates

SECTION 2: SCOPE OF WORK

GENERAL

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

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

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

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

PRESENTATION REQUIREMENTS

CONTROL SYSTEM

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

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

TOUCH PANELS

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

FLAT PANELS

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

LECTERN

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

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

MICROPHONES

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

DOCUMENT CAMERA

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

VIDEO CONFERENCING

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

AUDIO CONFERENCING

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

PODCASTING

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

SPEECH REINFORCEMENT SYSTEM

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

ASSISTED LISTENING SYSTEM

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

AUDIO DISTRIBUTION SYSTEM

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

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

CONFIDENCE MONITOR

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

BLU-RAY DVD PLAYER

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

TV CABLE

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

WARRANTY REQUIREMENTS

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

SUPPORT/SERVICE REQUIREMENTS

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

TRAINING REQUIREMENTS

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

DOCUMENTATION

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

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OFFICIAL PRICE SHEET

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

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MANDATORY SITE VISIT FORM

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

_____ _____
AID / OSP Representative **Date**

_____ _____
Vendor **Date**

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

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STANDARD TERMS & CONDITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attachment 7

HIPR (Health Insurance Premium Review) Cycle II Survey

Results Overview

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

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

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

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

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

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

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

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

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

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

Attachment 8

ARKANSAS INSURANCE DEPARTMENT BULLETINS SORTED BY YEAR

Please click here to view Arkansas Insurance Department Bulletins sorted by year.

Attachment 9

TABLE OF CONTENTS

ARKANSAS RATE REVIEW MANUAL

        - Group
            - New Product
            - Renewal
    - Federal - Impact of PPACA
- Reviewing Filings – High level
    - Actuarial Memorandum
    - Experience history
    - Projection
    - Requested rate actions

Individual Rate Review

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

Group Rate Review

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

Appendices

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