

Arkansas Insurance Department

Mike Beebe
Governor



Jay Bradford
Commissioner

December 6, 2011

BULLETIN NO. 6A-2011

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

FROM: ARKANSAS INSURANCE DEPARTMENT

SUBJECT: PREMIUM APPROVAL FOR INDIVIDUAL MAJOR MEDICAL POLICIES AND REVIEW OF INDIVIDUALLY UNDERWRITTEN MAJOR MEDICAL CERTIFICATES OF INSURANCE ISSUED THROUGH AN ASSOCIATION TO RESIDENTS OF ARKANSAS.

EFFECTIVE DATE: SEPTEMBER 1, 2011

Bulletin 6A-2011 replaces Bulletin 6-2011 in its entirety.

Pursuant to Ark Code Ann. §§23-79-109, 23-76-112 and 23-75-111, all premium rates for individual accident and health insurance policies or contracts must be approved by the Commissioner prior to those rates being implemented. Bulletin 4-79 sets forth the filing requirements for all such policies and contracts. This Bulletin will supersede Bulletin 4-79 as it applies to individual major medical policies as defined in AID Rule 18. For all individually underwritten major medical policies, certificates, or evidence of coverage issued through an association to residents of Arkansas regardless of where the association policy was issued, the filing requirements in this Bulletin shall apply. Insurers, Hospital Medical Service Corporations and Health Maintenance Organizations making premium rate filings shall furnish the following data:

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

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

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

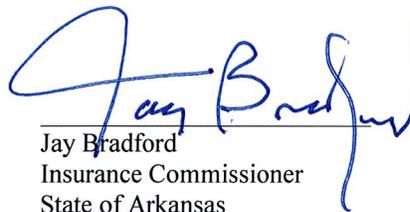
1. The impact of medical trend changes by major service categories;
2. The impact of utilization changes by major service categories;
3. The impact of cost-sharing changes by major service categories;
4. The impact of benefit changes;
5. The impact of changes in enrollee risk profile;

6. The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase;
7. The impact of changes in reserve needs;
8. The impact of changes in administrative costs related to programs that improve health care quality;
9. The impact of changes in other administrative costs;
10. The impact of changes in applicable taxes, licensing or regulatory fees;
11. Medial Loss Ratio;
12. The carrier's capital and surplus; and
13. Consumer comments regarding the rate filing.

For all rate filings that are subject to this Bulletin and 45 CFR Part 154 and meet or exceed the state-specific threshold or, if no state-specific threshold has been established, the threshold established by the Secretary of HHS, Insurers, Hospital Medical Service Corporations and Health Maintenance Organizations shall file Exhibit 3 with the Department.

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

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



Jay Bradford
Insurance Commissioner
State of Arkansas

12-6-11
Date

EXHIBIT 1

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

Information

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

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

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

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

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

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

B. Description of Worksheet Data Elements

Section A: Base Period Data

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

Section B Claims Projections

B1 Adjustment to the Current Rate

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

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

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

B2 Claims Projection for the Future Rate

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

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

Section C: Components of Current and Future Rates

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

Future Rate

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

Prior Estimate of Current Rate

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

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

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

Difference

These fields are calculated automatically.

Section D: Components of Medical Claims Changes

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

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

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

Section D: Components of the Rate Increase

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

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

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

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

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

Exhibit 2

III: Instructions for Completing Exhibit 2 of the Preliminary Justification

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

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

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

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

Exhibit 3

Instructions for Completing Exhibit 3 of the Preliminary Justification

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

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

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

List of Exhibit 3 Reporting Requirements:

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

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

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

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

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

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

- a. Loss Ratio Exhibit

- 7. The projected future loss ratio and a description of how it was calculated.**
 - a. Loss Ratio Exhibit: Anticipated lifetime loss ratio that combines cumulative and future experience, and description of how it was calculated

- 8. The projected lifetime loss ratio that combines cumulative and future experience, and a description of how it was calculated.**
 - a. Loss Ratio Exhibit

- 9. The Federal medical loss ratio (MLR) standard in the applicable market to which the rate increase applies, accounting for any adjustments allowable under Federal law.**
 - a. Loss Ratio Exhibit:
 - i. Anticipated loss ratio presumed reasonable according to the guidelines including adjustment for credibility if applicable
 - ii. Quality Improvement Costs

- 10. If the result under (7.) is less than the standard under (9.), a justification for this outcome is required.**

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

e Summary Worksheet

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

A. Base Period Data

Start Period: 05/01/2009 End Period: 04/30/2010

Service Categories	Member Months	Total Allowed	Net Claims	Member's Cost Sharing	Member's Cost Sharing PMPM	Net PMPM	Allowed PMPM
Inpatient	10,000	\$ 313,250.00	\$ 244,355.00	\$ 68,895.00	\$ 6.89	\$ 24.44	\$ 31.33
Outpatient	10,000	\$ 311,000.00	\$ 242,580.00	\$ 68,420.00	\$ 6.84	\$ 24.26	\$ 31.10
Professional	10,000	\$ 774,000.00	\$ 603,720.00	\$ 170,280.00	\$ 17.03	\$ 60.37	\$ 77.40
Prescription Drugs	10,000	\$ 498,000.00	\$ 368,500.00	\$ 129,500.00	\$ 12.95	\$ 36.85	\$ 49.80
Other	10,000	\$ 45,800.00	\$ 35,700.00	\$ 10,100.00	\$ 1.01	\$ 3.57	\$ 4.58
Capitation	10,000	\$ 75,000.00	\$ 75,000.00	\$ -	\$ -	\$ 7.50	\$ 7.50
Total	10,000	\$ 2,017,050.00	\$ 1,569,855.00	\$ 447,195.00	\$ 44.72	\$ 156.99	\$ 201.71

B. Claim Projections

B1. Adjustment to the Current Rate

Start Period: 01/01/2010 End Period: 12/31/2010

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Member's Cost Sharing
Inpatient	1.0154	\$ 31.81	\$ 25.13	0.21
Outpatient	1.0462	\$ 32.54	\$ 25.70	0.21
Professional	1.0284	\$ 79.60	\$ 62.88	0.21
Prescription Drugs	1.0669	\$ 53.13	\$ 39.85	0.25
Other	1.0155	\$ 4.65	\$ 3.67	0.21
Capitation	1.0100	\$ 7.58	\$ 7.58	0.00
Total		\$ 209.30	\$ 164.81	0.21

B2. Claims Projection for Future Rate

Start Period: 01/01/2011 End Period: 12/31/2011

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

C. Components of Current and Future Rates

	Future Rate		Prior Estimate of Current Rate		Difference	
	PMPM	%	PMPM	%	PMPM	%
1. Projected Net Claims	\$ 179.11	76.20%	\$ 159.20	75.73%	\$ 19.91	80.22%
2. Administrative Costs	\$ 45.75	19.46%	\$ 43.33	20.61%	\$ 2.42	9.75%
3. Underwriting Gain/Loss	\$ 10.19	4.34%	\$ 7.70	3.66%	\$ 2.49	10.03%
4. Total Rate	\$ 235.05	100.00%	\$ 210.23	100.00%	\$ 24.82	100.00%
5. Overall Rate Increase		11.81%				

D. Components of Rate Increase

Claims Components	Impact on Rate	Percent
1. Inpatient	\$ 1.97	9.87%
2. Outpatient	\$ 3.05	15.30%
3. Professional	\$ 5.51	27.68%
4. Prescription Drugs	\$ 5.24	26.32%
5. Other	\$ 0.30	1.50%
6. Capitation	\$ 0.16	0.80%
7. Cost Share Change	\$ (1.92)	-9.66%
8. Correction of Prior Net Claims Estimate	\$ 5.61	28.18%
9. Total	\$ 19.91	100.00%

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

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

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

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

F. Range and Scope of Proposed Increase

Number of Covered Individuals	900
Number of Covered Policyholders	800

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