UHAS UNITED HEALTH ACTUARIAL SERVICES LLC

Proposal for

Actuarial Rate Reviews of Life- and Health-Related Product Filings and Related Consulting Services for the State of West Virginia

RFQ #: INS14014

Cost Proposal

Original Document

11611 North Meridian Street - Suite 330 Carmel, IN 46032 www.UHASinc.com O: 317.575.7672 F: 317.575.7678

UHAS UNITED HEALTH ACTUARIAL SERVICES INC

February 4, 2014

State of West Virginia
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

Attn: Evelyn Melton
Phone: 304-558-2306
Fax: 304-558-4115
Email: evelyn.p.melton@wv.gov

Re: Solicitation #: INS14014

Dear Ms. Melton:

United Health Actuarial Services, Inc. (UHAS) is excited and pleased about participating in this procurement effort by the State of West Virginia to acquire Actuarial Consultants for Actuarial Rate Reviews of Life- and Health-Related Product Filings and Related Consulting Services. UHAS and its predecessor practice were founded over thirteen years ago with the goal of providing quality independent actuarial services at a reasonable cost. UHAS is headquartered in Carmel, Indiana.

As the current vendor on this project, we understand the importance of meeting the needs of the Office of the Insurance Commissioner (OIC). During our engagement we have provided rate reviews relating to numerous product and rate filings, we have also assisted in the interpretation and application of numerous provisions of the Affordable Care Act (ACA) and WV law. We believe that we are capable of continuing to meet and/or exceed the needs of the OIC including any assistance that may be necessary as the ACA continues through implementation and possible transitional modifications. We provide actuarial and management consulting services for a wide range of individual and group medical and supplemental insurance products and Long Term Care, as well as health & welfare actuarial and benefits consulting for both insured and self-insured plans. We will continue to bring this knowledge and expertise to this effort for the State of West Virginia.

UHAS guarantees to hold its response open for 180 days from the response due date. Our point of contact for this effort is Mr. John Ames FSA, MAAA, and Consulting Actuary, who is located at 6905 Sir Spencer Ct, Colleyville, TX 76034. He may be reached via phone at 817-416-9300 or via email at james@uhasinc.com. UHAS takes no exceptions or deviations to the requirements of the solicitation or the potential contract and our response is fully compliant with all instructions.

If we at UHAS can be of any assistance, or if we can provide any further information, please feel free to contact me at your convenience at (317)575-7672 or via e-mail at kvolkmar@uhasinc.com. We look forward to hearing from you and taking part in the next phase of this procurement.

Sincerely,

Karl G. Volkmar, FSA, MAAA, FCA
Principal & Senior Consulting Actuary

EXHIBIT A

REQUEST FOR QUOTATION
INS14014
Actuarial Rate Review of Life and Health Related Product Filings and Consulting Services

Item #	Year:	Description:	Hours:	Unit Price:	Extended Price:	Total:
1	1	Actuarial Rate Review of Life and Health product filings and consulting services	1000	$209.50	$--------	$209,500.00
2	2 (1st Renewal)	Actuarial Rate Review of Life and Health product filings and consulting services	1000	$209.50	$--------	$209,500.00
3	3 (2nd Renewal)	Actuarial Rate Review of Life and Health product filings and consulting services	1000	$209.50	$--------	$209,500.00
				Overall Total Price ---------->		$628,500.00

Note: Quantities (hours) listed above are estimates and are for evaluation purposes only. Actual need is not guaranteed or implied.

Vendor must submit an all-inclusive hourly rate for the required services which includes travel and related expenses, including supplies and general administrative expenses.

Award will be made to the responsible bidder meeting specifications with the lowest Overall Total Price.

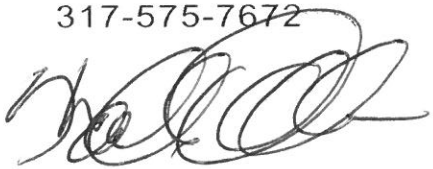
Vendor Name: United Health Actuarial Services, Inc.

Address: 11611 North Meridian Street – Suite 330
Carmel, IN 46032

E-mail: kvolkmar@uhasinc.com

Fax#: 317-575-7678

Phone# 317-575-7672

Signature: 

Date: February 3, 2014

UHAS UNITED HEALTH ACTUARIAL SERVICES INC

Proposal for

Actuarial Rate Reviews of Life- and Health-Related Product Filings and Related Consulting Services for the State of West Virginia

RFQ #: INS14014

Technical Proposal

Original Document

11611 North Meridian Street - Suite 330 Carmel, IN 46032 www.UHASinc.com O: 317.575.7672 F: 317.575.7678

UHAS UNITED HEALTH ACTUARIAL SERVICES INC

February 4, 2014

State of West Virginia
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

Attn: Evelyn Melton
Phone: 304-558-2306
Fax: 304-558-4115
Email: evelyn.p.melton@wv.gov

Re: Solicitation #: INS14014

Dear Ms. Melton:

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If we at UHAS can be of any assistance, or if we can provide any further information, please feel free to contact me at your convenience at (317)575-7672 or via e-mail at kvolkmar@uhasinc.com. We look forward to hearing from you and taking part in the next phase of this procurement.

Sincerely,

Karl G. Volkmar, FSA, MAAA, FCA
Principal & Senior Consulting Actuary

REQUEST FOR QUOTATION – INS14014

Actuarial Rate Review of Life and Health Related Product Filings and Consulting Services

REQUEST FOR QUOTATION SUMMARY

In the presentation of this Request for Quotation (RFQ), United Health Actuarial Services (UHAS) is submitting the requested material, including resumes, plus any additional information that it believes will facilitate the determination of the vendor for this contract. We have provided two copies (one original and one copy) of the following items:

- The completed, signed and dated solicitation document(s) acknowledging all of the terms and conditions of this 47 page solicitation which contains:
  - Instructions to Vendors Submitting Bids
  - General Terms and Conditions
  - Request for Quotation (#INS14014)
  - Exhibit A (Pricing)
  - Exhibit B (ASOP #8 – Regulatory Filings for Health Plan Entities)
  - Certification and Signature Page
  - Addendum Acknowledgement Form
  - Purchasing Affidavit
  - Vendor Preference Certificate

- The signed and dated acknowledgement of Addendum 1 – Questions & Answers INS14014.

- COMPANY DESCRIPTION AND RELEVANT EXPERIENCE - A description of UHAS, the scope of experience with public and private entities, and relevant experience working with regulatory agencies.

- RESOURCES AND QUALIFICATIONS – In response to Item 3. on Page 19 of the Solicitation titled QUALIFICATIONS, this includes:
  - A complete listing of all credentialed actuaries available to perform the requested services including the resumes of each with relevant education and work experience
  - An indication of work experience specific to the minimum qualifications listed in items 3.1.2. through 3.1.5.
  - Issues of Conflict of Interest (3.2.)
  - Additional information regarding Qualification Standard and Continuing Professional Development
  - Per Item 8. Page 9 of the Solicitation - REQUIRED DOCUMENTS – LICENSE(S)/CERTIFICATIONS/PERMITS, a screen shot of the professional credentials for each listed actuary from the Actuarial Directory (sponsored by the Society of Actuaries, American Academy of Actuarial, and other professional actuarial organizations).

- DELIVERABLES – Information on deliverables, communication and other services.

- PERFORMANCE REFERENCES – A list and brief summary of some of our current private and public sector clients.

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Solicitation

NUMBER	PAGE
INS14014	1

ADDRESS CORRESPONDENCE TO ATTENTION OF:
EVELYN MELTON
304-558-2306

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE
United Health Actuarial Services, Inc.
11611 N. Meridian St., Suite 330
Carmel, IN 46032

SHIP TO
INSURANCE COMMISSION
1124 SMITH STREET
CHARLESTON, WV
25305-0540 304-558-3707

DATE PRINTED
01/02/2014
BID OPENING DATE: 02/04/2014 BID OPENING TIME 1:30PM

LINE	QUANTITY	UOP	CAT NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
	THE WEST VIRGINIA PURCHASING DIVISION IS SOLICITING BIDS ON BEHALF OF THE DEPARTMENT OF REVENUE, OFFICES OF THE INSURANCE COMMISSIONER TO ESTABLISH AN OPEN-END CONTRACT FOR CONSULTING SERVICES AND ACTUARIAL RATE REVIEW OF LIFE AND HEALTH RELATED PRODUCT FILINGS PER THE ATTACHED SPECIFICATIONS & INSTRUCTIONS TO BIDDERS.					
0001	1 HR			946-12		
	ACTUARIAL SERVICES					
	****** THIS IS THE END OF RFQ INS14014 ****** TOTAL:					

SIGNATURE
TELEPHONE 317-575-7672
DATE February 3, 2014
TITLE Principal & Senior Consulting Actuary
FEIN 04-3738148
ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO SOLICITATION, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

INSTRUCTIONS TO VENDORS SUBMITTING BIDS

1. **REVIEW DOCUMENTS THOROUGHLY:** The attached documents contain a solicitation for bids. Please read these instructions and all documents attached in their entirety. These instructions provide critical information about requirements that if overlooked could lead to disqualification of a Vendor's bid. All bids must be submitted in accordance with the provisions contained in these instructions and the Solicitation. Failure to do so may result in disqualification of Vendor's bid.

2. **MANDATORY TERMS:** The Solicitation may contain mandatory provisions identified by the use of the words "must," "will," and "shall." Failure to comply with a mandatory term in the Solicitation will result in bid disqualification.

3. **PREBID MEETING:** The item identified below shall apply to this Solicitation.

   [✓] A pre-bid meeting will not be held prior to bid opening.

   [ ] A **NON-MANDATORY PRE-BID** meeting will be held at the following place and time:

   [ ] A **MANDATORY PRE-BID** meeting will be held at the following place and time:

   All Vendors submitting a bid must attend the mandatory pre-bid meeting. Failure to attend the mandatory pre-bid meeting shall result in disqualification of the Vendor's bid. No one person attending the pre-bid meeting may represent more than one Vendor.

   An attendance sheet provided at the pre-bid meeting shall serve as the official document verifying attendance. The State will not accept any other form of proof or documentation to verify attendance. Any person attending the pre-bid meeting on behalf of a Vendor must list on the attendance sheet his or her name and the name of the Vendor he or she is representing. Additionally, the person attending the pre-bid meeting should include the Vendor's E-Mail address, phone number, and Fax number on the attendance sheet. It is the Vendor's responsibility to locate the attendance sheet and provide the required information. Failure to complete the attendance sheet as required may result in disqualification of Vendor's bid.

All Vendors should arrive prior to the starting time for the pre-bid. Vendors who arrive after the starting time but prior to the end of the pre-bid will be permitted to sign in, but are charged with knowing all matters discussed at the pre-bid.

Questions submitted at least five business days prior to a scheduled pre-bid will be discussed at the pre-bid meeting if possible. Any discussions or answers to questions at the pre-bid meeting are preliminary in nature and are non-binding. Official and binding answers to questions will be published in a written addendum to the Solicitation prior to bid opening.

4. **VENDOR QUESTION DEADLINE:** Vendors may submit questions relating to this Solicitation to the Purchasing Division. Questions must be submitted in writing. All questions must be submitted on or before the date listed below and to the address listed below in order to be considered. A written response will be published in a Solicitation addendum if a response is possible and appropriate. Non-written discussions, conversations, or questions and answers regarding this Solicitation are preliminary in nature and are non-binding.

Question Submission Deadline: January 16, 2014

Submit Questions to: Evelyn P. Melton
2019 Washington Street, East
Charleston, WV 25305
Fax: 304-558-4115
Email: evelyn.p.melton@wv.gov

5. **VERBAL COMMUNICATION:** Any verbal communication between the Vendor and any State personnel is not binding, including that made at the mandatory pre-bid conference. Only information issued in writing and added to the Solicitation by an official written addendum by the Purchasing Division is binding.

6. **BID SUBMISSION:** All bids must be signed and delivered by the Vendor to the Purchasing Division at the address listed below on or before the date and time of the bid opening. Any bid received by the Purchasing Division staff is considered to be in the possession of the Purchasing Division and will not be returned for any reason. The bid delivery address is:

Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

The bid should contain the information listed below on the face of the envelope or the bid may not be considered:

SEALED BID
BUYER: _____
SOLICITATION NO.: _____
BID OPENING DATE: _____
BID OPENING TIME: _____
FAX NUMBER: _____

In the event that Vendor is responding to a request for proposal, the Vendor shall submit one original technical and one original cost proposal plus _____ convenience copies of each to the Purchasing Division at the address shown above. Additionally, the Vendor should identify the bid type as either a technical or cost proposal on the face of each bid envelope submitted in response to a request for proposal as follows:

BID TYPE: ☐ Technical
☐ Cost

7. **BID OPENING:** Bids submitted in response to this Solicitation will be opened at the location identified below on the date and time listed below. Delivery of a bid after the bid opening date and time will result in bid disqualification. For purposes of this Solicitation, a bid is considered delivered when time stamped by the official Purchasing Division time clock.

Bid Opening Date and Time: February 4, 2014 - Tuesday @ 1:30 P.M.

Bid Opening Location: Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

8. **ADDENDUM ACKNOWLEDGEMENT:** Changes or revisions to this Solicitation will be made by an official written addendum issued by the Purchasing Division. Vendor should acknowledge receipt of all addenda issued with this Solicitation by completing an Addendum Acknowledgment Form, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

9. **BID FORMATTING:** Vendor should type or electronically enter the information onto its bid to prevent errors in the evaluation. Failure to type or electronically enter the information may result in bid disqualification.

GENERAL TERMS AND CONDITIONS:

1. **CONTRACTUAL AGREEMENT:** Issuance of a Purchase Order signed by the Purchasing Division Director, or his designee, and approved as to form by the Attorney General's office constitutes acceptance of this Contract made by and between the State of West Virginia and the Vendor. Vendor's signature on its bid signifies Vendor's agreement to be bound by and accept the terms and conditions contained in this Contract.

2. **DEFINITIONS:** As used in this Solicitation/Contract, the following terms shall have the meanings attributed to them below. Additional definitions may be found in the specifications included with this Solicitation/Contract.

   2.1 "Agency" or **"Agencies"** means the agency, board, commission, or other entity of the State of West Virginia that is identified on the first page of the Solicitation or any other public entity seeking to procure goods or services under this Contract.

   2.2 "Contract" means the binding agreement that is entered into between the State and the Vendor to provide the goods and services requested in the Solicitation.

   2.3 "Director" means the Director of the West Virginia Department of Administration, Purchasing Division.

   2.4 "Purchasing Division" means the West Virginia Department of Administration, Purchasing Division.

   2.5 "Purchase Order" means the document signed by the Agency and the Purchasing Division, and approved as to form by the Attorney General, that identifies the Vendor as the successful bidder and Contract holder.

   2.6 "Solicitation" means the official solicitation published by the Purchasing Division and identified by number on the first page thereof.

   2.7 "State" means the State of West Virginia and/or any of its agencies, commissions, boards, etc. as context requires.

   2.8 "Vendor" or **"Vendors"** means any entity submitting a bid in response to the Solicitation, the entity that has been selected as the lowest responsible bidder, or the entity that has been awarded the Contract as context requires.

3. **CONTRACT TERM; RENEWAL; EXTENSION:** The term of this Contract shall be determined in accordance with the category that has been identified as applicable to this Contract below:

☐ **Term Contract**

Initial Contract Term: This Contract becomes effective on upon award

and extends for a period of one (1) year(s).

Renewal Term: This Contract may be renewed upon the mutual written consent of the Agency, and the Vendor, with approval of the Purchasing Division and the Attorney General's office (Attorney General approval is as to form only). Any request for renewal must be submitted to the Purchasing Division Director thirty (30) days prior to the expiration date of the initial contract term or appropriate renewal term. A Contract renewal shall be in accordance with the terms and conditions of the original contract. Renewal of this Contract is limited to two (2) ☒ successive one (1) year periods. Automatic renewal of this Contract is prohibited. Notwithstanding the foregoing, Purchasing Division approval is not required on agency delegated or exempt purchases. Attorney General approval may be required for vendor terms and conditions.

Reasonable Time Extension: At the sole discretion of the Purchasing Division Director, and with approval from the Attorney General's office (Attorney General approval is as to form only), this Contract may be extended for a reasonable time after the initial Contract term or after any renewal term as may be necessary to obtain a new contract or renew this Contract. Any reasonable time extension shall not exceed twelve (12) months. Vendor may avoid a reasonable time extension by providing the Purchasing Division Director with written notice of Vendor's desire to terminate this Contract 30 days prior to the expiration of the then current term. During any reasonable time extension period, the Vendor may terminate this Contract for any reason upon giving the Purchasing Division Director 30 days written notice. Automatic extension of this Contract is prohibited. Notwithstanding the foregoing, Purchasing Division approval is not required on agency delegated or exempt purchases, but Attorney General approval may be required.

Release Order Limitations: In the event that this contract permits release orders, a release order may only be issued during the time this Contract is in effect. Any release order issued within one year of the expiration of this Contract shall be effective for one year from the date the release order is issued. No release order may be extended beyond one year after this Contract has expired.

☐ **Fixed Period Contract:** This Contract becomes effective upon Vendor's receipt of the notice to proceed and must be completed within days.

☐ **One Time Purchase:** The term of this Contract shall run from the issuance of the Purchase Order until all of the goods contracted for have been delivered, but in no event shall this Contract extend for more than one fiscal year.

☐ **Other:** See attached.

4. **NOTICE TO PROCEED:** Vendor shall begin performance of this Contract immediately upon receiving notice to proceed unless otherwise instructed by the Agency. Unless otherwise specified, the fully executed Purchase Order will be considered notice to proceed

5. **QUANTITIES:** The quantities required under this Contract shall be determined in accordance with the category that has been identified as applicable to this Contract below.

☑ **Open End Contract:** Quantities listed in this Solicitation are approximations only, based on estimates supplied by the Agency. It is understood and agreed that the Contract shall cover the quantities actually ordered for delivery during the term of the Contract, whether more or less than the quantities shown.

☑ **Service:** The scope of the service to be provided will be more clearly defined in the specifications included herewith.

☐ **Combined Service and Goods:** The scope of the service and deliverable goods to be provided will be more clearly defined in the specifications included herewith.

☐ **One Time Purchase:** This Contract is for the purchase of a set quantity of goods that are identified in the specifications included herewith. Once those items have been delivered, no additional goods may be procured under this Contract without an appropriate change order approved by the Vendor, Agency, Purchasing Division, and Attorney General's office.

6. **PRICING:** The pricing set forth herein is firm for the life of the Contract, unless specified elsewhere within this Solicitation/Contract by the State. A Vendor's inclusion of price adjustment provisions in its bid, without an express authorization from the State in the Solicitation to do so, may result in bid disqualification.

7. **EMERGENCY PURCHASES:** The Purchasing Division Director may authorize the Agency to purchase goods or services in the open market that Vendor would otherwise provide under this Contract if those goods or services are for immediate or expedited delivery in an emergency. Emergencies shall include, but are not limited to, delays in transportation or an unanticipated increase in the volume of work. An emergency purchase in the open market, approved by the Purchasing Division Director, shall not constitute of breach of this Contract and shall not entitle the Vendor to any form of compensation or damages. This provision does not excuse the State from fulfilling its obligations under a One Time Purchase contract.

8. **REQUIRED DOCUMENTS:** All of the items checked below must be provided to the Purchasing Division by the Vendor as specified below.

☐ **BID BOND:** All Vendors shall furnish a bid bond in the amount of five percent (5%) of the total amount of the bid protecting the State of West Virginia. The bid bond must be submitted with the bid.

☐ **PERFORMANCE BOND:** The apparent successful Vendor shall provide a performance bond in the amount of . The performance bond must be issued and received by the Purchasing Division prior to Contract award. On construction contracts, the performance bond must be 100% of the Contract value.

☐ **LABOR/MATERIAL PAYMENT BOND:** The apparent successful Vendor shall provide a labor/material payment bond in the amount of 100% of the Contract value. The labor/material payment bond must be issued and delivered to the Purchasing Division prior to Contract award.

In lieu of the Bid Bond, Performance Bond, and Labor/Material Payment Bond, the Vendor may provide certified checks, cashier's checks, or irrevocable letters of credit. Any certified check, cashier's check, or irrevocable letter of credit provided in lieu of a bond must be of the same amount and delivered on the same schedule as the bond it replaces. A letter of credit submitted in lieu of a performance and labor/material payment bond will only be allowed for projects under $100,000. Personal or business checks are not acceptable.

☐ **MAINTENANCE BOND:** The apparent successful Vendor shall provide a two (2) year maintenance bond covering the roofing system. The maintenance bond must be issued and delivered to the Purchasing Division prior to Contract award.

☑ **WORKERS' COMPENSATION INSURANCE:** The apparent successful Vendor shall have appropriate workers' compensation insurance and shall provide proof thereof upon request.

☐ **INSURANCE:** The apparent successful Vendor shall furnish proof of the following insurance prior to Contract award and shall list the state as a certificate holder:

☐ **Commercial General Liability Insurance:**
or more.

☐ **Builders Risk Insurance:** builders risk – all risk insurance in an amount equal to 100% of the amount of the Contract.

☐

☐

☐

☐

☐

The apparent successful Vendor shall also furnish proof of any additional insurance requirements contained in the specifications prior to Contract award regardless of whether or not that insurance requirement is listed above.

☑ **LICENSE(S) / CERTIFICATIONS / PERMITS:** In addition to anything required under the Section entitled Licensing, of the General Terms and Conditions, the apparent successful Vendor shall furnish proof of the following licenses, certifications, and/or permits prior to Contract award, in a form acceptable to the Purchasing Division.

☑ Membership Certificate of the American Academy of Actuaries (MAAA)

☑ Fellow of the Society of Actuaries (FSA)

☐

☐

The apparent successful Vendor shall also furnish proof of any additional licenses or certifications contained in the specifications prior to Contract award regardless of whether or not that requirement is listed above.

9. **LITIGATION BOND:** The Director reserves the right to require any Vendor that files a protest of an award to submit a litigation bond in the amount equal to one percent of the lowest bid submitted or $5,000, whichever is greater. The entire amount of the bond shall be forfeited if the hearing officer determines that the protest was filed for frivolous or improper purpose, including but not limited to, the purpose of harassing, causing unnecessary delay, or needless expense for the Agency. All litigation bonds shall be made payable to the Purchasing Division. In lieu of a bond, the protester may submit a cashier's check or certified check payable to the Purchasing Division. Cashier's or certified checks will be deposited with and held by the State Treasurer's office. If it is determined that the protest has not been filed for frivolous or improper purpose, the bond or deposit shall be returned in its entirety.

10. **ALTERNATES:** Any model, brand, or specification listed herein establishes the acceptable level of quality only and is not intended to reflect a preference for, or in any way favor, a particular brand or vendor. Vendors may bid alternates to a listed model or brand provided that the alternate is at least equal to the model or brand and complies with the required specifications. The equality of any alternate being bid shall be determined by the State at its sole discretion. Any Vendor bidding an alternate model or brand should clearly identify the alternate items in its bid and should include manufacturer's specifications, industry literature, and/or any other relevant documentation demonstrating the equality of the alternate items. Failure to provide information for alternate items may be grounds for rejection of a Vendor's bid.

11. **EXCEPTIONS AND CLARIFICATIONS:** The Solicitation contains the specifications that shall form the basis of a contractual agreement. Vendor shall clearly mark any exceptions, clarifications, or

other proposed modifications in its bid. Exceptions to, clarifications of, or modifications of a requirement or term and condition of the Solicitation may result in bid disqualification.

12. **LIQUIDATED DAMAGES:** Vendor shall pay liquidated damages in the amount for

This clause shall in no way be considered exclusive and shall not limit the State or Agency's right to pursue any other available remedy.

13. **ACCEPTANCE/REJECTION:** The State may accept or reject any bid in whole, or in part. Vendor's signature on its bid signifies acceptance of the terms and conditions contained in the Solicitation and Vendor agrees to be bound by the terms of the Contract, as reflected in the Purchase Order, upon receipt.

14. **REGISTRATION:** Prior to Contract award, the apparent successful Vendor must be properly registered with the West Virginia Purchasing Division and must have paid the $125 fee if applicable.

15. **COMMUNICATION LIMITATIONS:** In accordance with West Virginia Code of State Rules §148-1-6.6, communication with the State of West Virginia or any of its employees regarding this Solicitation during the solicitation, bid, evaluation or award periods, except through the Purchasing Division, is strictly prohibited without prior Purchasing Division approval. Purchasing Division approval for such communication is implied for all agency delegated and exempt purchases.

16. **FUNDING:** This Contract shall continue for the term stated herein, contingent upon funds being appropriated by the Legislature or otherwise being made available. In the event funds are not appropriated or otherwise made available, this Contract becomes void and of no effect beginning on July 1 of the fiscal year for which funding has not been appropriated or otherwise made available.

17. **PAYMENT:** Payment in advance is prohibited under this Contract. Payment may only be made after the delivery and acceptance of goods or services. The Vendor shall submit invoices, in arrears, to the Agency at the address on the face of the purchase order labeled "Invoice To."

18. **UNIT PRICE:** Unit prices shall prevail in cases of a discrepancy in the Vendor's bid.

19. **DELIVERY:** All quotations are considered freight on board destination ("F.O.B. destination") unless alternate shipping terms are clearly identified in the bid. Vendor's listing of shipping terms that contradict the shipping terms expressly required by this Solicitation may result in bid disqualification.

20. **INTEREST:** Interest attributable to late payment will only be permitted if authorized by the West Virginia Code. Presently, there is no provision in the law for interest on late payments.

21. **PREFERENCE:** Vendor Preference may only be granted upon written request and only in accordance with the West Virginia Code § 5A-3-37 and the West Virginia Code of State Rules. A Resident Vendor Certification form has been attached hereto to allow Vendor to apply for the preference. Vendor's

failure to submit the Resident Vendor Certification form with its bid will result in denial of Vendor Preference. Vendor Preference does not apply to construction projects.

22. **SMALL, WOMEN-OWNED, OR MINORITY-OWNED BUSINESSES:** For any solicitations publicly advertised for bid on or after July 1, 2012, in accordance with West Virginia Code §5A-3-37(a)(7) and W. Va. CSR § 148-22-9, any non-resident vendor certified as a small, women-owned, or minority-owned business under W. Va. CSR § 148-22-9 shall be provided the same preference made available to any resident vendor. Any non-resident small, women-owned, or minority-owned business must identify itself as such in writing, must submit that writing to the Purchasing Division with its bid, and must be properly certified under W. Va. CSR § 148-22-9 prior to submission of its bid to receive the preferences made available to resident vendors. Preference for a non-resident small, women-owned, or minority owned business shall be applied in accordance with W. Va. CSR § 148-22-9.

23. **TAXES:** The Vendor shall pay any applicable sales, use, personal property or any other taxes arising out of this Contract and the transactions contemplated thereby. The State of West Virginia is exempt from federal and state taxes and will not pay or reimburse such taxes.

24. **CANCELLATION:** The Purchasing Division Director reserves the right to cancel this Contract immediately upon written notice to the vendor if the materials or workmanship supplied do not conform to the specifications contained in the Contract. The Purchasing Division Director may cancel any purchase or Contract upon 30 days written notice to the Vendor in accordance with West Virginia Code of State Rules § 148-1-7.16.2.

25. **WAIVER OF MINOR IRREGULARITIES:** The Director reserves the right to waive minor irregularities in bids or specifications in accordance with West Virginia Code of State Rules § 148-1-4.6.

26. **TIME:** Time is of the essence with regard to all matters of time and performance in this Contract.

27. **APPLICABLE LAW**: This Contract is governed by and interpreted under West Virginia law without giving effect to its choice of law principles. Any information provided in specification manuals, or any other source, verbal or written, which contradicts or violates the West Virginia Constitution, West Virginia Code or West Virginia Code of State Rules is void and of no effect.

28. **COMPLIANCE**: Vendor shall comply with all applicable federal, state, and local laws, regulations and ordinances. By submitting a bid, Vendors acknowledge that they have reviewed, understand, and will comply with all applicable law.

29. **PREVAILING WAGE:** On any contract for the construction of a public improvement, Vendor and any subcontractors utilized by Vendor shall pay a rate or rates of wages which shall not be less than the fair minimum rate or rates of wages (prevailing wage), as established by the West Virginia Division of Labor under West Virginia Code §§ 21-5A-1 et seq. and available at http://www.sos.wv.gov/administrative-law/wagerates/Pages/default.aspx. Vendor shall be responsible for ensuring compliance with prevailing wage requirements and determining when prevailing wage

requirements are applicable. The required contract provisions contained in West Virginia Code of State Rules § 42-7-3 are specifically incorporated herein by reference.

30. **ARBITRATION:** Any references made to arbitration contained in this Contract, Vendor's bid, or in any American Institute of Architects documents pertaining to this Contract are hereby deleted, void, and of no effect.

31. **MODIFICATIONS**: This writing is the parties' final expression of intent. Notwithstanding anything contained in this Contract to the contrary, no modification of this Contract shall be binding without mutual written consent of the Agency, and the Vendor, with approval of the Purchasing Division and the Attorney General's office (Attorney General approval is as to form only). **No Change shall be implemented by the Vendor until such time as the Vendor receives an approved written change order from the Purchasing Division.**

32. **WAIVER:** The failure of either party to insist upon a strict performance of any of the terms or provision of this Contract, or to exercise any option, right, or remedy herein contained, shall not be construed as a waiver or a relinquishment for the future of such term, provision, option, right, or remedy, but the same shall continue in full force and effect. Any waiver must be expressly stated in writing and signed by the waiving party.

33. **SUBSEQUENT FORMS:** The terms and conditions contained in this Contract shall supersede any and all subsequent terms and conditions which may appear on any form documents submitted by Vendor to the Agency or Purchasing Division such as price lists, order forms, invoices, sales agreements, or maintenance agreements, and includes internet websites or other electronic documents. Acceptance or use of Vendor's forms does not constitute acceptance of the terms and conditions contained thereon.

34. **ASSIGNMENT**: Neither this Contract nor any monies due, or to become due hereunder, may be assigned by the Vendor without the express written consent of the Agency, the Purchasing Division, the Attorney General's office (as to form only), and any other government agency or office that may be required to approve such assignments. Notwithstanding the foregoing, Purchasing Division approval may or may not be required on certain agency delegated or exempt purchases.

35. **WARRANTY**: The Vendor expressly warrants that the goods and/or services covered by this Contract will: (a) conform to the specifications, drawings, samples, or other description furnished or specified by the Agency; (b) be merchantable and fit for the purpose intended; and (c) be free from defect in material and workmanship.

36. **STATE EMPLOYEES:** State employees are not permitted to utilize this Contract for personal use and the Vendor is prohibited from permitting or facilitating the same.

37. **BANKRUPTCY**: In the event the Vendor files for bankruptcy protection, the State of West Virginia may deem this Contract null and void, and terminate this Contract without notice.

38. **[RESERVED]**

39. **CONFIDENTIALITY**: The Vendor agrees that it will not disclose to anyone, directly or indirectly, any such personally identifiable information or other confidential information gained from the Agency, unless the individual who is the subject of the information consents to the disclosure in writing or the disclosure is made pursuant to the Agency's policies, procedures, and rules. Vendor further agrees to comply with the Confidentiality Policies and Information Security Accountability Requirements, set forth in http://www.state.wv.us/admin/purchase/privacy/default.html.

40. **DISCLOSURE:** Vendor's response to the Solicitation and the resulting Contract are considered public documents and will be disclosed to the public in accordance with the laws, rules, and policies governing the West Virginia Purchasing Division. Those laws include, but are not limited to, the Freedom of Information Act found in West Virginia Code § 29B-1-1 et seq.

    If a Vendor considers any part of its bid to be exempt from public disclosure, Vendor must so indicate by specifically identifying the exempt information, identifying the exemption that applies, providing a detailed justification for the exemption, segregating the exempt information from the general bid information, and submitting the exempt information as part of its bid but in a segregated and clearly identifiable format. Failure to comply with the foregoing requirements will result in public disclosure of the Vendor's bid without further notice. A Vendor's act of marking all or nearly all of its bid as exempt is not sufficient to avoid disclosure and WILL NOT BE HONORED. Vendor's act of marking a bid or any part thereof as "confidential" or "proprietary" is not sufficient to avoid disclosure and WILL NOT BE HONORED. In addition, a legend or other statement indicating that all or substantially all of the bid is exempt from disclosure is not sufficient to avoid disclosure and WILL NOT BE HONORED. Vendor will be required to defend any claimed exemption for nondisclosure in the event of an administrative or judicial challenge to the State's nondisclosure. Vendor must indemnify the State for any costs incurred related to any exemptions claimed by Vendor. Any questions regarding the applicability of the various public records laws should be addressed to your own legal counsel prior to bid submission.

41. **LICENSING:** In accordance with West Virginia Code of State Rules §148-1-6.1.7, Vendor must be licensed and in good standing in accordance with any and all state and local laws and requirements by any state or local agency of West Virginia, including, but not limited to, the West Virginia Secretary of State's Office, the West Virginia Tax Department, West Virginia Insurance Commission, or any other state agency or political subdivision. Upon request, the Vendor must provide all necessary releases to obtain information to enable the Purchasing Division Director or the Agency to verify that the Vendor is licensed and in good standing with the above entities.

42. **ANTITRUST:** In submitting a bid to, signing a contract with, or accepting a Purchase Order from any agency of the State of West Virginia, the Vendor agrees to convey, sell, assign, or transfer to the State of West Virginia all rights, title, and interest in and to all causes of action it may now or hereafter acquire under the antitrust laws of the United States and the State of West Virginia for price fixing and/or unreasonable restraints of trade relating to the particular commodities or services purchased or acquired

by the State of West Virginia. Such assignment shall be made and become effective at the time the purchasing agency tenders the initial payment to Vendor.

43. **VENDOR CERTIFICATIONS:** By signing its bid or entering into this Contract, Vendor certifies (1) that its bid was made without prior understanding, agreement, or connection with any corporation, firm, limited liability company, partnership, person or entity submitting a bid for the same material, supplies, equipment or services; (2) that its bid is in all respects fair and without collusion or fraud; (3) that this Contract is accepted or entered into without any prior understanding, agreement, or connection to any other entity that could be considered a violation of law; and (4) that it has reviewed this RFQ in its entirety; understands the requirements, terms and conditions, and other information contained herein. Vendor's signature on its bid also affirms that neither it nor its representatives have any interest, nor shall acquire any interest, direct or indirect, which would compromise the performance of its services hereunder. Any such interests shall be promptly presented in detail to the Agency.

    The individual signing this bid on behalf of Vendor certifies that he or she is authorized by the Vendor to execute this bid or any documents related thereto on Vendor's behalf; that he or she is authorized to bind the Vendor in a contractual relationship; and that, to the best of his or her knowledge, the Vendor has properly registered with any State agency that may require registration.

44. **PURCHASING CARD ACCEPTANCE:** The State of West Virginia currently utilizes a Purchasing Card program, administered under contract by a banking institution, to process payment for goods and services. The Vendor must accept the State of West Virginia's Purchasing Card for payment of all orders under this Contract unless the box below is checked.

    ☐ Vendor is not required to accept the State of West Virginia's Purchasing Card as payment for all goods and services.

45. **VENDOR RELATIONSHIP:** The relationship of the Vendor to the State shall be that of an independent contractor and no principal-agent relationship or employer-employee relationship is contemplated or created by this Contract. The Vendor as an independent contractor is solely liable for the acts and omissions of its employees and agents. Vendor shall be responsible for selecting, supervising, and compensating any and all individuals employed pursuant to the terms of this Solicitation and resulting contract. Neither the Vendor, nor any employees or subcontractors of the Vendor, shall be deemed to be employees of the State for any purpose whatsoever. Vendor shall be exclusively responsible for payment of employees and contractors for all wages and salaries, taxes, withholding payments, penalties, fees, fringe benefits, professional liability insurance premiums, contributions to insurance and pension, or other deferred compensation plans, including but not limited to, Workers' Compensation and Social Security obligations, licensing fees, *etc.* and the filing of all necessary documents, forms and returns pertinent to all of the foregoing. Vendor shall hold harmless the State, and shall provide the State and Agency with a defense against any and all claims including, but not limited to, the foregoing payments, withholdings, contributions, taxes, Social Security taxes, and employer income tax returns.

46. **INDEMNIFICATION:** The Vendor agrees to indemnify, defend, and hold harmless the State and the Agency, their officers, and employees from and against: (1) Any claims or losses for services rendered

by any subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with the performance of the Contract; (2) Any claims or losses resulting to any person or entity injured or damaged by the Vendor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used under the Contract in a manner not authorized by the Contract, or by Federal or State statutes or regulations; and (3) Any failure of the Vendor, its officers, employees, or subcontractors to observe State and Federal laws including, but not limited to, labor and wage and hour laws.

47. **PURCHASING AFFIDAVIT:** In accordance with West Virginia Code § 5A-3-10a, all Vendors are required to sign, notarize, and submit the Purchasing Affidavit stating that neither the Vendor nor a related party owe a debt to the State in excess of $1,000. The affidavit must be submitted prior to award, but should be submitted with the Vendor's bid. A copy of the Purchasing Affidavit is included herewith.

48. **ADDITIONAL AGENCY AND LOCAL GOVERNMENT USE:** This Contract may be utilized by and extends to other agencies, spending units, and political subdivisions of the State of West Virginia; county, municipal, and other local government bodies; and school districts ("Other Government Entities"). This Contract shall be extended to the aforementioned Other Government Entities on the same prices, terms, and conditions as those offered and agreed to in this Contract. If the Vendor does not wish to extend the prices, terms, and conditions of its bid and subsequent contract to the Other Government Entities, the Vendor must clearly indicate such refusal in its bid. A refusal to extend this Contract to the Other Government Entities shall not impact or influence the award of this Contract in any manner.

49. **CONFLICT OF INTEREST:** Vendor, its officers or members or employees, shall not presently have or acquire any interest, direct or indirect, which would conflict with or compromise the performance of its obligations hereunder. Vendor shall periodically inquire of its officers, members and employees to ensure that a conflict of interest does not arise. Any conflict of interest discovered shall be promptly presented in detail to the Agency.

50. **REPORTS:** Vendor shall provide the Agency and/or the Purchasing Division with the following reports identified by a checked box below:

☑ Such reports as the Agency and/or the Purchasing Division may request. Requested reports may include, but are not limited to, quantities purchased, agencies utilizing the contract, total contract expenditures by agency, etc.

☐ Quarterly reports detailing the total quantity of purchases in units and dollars, along with a listing of purchases by agency. Quarterly reports should be delivered to the Purchasing Division via email at purchasing.requisitions@wv.gov.

51. **BACKGROUND CHECK:** In accordance with W. Va. Code § 15-2D-3, the Director of the Division of Protective Services shall require any service provider whose employees are regularly employed on the grounds or in the buildings of the Capitol complex or who have access to sensitive or critical information

to submit to a fingerprint-based state and federal background inquiry through the state repository. The service provider is responsible for any costs associated with the fingerprint-based state and federal background inquiry.

After the contract for such services has been approved, but before any such employees are permitted to be on the grounds or in the buildings of the Capitol complex or have access to sensitive or critical information, the service provider shall submit a list of all persons who will be physically present and working at the Capitol complex to the Director of the Division of Protective Services for purposes of verifying compliance with this provision.

The State reserves the right to prohibit a service provider's employees from accessing sensitive or critical information or to be present at the Capitol complex based upon results addressed from a criminal background check.

Service providers should contact the West Virginia Division of Protective Services by phone at (304)558-9911 for more information.

52. **PREFERENCE FOR USE OF DOMESTIC STEEL PRODUCTS:** Except when authorized by the Director of the Purchasing Division pursuant to W. Va. Code § 5A-3-56, no contractor may use or supply steel products for a State Contract Project other than those steel products made in the United States. A contractor who uses steel products in violation of this section may be subject to civil penalties pursuant to W. Va. Code § 5A-3-56. As used in this section:

    a. "State Contract Project" means any erection or construction of, or any addition to, alteration of or other improvement to any building or structure, including, but not limited to, roads or highways, or the installation of any heating or cooling or ventilating plants or other equipment, or the supply of and materials for such projects, pursuant to a contract with the State of West Virginia for which bids were solicited on or after June 6, 2001.

    b. "Steel Products" means products rolled, formed, shaped, drawn, extruded, forged, cast, fabricated or otherwise similarly processed, or processed by a combination of two or more or such operations, from steel made by the open heath, basic oxygen, electric furnace, Bessemer or other steel making process.

    The Purchasing Division Director may, in writing, authorize the use of foreign steel products if:

    a. The cost for each contract item used does not exceed one tenth of one percent (.1%) of the total contract cost or two thousand five hundred dollars ($2,500.00), whichever is greater. For the purposes of this section, the cost is the value of the steel product as delivered to the project; or

    b. The Director of the Purchasing Division determines that specified steel materials are not produced in the United States in sufficient quantity or otherwise are not reasonably available to meet contract requirements.

53. PREFERENCE FOR USE OF DOMESTIC ALUMINUM, GLASS, AND STEEL: In Accordance with W. Va. Code § 5-19-1 et seq., and W. Va. CSR § 148-10-1 et seq., for every contract or subcontract, subject to the limitations contained herein, for the construction, reconstruction, alteration, repair, improvement or maintenance of public works or for the purchase of any item of machinery or equipment to be used at sites of public works, only domestic aluminum, glass or steel products shall be supplied unless the spending officer determines, in writing, after the receipt of offers or bids, (1) that the cost of domestic aluminum, glass or steel products is unreasonable or inconsistent with the public interest of the State of West Virginia, (2) that domestic aluminum, glass or steel products are not produced in sufficient quantities to meet the contract requirements, or (3) the available domestic aluminum, glass, or steel do not meet the contract specifications. This provision only applies to public works contracts awarded in an amount more than fifty thousand dollars ($50,000) or public works contracts that require more than ten thousand pounds of steel products.

The cost of domestic aluminum, glass, or steel products may be unreasonable if the cost is more than twenty percent (20%) of the bid or offered price for foreign made aluminum, glass, or steel products. If the domestic aluminum, glass or steel products to be supplied or produced in a "substantial labor surplus area", as defined by the United States Department of Labor, the cost of domestic aluminum, glass, or steel products may be unreasonable if the cost is more than thirty percent (30%) of the bid or offered price for foreign made aluminum, glass, or steel products.

This preference shall be applied to an item of machinery or equipment, as indicated above, when the item is a single unit of equipment or machinery manufactured primarily of aluminum, glass or steel, is part of a public works contract and has the sole purpose or of being a permanent part of a single public works project. This provision does not apply to equipment or machinery purchased by a spending unit for use by that spending unit and not as part of a single public works project.

All bids and offers including domestic aluminum, glass or steel products that exceed bid or offer prices including foreign aluminum, glass or steel products after application of the preferences provided in this provision may be reduced to a price equal to or lower than the lowest bid or offer price for foreign aluminum, glass or steel products plus the applicable preference. If the reduced bid or offer prices are made in writing and supersede the prior bid or offer prices, all bids or offers, including the reduced bid or offer prices, will be reevaluated in accordance with this rule.

SPECIFICATIONS

1. **PURPOSE AND SCOPE:** The West Virginia Purchasing Division is soliciting bids on behalf of the Offices of the Insurance Commissioner (OIC), an agency of the West Virginia Department of Revenue, to establish a contract for actuarial rate review of life and health related product filings and consulting services. Life and health product filings include, but are not limited to, accident and sickness, long term care, disability, annuity, health, major medical, credit and Medicare supplement products for individual and group plans. The firm may provide other management consulting services for the OIC. These additional services may include appearances by the firm's personnel before legislative and executive bodies, or others to respond to questions or give reports. The firm may be required to provide testimony at rate hearings. These services may also include the preparation of related written reports. All work under the proposed contract will be under the direction of the Insurance Commissioner or his designee. Written reports and findings must be submitted initially in draft form in order that any necessary changes may be discussed and agreed upon before final acceptance. The actuarial firm may provide other management consulting services and perform special reviews and/or analysis of life and health products for the OIC.

2. **DEFINITIONS:** The terms listed below shall have the meanings assigned to them below. Additional definitions can be found in section 2 of the General Terms and Conditions.

   2.1. "Contract Services" means the firm awarded the contract as a result of this RFQ will assist the Insurance Commissioner and Director of Rates and Forms in reviewing life and health product filings for individual, group and association product offerings. The review shall include, but may not be limited to, analysis of trending, credibility, lapse ratios, development factors, durational factors, geographical factors, loss development, loss ratios, rating bands and all other components of a rate filing. It is expected that the review will document the justification for the rate adjustment, concerns with factors used or selected, support of the factors, identify areas of concern, documentation to support the indicated and requested rate levels, projected premium impact and projected premium impact to consumers. The initial review and related report shall be submitted to the OIC within 30 days of receiving the filing from the OIC. All follow-up questions and correspondence shall be between the OIC and the carrier.

   2.1.1. The actuarial firm may provide other management consulting services and perform special reviews and/or analysis of life and health related products to the

OIC. These additional services may include appearances by the actuary's personnel before judicial, legislative, and executive bodies, or others to respond to questions of an actuarial nature or to give reports. These services may also include the preparation of written reports concerning actuarial matters as deemed necessary by the OIC. All work under the proposed contract will be under the direction of the Insurance Commissioner or his designee. Written reports and actuarial findings must be submitted initially in draft form in order that any necessary changes may be discussed and agreed upon before final acceptance.

2.2. "Pricing Page" means the pages upon which Vendor should list its proposed price for the Contract Services. The Pricing Page is either included on the last page of this RFQ or attached hereto as Exhibit A.

2.3. "RFQ" means the official request for quotation published by the Purchasing Division and identified as INS14014.

3. QUALIFICATIONS: Vendor shall have the following minimum qualifications:

3.1. Any actuarial firm submitting a quotation under this procurement shall meet or exceed the minimum qualification set for in this RFQ. Those quotations not meeting the mandatory specifications will be eliminated. Any actuarial firm submitting a quotation under this procurement shall meet or exceed the minimum qualifications as follows:

3.1.1. One or more members assigned to this contract must be a Fellow of the Society of Actuaries (FSA) and/or a Member of the American Academy of Actuaries (MAAA).

3.1.2. Members assigned this contract must have at least five (5) years of experience with life and health products. The Vendor should provide resume' to include information regarding the number of years of qualification, experience and training and relevant continuing professional education of the specific staff to be assigned to this job. Resume' should be submitted prior to award.

3.1.3. Members assigned this contract must have at least five (5) years of experience specifically with long term care products. The Vendor should provide resume' to include information regarding the number of years of qualification, experience and training and relevant continuing professional education of the specific staff to be assigned to this job. Resume' should be submitted prior to award.

3.1.4. Members assigned this contract must be knowledgeable of Actuarial Standard Practice No. 8 (EXHIBIT B).

3.1.5. One or more members to be assigned to this contract must be experienced in providing rate review services to state insurance regulators.

3.2 The firm shall have no conflict of interest with regard to any carrier that is actively writing individual or group life and health products in the West Virginia market.

4. MANDATORY REQUIREMENTS:

4.1. Mandatory Contract Services Requirements and Deliverables: Contract Services must meet or exceed the mandatory requirements listed below.

4.1.1. The Vendor shall provide actuarial review of life and health product filings and consulting services to the West Virginia Offices of the Insurance Commissioner.

4.1.1.1. The amount of the quotation submitted by each potential vendor shall be a fixed hourly rate for services rendered. This rate shall be the same regardless of which partner or member performs the services and shall be sufficient to cover any and all incidental expenses.

4.1.1.2. The Vendor shall provide all additional services as described in section 2.1 "Contract Services" of this Request For Quotation.

5. CONTRACT AWARD:

5.1. Contract Award: The Contract is intended to provide Agency with a purchase price for the Contract Services. The Contract shall be awarded to the Vendor that provides the Contract Services meeting the required specifications for the lowest overall total price as shown on the Pricing Pages.

5.2. Pricing Page: Vendor should complete the Pricing Page by supplying an hourly rate for Actuarial Rate Review of Life and Health product filings and consulting services. Vendor should complete the Pricing Page in full as failure to complete the Pricing Page in its entirety may result in Vendor's bid being disqualified.

Notwithstanding the foregoing, the Purchasing Division may correct errors as it deems appropriate. Vendor should type or electronically enter the information into the Pricing Page to prevent errors in the evaluation.

6. **PERFORMANCE:** Vendor and Agency shall agree upon a schedule for performance of Contract Services and Contract Services Deliverables, unless such a schedule is already included herein by Agency. In the event that this Contract is designated as an open-end contract, Vendor shall perform in accordance with the release orders that may be issued against this Contract.

7. **PAYMENT:** Agency shall pay the hourly rate, as shown on the Pricing Pages, for all Contract Services performed and accepted under this Contract. Vendor shall accept payment in accordance with the payment procedures of the State of West Virginia.

8. **TRAVEL:** Vendor shall be responsible for all mileage and travel costs, including travel time, associated with performance of this Contract. Any anticipated mileage or travel costs may be included in the flat fee or hourly rate listed on Vendor's bid, but such costs will not be paid by the Agency separately.

9. **FACILITIES ACCESS:** Performance of Contract Services may require access cards and/or keys to gain entrance to Agency's facilities. In the event that access cards and/or keys are required:

   9.1. Vendor must identify principal service personnel which will be issued access cards and/or keys to perform service.

   9.2. Vendor will be responsible for controlling cards and keys and will pay replacement fee, if the cards or keys become lost or stolen.

   9.3. Vendor shall notify Agency immediately of any lost, stolen, or missing card or key.

   9.4. Anyone performing under this Contract will be subject to Agency's security protocol and procedures.

   9.5. Vendor shall inform all staff of Agency's security protocol and procedures.

10. VENDOR DEFAULT:

10.1. The following shall be considered a vendor default under this Contract.

10.1.1. Failure to perform Contract Services in accordance with the requirements contained herein.

10.1.2. Failure to comply with other specifications and requirements contained herein.

10.1.3. Failure to comply with any laws, rules, and ordinances applicable to the Contract Services provided under this Contract.

10.1.4. Failure to remedy deficient performance upon request.

10.2. The following remedies shall be available to Agency upon default.

10.2.1. Cancellation of the Contract.

10.2.2. Cancellation of one or more release orders issued under this Contract.

10.2.3. Any other remedies available in equity.

11. MISCELLANEOUS:

11.1. Contract Manager: During its performance of this Contract, Vendor must designate and maintain a primary contract manager responsible for overseeing Vendor's responsibilities under this Contract. The Contract manager must be available during normal business hours to address any customer service or other issues related to this Contract. Vendor should list its Contract manager and his or her contact information below.

Contract Manager: John Ames
Telephone Number: 817-416-9300
Fax Number: 317-575-7678
Email Address: james@uhasinc.com

ACTUARIAL STANDARDS BOARD

Actuarial Standard of Practice No. 8

Regulatory Filings for Health Plan Entities

Revised Edition

Developed by the
Task Force to Revise ASOP No. 8 of the
Health Committee of the
Actuarial Standards Board

Adopted by the
Actuarial Standards Board
December 2005
Updated for Deviation Language Effective May 1, 2011

(Doc. No. 129)

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December 2005

TO: Members of Actuarial Organizations Governed by the Standards of Practice of the Actuarial Standards Board and Other Persons Interested in Regulatory Filings for Health Plan Entities

FROM: Actuarial Standards Board (ASB)

SUBJ: Actuarial Standard of Practice (ASOP) No. 8

This booklet contains the final version of the revision of ASOP No. 8, now titled *Regulatory Filings for Health Plan Entities.*

Background

The ASB originally adopted ASOP No. 8, *Regulatory Filings for Rates and Financial Projections for Health Plans* (Doc. No. 010), in 1989. Under the guidance of the ASB Health Committee, the Task Force to Revise ASOP No. 8 has prepared this revision to be consistent with the current ASOP format and to reflect current, generally accepted actuarial practices with respect to regulatory filings for health plan entities.

Exposure Draft

The exposure draft of this ASOP was issued in September 2004 with a comment deadline of March 31, 2005. Fourteen comment letters, showing thoughtful insight of the issues, were received and considered in developing the final ASOP. For a summary of the substantive issues contained in the exposure draft comment letters and the responses, please see appendix 2.

The most significant changes since the exposure draft were as follows:

1. The language on applicable law in section 1.2 was updated to be consistent with current boilerplate language to be used in other ASOPs and removed from section 2.1.

2. The task force modified the language regarding section 3.2.2, Consistency with Business Plans (now section 3.2.3, Use of Business Plans to Project Future Results), to address commentators' concerns regarding the actuary's use of any relevant information from any business plan(s) as part of the process of setting assumptions and methodologies used in the filing. The task force also removed the requirement of consistency in assumptions between the business plan and the filing.

3. The task force modified section 3.2.3, Reasonableness of Assumptions, in the exposure draft and moved it to the last section within 3.2, Issues and Recommended Practices for Health

Filings. The language clarifies the requirements when the actuary reviews the reasonableness of assumptions.

4. The task force modified the language in section 3.2.6, New Plans or Benefits, to address the issues regarding data raised by the commentators.

5. The task force modified section 3.3, Reliance on Others (now Reliance on Data or Other Information Supplied by Others), to use language consistent with other recent ASOPs.

6. The task force changed the language in section 4.3, Deviation from Standard, to be consistent with that used in other recent ASOPs.

The Health Committee thanks all those who commented on the exposure draft.

The ASB voted in December 2005 to adopt this standard.

Task Force to Revise ASOP No. 8

Paul R. Fleischacker, Chairperson

Timothy D. Courtney	Julia T. Philips
John M. Friesen	William H. Phillips
Michael R. Gross	William R. Sarniak
James M. Gutterman	John W.C. Stark

Health Committee of the ASB

Alan D. Ford, Chairperson

Michael S. Abroe	John M. Friesen
Gary L. Brace	James M. Gutterman
Robert G. Cosway	Mary J. Murley
Paul R. Fleischacker	John W.C. Stark

Actuarial Standards Board

Michael A. LaMonica, Chairperson

Cecil D. Bykerk	William A. Reimert
William C. Cutlip	Lawrence J. Sher
Lew H. Nathan	Karen F. Terry
Godfrey Perrott	William C. Weller

ACTUARIAL STANDARD OF PRACTICE NO. 8

REGULATORY FILINGS FOR HEALTH PLAN ENTITIES

STANDARD OF PRACTICE

Section 1. Purpose, Scope, Cross References, and Effective Date

1.1 Purpose—This actuarial standard of practice (ASOP) provides guidance to actuaries when performing professional services with respect to preparing or reviewing required regulatory filings for health plan entities and health benefit plans provided by health plan entities.

1.2 Scope—This standard applies to actuaries when performing professional services with respect to preparing or reviewing health filings, as defined in section 2.3, required by and made to state insurance departments, state health departments, the federal government, and other regulatory bodies. Health filings require projection of future contingent events and can be categorized into two broad categories: rate or benefit filings and financial projection filings. Some of these filings are made on behalf of health plan entities, such as filings made in conjunction with applications for licensure. Other filings are required for health benefit plans provided by health plan entities, such as filings for approval of rates. Such filings may be required for new and existing health plan entities, for new health benefit plans, and for revisions to existing health benefit plans.

The filings covered by this standard do not include filings to certify compliance with rating methods and other actuarial practices applicable to carriers for small employer health benefit plans (see ASOP No. 26, *Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans*); statements of actuarial opinion relating to statutory financial statements of health plan entities (see ASOP No. 22, *Statements of Opinion Based on Asset Adequacy Analysis by Actuaries for Life and Health Insurers*, and ASOP No. 28, *Compliance with Statutory Statement of Actuarial Opinion Requirements for Hospital, Medical, and Dental Service or Indemnity Corporations, and for Health Maintenance Organizations*); and filings that are solely experience reports and do not require projection of future contingent events.

This standard is not meant to provide a complete set of recommended practices for the determination of health rates, financial projection entries, or other numerical information required to be included in health filings. It represents areas of inquiry and analysis that an actuary should consider when preparing or reviewing a required health filing for purposes of compliance with applicable law.

If the actuary departs from the guidance set forth in this standard in order to comply with applicable law (statutes, regulations, and other legally binding authority), or for any other reason the actuary deems appropriate, the actuary should refer to section 4.

1.3 Cross References—When this standard refers to the provisions of other documents, the reference includes the referenced documents as they may be amended or restated in the future, and any successor to them, by whatever name called. If any amended or restated document differs materially from the originally referenced document, the actuary should consider the guidance in this standard to the extent it is applicable and appropriate.

1.4 Effective Date—This standard is effective for all applicable filing work performed on or after May 1, 2006.

Section 2. Definitions

The terms below are defined for use in this actuarial standard of practice.

2.1 Financial Projection—A projection of covered lives, premiums, claims, expenses, capital and surplus, or other financial quantities that may be required by applicable law.

2.2 Health Benefit Plan—A contract or other financial arrangement providing hospital, medical, prescription drug, dental, vision, disability income, accidental death and dismemberment, long-term care, or other health-related benefits, whether on a reimbursement, indemnity, or service benefit basis, irrespective of the type of health plan entity that provides the benefits.

2.3 Health Filing—A required regulatory filing, at least one element of which requires projection of future contingent events, for rates or benefits, or financial projections.

Rate or benefit filings include, but are not limited to, the following:

a. filings of manual rates and rating factors;

b. filings of rating methodology, such as experience rating formulas and factors;

c. statements of actuarial soundness or rate adequacy, as may be defined by the regulatory body, for future rating periods;

d. certification of benefit values; and

e. other filings of similar nature as may be required by the regulatory body.

Financial projection filings include, but are not limited to, any filings in which the financial projections are a stand-alone requirement, such as those for licensure

requirements, or are a requirement of a broader filing, such as a rate filing or projections of future capital and surplus or other regulatory benchmark requirements.

2.4 Health Plan Entity—An insurance company, health maintenance organization, hospital or medical service organization, self-insured health benefit plan sponsor, governmental health benefit plan sponsor, or any other health benefit plan sponsor from which health filings are required.

2.5 Regulatory Benchmark—A measurement, such as a loss ratio or capital ratio, specified by applicable law, which is used by the regulatory authority as a basis upon which to evaluate a health filing.

2.6 Time Value of Money—The principle that an amount of money available at an earlier point in time has different usefulness and value than the same amount of money has at a later point in time.

Section 3. Analysis of Issues and Recommended Practices

3.1 Introduction—Many jurisdictions require health filings that demonstrate compliance with applicable law, which may vary considerably as to the requirements and procedures for these filings. In many cases, such law may be silent as to the assumptions and methodology to be used, thus giving the actuary significant discretion to exercise professional judgment in preparing and reviewing the filings.

3.2 Issues and Recommended Practices for Health Filings—The actuary should consider the following:

3.2.1 Purpose of Filing—When preparing a filing, the actuary should include in the filing a statement of its purpose, identifying the applicable law it is intended to comply with. For example, the actuary might state, "The only purposes of this rate filing are to document the rates and to demonstrate that the anticipated loss ratio of this product with those rates meets the minimum requirements of Section XX of the statutes of [name of state]. This filing may not be appropriate for other purposes."

If, in the actuary's professional judgment, applicable law is ambiguous, the actuary should describe how the actuary interpreted the requirements when preparing the filing. For example, the statute may say, "Provide a business plan demonstrating future solvency." The actuary then might state, "This projection of financial results is intended to demonstrate that the business plan reasonably anticipates surplus exceeding $XX million for the following Y years."

3.2.2 Assumptions—The actuary should consider which assumptions are necessary for the filing. Such assumptions may include the following:

a. premium levels and future rate changes;

b. enrollment projections;

c. morbidity, mortality, and lapsation levels and trends;

d. expenses, commissions, and taxes;

e. investment earnings and the time value of money;

f. health cost trends;

g. expected financial results, such as profit margin, surplus contribution, and surplus level;

h. expected impact of contractual arrangements with health care providers and administrators; and

i. expected impact of reinsurance and other financial arrangements.

3.2.3 Use of Business Plans to Project Future Results—The actuary should request and review any existing and relevant business plans for the health plan entity or health benefit plan that is the subject of the filing. The actuary should consider the information therein along with any other information relevant to the business plan as a part of the setting of the assumptions and methodologies used in the filing.

3.2.4 Use of Past Experience to Project Future Results—When setting assumptions, the actuary should adjust past experience for any known or expected changes that, in the actuary's professional judgment, are likely to materially affect expected future results. These may include, but are not limited to, changes in the following:

a. selection of risks;

b. demographic and risk characteristics of the insured population;

c. policy provisions;

d. business operations;

e. premium rates, claim payments, expenses, and taxes;

f. trends in mortality, morbidity, and lapse; and

g. administrative procedures.

The actuary should make adjustments to past experience based on earned premiums and incurred claims, as appropriate, in a way that reasonably matches claim experience to exposure. For example, the actuary should not use ratios of paid claims to collected premiums to project future incurred loss ratios except with appropriate adjustment.

The actuary should update prior earned premium and incurred claim estimates to reflect premium and claim development experience to date when, in the actuary's professional judgment, the difference is material.

The actuary may express past experience in terms of aggregate premium, claim, and reserve amounts, or in terms of unit results, such as incidence rates and average premium and claim amounts.

The actuary should consider the applicability and statistical credibility of the data and make appropriate modifications, if necessary.

3.2.5 Recognition of Plan Provisions—The actuary should consider pertinent plan documents or contracts and, as described to the actuary, established administrative procedures, any plan interpretations that are not written in the plan documents, and any arrangements with providers of health care.

3.2.6 New Plans or Benefits—The actuary should consider available data relevant to new plans or benefits. If using a model (for example, in the absence of sufficient data), the actuary should use a model that is reasonable and consistent with similar benefits or plans of coverage, if any, and that, if appropriate for the plan or benefit, takes into account the general characteristics of the health care delivery system.

3.2.7 Projection of Future Capital and Surplus—As part of a health filing, the actuary may be called upon to project future capital and surplus for the entire health plan entity or a portion of it, such as a business unit. In doing so, the actuary should base the projection on reasonable assumptions that take into account any internal or external future actions as described to the actuary that, in the actuary's professional judgment, are likely to have a material effect on capital or surplus.

3.2.8 Regulatory Benchmark—The actuary may be called upon to project results in relation to a regulatory benchmark for the entire health plan entity or a portion of it, such as a line of business. The actuary should base the projection on appropriate available information about the relevant book of business.

3.2.9 Reasonableness of Assumptions—The actuary should review the assumptions employed in the filing for reasonableness. The assumptions should be reasonable in the aggregate and for each assumption individually. The support for reasonableness should be determined based on the actuary's professional judgment, using relevant information available to the actuary. This information

may include, but is not limited to, business plans; past experience of the health plan entity or the health benefit plan; and any relevant industry and government studies that are generally known and reasonably available to the actuary. The actuary should make a reasonable effort to become familiar with such studies.

3.3 Reliance on Data or Other Information Supplied by Others—When relying on data or other information supplied by others, the actuary should refer to ASOP No. 23, *Data Quality*, for guidance.

3.4 Documentation—The actuary should prepare and retain documentation in compliance with the requirements of ASOP No. 31, *Documentation in Health Benefit Plan Ratemaking*, if applicable, and ASOP No. 41, *Actuarial Communications*. The actuary should also prepare and retain documentation to demonstrate compliance with the disclosure requirements of section 4.1.

Section 4. Communications and Disclosures

4.1 Communications and Disclosures—When issuing actuarial communications relating to regulatory filings for health plan entities, the actuary should refer to ASOP No. 23 and ASOP No. 41. In addition, such actuarial communications should disclose the following:

a. the sources of information;

b. any material information supplied by others and the extent of the actuary's reliance on such information;

c. any unresolved concerns the actuary may have about the information that could have a material effect on the actuarial work product;

d. limitations on the use of the actuarial work product;

e. any conflicts arising from applicable law;

f. the disclosure in ASOP No. 41, section 4.2, if any material assumption or method was prescribed by applicable law (statutes, regulations, and other legally binding authority);

g. the disclosure in ASOP No. 41, section 4.3, if the actuary states reliance on other sources and thereby disclaims responsibility for any material assumption or method selected by a party other than the actuary; and

h. the disclosure in ASOP No. 41, section 4.4, if, in the actuary's professional judgment, the actuary has otherwise deviated materially from the guidance of this ASOP.

Appendix 1

Background and Current Practices

Note: This appendix is provided for informational purposes but is not part of the standard of practice.

Background

Many jurisdictions require the filing of actuarial memoranda or similar documents in connection with health plan entities. An actuary may be involved in the preparation or review of these filings. The applicable laws differ as to their content, scope, and requirements. Many laws are silent as to procedures and assumptions to be employed, thus giving the actuary significant discretion to exercise professional judgment in these areas.

Current Practices

The previous ASOP No. 8 had been in place since 1989. Although the task force believes that the previous standard represented generally accepted practice, this revision more accurately reflects current practices.

Appendix 2

Comments on the Exposure Draft and Responses

The exposure draft of this revised actuarial standard of practice (ASOP), *Regulatory Filings for Health Plan Entities,* was issued in September 2004, with a comment deadline of March 31, 2005. Fourteen comment letters were received, some of which were submitted on behalf of multiple commentators, such as by firms or committees. For purposes of this appendix, the term "commentator" may refer to more than one person associated with a particular comment letter. The Task Force to Revise ASOP No. 8 carefully considered all comments received. Summarized below are the significant issues and questions contained in the comment letters and responses to each, which may have resulted from ASB, Health Committee, or task force discussion. Unless otherwise noted, the section numbers and titles used below refer to those in the exposure draft.

GENERAL COMMENTS	
Comment	One commentator questioned whether credit disability filings were subject to ASOP No. 8 since typically such filings require only that the actuary conform to the state's published "prima facie" rates and, thus, the filings are not "projections of future contingent events." The commentator questioned whether ASOP No. 8 should exclude credit disability in these situations.
Response	The task force did not think such a specific exclusion was appropriate and believed the general description of inclusions and exclusions was sufficient.
Comment	One commentator noted that some other standards (for example, ASOP Nos. 26 and 28) describe specific "regulatory filings for health plan entities" and that, either the relationship between these standards and ASOP No. 8 needed to be clarified in the latter, or that the name of the proposed standard was too broad and needed to be replaced.
Response	The task force noted that these filings are already specifically excluded in the second paragraph of section 1.2 and that these exclusions should adequately address these concerns.
Comment	One commentator was concerned that the scope of the proposed ASOP was too broad, stating individual health insurance carriers are often asked by regulators about the benefit cost(s) of mandates and that, depending on what the definition of a benefit filing is, almost every request could require more work or even an actuarial memorandum. Also, in many cases, the regulatory entity has a prescribed form that does not lend itself to many of the proposed requirements. For example, many states have electronic forms that allow for entering only a number or a few numbers; in most cases, there is not room to provide all of the qualifications or caveats that could be included. In addition, there is often no means to follow up with a full report.
Response	The task force believes that the definition of section 2.4 adequately addresses these concerns. The task force does not believe requests for information regarding, for example, benefit cost(s) of mandates would fall under the category of required filings.
Comment	One commentator suggested adding materiality criteria in the section that discusses reasonableness of assumptions.
Response	The task force chose not to make a distinction between levels of materiality of assumption. The task force did not want to include a formal definition of materiality in this standard, as materiality is a subjective concept and often depends on professional judgment.

SECTION 1. PURPOSE, SCOPE, CROSS REFERENCES, AND EFFECTIVE DATE	
Section 1.1, Purpose	
Comment	One commentator stated that "required regulatory filings" is less clear than the language in the prior standard. One of the most common types of filings is a filing for a rate increase. Most often, the filing is made to increase rates, not to meet a regulatory requirement to file. The commentator suggested striking the work "required" and striking it in the second to last paragraph of section 1.2.
Response	The task force noted that it had previously considered this issue and concluded purposely to insert the word "required" to differentiate between filings that are required by regulatory authorities, such as those required when filing for a rate increase, and other information that actuaries may submit to health regulators, such as a regulator's request for an estimate of the cost impact of a proposed regulation.
Section 1.2, Scope	
Comment	The transmittal memorandum of the exposure draft asked whether the scope was appropriate. One commentator agreed it was but believed that the second sentence could be clearer if worded as follows: "Health filings covered by this standard are filings that require projection of future contingent events in order to meet the given regulatory requirements. These health filings can be categorized into two broad categories: rate or benefit filings and financial projection filings."
Response	The task force believes that these concerns are adequately covered in sections 1.2 and section 2.3. The task force noted that most of the commentators on the first three questions asked in the transmittal memorandum agreed that the scope was appropriate and that the ASOP was clear as to whom it applied and to what types of health filings were covered.
Comment	The transmittal memorandum of the exposure draft asked whether the ASOP was clear that it applies to projections relating to capital and surplus requirements, which would include, for example, minimum risk-based capital and surplus requirements in states that have adopted the NAIC Risk-Based Capital (RBC) for Health Organizations Model Act. One commentator stated that, if the ASB wishes to further emphasize application to projections related to capital and surplus requirements, then it could include the example given above.
Response	The task force believed the descriptions were sufficiently clear to provide guidance on which filings were subject to the standard, noting that two other commentators agreed with this.
Comment	One commentator was concerned with the last paragraph regarding conflict with applicable law and believed that the last phrase should be strengthened to require the actuary to disclose items such as the nature of the departure from the requirements of the standard, the financial effects thereof, and the specific provisions of the applicable law.
Response	The task force updated the wording to be consistent with the current language to be used in other ASOPs and believed the revised language more closely addressed some of the commentator's concerns. The task force did not agree that the standard should specify what the actuary's disclosure should contain in the event of the standard conflicting with applicable law and believed that the revised wording, in combination with section 4, Communications and Disclosures, provided adequate guidance.
Comment	One commentator was concerned that including "case law" and "statutes" in a definition of applicable law might unreasonably require the actuary to be knowledgeable about court interpretations or even require the unauthorized practice of law.
Response	The definition of "applicable law" was deleted since it is now defined in "boilerplate" language in section 1.2. The task force does not believe the definition puts actuaries in the position of unauthorized practice of law, but the standard does require actuaries to be knowledgeable of applicable law germane to the actuarial assignment.

Comment	One commentator suggested that a discussion of any conflict between the standard and applicable law should be placed in the body of the standard rather than in the scope.
Response	The task force believed the current placement was appropriate and consistent with other ASOPs.
SECTION 2. DEFINITIONS	
Section 2.2, Financial Projection (now section 2.1)	
Comment	One commentator suggested inserting "covered" before "expenses."
Response	The task force believed that, if this word were added, the actuary could interpret it to mean expenses covered, for example, by premiums. Financial projections should include all expenses, which may or may not be covered by premiums. As such, the task force concluded not to add this word.
Comment	One commentator stated that a projection of covered lives in the absence of financial quantities was not considered a "financial projection" and that "covered lives" should be removed from the list. The commentator also suggested changing "administrative expenses" to "expenses" since claims are expenses too and noted that in other places in the standard "expenses" means "administrative expenses."
Response	The task force believed that covered lives often are included in financial projections and should be included in the projection. The task force also believed that "expenses" as a general term provided adequate guidance, particularly since claims are mentioned as a separate item.
Section 2.3, Health Benefit Plan (now section 2.2)	
Comment	One commentator expressed concern that "health benefit plan" is a defined term in numerous state insurance laws, but the ASOP defines it differently. The commentator suggested substituting a term such as "health coverage plan."
Response	The task force believed that the definition needed to be sufficiently broad and inclusive to cover all states' requirements and that definition contained in the exposure draft was sufficiently clear to avoid confusion with statutory language. The task force noted that terms in section 2 are defined only for their use within this standard and may depart from definitions used in other actuarial literature.
Comment	One commentator suggested adding "hospital" before "medical" and adding this sentence to the end of the paragraph: "A discount-only plan is not a health benefit plan."
Response	The task force agreed and made the first suggested change. On the second suggestion, the task force noted that, at this time, this type of product would not be subject to this ASOP since it would not require a health filing as defined under section 2.4 and believed it was unnecessary to add this sentence.
Section 2.4, Health Filing (now section 2.3)	
Comment	One commentator suggested that a definition of "manual rates" be included and that ASOP No. 8 should be expanded to cover the derivation and proper use of manual rates.
Response	The task force believed the term "manual rates" was well enough understood in the context of health filings and did not need to be defined in this ASOP. The task force did not believe that a discussion of the derivation or use of manual rates was an appropriate subject for this ASOP.

Comment	One commentator was concerned that the definition was too restrictive and questioned whether the phrase "certification of benefit values" includes filings where an actuary certifies that two sets of benefits are equivalent, which would not always require a projection into the future and may be strictly based on the current experience.
Response	The task force intends that, for a filing to be subject to this ASOP, the filing be required by a regulatory authority and that at least one element of the filing requires projection of future contingent events. If the filing does not have both of these requirements, the filing is not subject to this ASOP. In the example given by the commentator, if the benefit equivalence calculation requires a projection of future contingent events, and the actuary chooses to use current experience with zero trend, and the filing is required by a regulatory authority, the filing would be subject to this ASOP.
Comment	One commentator suggested striking the phrase "as may be defined by the regulatory body" because it does not help to strengthen the section and may in fact do harm, as applicable law can define anything as "actuarial soundness" or "rate adequacy." The power of the "regulatory body" should not be defined to dictate unsound practice.
Response	The task force noted that it had previously considered this issue and had intentionally concluded to add this language. The task force had discussed including a definition of "actuarial soundness" in this ASOP but concluded that "actuarial soundness" is a broader industry issue and decided to limit its inclusion to cover those situations in which states have specific requirements, for example, that the actuary opine that the rates are reasonable in relation to the benefits provided or that the rates meet mandated minimum loss ratio requirements.
Comment	One commentator recommended replacing the last paragraph of the section with the following: "A financial projection or business plan filing includes, but is not limited to, any filings in which the financial projections are a stand-alone requirement, such as those for licensure requirements, or are a requirement of a broader filing, such as a rate filing or projections of future capital and surplus or other regulatory benchmark requirements."
Response	The task force noted that the suggested wording was basically the same as that contained in the exposure draft except adding the wording about business plan. The task force did not believe the reference to business plan in this paragraph was necessary.
Comment	One commentator stated that the term "health filing" is based on the undefined term "required regulatory filing." As a result, the scope of the definition is left unclear. No distinction is made between a legal requirement and an administrative request that is unsupported by statute or regulation. The commentator suggested adding the following definition of a required regulatory filing: "A required regulatory filing is a filing required by statute or regulation."
Response	The task force believed the definition of "health filing" in the exposure draft provided adequate guidance and that the proposed definition was circular.
Section 2.7, Time Value of Money (now section 2.6)	
Comment	One commentator suggested dropping the phrase "usefulness and" and leaving the term defined in terms of value only, perhaps by adding the word "monetary" before "value." Another commentator believed the definition and references to "earlier" and "later" in particular were not clear.
Response	The task force considered the wording in light of the comments but concluded that the definition, which is used in other ASOPs, was sufficiently clear.

SECTION 3. ANALYSIS OF ISSUES AND RECOMMENDED PRACTICES	
Section 3.2.1, Purpose of Filing	
Comment	One commentator noted that the example in the second paragraph appeared to provide more precision than appeared to be implied by the requirement in the first sentence of this paragraph, which required the actuary only to "describe" the interpretation of the regulatory requirements. The commentator questioned what level of precision is appropriate for the description and believed that "describe" does not provide any notion of the degree of completeness needed.
Response	The task force believed the wording was appropriate and did not believe the standard should be too prescriptive.
Section 3.2.2, Consistency With Business Plan (now section 3.2.2, Assumptions, and section 3.2.3, Use of Business Plans to Project Future Results)	
Comment	One commentator suggested alternative language that would require assumptions to be consistent with contemporaneous health filings relating to the health benefit plan subject to the current filing; one commentator suggested strengthening the requirement that "the actuary should use assumptions and methodologies that are consistent with the business plan...."
Response	Section 3.2.2 from the exposure draft was reorganized into new sections 3.2.2, Assumptions, and 3.2.3, Use of Business Plans to Project Future Results, to better address these different but connected issues.
Comment	One commentator noted that the term "persistency" appears without definition. While the term has an unambiguous meaning in an individual life insurance setting, it could have multiple applications in the health insurance arena.
Response	The task force considered this and believed that the meaning should be clear within the context of each filing. The task force did not believe a definition was necessary.
Comment	One commentator stated that, in any given filing, certain assumptions may not be material and that this should be so noted in the ASOP.
Response	The task force did not believe such a statement was necessary. As noted in the task force's response to the last comment under General Comments, the task force chose not to make a distinction between levels of materiality of assumptions and did not want to include a formal definition of materiality in this standard, as materiality is a subjective concept and often depends on professional judgment.
Comment	Several commentators expressed concerns and raised important issues and questions on the opening paragraph of this section, including the following: One commentator found that certain terms such as "business plan," "sales results," and "overall" in "overall business results" were undefined. One commentator questioned whether the relevant sections of the business plan should be disclosed in the actuarial communication. One commentator believed the phrase "as known to the actuary" was too lenient and that the actuary should review the components of the business plan that are relevant to the determination of reasonable assumptions. One commentator noted that business plans developed by health plans to support the internal plan management serve a different purpose than the projections used to support pricing and regulatory filings. For example, they are often intended to set challenging performance goals rather than most likely outcome. The commentator stated that it would be inappropriate to base pricing assumptions on such projections, as there is no guarantee that they represent a reasonable expectation of future experience. Further, the commentator suggested that business plans subject to regulatory filing and review should be included in the definition of a health filing.

Response	The task force agreed with many of the comments and renamed the title and rewrote the section to address these issues. It is recognized there are many types of business plans, ranging from formal written documents to informal verbal discussions. To avoid being prescriptive, the language was changed to require the consideration of relevant information from whatever business plan exists and included wording about requesting such plan, although obvious. The task force removed references to consistent assumptions. The task force believed that the issue regarding documentation is adequately covered in sections 3.4 and section 4.1.
Comment	One commentator found that sections 3.2.2 and 3.2.3 of the exposure draft when read together were troublesome. Section 3.2.2 would have required consistency with the business plan. Section 3.2.3. would have described a review for reasonableness versus, among other factors, the business plan. The commentator proposed several changes to both sections, including a proposed redraft of section 3.2.2.
Response	The task force substantially rewrote sections 3.2.2 and 3.2.3, (now sections 3.2.2, 3.2.3, and 3.2.9, Reasonableness of Assumptions) and believes that these revisions adequately address the concerns mentioned.
Section 3.2.3, Reasonableness of Assumptions (now section 3.2.9)	
Comment	One commentator questioned whether the actuary should state the extent to which the assumptions are the actuary's own or that he or she is reviewing those of some other technician (who may or may not be an actuary) and perhaps assessing them to meet only the lower standard of "not unreasonable" or "in a reasonable range." The commentator stated that two aspects should be reported: (a) the applicable standard of reasonableness; and (b) who the author is. The commentator noted that, in assessing anything prepared by an actuary, the actuary's assessment is going to be strongly affected by whether the assumptions were devised by the signing actuary or by someone else and, for that matter, whether the actuary was independent or employed by the organization from which the assumptions came and questioned whether that should be the case.
Response	The task force rewrote this section and believes that this revision addresses many of the commentator's concerns.
Comment	One commentator stated that two ideas seem important here. First, the model chosen can be important because some models make assumptions explicit while other models make the same assumptions implicit. Second, it seems inappropriate to exempt implicit assumptions from the same scrutiny as the explicit assumptions. The commentator suggested renaming the section "Reasonableness of Projection Model and Assumptions."
Response	The task force believed that no change was necessary since this section applies to all assumptions, both implicit and explicit.
Comment	Two commentators raised the issue regarding materiality of assumptions and suggested wording changes to the effect that "each material assumption should be reasonable."
Response	The task force believed that it was important that all assumptions be identified and that the support for reasonableness of the assumptions be based on the actuary's professional judgment. As noted in the task force's response to the last comment under General Comments, the task force chose not to make a distinction between levels of materiality of assumptions and did not want to include a formal definition of materiality in this standard, as materiality is a subjective concept and often depends on professional judgment.
Comment	One commentator recommended retaining the old language in this section requiring assumptions to be reasonable based on all information available to the actuary and suggested replacing the last two sentences with the following: "The support for reasonableness should be determined based on the actuary's professional judgment, using relevant information available to the actuary. This information may include, but is not limited to, past experience of the health plan entity or the health benefit plan, and any relevant industry and government studies."
Response	The task force substantially agreed with most of the commentator's comments and made appropriate changes to this section while adding another sentence outlining the actuary's duty to make a reasonable effort to become familiar with relevant studies.

Section 3.2.4, Use of Past Experience to Project Future Results	
Comment	One commentator suggested striking "in the actuary's professional judgment," citing it extraneous.
Response	The task force believed that decisions about materiality often depend on the actuary's professional judgment and, as such, concluded not to strike those words.
Comment	One commentator suggested that, in 3.2.4(d) the comma between "benefit" and "expense" be replaced with the word "and."
Response	The task force clarified this section (now section 3.2.4 (e)) with revised wording.
Comment	One commentator recommended including the concept of "known" changes in the first paragraph and noted that there may be changes that have taken place between the end of the experience period and the date of the filing that are known and will materially affect expected future results.
Response	The task force agreed and made the change.
Comment	One commentator noted the wording of item 3.2.4(e) is potentially confusing and recommended using either "trends in mortality and morbidity" or "trends in mortality and in the utilization and cost of services."
Response	The task force agreed and revised the section (now section 3.2.4(f)) for clarity.
Comment	One commentator stated that the discussion in the second paragraph refers to paid and incurred "claims" and to "earned premiums," etc., and yet the principles are more general and extend beyond premiums and claims to any financial flows with similar characteristics, for example, capitation income and payments, government subsidy or "reinsurance" payments, risk adjustments, state risk pool assessments, etc. The commentator asked whether more general language should be used.
Response	The task force believed that more general language was not necessary. The items mentioned are, for the most part, an element of premiums or incurred claims, for example, capitation income would be part of earned premiums and capitation payments are a part of incurred claims.
Section 3.2.5, Recognition of Plan Provisions	
Comment	One commentator stated that the phrase "as described to the actuary" in this context should be acceptable only if such descriptions are carefully documented with sufficient specificity to designate the contract provisions precisely.
Response	The task force believed that this is adequately covered with the requirements in sections 3.4 and section 4.1.
Comment	One commentator found the meaning "plan documents" unclear and questioned whether it could include employer contracts, employee certificates, group administration manuals, provider contracts, etc.
Response	The task force believed that plan documents and unwritten procedures, such as those mentioned by the commentator, can provide useful information about the plan. The task force believed that further clarification was not necessary.

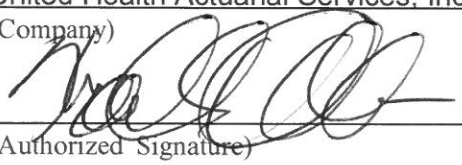
Section 3.2.6, New Plans or Benefits	
Comment	One commentator suggested that the first sentence could be shortened to say, "The actuary should consider available relevant data," because the wording as it stands almost limits the paragraph to an actuary on the filing end and excludes the actuary on the reviewing end.
Response	The task force agreed and rewrote this sentence to clarify the language.
Comment	One commentator recommended rewording the second sentence of this section as follows: "In the absence of such data, the actuary should use a reasonable model that is consistent with similar benefits or plans of coverage offered by the health plan entity and that, if appropriate for the plan or benefit, takes into account the general characteristics of the health care delivery system." Another commentator believed that the second sentence was incomplete in that the model, by itself, does nothing and that the standard should state what to do with the model. The commentator believed that the standard meant that the actuary should consider the elements of the new benefits, find other existing coverages that have matching benefits to the new plan, see if the experience would apply to the new plan, and, if it does not, keep looking until a match is found.
Response	This section was rewritten. Although the wording is very similar, the phrasing has been rearranged somewhat for clarification. With regards to the second comment, the task force means that the actuary is to select a model that is intended to develop data that can be used for estimating the value of new plans or benefits from data on existing plans, when directly relevant data on the new plan are not available. The language does not require that the benefits and the experience match exactly. As with all other items under section 3.2, the results of such a model would be considered for the health filing.
Section 3.2.7, Projection of Future Capital and Surplus	
Comment	One commentator stated that the phrase "as described to the actuary" should not be used without a requirement to document what was described to the actuary.
Response	The task force believes that this is adequately covered with the requirements in sections 3.4 and section 4.1.
Section 3.2.8, Investment Income	
Comment	One commentator recommended revising section 3.2.8 of the exposure draft by substituting "reasonable earnings rates" for "a reasonable earnings rate." This would (a) allow for earnings rates varying by the average duration of liabilities; and (b) leave room for stochastic interest rate studies (admittedly rare at present, but a concern for very long-term products such as LTC). The present wording seems to require use of a single rate.
Response	This section was deleted but the term "investment earnings" has been included without further description in the list of assumption in new section 3.2.2, Assumptions.
Section 3.2.9, Regulatory Benchmark (now section 3.2.8)	
Comment	One commentator believed that the second sentence was a general statement that applied to any filing and, thus, belonged in section 3.2.4. The commentator suggested that, if it is desirable to mention regulatory benchmark in the standard, it should be done in section 3.2.1.
Response	The task force believed that sections 3.2.4 and 3.2.6 already provide for the use of appropriate relevant information in their respective descriptions. The task force considered the commentator's second suggestion regarding having regulatory benchmark be a part of section 3.2.1. The task force concluded to keep it as a separate subsection under section 3.2 because of the importance and relative uniqueness of these types of projections.

Section 3.3, Reliance On Others (now Reliance on Data or Other Information Supplied by Others)	
Comment	One commentator recommended that the word "descriptions" be included so that it would read, "…on information, including data and descriptions…." Another commentator expressed concern about the reliance on information supplied by others and any due diligence the actuary should perform on that information.
Response	The task force revised this section to be consistent with language used in other current ASOPs and notes that ASOP No. 23, *Data Quality*, provides expanded guidance on these issues.
SECTION 4. COMMUNICATIONS AND DISCLOSURES	
Section 4.1, Communication and Disclosures	
Comment	One commentator expressed concern with item 4.1(b), stating actuaries will adopt blanket boilerplate statements that absolve them of the responsibility to inform the employer or client who may rely on their judgments and what they relied on.
Response	The task force agreed and modified the language.
Comment	One commentator expressed a concern about whether the actuary has been required to estimate the extent that adopting an assumption dictated by laws or regulations has changed the results of the calculations. The commentator suggested that one way to do this would be to make section 4.1(e) more explicit, for example, by stating, "any conflicts arising from applicable law or regulations and their effects on the calculations."
Response	The task force decided not to change the language from that contained in the exposure draft. The task force believed that this suggested requirement would put a greater burden on the actuary and does not necessarily reflect generally accepted practice. It may be a good thing to know but would not be part of a required regulatory filing.

CERTIFICATION AND SIGNATURE PAGE

By signing below, I certify that I have reviewed this Solicitation in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this bid or proposal for review and consideration; that I am authorized by the bidder to execute this bid or any documents related thereto on bidder's behalf; that I am authorized to bind the bidder in a contractual relationship; and that to the best of my knowledge, the bidder has properly registered with any State agency that may require registration.

United Health Actuarial Services, Inc.
(Company)



(Authorized Signature)

Karl G. Volkmar, Principal & Senior Consulting Actuary
(Representative Name, Title)

317-575-7672 317-575-7678
(Phone Number) (Fax Number)

February 3, 2014
(Date)

ADDENDUM ACKNOWLEDGEMENT FORM

SOLICITATION NO.: INS14014

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[X] Addendum No. 1	[ ] Addendum No. 6
[ ] Addendum No. 2	[ ] Addendum No. 7
[ ] Addendum No. 3	[ ] Addendum No. 8
[ ] Addendum No. 4	[ ] Addendum No. 9
[ ] Addendum No. 5	[ ] Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

United Health Actuarial Services, Inc.
Company

Authorized Signature

February 3, 2014
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

RFQ No. INS14014

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

MANDATE: Under W. Va. Code §5A-3-10a, no contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and: (1) the debt owed is an amount greater than one thousand dollars in the aggregate; or (2) the debtor is in employer default.

EXCEPTION: The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

DEFINITIONS:

"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Employer default" means having an outstanding balance or liability to the old fund or to the uninsured employers' fund or being in policy default, as defined in W. Va. Code § 23-2c-2, failure to maintain mandatory workers' compensation coverage, or failure to fully meet its obligations as a workers' compensation self-insured employer. An employer is not in employer default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

AFFIRMATION: By signing this form, the vendor's authorized signer affirms and acknowledges under penalty of law for false swearing (W. *Va. Code* §61-5-3) that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.

WITNESS THE FOLLOWING SIGNATURE:

Vendor's Name: United Health Actuarial Services, Inc

Authorized Signature: _____ Date: February 3, 2014

State of Indiana

County of Hamilton, to-wit:

Taken, subscribed, and sworn to before me this 3rd day of February, 2014.

My Commission expires 2/13/2019, 2019.

AFFIX SEAL HERE

NOTARY PUBLIC _____

County of Marion, In

2/3/14

BETSY LEIGH GODBY
Notary Public, State of Indiana
SEAL
My Commission Expires 2/13/2019

Rev. 07/12

State of West Virginia
VENDOR PREFERENCE CERTIFICATE

Certification and application* is hereby made for Preference in accordance with ***West Virginia Code***, §5A-3-37. (Does not apply to construction contracts). ***West Virginia Code***, §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the ***West Virginia Code***. This certificate for application is to be used to request such preference. The Purchasing Division will make the determination of the Resident Vendor Preference, if applicable.

1. **Application is made for 2.5% resident vendor preference for the reason checked:**

___ Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

___ Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; or 80% of the ownership interest of Bidder is held by another individual, partnership, association or corporation resident vendor who has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

___ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business in West Virginia continuously for the four (4) years immediately preceding the date of this certification; **or,**

2. **Application is made for 2.5% resident vendor preference for the reason checked:**

___ Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

3. **Application is made for 2.5% resident vendor preference for the reason checked:**

___ Bidder is a nonresident vendor employing a minimum of one hundred state residents or is a nonresident vendor with an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia employing a minimum of one hundred state residents who certifies that, during the life of the contract, on average at least 75% of the employees or Bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

4. **Application is made for 5% resident vendor preference for the reason checked:**

___ Bidder meets either the requirement of both subdivisions (1) and (2) or subdivisions (1) and (3) as stated above; **or,**

5. **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**

___ Bidder is an individual resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard and has resided in West Virginia continuously for the four years immediately preceding the date on which the bid is submitted; **or,**

6. **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**

___ Bidder is a resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard, if, for purposes of producing or distributing the commodities or completing the project which is the subject of the vendor's bid and continuously over the entire term of the project, on average at least seventy-five percent of the vendor's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years.

7. **Application is made for preference as a non-resident small, women- and minority-owned business, in accordance with West Virginia Code §5A-3-59 and *West Virginia Code of State Rules*.**

X Bidder has been or expects to be approved prior to contract award by the Purchasing Division as a certified small, women- and minority-owned business.

Bidder understands if the Secretary of Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) reject the bid; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contractor purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to the Purchasing Division and authorizes the Department of Revenue to disclose to the Director of Purchasing appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

Under penalty of law for false swearing (West Virginia Code, §61-5-3), Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

Bidder: United Health Actuarial Services, Inc **Signed:** _____

Date: February 3, 2014 **Title:** Principal & Senior Consulting Actuary

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: INS14014

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United Health Actuarial Services, Inc.
Company

Authorized Signature

February 3, 2014
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

COMPANY DESCRIPTION AND RELEVANT EXPERIENCE

United Health Actuarial Services (UHAS) is a health actuarial consulting firm that employs seasoned actuarial professionals that are collectively experienced in the full spectrum of health-related actuarial practice including individual and group medical and prescription drug products, Medicare-related coverages, long-term care insurance, various supplemental health insurance products, reinsurance, employee benefits and OPEB valuations. The experience covers all actuarial functions including product development, pricing, rate review, experience analysis, filing, valuation, reporting and network development and pricing. The actuaries involved in these activities routinely manage complex and diverse projects and develop statistics, metrics, benchmarks, and models for testing rate adequacy and increases, performance measurement, forecasting, and trend analysis. In addition, certain key staff members have life insurance backgrounds that allow them to provide actuarial support relating to life insurance products.

UHAS was started by Karl Volkmar, Principal & Senior Consulting Actuary, in 2000 and is headquartered in Carmel, Indiana. UHAS has the financial capacity to undertake the responsibilities required under this contract. The company has grown consistently since inception and had revenues of approximately $4 MM in 2013. We would be happy to produce supporting corporate financial statements and/or tax returns, if desired.

UHAS holds numerous engagements in both the public and private sectors. Specific to this project, UHAS has extensive experience in the review of rates (including rate increases) on behalf of regulators and insurance carriers. In addition to other clients, we are currently performing the primary rate review on behalf of the Center for Consumer Information and Insurance Oversight (CCIIO) for both the individual and small group market for states which had not been found to have effective rate review programs.

As you are aware, we are also performing rate reviews and providing other consulting services for your Director of Rates and Forms and Life and Health Analysts as well as developing needed information for the Insurance Commissioner.

On the policy/regulatory side, UHAS consultants have developed and assisted with the interpretation of relevant rules/regulations regarding rate-review, Patient Protection and Affordability Act (PPACA) implementation, etc. We have a number of carrier clients which rely upon us for many, if not all, of their actuarial functions including rating and experience review.

To demonstrate our experience working with regulatory agencies, UHAS offers the following details on specific tasks which align with many of the requirements set forth in this RFQ:

- Sole contractor for reviewing rate filings for CCIIO per the requirements of the PPACA:

  UHAS has played a pivotal role in the PPACA rate review process. Our task is to review the rate filings, test the assumptions and projections, document our findings and make recommendations regarding the reasonableness of the rate increase requests.

  We have performed rate reviews on all filings for which the filed increases were in excess of the required thresholds in states which were deemed to not have an effective

rate review process for the individual and/or small group markets. This included complete reviews of the filings and all assumptions used in developing the filed rate revisions. We review carrier experience in a manner consistent with Federal regulation and, where appropriate, state regulation to determine if the rate actions are reasonable. The primary elements of the determination are whether rate changes are excessive, unjustified or unfairly discriminatory. Following the analysis of these criteria, UHAS puts forth recommendations to CCIIO regarding the appropriateness of the rate actions.

The majority of the work to-date has been on products which had rates effective in 2013 and, hence, the use of the now required Uniform Rate Review Template (URRT) was not required. Also, the standards applicable prior to 2014 were different than what will be applicable going forward. These new rules applicable under PPACA will result in different handling of most medical rate filings. We are very experienced with medical risk management principles and their application to the actuarial standards that must be adhered to. As such, UHAS has the expertise needed to evaluate rate filings under the new environment.

UHAS also worked with the CCIIO rate review actuary on filings that were developed for the 2014 plan year. This included both the rate setting for selected new plans as well as the review of carrier compliance with rating rules for roughly 150 plans for both on and off of the exchanges, both group and individual.

Our consulting role has recently been expanded to handle the rate reviews for non-grandfathered plans which are impacted by the Transitional Policy allowed for policy years starting between January 1, 2014 and October 1, 2014 per a CMS directive to the state insurance commissioners.

- Contractor for consulting services and actuarial rate review for life and health related product filings for the state of West Virginia:

  UHAS is completing its initial term as the actuarial consultants for the West Virginia Office of the Insurance Commissioner. In that capacity we have performed rate filing reviews, developed a rate review manual, trained personnel in the actuarial aspects of rate development and provided education and assistance in interpretation and implementation of the Affordable Care Act. A goal of the department was to leverage our services in order to be approved as an "effective review program" under PPACA.

  In addition to the above, UHAS was also awarded the contract to provide actuarial services relating to Essential Health Benefits (EHB) including the development of projected costs for each of the detailed EHB offered by the 10 potential benchmark plans in West Virginia. This study supported the state's efforts to create a single benchmark plan for the Health Care Exchange.

  Consulting included departmental visits and training as well as face-to-face meetings with the WV Insurance Commissioner. Over the last 32 months, UHAS has delivered various training programs to the rate and form review team addressing the many issues introduced in PPACA including Exchanges, EHBs, and the 3Rs, as well as rate review challenges that are likely with new product submissions.

For each of the above, UHAS has developed a model for projecting appropriate experience and calculating a range of acceptable rate increases. The model accepts data such as base period claims, premiums (and historic rate increases), and membership, allows for a set of assumptions such as target loss ratio, trend and any applicable adjustments to base experience (e.g., demographic shifts, plan changes, etc.), and calculates the rate increase required to reach the target loss ratio. The model attempts to duplicate the carrier's projection using their own assumptions and has columns to develop a range of acceptable rate increases using our own set of preferred data and assumptions.

In this process we have evaluated each of the carrier assumptions for reasonableness and where values appeared inappropriate we would use what we determined to be a more reasonable value(s).

Obviously, much more judgment and a few more steps will be involved in the future. The addition of the impact of the 3Rs will present more variability in claim/MLR levels and thus the magnitude of rate adjustments. Carriers will be challenged with estimating current and future claim levels as stable and reliable data will not be available for many years. These will present challenges not only for the carriers, but also for regulators as they need to determine if presented rate adjustments are indeed reasonable.

- Contractor for consulting services and actuarial rate review for Long Term Care product filings for the state of West Virginia:

  UHAS currently completes LTC premium rate increase filings for the West Virginia Department of Insurance, which it has done since 2011. For these rate filing reviews, UHAS has developed a consistent and efficient process to review requested premium rate increases that produce defendable recommendations. UHAS also supports the department through staff preparation for onsite meetings requested by carriers to discuss a denial of a premium rate increase. In addition, UHAS conducted a training session to help the West Virginia reviewing staff to better understand the components of a LTC rate increase filing, the process associated with reviewing a filing and to educate staff on the distinction between a rate stability rate increase filing and a loss ratio rate increase filing.

- Contractor for consulting services and actuarial rate review for Long Term Care product filings for the state of California:

  UHAS also completes LTC new product and rate increase filings for the California Department of Insurance (CA DOI). UHAS is included in a pool of consultants that the CA DOI utilizes to review LTC filings. We have been performing these reviews since 2008, with two actuaries currently involved in the review of these LTC filings.

Proficiency in the area of health insurance pricing and reviewing major medical rate filings

In addition to the above mentioned work specific to the public sector which includes examples of review of numerous major medical health insurance filings, UHAS has projects with various insurance carriers. Two of the more recent projects include Advantage Health Plans in Indiana and Pekin Insurance in Illinois. UHAS provides all actuarial work for the companies including the recent pricing of new PPACA-compliant products. This work included the assembly of the Actuarial Memorandum, Unified Rate Review Template and Rate Tables. This assembly

included the determination of an index rate for the single risk pool (i.e., for the market), allowable market level adjustments (e.g., reinsurance, risk adjustment) and the allowable plan level adjustments such as cost-sharing design, network, and administrative expenses. All assumptions used in the development of these values were described in the Actuarial Memorandum prepared by UHAS on behalf of the carrier.

As with all actuaries, the majority of our historical work experience was under the pre-2014 rules and methodology. Knowledge of the new environment is limited to 2014 product work. While 2014 brings a new set of rules, techniques and data sources, actuaries trained in rate development are able to pull together assumptions and data that are intended to reflect the new rules and marketplace. Because of our work with CCIIO we have been exposed to the filings of over 60 separate issuers both on and off of the exchange.

Our relationship with CCIIO makes us uniquely qualified to know, and in some cases influence, the federal government's intent and approach to numerous issues. With the broad and sweeping changes that have accompanied PPACA and the subsequent adjustments, there have been numerous issues that have not been contemplated in the already-released regulations and Q&As. Our observations, insights and recommendations have been offered since the inception of our consulting agreement to help establish some of the processes in place today.

Because of the collective years of pre-UHAS experience working as senior executives and chief actuaries for health insurance carriers, many of our consultants are able to bring a more pragmatic approach to developing methodologies and assumptions used in determining the risk models appropriate for the new insurance environment. In these regulatory roles, we have observed a variety of techniques, data submissions and, at times, skewed or biased information provided by carriers to generate the carriers' maximum or desired increase. These include conservative estimates of IBNR, unsupportable trend values and accelerated levels of selection wear-off. With our numerous years of hands-on rating and rate justification, UHAS, in its rate review capacity, has been able to ascertain with a high degree of confidence the adequacy and appropriateness of the rate levels submitted and remove any company bias or conservatism. As carriers introduce new methodologies as well as public and company data sources in the rate-development process, our actuarial and carrier experience will prove to be a valuable asset in assessing the appropriateness of filed increases.

Given all of the above, UHAS is very familiar with the rate review process in general, as well as numerous techniques, methodologies and formats presented by insurance carriers in the rate filing process. As new methodologies and assumptions are introduced, we believe our experience has us in a position to not only evaluate the assumptions, but to determine whether or not they are reasonable and supportable.

Related to our public sector work, we have received filings through numerous submission protocols including SERFF, HIOS and other federal platforms. We have tools to convert most PDF files to Excel or Word files to facilitate our analyses. We also cross-check data and reports within submission for consistency.

Proficiency in the area of long term care insurance pricing and reviewing LTC rate filings

In addition to working LTC state filings, UHAS has worked on LTC-related projects for other public-sector clients and many private sector clients as well. For example, UHAS has completed the California Public Employees' Retirement System (CalPERS) LTC annual valuations since

2004, and UHAS completed a review of the Federal LTC Program for Office of Personnel Management. For the private sector, UHAS has developed new LTC products and has completed a multitude of inforce product/rate management and valuation/financial reporting projects.

RESOURCES AND QUALIFICATIONS

United Health Actuarial Services (UHAS) Resources

This section of our proposal describes available resources for this contract. We present our proposed staffing, deployment and organization of personnel and the personnel qualifications and resumes of those available to be assigned to this contract.

Note that UHAS has recently added to their staff of credentialed actuaries. Adam Singleton joined our staff from Humana within the last 6 months, and Sidney Richard and Shana O'Dell are transitioning from their positions at Everence Association and working with us on a regular basis. Each has many years of experience in the health field including regulatory filings.

We believe that the key role(s) for this project could be sufficiently staffed by the nine credentialed actuaries listed below:

Karl Volkmar, FSA, MAAA, FCA
John Ames, FSA, MAAA
Ben Brandon, FSA, MAAA
Mark Shaw, FSA, MAAA, CERA
Constance Rogers, FSA, MAAA
Clark Heitkamp, FSA, MAAA, LTCP
Sidney Richard, FSA, MAAA
Shana O'Dell, FSA, MAAA
Adam Singleton, FSA, MAAA

These actuaries are seasoned professionals and experienced in the full spectrum of health-related actuarial practice including individual and group medical and prescription drug insurance, Medicare-related coverages, long-term care insurance, various supplemental health insurance products, reinsurance, and employee benefits and OPEB valuations.

UHAS will assign John Ames as project manager who will be responsible for managing the timely flow and planning of required tasks and will be the point-person for communications with the West Virginia OIC. It is our initial intent that the other actuaries would take direction from the project manager and would participate as needed in the required tasks.

The qualifications and background of the above-mentioned personnel are summarized below:

Karl Volkmar FSA, MAAA, FCA – Principal and Senior Consulting Actuary

Karl, a seasoned health actuary and executive with over 20 years of senior management and consulting experience, is the founder and principal of United Health Actuarial Services, Inc. He and his firm provide health actuarial and management consulting services for a wide range of individual and group medical and supplemental insurance products, and health & welfare actuarial and benefits consulting services for both insured and self-insured plans.

Karl worked for well-known insurance companies and consulting firms until starting the predecessor practice to UHAS in 2000. UHAS has since developed a seasoned staff and large, diverse client base, and one of its largest and fastest-growing practice areas is its government-centered actuarial practice. Karl has performed actuarial services for a variety of organizations as both an employee and a consultant since 1985. He has provided and/or supported the full

spectrum of health-related actuarial services (e.g., product development/pricing, rate filings, financial projections, valuation services, etc.) in a wide variety of settings. With substantial credentials, published articles and strong industry service, Karl is a recognized leader in the health insurance industry.

Karl is a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, and a Fellow of the Conference of Consulting Actuaries. He received his B.S. in Actuarial Science from the University of Illinois.

John Ames FSA, MAAA, FLMI – Consulting Actuary
John is a Consulting Actuary with United Health Actuarial Services. He is primarily engaged in various projects dealing with the interpretation and implementation of PPACA and other medical product issues.

John has over 30 years of experience in the health insurance field having held positions responsible for strategy, implementation and risk management of all actuarial functions as well as overall company direction. Immediately prior to joining UHAS, John was a senior vice president actively involved in product design, rating and underwriting for HealthMarkets, a $2.0 billion health insurer. He brings a broad range of actuarial and business expertise and innovative problem solving to assist various clients.

Prior to that, John was a Senior Vice President and Chief Actuary for Trustmark Insurance Company's group division. In addition to the PPACA projects including rate review for CCIIO, he is currently assisting with this current assignment and a couple of small regional health carriers in their 2014 product portfolio.

John is a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, and a Fellow of the Life Management Institute. He received his B.S. in Actuarial Science from the University of Illinois.

Ben Brandon FSA, MAAA – Consulting Actuary
Ben is a Consulting Actuary with United Health Actuarial Services. He is responsible for managing the Government Services line of business as well as the Retiree Health & Welfare and other employee benefits issues.

Ben has over 19 years of experience in the health insurance and employee benefits industry, having held positions in both the consulting and insurance realms. Immediately prior to joining the firm, Ben was a Principal at Mercer, where he worked on numerous FAS 106 valuations and retiree health plan redesigns. He also acted as an advisor on employer stop-loss issues.

In addition to his employee benefits background, Ben has worked in a variety of health-related actuarial positions including Assistant Vice-President at a global reinsurer and as the Director of Actuarial Services for a large Managed Medicaid entity, where he became a member of the American Academy of Actuaries' Medicaid Rate-Setting workgroup. He is currently in charge of the West Virginia rate review/consulting services contract and has had lead responsibility for reviewing filings and developing a rate review manual and training the rates and forms staff with the goal of attaining recognition as an "effective rate review program" as required by PPACA.

Ben is a Fellow of the Society of Actuaries and Member of the American Academy of Actuaries. He received a B.S. in Materials Engineering from Rutgers University in New Jersey.

Mark E. Shaw FSA, CERA, MAAA, FLMI – Senior Consulting Actuary
Mark is a Consulting Actuary with United Health Actuarial Services. He is a leader in the firm's medical and supplemental insurance practice and also provides expert witness and risk management services.

Mark is in his 30th year of working in the life and health insurance industry and has held top actuarial and risk management positions at three Fortune 500 insurers. Immediately prior to joining UHAS, Mark was Senior Vice President of Strategic Development at Assurant, where he was a strategic advisor to the supplemental health business, evaluated and developed business plans for international opportunities for Assurant's health products and explored M&A opportunities. Prior to that, he was SVP and Chief Actuary of Assurant's group medical business.

In addition to his life and health insurance actuarial background, Mark has worked as the global head of risk management at an international insurer. For three (3) years he led the Society of Actuaries' Enterprise Risk Management sub-group of the Risk Management Task Force.

Mark is a Fellow of the Society of Actuaries, a Chartered Enterprise Risk Analyst, a Fellow of the Life Management Institute and a Member of the American Academy of Actuaries. He received a B.B.A. in Actuarial Science from Georgia State University in Atlanta, Georgia.

Constance D. Rogers FSA, MAAA – Consulting Actuary
Constance is a Consulting Actuary with United Health Actuarial Services. She has over 20 years of experience with a wide-range of health insurance products: individual and group medical and supplemental products; Medicare supplement; long-term care products; and health and welfare consulting for self-insured plans. Services provided include those relating to product/plan pricing/re-pricing, experience studies, financial analysis, litigation support and valuation support.

Constance has worked as a consultant for 10 years. Prior to entering the consulting field, she worked at a fraternal insurance company, where she was responsible for all aspects of actuarial practice supporting the company's Medicare supplement line: pricing/re-pricing, compliance, experience analysis, claim valuation, policy valuation, financial projection/analysis, and financial reporting.

Constance is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. She received a B.S. in Applied Mathematics from Ball State University in Muncie, Indiana.

Clark Heitkamp, FSA, MAAA. LTCP – Consulting Actuary
Clark is a Consulting Actuary with United Health Actuarial Services. He specializes in the firm's long-term care insurance practices in addition to other supplemental insurance products including Disability Income and Critical Illness.

Clark has over 20 years of experience in the life and health insurance industry and specifically has over 13 years of experience for long-term care insurance. He has held positions in insurance companies prior to joining UHAS. Immediately prior to joining UHAS, Clark was a Director of

Long-term Care Insurance at Mutual of Omaha where he developed business plans, managed profitability, developed several new products, and executed corrective actions.

In addition to his long-term care experience, Clark has worked in a variety of life and health-related actuarial positions at both Mutual of Omaha and a top reinsurance company. His life insurance experience includes product development and management, experience analysis, XXX regulation, illustrations and reinsurance of multiple variations of term and universal life products.

Clark is a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, and a Long Term Care Professional. He received a B.S. in Actuarial Science from the University of Nebraska in Lincoln.

Sidney Richard, FSA, MAAA – Consulting Actuary
Sid is a Consulting Actuary with United Health Actuarial Services.

Prior to joining UHAS, Sid served as Chief Actuary with Everence Financial (formerly MMA, Mennonite Mutual Aid) from 1997 to present with various other roles with Everence since 1979. He has worked on various product lines including Medicare Supplement, Medicare Advantage, individual and small group insurance, large group pools, statutory financial statements, annuity and life insurance. His functional experience includes product development and pricing, renewal rating, regulatory filing and approvals, analysis of experience, financial results, trends and key metrics, budgeting and projections and valuation.

Sid is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. He received a B.A. in Mathematics from Goshen College 1976 and a M.S. in Mathematics from The Ohio State University in 1979.

Shana R. O'Dell FSA, MAAA – Consulting Actuary
Shana is a Consulting Actuary with United Health Actuarial Services.

Prior to consulting, Shana worked for over 20 years for Everence Association, Inc. where she was responsible for all aspects of actuarial practice supporting the company's individual health and small group health lines of business: pricing/re-pricing, compliance, experience analysis, claim valuation, policy valuation, financial projection/analysis, and financial reporting.

Shana is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. She received a B.S. in Applied Mathematics from Kent State University in Ohio.

Adam Singleton, FSA, MAAA, – Consulting Actuary
Adam is a Consulting Actuary with over 19 years of diverse actuarial, medical economics, and provider reimbursement experience. Adam is an expert in developing processes and approaches for analyzing medical cost and utilization trends particularly related to provider networks.

Prior to joining UHAS, Adam spent over 13 years at Humana most recently as a Director in Humana's National Provider Contracting Division where he built a specialized medical economics department that focused on network cost and provider reimbursement benchmarking analytics.

Adam has experience with strategic, regulatory, and pricing analysis in two different health care reform environments working as an Individual market pricing actuary after the passage of H.B. 250 in Kentucky during the mid-1990's and more recently as an internal consultant and advisor at Humana for PPACA regarding topics such as the impact of the "3-R's" on provider risk sharing.

Adam is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. He received his B.S. in Mathematics from the University of Louisville.

Additional UHAS Personnel

In addition to the above personnel, UHAS employs support personnel with a variety of actuarial and data-related skills and experience. Accordingly, we feel that UHAS is well-positioned to handle a project of this scope. We do not foresee any constraints on the availability of the assigned personnel and expect to meet the demands of this project as described in the RFP. There are no plans to utilize the resources of any subcontractors; however, should the need arise we have access to qualified actuaries and would insure that they meet the same standards required by the state.

Management Plan and Facilities

John Ames will be assigned as project manager for this contract. He will be responsible for timely flow of work and communication with the appropriate department of the OIC. Under his supervision, an internal log will be created to help manage the assignment and successful completion of the required tasks.

We intend to dedicate one FSA/Consulting Actuary this engagement; additional personnel will participate as dictated by the demands of the engagement at any given time.

Working with UHAS you can expect the following general practices to apply:

- Documentation of all work – Having been a successful actuarial firm for many years, UHAS is accustomed to stringent documentation requirements. UHAS would maintain a high level of organization in its electronic file structures and e-mail correspondence related to this project. Summary notes, descriptions of methodologies and data, and worksheets would be clearly labeled and easy to follow.

- Meeting urgent turnaround times for analysis – UHAS understands that this is an important and visible engagement. Accordingly we would attempt to balance the quality, accuracy and speed of our analyses with the need for a deeper review. UHAS is very conscientious and sensitive regarding timing issues and is adept at meeting timeframes and satisfying clients with such high-pressure demands. We would work with the department to determine when and if a deeper analysis is warranted.

- Peer review - Each of our rate reviews would undergo a peer review by a credentialed actuary before submission of the final report.

- Attending meetings and conference calls – As necessary, UHAS would make itself available for conference calls/webinars and/or in-person meetings.

QUALIFICATIONS *(Pages 19-20 of the Solicitation): Vendor shall have the following minimum qualifications:*

3.1 Any actuarial firm submitting a quotation under this procurement shall meet or exceed the minimum qualification set for in this RFQ. Those quotations not meeting the mandatory specifications will be eliminated. Any actuarial firm submitting a quotation under this procurement shall meet or exceed the minimum qualifications as follows:

3.1.1. One or more members assigned to this contract must be a Fellow of the Society of Actuaries (FSA) and/or a Member of the American Academy of Actuaries (MAAA).

Response: See resumes above and the screen print of each actuary for credentials. All of the lead actuaries on this project hold the designations of both FSA and MAAA.

3.1.2. *Members assigned this contract must have at least five (5) years of experience with life and health products. The Vendor should provide resume' to include information regarding the number of years of qualification, experience and training and relevant continuing professional education of the specific staff to be assigned to this job. Resume' should be submitted prior to award.*

Response: See resumes above for experience specific to product work and experience. All of the actuaries would meet this experience requirement in life and/or health products.

3.1.3. Members assigned this contract must have at least five (5) years of experience specifically with long term care products. The Vendor should provide resume' to include information regarding the number of years of qualification, experience and training and relevant continuing professional education of the specific staff to be assigned to this job. Resume' should be submitted prior to award.

Response: See resumes above for experience specific to product work and experience. Our staff has significant experience and expertise in long term care products. We have three actuaries that meet and exceed the above requirements including Karl Volkmar, Mark Shaw, and Clark Heitkamp. While all three of these actuaries have significant experience with long term care products, Clark Heitkamp dedicates most of his consulting efforts focused on this product line, and we anticipate that he would be assigned any work related to long term care products.

3.1.4. Members assigned this contract must be knowledgeable of Actuarial Standard Practice No. 8 (EXHIBIT B).

Response: This is to certify that each of the above actuaries performing professional actuarial services with respect to reviewing regulatory filings is knowledgeable of and follows the guidelines of the Actuarial Standards of Practice No. 8 as well as the additional standards of practice addressed in ASOP No.8 including Data Quality (ASOP No. 23) and Communication (ASOP No.41).

3.1.5. *One or more members to be assigned to this contract must be experienced in providing rate review services to state insurance regulators.*
Response: See resumes above for experience specific to product work and experience. Actuaries currently/recently involved in providing rate review services to state insurance regulators include Karl Volkmar, John Ames, Ben Brandon, Mark Shaw, Connie Rogers and Clark Heitkamp. John, Ben and Clark would be primary on this contract with work assigned based on the product. Others would be used as needed.

3.2 *The firm shall have no conflict of interest with regard to any carrier that is actively writing individual or group life and health products in the West Virginia market.*
Response: We are not aware of any conflicts at this time. Per the stated direction from the state and based on company practice, if there is a conflict of interest with regard to the review of any carrier, we would choose an actuary on staff with no conflict of interest in regard to the carrier or, if necessary, sub-contract with another qualified actuarial firm to provide the review.

AAA Qualification Standards and Continuing Professional Development

UHAS understands the importance of appropriate credentials, requirements and standards as set forth by the American Academy of Actuaries (AAA) for public service actuaries issuing Statements of Actuarial Opinion (SAO).

To further document our credentials specifically as it relates to individuals functioning as public service actuaries, each actuary included in our RFQ and listed below was provided a link to the Qualification Standards (QS) for Actuaries Issuing Statements of Actuarial Opinion in the United States. (http://www.actuary.org/files/qualification_standards.pdf) On pages 26 and 27 of this document, the specific standards for public service actuaries are addressed.

Additionally, as these filings will include the review of other actuaries' SAOs, Precept 10 of the Code of Professional Conduct which covers Courtesy and Cooperation in handling differences of opinion would be directly applicable to this engagement (http://www.actuary.org/pdf/prof/code_of_conduct.pdf).

Each of the actuaries listed below has reviewed the information referenced above and has indicated that they meet the AAA Qualification Standards for public service actuaries. In fact, there are several that are currently engaged in projects for public service organizations.

In addition, each of these actuaries is "Compliant" with Continuing Professional Development (CPD) requirements for 2012-2013.

ACTUARY	Meets QS for public service actuaries	Compliant with CPD (2012-2013)
Karl Volkmar, FSA, MAAA, FCA	Yes	Yes
John Ames, FSA, MAAA	Yes	Yes
Ben Brandon, FSA, MAAA	Yes	Yes
Mark Shaw, FSA, MAAA, CERA	Yes	Yes
Constance Rogers, FSA, MAAA	Yes	Yes
Clark Heitkamp, FSA,MAAA,LTCP	Yes	Yes
Sidney Richard, FSA, MAAA	Yes	Yes
Shana O'Dell, FSA, MAAA	Yes	Yes
Adam Singleton, FSA, MAAA	Yes	Yes

REQUIRED DOCUMENTS – LICENSE(S)/CERTIFICATIONS/PERMITS - The actual proof of certification as requested in Item 8. of the solicitation is presented in an attachment with the heading "Professional Credentials (Source: Actuarial Directory)". These screen shots are attached and online access to this information is available at https://www.actuarialdirectory.org/SearchDirectory/tabid/242/Default.aspx.

DELIVERABLES

As far as communication, UHAS would present any questions, issues or findings to the WV OIC in a format that could easily be forwarded on to the appropriate audience as this minimizes the work required on the part of the client. There have been occasions where we have received permission to work directly with the carrier to minimize turnaround time and facilitate the quickest response possible. We are open to whatever protocol the Department prefers. Unless otherwise instructed, the final report would consist of:

- The Filing Details;
- An Executive Summary;
- The Rate Review Standard;
- Conclusions regarding compliance with the rate review standards;
- Conclusions regarding assumptions related to the filing (itemized);
- Conclusions regarding compliance with required standards;
- A Statement of Qualifications;
- A Statement of Reliance;
- Caveats & Limitations; and,
- The appropriate excel worksheets.

Technical support and expert testimony given in conjunction with rate hearings

UHAS has developed a team of "seasoned" actuaries who have substantial experience working with government agencies and private enterprises. Our actuaries have worked in actuarial and non-actuarial leadership positions and are comfortable interacting with technical and non-technical audiences, such as state and federal regulators, insurance and managed care organization executives, health care benefit managers for corporations and government entities.

To date, UHAS has not represented any regulatory body in a major medical rate hearing. However, members of the staff have been involved in hearings and depositions on behalf of client companies and carriers for which they worked prior to becoming a consultant. We have testified in two Florida rate hearings relating to proposed rate increases on stand-alone home health care products on behalf of an insurer. Relative to expert work that has been done in the context of administrative hearings, we have represented one of our clients, a trade association, as they challenged a LTC rate increase requests in KY on LTC products that had been sold to their members. We have testified in a hearing (ongoing) regarding excess accumulation of surplus which should be used on community health plans per regional jurisdiction. Other experiences prior to working for UHAS include testifying in administrative hearings in FL, MI and MD over rate-filing related issues and depositions related to pricing strategy and rating practices.

Additional projects or reports such as statewide rate analysis, market analysis, educational or training sessions

UHAS has performed numerous rate and benefit comparisons for both the individual and small group markets. For the individual market, numerous combinations of rating and benefit factors can be analyzed to find the magnitude of rate change for people/policies under different scenarios such as by age, gender, family composition/number of children, tobacco use, and maternity coverage. Rate comparisons have been completed between carriers and by metal level plans. Within the small group market, similar work has been performed including differentiation

by size of group (2-9 lives and 10-50), average employee age, employee composition and family composition.

We are currently in the process of preparing a market analysis of small group rates for both on- and off-exchange products in the state of Indiana for one of our client companies. This includes rates and benefit design.

As with your Rate and Forms team, we have presented numerous topics, initially face-to-face and recently through the Go-To-Meeting product, relative to the Affordable Care Act and its impact on day-to-day work.

We have also participated in various other LTC projects including providing technical expertise and reviewing the model for the Federal CLASS Act and reviewing a LTC product for the U.S. Office of Personnel Management.

Resources available to meet deliverables

We have access to each of the credentialed actuaries listed above. All, with the exception of Adam Singleton have either assisted on the recent CCIIO medical rate reviews as needed or have recently been employed by companies where they were involved in the rate filing/peer review process. It is anticipated that cases will be the responsibility of the project manager who will, together with additional resources as needed, perform the rate review. Peer review will be performed by another credentialed team member. We also have support staff that is available to perform various duties as their skill and training allows.

PERFORMANCE REFERENCES

We were awarded the sole contract for reviewing rate filings for the Center for Consumer Information and Insurance Oversight ("CCIIO") per the requirements of the Patient Protection and Affordability Act ("PPACA") on July 12, 2011. We have performed this service on over 130 submissions since that time. Below is the relevant information related to this engagement:

Entity: CCIIO
Contact: Dennis Yu (recently replaced Keith Powell)
Phone: 410-786-1657 – See NOTE below
Email: Dennis.Yu@cms.hhs.gov
Project Start: July 12, 2011
Status: Ongoing
Project Amount: TBD
Staff: John Ames, Ben Brandon, Karl Volkmar, Mark Shaw, Constance Rogers
Description of Work: UHAS has been engaged to review the individual and small group rate filings of those insurers whose rate increases exceed the unreasonable threshold as defined by HHS in the states that do not have effective rate review programs. Our initial task was to review the rate filings, test the assumptions and projections, document our findings and make a recommendation to HHS regarding the reasonableness of the rate increase request. Our responsibilities have expanded to include review of on and off exchange submissions for compliance with market rating rules, review of 2014 rate filings and, in light of the recent directives by the Obama administration, review grandfathered plans with policy years beginning between January and October of 2014 that are now allowed to renew into 2014.

NOTE: *We have been informed that federal contracting policies may restrict our ability to utilize Mr. Dennis Yu as a reference for this project. As such we have contacted Mr. Keith Powell who held this position prior to Mr. Yu. He has agreed serve as a reference as we had worked with him for the majority of the project. We have provided his contact information here.*
Phone: (502) 640-6577, Email: KentGr@aol.com

Entity: California Department of Insurance (CA DOI)
Contact: Linda Ball – Senior Life Actuary
Phone: 213-346-6151
Email: linda.ball@insurance.ca.gov
Project Start: December 2008
Status: Ongoing
Project Amount: TBD
Staff: Karl Volkmar, Mark Shaw, Clark Heitkamp
Description of Work: UHAS was engaged to review filings and support the CA DOI in its review of LTC rate filings, as needed. The CA DOI utilizes a pool of consultants to review filings. This engagement is for the review of rate filings of both new and existing products.

On the private/carrier side, we provide all actuarial support for Advantage Health Solutions, Inc. and Indiana based provider-owned health plan that sells group health products.

Entity: Advantage Health Solutions, Inc.
Contact: David Meguschar, Vice President Business Strategy and Development
Phone: 317-816-6701
Email: dmeguschar@advantageplan.com
Start: September 2006/January 2013
Status: Ongoing
Project Amount: TBD
Staff: Ben Brandon, Karl Volkmar, John Ames, Adam Singleton, Mark Shaw
Description of Work: UHAS initially began providing primarily underwriting support in September of 2006 with minor actuarial assignments which transitioned into full actuarial support in January 2013 when Advantage terminated their contract with a national consulting firm.

We now provide all actuarial support for the company's large and small group health products. This includes rate development and all rate filing related work, assistance with benefit modifications to meet the needed metal tiers, the develop of regular experience reports and analysis, rating tool development for small and large group, actuarial rate certifications, assessing network risk sharing structures, reinsurance, valuation and appointed actuary duties.

We provide similar support to Pekin Life Insurance in Illinois.

Entity: Pekin Life Insurance Company – Pekin, Illinois
Contact: Brian Lee, Senior Vice President and COO
Phone: 800-322-0160
Email: blee@pekininsurance.com
Start: Mid -2009
Status: Ongoing
Project Amount: TBD
Staff: Mark Shaw, Ben Brandon, Karl Volkmar, Constance Rogers
Description of Work: UHAS acts as the actuarial team for all of Pekin's health lines of business. We provide claim reserve certification for their Valuation Actuary and also perform all of their health product development, rate filings and experience analysis, etc.

At a higher level, UHAS provides actuarial and management consulting services for a wide range of individual and group medical and supplemental insurance products, and health & welfare actuarial and benefits consulting for both insured and self-insured plans. Our experienced team of professionals and network of subcontractors can provide the full range of health actuarial services, including:

- Compliance and statutory reporting
- Employer health & welfare benefits pricing and design
- Experience and financial analysis
- Expert witness and litigation support
- Implementation support
- Provider and Network analysis and development
- Liaison and negotiation support
- Merger & acquisition support
- Participation in all aspects of company management
- Peer review

- Product/plan development and pricing/re-pricing
- Retiree/OPEB valuations

CONCLUSION

United Health Actuarial Services, Inc. sincerely appreciates the opportunity to present our proposal to the State of West Virginia to acquire Health Actuarial Consultants to provide actuarial rate review of Life and Health Related Products Filings and Consulting Services. We are confident the information presented throughout our response proves that we have the experience, knowledge, capabilities and resources necessary to provide superior performance. We look forward to participating in the next phase of this procurement process.

Professional Credentials (Source: Actuarial Directory)

Member Detail

https://www.actuarialdirectory.org/SearchDirectory/MemberDetail/tabid/249/Default.aspx?CustomerRecord=9abKDBM2oPxbQTwd++65agClf+XoJ53HImnaeyI7krlgHUCc3eQrjQ==

Links to Actuarial Organizations:
Society of Actuaries
American Academy of Actuaries
American Society of Pension Professionals & Actuaries
Canadian Institute of Actuaries
Casualty Actuarial Society
Conference of Consulting Actuaries
The Actuarial Foundation
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Links to Other Sites

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Karl Glen Volkmar

Personal Information

Karl Glen Volkmar
Principal & Senior Consulting Actuary
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Carmel, IN 46032-4529
United States

Tel: 1(317)575-7672
Fax: 1(317)575-7678
Email: kvolkmar@uhasinc.com

Professional Biography
A seasoned health actuary and executive with nearly 20 years of senior management and consulting experience. Karl Volkmar and his firm, United Health Actuarial Services, Inc. ("UHAS"), provide health actuarial and management consulting services for a wide range of individual and group medical and supplemental insurance products, and health & welfare actuarial and benefits consulting services for both insured and self-insured plans.

Links
View my Linkedin page
Follow me on Twitter

Designations
MAAA 1989
FSA 2000
FCA 2005

SOA Continuing Professional Development Requirement
Compliant(2012-2013)
Compliant(2011-2012)

Academic Degrees
B.S.

Other Professional Designations

Industry
Consulting

Primary Area of Practice
Health

Specializations
Disability Income Insurance
Employee Health Benefits
Financial Reporting
Health Insurance - Commercial
Health Insurance – Public Systems
Long Term Care Insurance
Product Pricing/Development
Provider Systems
Regulatory
Reinsurance
Underwriting
Valuation/Reserving

Society of Actuaries Sections
Entrepreneurial Actuaries
Financial Reporting
Health
International
Investment
Joint Risk Management (SOA - CAS - CIA)
Long Term Care Insurance
Management & Personal Development
Marketing & Distribution
Product Development
Reinsurance
Smaller Insurance Company
Social Insurance & Public Finance

Member Detail

https://www.actuarialdirectory.org/SearchDirectory/MemberDetail/tabid/249/Default.aspx?CustomerRecord=KvMJ5/58tHy2wRT4hmL/PtJyrmgABEHwKtEDl3ENleEVsnzJnNNoQw==#

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John F Ames

Personal Information

John F Ames
Consulting Actuary
United Health Actuarial Services Inc
6905 Sir Spencer Ct
Colleyville, TX 76034
United States

Tel: (817) 528-1617
Email: james@uhasinc.com

Designations
MAAA 1983
FSA 1987

SOA Continuing Professional Development Requirement
Compliant(2012-2013)
Compliant(2011-2012)

Academic Degrees

Other Professional Designations
FLMI
HIAA

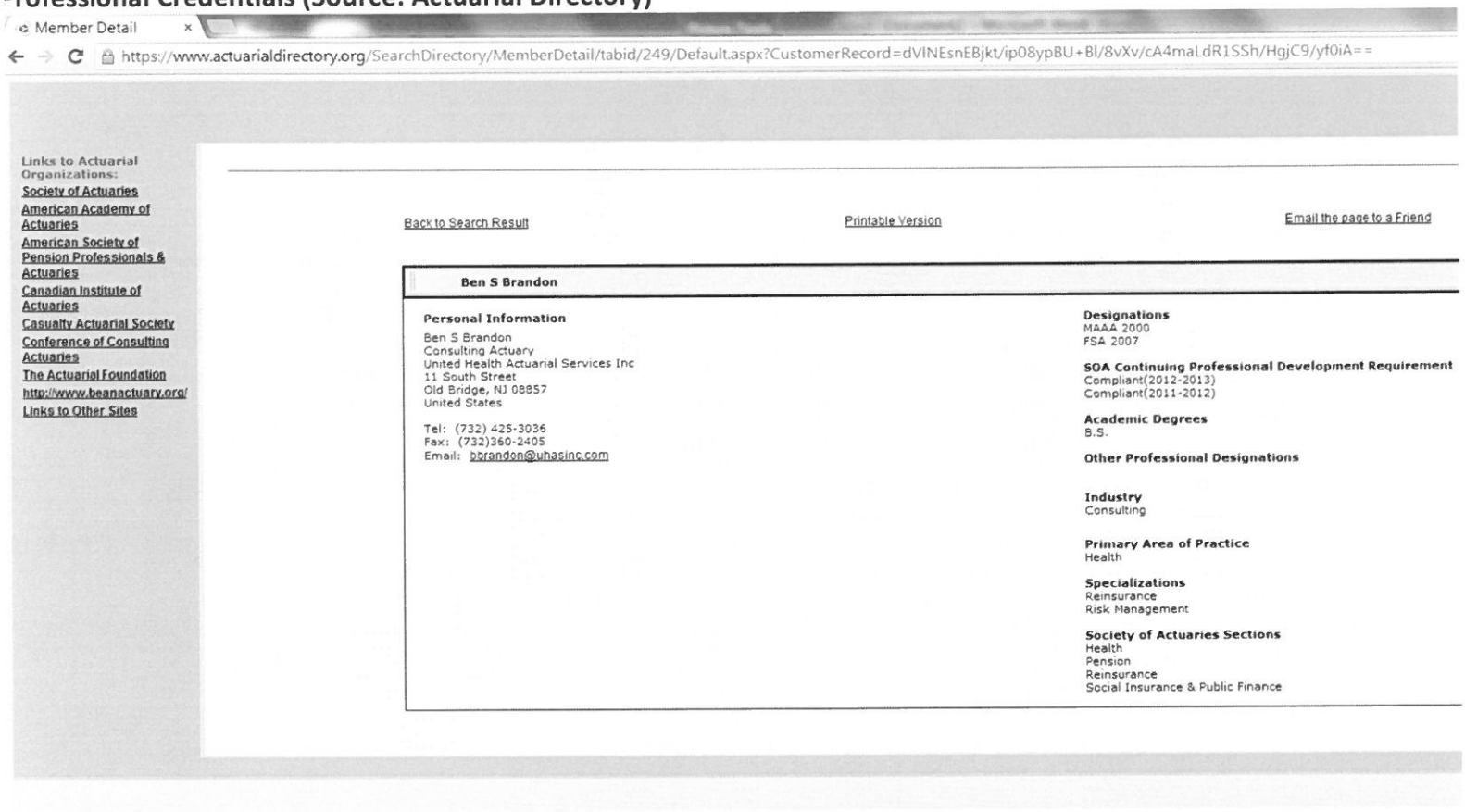
Industry
Consulting

Primary Area of Practice
Health

Specializations
Product Pricing/Development
Risk Management

Society of Actuaries Sections
Health
Smaller Insurance Company

Professional Credentials (Source: Actuarial Directory)



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Conference of Consulting Actuaries
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Ben S Brandon

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United Health Actuarial Services Inc
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Old Bridge, NJ 08857
United States

Tel: (732) 425-3036
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Email: bbrandon@uhasinc.com

Designations
MAAA 2000
FSA 2007

SOA Continuing Professional Development Requirement
Compliant(2012-2013)
Compliant(2011-2012)

Academic Degrees
B.S.

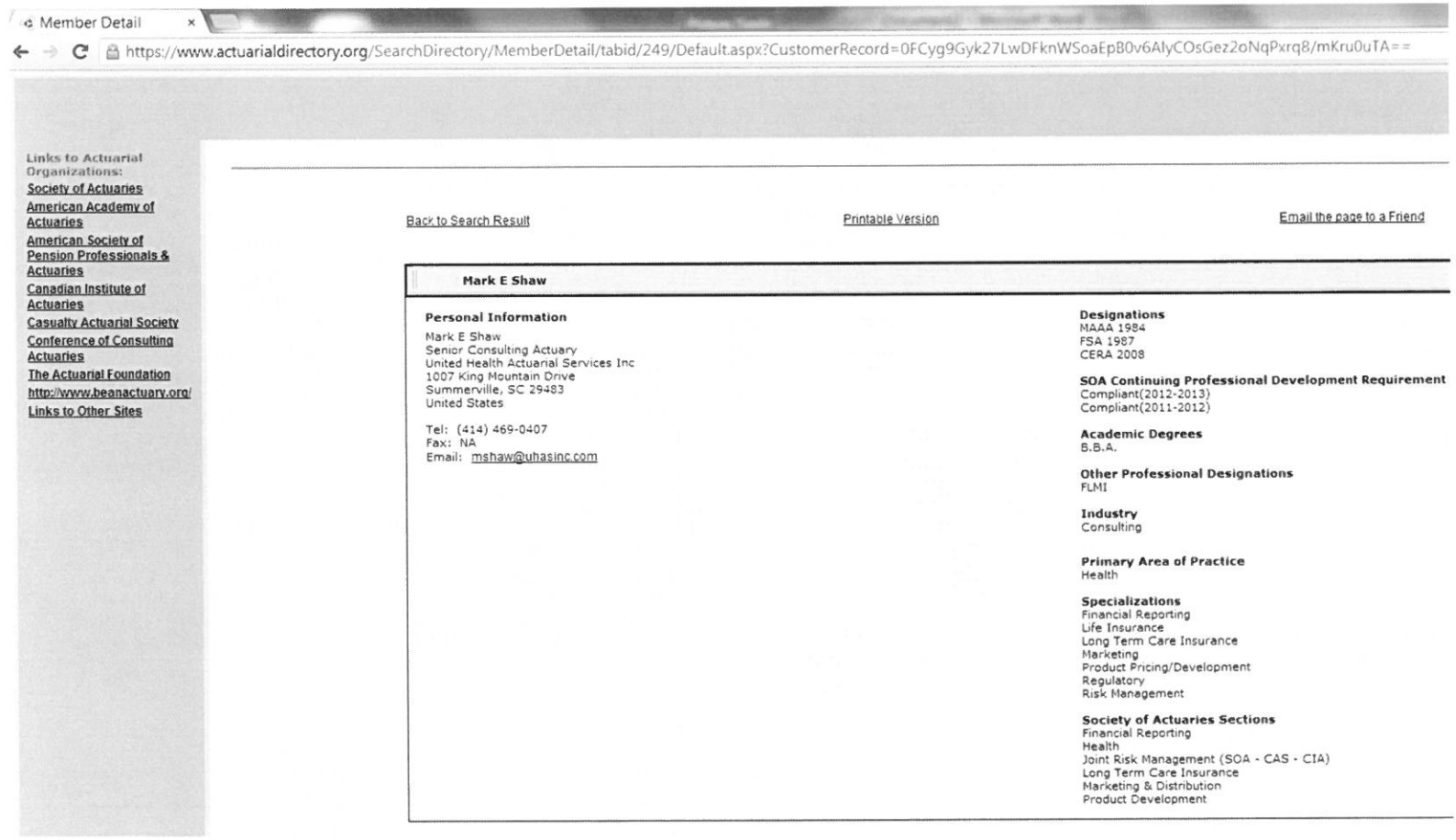
Other Professional Designations

Industry
Consulting

Primary Area of Practice
Health

Specializations
Reinsurance
Risk Management

Society of Actuaries Sections
Health
Pension
Reinsurance
Social Insurance & Public Finance



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Casualty Actuarial Society
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Designations
MAAA 1984
FSA 1987
CERA 2008

SOA Continuing Professional Development Requirement
Compliant(2012-2013)
Compliant(2011-2012)

Academic Degrees
B.B.A.

Other Professional Designations
FLMI

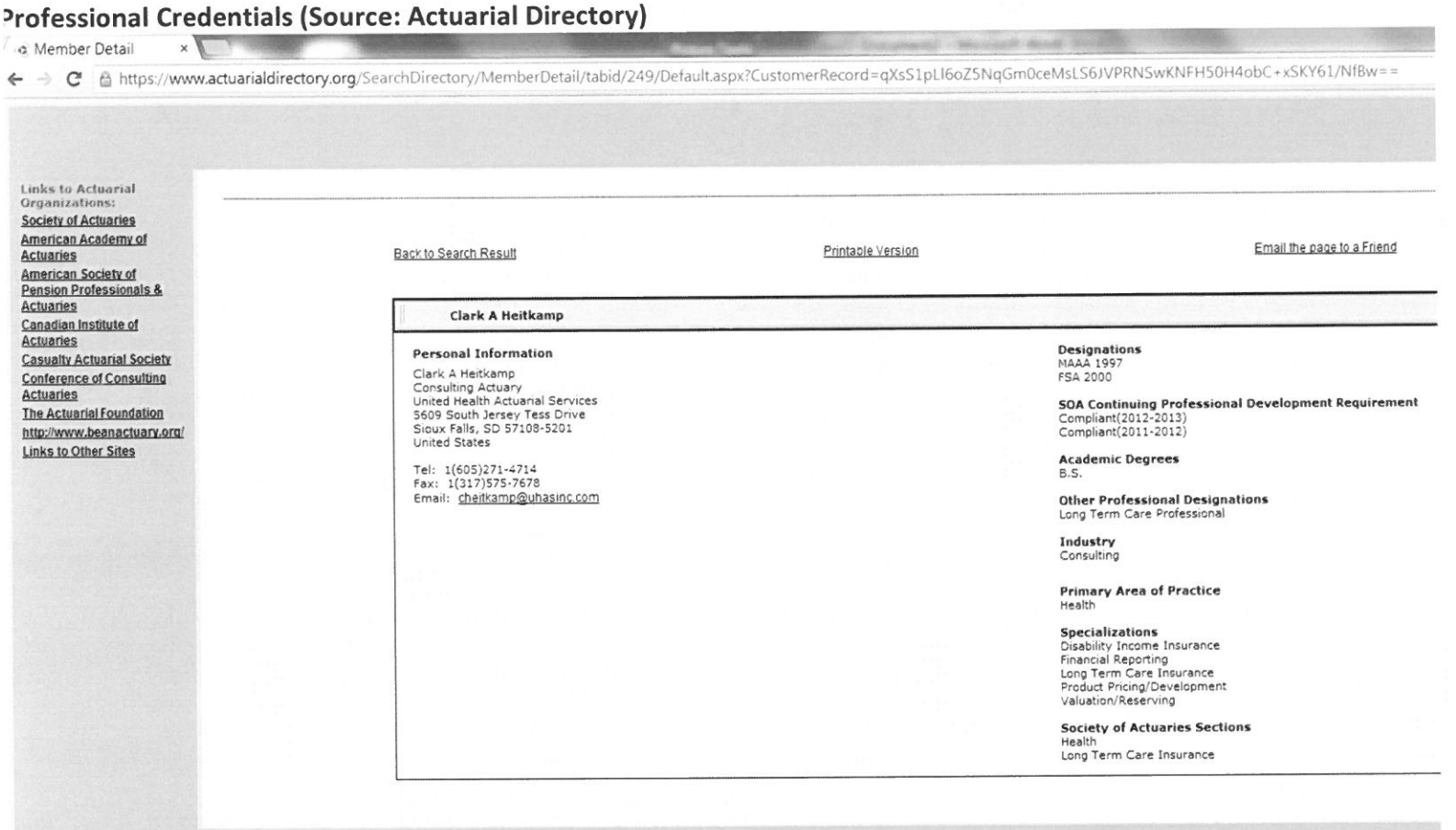
Industry
Consulting

Primary Area of Practice
Health

Specializations
Financial Reporting
Life Insurance
Long Term Care Insurance
Marketing
Product Pricing/Development
Regulatory
Risk Management

Society of Actuaries Sections
Financial Reporting
Health
Joint Risk Management (SOA - CAS - CIA)
Long Term Care Insurance
Marketing & Distribution
Product Development

Professional Credentials (Source: Actuarial Directory)



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Designations
MAAA 1997
FSA 2000

SOA Continuing Professional Development Requirement
Compliant(2012-2013)
Compliant(2011-2012)

Academic Degrees
B.S.

Other Professional Designations
Long Term Care Professional

Industry
Consulting

Primary Area of Practice
Health

Specializations
Disability Income Insurance
Financial Reporting
Long Term Care Insurance
Product Pricing/Development
Valuation/Reserving

Society of Actuaries Sections
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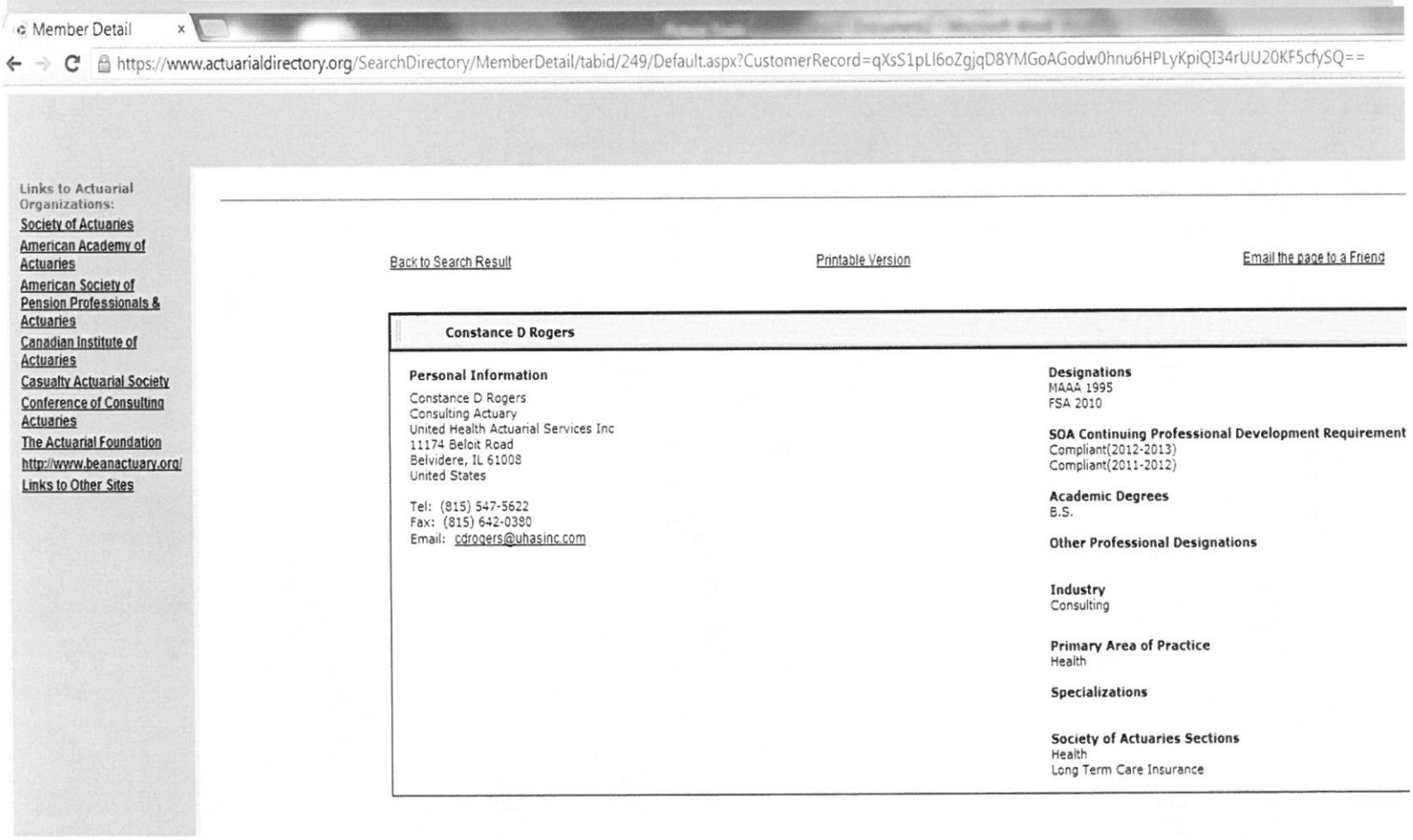
Long Term Care Insurance



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Conference of Consulting Actuaries
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Constance D Rogers

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Email: cdrogers@uhasinc.com

Designations
MAAA 1995
FSA 2010

SOA Continuing Professional Development Requirement
Compliant(2012-2013)
Compliant(2011-2012)

Academic Degrees
B.S.

Other Professional Designations

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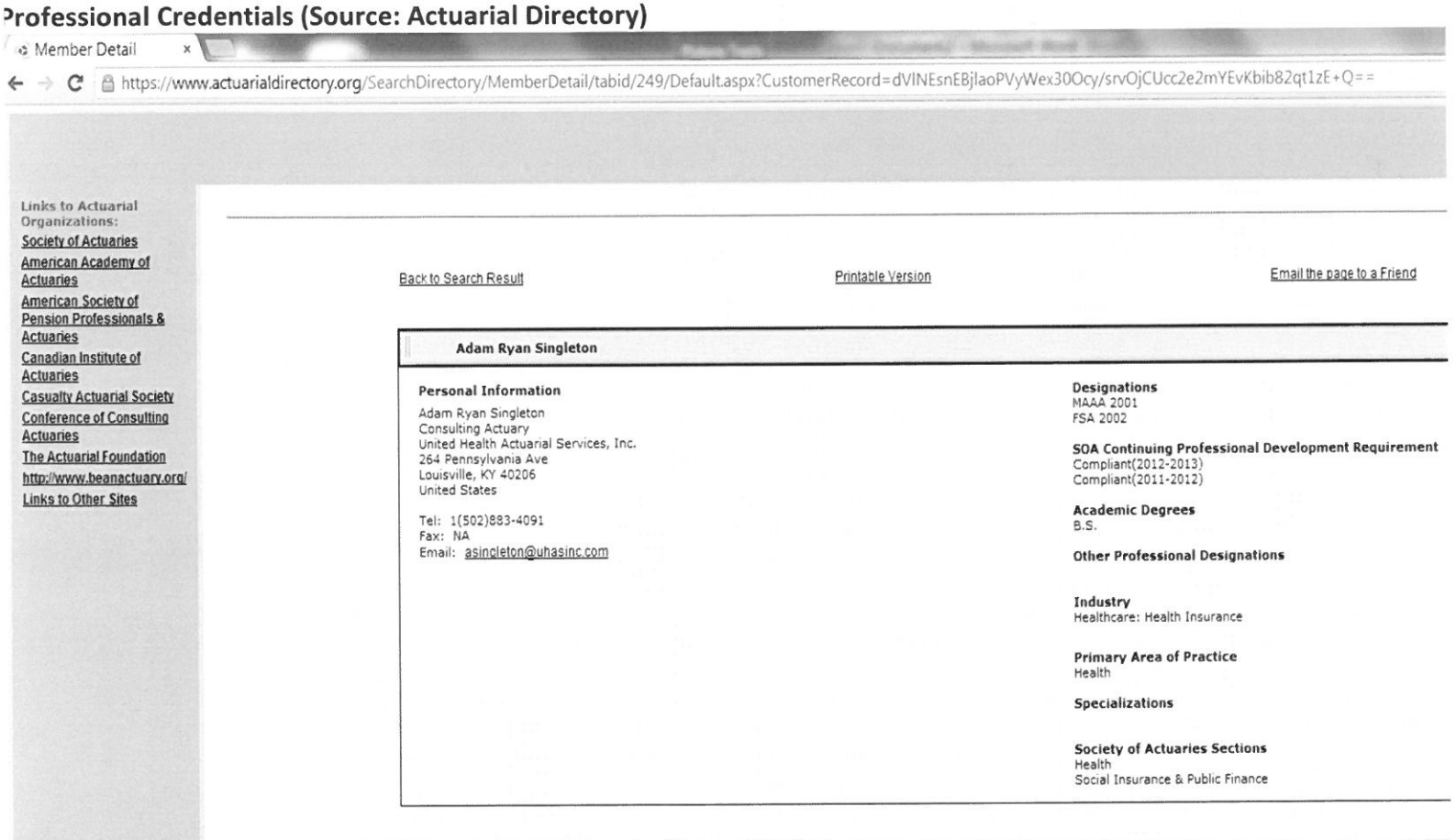
Long Term Care Insurance

Professional Credentials (Source: Actuarial Directory)



Member Detail

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Links to Actuarial Organizations:
Society of Actuaries
American Academy of Actuaries
American Society of Pension Professionals & Actuaries
Canadian Institute of Actuaries
Casualty Actuarial Society
Conference of Consulting Actuaries
The Actuarial Foundation
http://www.beanactuary.org/
Links to Other Sites

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United Health Actuarial Services, Inc.
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Designations
MAAA 2001
FSA 2002

SOA Continuing Professional Development Requirement
Compliant(2012-2013)
Compliant(2011-2012)

Academic Degrees
B.S.

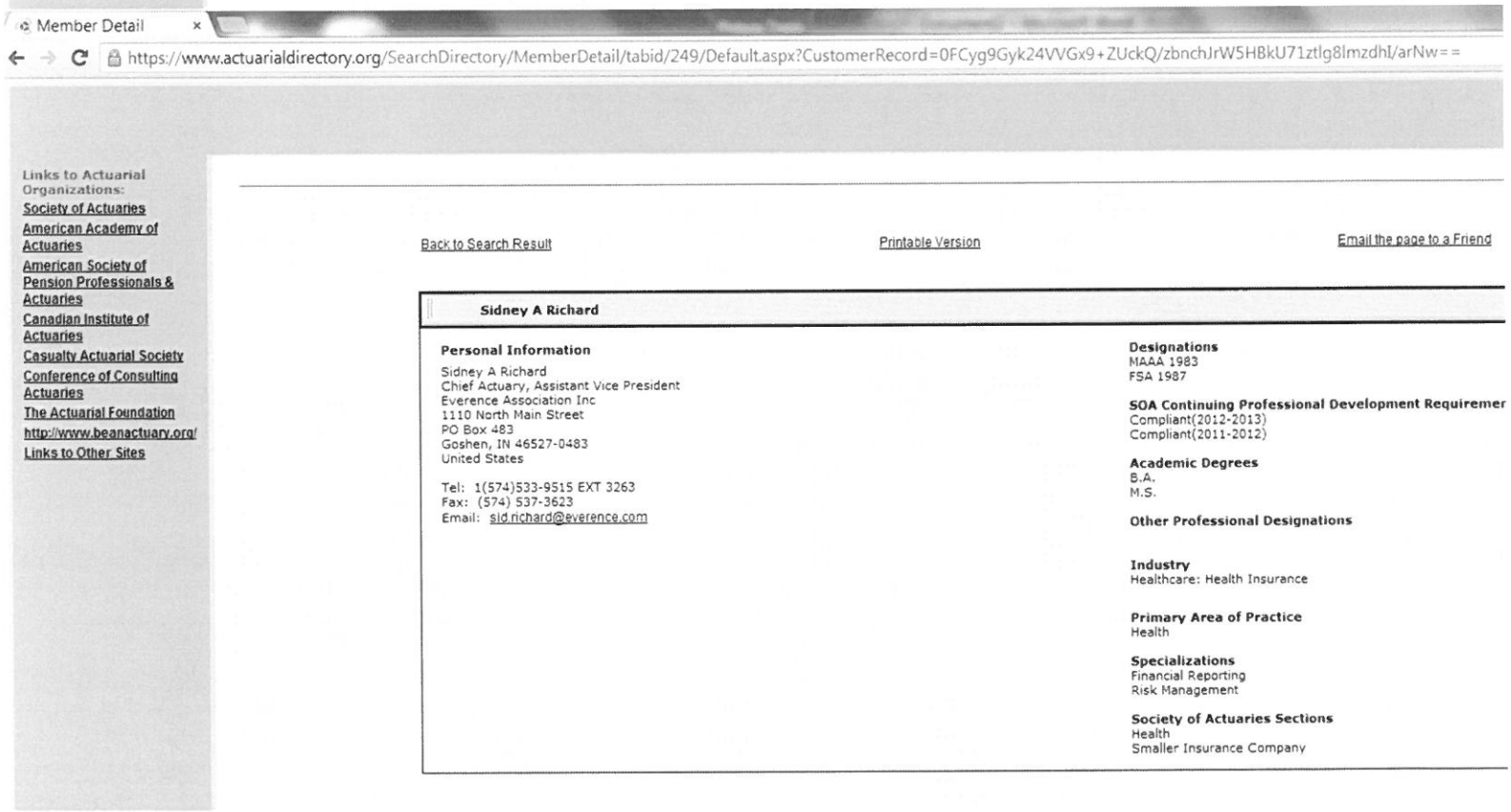
Other Professional Designations

Industry
Healthcare: Health Insurance

Primary Area of Practice
Health

Specializations

Society of Actuaries Sections
Health
Social Insurance & Public Finance



Member Detail

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Sidney A Richard

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Fax: (574) 537-3623
Email: sid.richard@everence.com

Designations
MAAA 1983
FSA 1987

SOA Continuing Professional Development Requiremer
Compliant(2012-2013)
Compliant(2011-2012)

Academic Degrees
B.A.
M.S.

Other Professional Designations

Industry
Healthcare: Health Insurance

Primary Area of Practice
Health

Specializations
Financial Reporting
Risk Management

Society of Actuaries Sections
Health
Smaller Insurance Company

Professional Credentials (Source: Actuarial Directory)