HEALTH REFORM TOOLKIT SERIES

RESOURCES FROM THE MASSACHUSETTS EXPERIENCE

Determining Health Benefit Designs to be Offered on a State Health Insurance Exchange

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HealthConnector

Robert Wood Johnson Foundation

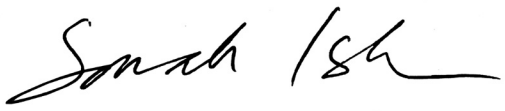
November 2011

This spring, as the Patient Protection and Affordable Care Act (ACA) celebrated its first birthday, Massachusetts commemorated five years implementing and operating the Commonwealth's 2006 health reform law. Marking these milestones, the Blue Cross Blue Shield of Massachusetts Foundation, the Robert Wood Johnson Foundation, and the Commonwealth Health Insurance Connector Authority developed the *Health Reform Toolkit Series* to offer insight on key health reform topics to state leaders in the process of ACA implementation.

The *Health Reform Toolkit Series* is designed to share examples, templates, experiences, and lessons learned from Massachusetts' implementation of health reform to help other states plan, build, and implement elements of ACA. Each toolkit includes a written narrative "guide" as well as a variety of primary source documents: organizational structures, job descriptions, requests for proposals and quotations, and other work products from Massachusetts' health reform implementation experience. In particular, this toolkit offers ideas and resources to help states determine health benefit designs to be offered on the state health insurance exchanges.

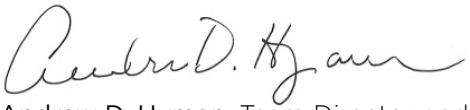
We hope these toolkits are useful resources for a variety of health reform stakeholders, and we welcome your feedback. If you have thoughts on ways we can enhance the series, please contact the Blue Cross Blue Shield of Massachusetts Foundation at policy@bcbsmafoundation.org. If you would like more information from the Health Connector on a particular implementation topic, please contact its Public Information Unit (Connector@state.ma.us).

Sincerely,



Sarah Iselin, President
Blue Cross Blue Shield of Massachusetts Foundation

Glen Shor, Executive Director
Commonwealth Health Insurance Connector Authority



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Acknowledgments

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The mission of the Blue Cross Blue Shield of Massachusetts Foundation is to expand access to health care. It focuses on collaborating with public and private stakeholders to develop measurable and sustainable solutions that benefit uninsured, vulnerable, and low-income individuals and families in the Commonwealth. The Foundation was formed in 2001 with an endowment from Blue Cross Blue Shield of Massachusetts. It operates separately from the company and is governed by its own Board of Directors.

About the Toolkit Series

The 2010 national health reform law, the Patient Protection and Affordable Care Act (ACA), expands health insurance coverage to an estimated 32 million uninsured Americans. A key component of the ACA is the requirement that each state either develop or participate in a **health insurance exchange.** An exchange is a kind of virtual marketplace through which individuals and small businesses can shop for and purchase health insurance. Under the ACA, state health insurance exchanges must be available for use by consumers to purchase health insurance with an effective date no later than January 1, 2014.

In drafting the ACA, Congress drew heavily from the successful state health reform initiative adopted in 2006 by Massachusetts. (See Massachusetts health reform law and related resources.) Over the course of Massachusetts' planning and implementation efforts, state officials and administrators encountered many of the issues, challenges, and opportunities that are currently facing states in implementing national health reform.

This toolkit is part of a series designed to share examples, templates, experiences, and lessons learned from Massachusetts' implementation of health reform with other states beginning their own health reform planning efforts. You can find this toolkit and others in the series online at www.bluecrossfoundation.org.

Oversight of Massachusetts' Health Exchange Includes Key State Agencies.

In Massachusetts, the state opted to create a quasi-independent state agency, the Commonwealth Health Insurance Connector Authority (the Connector), to create and manage the health insurance exchange. The Connector is charged with defining the characteristics of health insurance products that can be sold through the exchange, but it has no statutory authority to review or set rates or monitor the services provided under Commonwealth Choice. The state's Division of Insurance (DOI), Group Insurance Commission (GIC), and the State's Medicaid authority, MassHealth, each hold one ex-officio seat on the 11-member Board that oversees the Connector, providing important links among the agencies and ensuring that they are represented to the Connector (along with the interests of consumers, small businesses, organized labor, and health insurance brokers). The Board also includes individuals with specific expertise in health insurance, health policy, and related fields.

Focus of this Toolkit

Massachusetts offers a single health insurance exchange that serves subsidized and unsubsidized individual purchasers, as well as small businesses. Each of these markets – subsidized individual, unsubsidized individual, and unsubsidized small group insurance – is served by separate parts of the exchange and offers different health plan choices. Within the individual health insurance market, Massachusetts offers two programs: 1) Commonwealth Choice, which offers purchasers a range of private health plans meeting criteria specifically developed for the Massachusetts Commonwealth Health Insurance Connector Authority's heath insurance exchange (the Connector); and 2) Commonwealth Care, which provides subsidized health plans designed to meet the needs of individuals with family incomes at or below 300 percent of the federal poverty level and without access to employer-sponsored health insurance.

This toolkit focuses specifically on Massachusetts' experience developing the part of the exchange that serves *unsubsidized, individual* purchasers (known as Commonwealth Choice). This experience includes developing, through a public procurement process, specific health insurance products that allow for easy comparison on the basis of quality, benefits, provider networks, cost sharing, and premiums. While much of this experience will be relevant to a market that also includes subsidized purchasers, states should be aware that additional policy

considerations may apply in designing health care products for low-income populations.

Throughout this Toolkit Guide you will find references and links to specific examples of work products from Massachusetts' experience, which may be used to inform other states' planning efforts. Even if the implementation strategies and steps described in this Toolkit Guide do not apply directly to your state, the tools, templates, and examples may provide useful resources that can be modified or adapted to support your state's unique approach.

> "The principal role of the exchange is to provide meaningful choice to consumers in purchasing health insurance. That means ensuring that they have access to products that provide the benefits that matter most to them, and that they can easily compare costs for those products.
>
> **Glen Shor,** Executive Director, Connector

Massachusetts' Approach to Designing a Health Insurance Exchange

Health insurance exchanges are designed to increase the number of people with health insurance by providing a marketplace for consumers and small businesses to compare and purchase health insurance.

In establishing their exchanges, states may pursue many different strategies that are driven by economic, political, and philosophical considerations. For example, some states may choose to use their health insurance exchanges merely as hubs through which consumers can access information and make purchasing decisions about any health insurance product[1] meeting minimum standards established by the ACA and available in their states. This approach, sometimes called the "any willing provider" approach, is rooted in a belief that consumers should be given as much choice as possible and that consumers need only minimal assistance from the state in determining whether the health insurance product meets their needs for quality and value.

In Massachusetts, the health insurance exchange was intended, from its inception, to be not just a storefront for all insurance carriers but a tool that allows consumers to purchase health insurance that meets the state's standards for minimum creditable coverage and the consumer's expectations for quality and value. To accomplish this, the Massachusetts Commonwealth Health Insurance Connector Authority (the Connector) has actively structured the shopping experience to offer choice, transparency, and simplicity, including carefully defining the products allowed on its shelf to ensure value and facilitate informed comparisons.

The Connector works actively with health insurance carriers, consumer organizations, and other stakeholders to support consumer comparisons and decisions based on benefit design, cost, and overall value. Easy-to-use information on the Connector's website is supplemented by a customer support line that receives more than 650,000 calls annually and guides consumers through the product choices available to them. By ensuring that consumers are not overwhelmed by the number of choices and complexity of products, the Connector works to create a more even, competitive playing field for the health insurance carriers participating in the exchange.

1 Here and throughout this Toolkit Guide, the term "product" is used to mean a specific health insurance plan, and "carrier" is used to mean a health insurance company that offers health insurance products to enrollees, either directly or through another entity.

Massachusetts' Experience Indicates that Most Consumers Prefer a Limited Choice of Products.

The Massachusetts experience illustrates that "consumer choice" is a complicated concept and that maximizing choice requires more than increasing the number of options available to consumers. "When we first started out, many people wanted to open the gates and let in as many carriers and products as possible," says Kate Bicego, Consumer Education and Enrollment Manager at Health Care For All, a Massachusetts-based health consumer advocacy group dedicated to making adequate and affordable health care accessible to everyone. "But it left consumers saying, 'I don't know how to compare.'"

Bicego manages a consumer helpline at Health Care For All that responds to 35,000 calls annually from consumers trying to navigate their responsibilities to purchase health insurance under Massachusetts law – over half of whom have primary languages other than English. Many of these consumers felt overwhelmed by too many choices, she said – a finding confirmed by the Connector's own consumer surveys and focus groups.

In addition, adds Brian Rosman, Health Care For All's Research Director, relying on actuarial values[1] as the basis for defining levels of coverage meant that consumers were "comparing apples to lava." In Rosman's view, unfiltered "choice" means that health insurance carriers can actually avoid competition, creating so many distinctions that consumers have no way to compare health insurance products on the basis of cost or value. "By standardizing the benefits packages, Massachusetts is able to give consumers an opportunity to make meaningful comparisons – a real choice," he said.

Bicego notes that states that do not require the same levels of coverage as Massachusetts can still support consumers by certifying a limited number of carriers and products, allowing side-by-side comparisons of similar products, defining confusing jargon such as "out-of-pocket maximum," and providing information in multiple languages. Including consumer advocacy groups on policy and decision-making boards is a great first step, she adds.

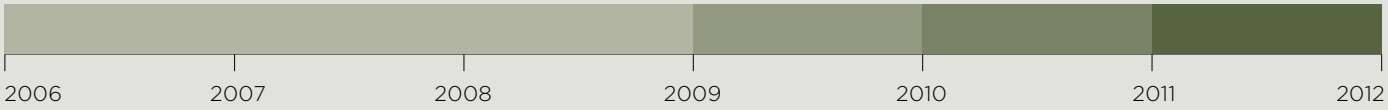
1 As used in the ACA, "actuarial value" means the portion of the total cost of covered benefits that are paid by a health insurance plan. For example, a plan with an actuarial value of 80% means that the plan will pay 80% of expected medical costs of covered benefits incurred by a group of enrollees, and the enrollees will pay 20% through deductibles, copayments, and other cost sharing. In general, the higher the actuarial value, the less an enrollee will have to pay out-of-pocket to cover his or her health care expenses.

Timeline: Implementation of Commonwealth Choice

Phase 1 (2006-2009)
Active purchaser with products defined by actuarial value

Phase 2 (2009-2010)
Standardized product designs (cost sharing) to facilitate consumer comparisons

Phase 3 (2011 +)
Refined product designs to streamline comparisons



Massachusetts' implementation of Commonwealth Choice to date has occurred in three phases. First, from 2006-2009, the Connector developed a health insurance exchange offering a limited range of products that were defined and offered to consumers based largely on their actuarial values. This approach incorporated three core strategies designed to support meaningful consumer choice and informed decision making:

- Ensuring that products offered through the exchange met high standards for quality and value;
- Categorizing the products into "tiers" of products with similar actuarial values to help consumers identify the products that best met their needs; and
- Limiting the number of carriers and products available through the exchange so that consumers are not overwhelmed by their choices.

Second, beginning in 2009, the Connector added another strategy: standardizing product designs to allow for more direct consumer comparisons of carriers, products, and costs. And finally, in 2011, the Connector refined the product designs to reflect additional feedback from consumers and carriers. These three phases, including specific implementation steps, challenges, and resources, are described below.

> "Traditionally, health insurance is sold, not bought. State health insurance exchanges need to empower consumers to be able to make meaningful comparisons based on price and product features that are important to them.
>
> **Kevin Counihan,** former Chief Marketing Officer, Connector

Phase 1: Using Actuarial Value as the Basis for Choice of Carriers and Products (2006-2009)

The ACA requires health insurance products participating in state health insurance exchanges to provide a federally determined "essential benefits package." Regulations defining this package in detail have not yet been issued but will include such categories of services as hospitalization, doctor's visits, emergency services, prescription drugs, and behavioral health treatment.

In addition, the ACA articulates four tiers, or levels, of coverage: Platinum, Gold, Silver, and Bronze. Each tier is defined by its "actuarial value." A product offered in the Platinum tier must cover 90 percent of expected medical costs for covered services across a typical group of enrollees, Gold must cover 80 percent, Silver must cover 70 percent, and Bronze must cover 60 percent.

The approach used in the ACA is based in part on the initial design of Massachusetts' health insurance exchange, which also required carriers to provide a specified actuarial benefit value within each product tier. Massachusetts established tiers at the Gold (or "premium"), Silver (or "value"), and Bronze (or "basic") levels. It also established a separate tier for Young Adult Plans (YAPs). YAPs are products offered through the Connector specifically for adults ages 18-26. Unlike all other unsubsidized products on the Connector, YAPs are exclusive to the Connector and may not be offered outside the exchange.

In 2006, in order to identify carriers eligible to participate in the exchange, the Connector issued a Request for Responses (RFR) inviting health insurers to propose specific products to be offered at each tier and providing specific criteria for scoring bidders' responses. To ensure a vibrant exchange, all carriers serving 5,000 or more Massachusetts residents were required by law to submit a response to the RFR.

The RFR's scoring criteria focused on several factors, including:

- Individual premium and estimated cost-sharing. The Connector used actuarial consultants to help calculate, compare, and verify the estimated annual out-of-pocket expenses based on average utilization of a "market basket" of services.
- Product design and preferred features. The Connector scored carriers on features such as a select network,

access to centers of excellence for complex procedures, innovative pharmacy management, wellness incentives, and consumer engagement.

- Marketing plan and marketability. Carriers that demonstrated an understanding of the role of the Connector and a creative strategy to reach the target market (such as marketing materials in multiple languages) received higher scores.

- Network access and geographic coverage. Using network standards promulgated by the Division of Insurance (DOI), plan networks were required to include at least one hospital in each county for which they propose coverage and meet certain requirements regarding access to primary care providers in each zip code in the service area.

(See 2006 Request for Responses from Health Benefit Plans.)

> “People don’t want an overwhelming number of choices. They want some choice, and they want the ability to make meaningful comparisons that allow them to purchase insurance that meets their needs for access, services, and cost.
>
> **Kate Bicego,** Consumer Education and Enrollment Manager, Health Care For All

The Connector required carriers submitting responses to offer at least six products: one Gold product; three Silver products reflecting High, Medium, and Low benefit levels; and two Bronze products (both using the same product design, but one with prescription drug coverage and one without).[2] Carriers were also permitted, but not required, to submit bids for two Young Adult products – one product design, but one with prescription drug coverage and one without.

Responses were scored based on the specific criteria identified in the RFR and then tallied, and the total number of points was used to determine which carriers would be recommended to the Board to receive a “Seal of Approval” and be permitted to offer their products for purchase through the Connector. Seals of Approval for Young Adult products were also awarded through this RFR process but scored separately.

Although ten carriers submitted responses that met the technical requirements of the RFR, only six of the seven highest-scoring carriers were awarded the Seal of Approval. An important consideration in determining how many carriers would be allowed to participate in the Connector was ensuring that all consumers, regardless of where they lived, had a choice of carriers and products. The decision to include six carriers resulted in nearly all residents of Massachusetts having a choice of at least three products with different carriers, with most residents having a choice of four or five products and carriers.

Once awarded a Seal of Approval, carriers entered into contracts with the Connector that allowed them to participate in the health exchange. Contracts were for one year with annual renewals. (See 2007 Form Agreement Between the Connector and Participating Carriers.) An important component of the contracts was establishing terms for an administrative fee to be paid to the Connector to help fund the call center, billing and collections, and payment of broker commissions. The contract also required “co-branding” with the Connector for all health insurance products sold through the exchange (Section 3.4) and submission of specific cost data (Section 3.12).

2 Partly as a result of consumer research and advocacy during this process, regulations were adopted specifying that, with the exception of Young Adult Plans, only plans that included prescription drug coverage would meet the “minimum creditable coverage” requirements of the state law and would be allowed to be sold through the exchange.

Pursuant to Massachusetts law, all health insurance products sold on the exchange can also be sold outside the exchange, but they must be offered at the same rates both inside and outside the exchange (Section 3.14). This requirement, which is also included in the ACA, reduces the risk that carriers will market their products to healthier enrollees outside the exchange at a lower cost than within the exchange. To make health insurance more affordable for individual purchasers, Massachusetts requires each carrier to base its rates on its entire pool of small group and individual purchasers, both outside and within the Connector. (See DOI regulations at 211 CMR 66.08.) Carriers are permitted to offer outside of the Connector products that are different than those offered within the Connector, and the standard carrier contract confirms that participation in the Connector does not affect these products (Section 3.1.B).

Phase 2: Standardizing product designs to facilitate consumer comparisons based on quality, benefits, and cost (2009-2010)

In Massachusetts, the decision to develop standardized product designs at each tier grew, in part, out of consumer feedback during the first phase of implementing health reform. Although having separate tiers and offering a limited number of carriers and products were viewed as helpful, consumers indicated that they were still confused by the broad range of cost-sharing and benefit designs that existed, especially within each tier. For example, a product with a low deductible and very high copayment requirements may have the same actuarial value as a product with a high deductible and low copayments. This variation within tiers made comparisons across products difficult for all but the most sophisticated purchasers.

> “With standardized benefits and cost sharing at each product tier in the exchange, consumers don’t have to worry that there’s some sort of ‘gotcha’ in the health insurance they purchase. They can know that they are comparing equivalent products and so make better informed decisions based on premium and provider network differences.
>
> **Nancy Turnbull,** Senior Lecturer on Health Policy and Associate Dean for Educational Programs, Harvard School of Public Health, and Member, Connector Board

In March of 2009, less than two months before the release of the Connector’s next scheduled RFR, the Connector conducted five focus groups and surveyed 1,200 individuals who enrolled in health insurance through the Connector’s website. They asked consumers if: 1) they would be willing to give up some choices in exchange for an easier way to compare products, and 2) what benefits or product characteristics were most important to a meaningful comparison. (See Summary of April 2009 Focus Groups.)

Findings from this research convinced the Connector Board and staff that consumers needed a simpler way to compare products based on price and the benefits most important to them. Based on that research, Connector staff re-wrote the RFR soliciting carrier participation in the exchange to modify the “actuarial value” model to begin to standardize the product designs and cost sharing offered within each actuarial tier. To accomplish this, they considered several factors:

- What benefits and features do consumers say are most important to them? These benefits formed the basis of standardization within each tier and benefit level. The benefits identified for standardization included annual deductibles; annual out-of-pocket maximums; and copayments for doctor’s visits, emergency rooms, generic prescriptions, and hospital stays. (See 2009 Request for Responses from Health Benefit Plans and comparison shopping on the Connector website.)

- What kinds of health insurance products are most popular with consumers, and what are the benefits and features that make them popular? Connector staff conducted market research both inside and outside the exchange to identify top-selling products, and used that information to supplement consumer research.

- How are these benefits addressed at each tier among products already being offered on the Connector? In many instances, Connector staff identified the existing product with the greatest enrollment in each tier to serve as the standard. This helped to minimize disruption to members, carriers, and the exchange overall. In other instances, staff reviewed all products offered in a specific tier and selected the "modal average" cost-sharing requirements as the standard.

There are no specific tools or methodologies for conducting this kind of analysis, and Connector Board members and staff generally agree that this process relied as much on "gut" instinct as on science. The challenge was to design products that met consumer needs, but also considered the preferences and business needs of the carriers. "It was like solving for a 36-variable equation," said one staff member involved in the process. Staff created multiple matrices comparing trade-offs in cost-sharing and benefit levels to assist in the analysis. (See April 2009 PowerPoint to Connector Board.)

After completing its analysis, the Connector issued an RFR requiring carriers to submit bids based on very specific, standard product designs at each of seven tiers: Gold, Silver High, Silver Medium, Silver Low, Bronze High, Bronze Medium, and Bronze Low. This was a larger number of tiers and products than recommended by some Board members, but was approved as a compromise to avoid disruption to the exchange. Carriers were also permitted, but not required, to submit four Young Adult products in two tiers: YAP High and YAP Low. In each tier, carriers submitted two separate products using the same product design, but one with prescription drug coverage and one without.

The RFR specified the level of copayment or deductible permitted for each product feature on "plan design worksheets" that were provided as part of the RFR. The RFR also required carriers to provide the Connector with a rating table for each product offered so that premiums could be calculated and compared. As a result of the bidding structure required in the RFR, the number of product designs offered on the exchange decreased from thirty-six to nine.

> "The question every exchange should be asking is, 'What products do I need on my shelf to make consumers want to come to the exchange to buy health insurance?' Subsidies alone may not be compelling enough to attract consumers.
>
> **Patrick Holland,** former Chief Financial Officer, Connector

> "The lesson for me in negotiating to establish standardized product designs was 'learn to live with tension.' It's not a science and it doesn't always go smoothly – but, in our case, I think we got it mostly right.
>
> **Celia Wcislo,** Assistant Division Director and Vice President At-Large, 1199 SEIU United Healthcare Workers East, and Member, Connector Board

Standardization Can Level the Playing Field for Smaller Carriers.

When consumers have the ability to compare similar health insurance products based on cost, the insurance market can shift in unanticipated ways. Neighborhood Health Plan (NHP), a Massachusetts carrier that historically focused on serving Medicaid and other low-income populations through partnerships with community health centers, currently has 35 percent of the market for unsubsidized individual and small business products offered through the health exchange. With a commercial market share of less than two percent of their total business inside and outside the exchange, NHP illustrates the impact that standardizing benefits can have on consumer choices.

"When individuals control their own purchasing, price will drive their decisions – and the exchange offers a place for consumers to make apples-to-apples comparisons," says Carla Bettano, Vice President for Business Development at NHP. Bettano notes that small business purchasers may be more affected by factors other than price, such as the breadth of the provider network available under each product, "but for the individual market, price is the most compelling driver."

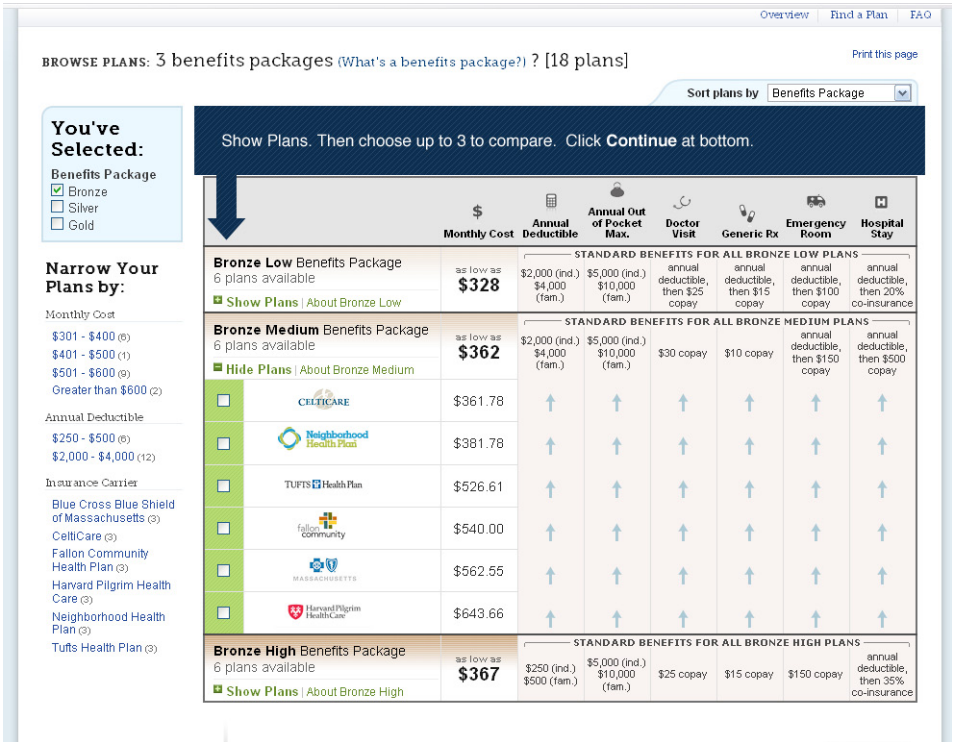
Bettano says that she agrees with many carriers that having the ability to be innovative with product designs is important. However, she adds, "standardizing product designs totally leveled the playing field" for NHP with the much larger commercial carriers in both the individual and small group markets and allowed NHP to thrive.

Seven carriers received a Seal of Approval through this procurement process. Geography remained a critical factor for the Connector in determining the number of carriers that would be allowed to participate in the exchange. Currently, more than 90 percent of enrollees participate in products offered by only four of the exchange's approved carriers, but the others are essential to offering a choice of quality products to people living in the more rural, western region of the state.

The following screen shot from the Connector's website prior to standardization shows a comparison of products for a 50-year-old individual living in Boston. All the products have the same actuarial value, but the benefits and cost-sharing requirements vary widely. As a result, consumers cannot easily determine what explains the 50 percent variation in premium cost:

Tier	Plan	Premium*	Deductible	Co-Payments			Hospital Stay	Doctors You Can See	Choose Plan
				Doctor	RX	ER			
B	☐ *Neighborhood Health Plan* NHPThree Select	$314.15	$2,000/$4,000	$25	$15 after Rx deductible / 50% co-insurance after Rx deductible / 50% co-insurance after Rx deductible	$100 after deductible	20% co-insurance after deductible	Find Doctor	View Plan
B	☐ *Fallon Community Health Plan* FCHP Direct Care	$392.00	$2,000/$4,000	$25	$15 / $50 / $100	$200	$500 per admission after deductible	Find Doctor	View Plan
B	☐ *Tufts Health Plan* Advantage HMO Select 2000 (Limited choice of doctors & hospitals)	$421.38	$2,000/$4,000	$40	$20 after Rx deductible / $50 after Rx deductible / $75 after Rx deductible	$200	$0 after deductible	Find Doctor	View Plan
B	☐ *Harvard Pilgrim Health Care* Harvard Pilgrim Core Coverage 1750	$451.56	$1,750/$3,500	$25 copay up to 3 medical care office visits per individual (or 6 per family); next visits are subject to the deductible; then 20% co-insurance thereafter	$15 / 50% co-insurance after Rx deductible / 50% co-insurance after Rx deductible	$250	20% co-insurance after deductible	Find Doctor	View Plan
B	☐ *Fallon Community Health Plan* FCHP Select Care	$454.00	$2,000/$4,000	$25	$15 / $50 / $100	$200	$500 per admission after deductible	Find Doctor	View Plan
B	☐ *Blue Cross Blue Shield of Massachusetts*	$476.13	$250 per plan year/$500 per	$25	$15 / 50% co-insurance after Rx deductible /	$150	35% co-insurance	Find Doctor	View Plan

Following standardization, consumers on the Connector's website can easily view the range of approaches to cost sharing available to them, and they can compare products on the basis of premium costs:



> "We learned to be judicious in identifying benefits for standardization. States will need to balance importance to consumers with the administrative burden on carriers. In our experience, it is too easy to lose points with carriers without winning any from consumers. You need to know what's important to consumers and focus on that.
>
> **Kaitlyn Kenney,** Director of Policy and Research, Connector

Some Massachusetts carriers warn that too much standardization and emphasis on price can have the unintended effect of discouraging product innovation and can affect carriers' internal costs and workflow. For example, carriers participating in the health exchange are required by the Connector to comply with a standard set of policies and procedures related to issues such as non-payment of premiums, disenrollment, and renewals. However, carriers already have such policies in place and processes to implement them in their commercial products, so requiring a new set of policies may require internal staff training, new processes for documentation, and strategies to minimize confusion for consumers.

In Massachusetts, market share among products being offered on the exchange shifted coinciding with the introduction of standardized product designs and web-based tools to support comparisons on price. Though there may have been other factors driving the changes in purchasing patterns, it is worth noting that smaller, lesser-known carriers increased market share when consumers could compare products with similar benefits and see, at a glance, that the products offered more competitive prices. Some larger carriers with more name recognition lost market share in this price-competitive environment. In 2009, the development of the exchange as a distribution channel and "market organizer" also helped attract the first new health insurance carrier – CeltiCare Health Plan – to enter the Massachusetts market in decades.

In addition, carriers point out that standardization requires them to create new products that may differ from those they developed for the commercial market or the first phase of the exchange. Because all existing products must

continue to be offered to existing enrollees, the creation of new products has resulted in many carriers needing to significantly expand their product lines. According to some carriers, each new product increases administrative costs and complexities and creates opportunities for confusion among enrollees with similar, but not identical, products.

Phase 3: Refining the exchange to reflect consumer and carrier needs (2011-present)

In April 2011, the Connector issued a third RFR, continuing its standardized product design approach but making several refinements to simplify consumer comparisons. In particular, a review of product offerings noted that there were 15 products offered at the Silver tier – including High, Medium, and Low categories – but 60 percent of enrollees chose one of just five products. (See January 2011 PowerPoint to Connector Board.) In addition, having three categories of products within the Silver tier meant that the differences among categories were relatively minor, making it harder for consumers to decide which category of products best met their needs.

To streamline the shopping experience for consumers and reduce administrative costs for carriers, the Connector eliminated Silver Medium as a category under the Silver tier. Under this revision, consumers will continue to have a choice of Silver products (Silver High and Silver Low) and will more easily be able to compare prices, available networks, and other benefits. (See 2011 Request for Responses from Health Benefit Plans.)

To provide stability for carriers participating in this part of the exchange, the revised RFR offered 18-month contracts (rather than one year). The RFR also eliminated standardized member cost sharing for some benefits that either were not priorities for consumers or were particularly burdensome for carriers to accommodate. These included cost sharing requirements for inpatient skilled nursing facilities, outpatient mental health office visits, routine vision care, and ambulance services.

> “To be seen as credible, carriers and consumers have to believe that the exchange is truly different. You need to exceed their preconceived notions of a government agency on the dimensions of customer service, efficiency, and transparency. If the exchange is part of an existing state agency, you may want to design and brand some degrees of separation between the health exchange and the rest of the agency that has responsibility for the exchange.
>
> **Patrick Holland,** former Chief Financial Officer, Connector

Nine carriers applied and eight were selected to receive a Seal of Approval and enter into contracts to offer their products on the exchange for unsubsidized individual purchasers. (See 2011 Seal of Approval PowerPoint.) As in the previous procurements, carriers are obligated to provide a product at all tiers and categories offered on this part of the exchange. (See 2011 Form Agreement between the Connector and Participating Carriers.)

Additional Lessons Learned

In developing Massachusetts’ health insurance exchange and defining the health insurance products that can be offered through the exchange, Connector staff and stakeholders addressed several specific challenges related to design and implementation. Some of the lessons learned through this process are described below.

1. An effective regulatory environment allows the health insurance exchange to collaborate and build credibility with carriers and consumers.

Policy decisions regarding whether a health insurance exchange will limit the number and types of products that can participate can blur the lines between supporting a competitive marketplace and regulating the industry. In Massachusetts, earning credibility among carriers for the Connector as a marketplace was made easier by the fact that the state's Division of Insurance (DOI) had already implemented significant health insurance market reforms prior to adoption of the state's health reform law.[3] Policy and regulatory decisions that were politically sensitive – such as a prohibition on medical underwriting – were already in place, allowing the Connector to focus on implementing the specific design of the health exchange.

> "The Connector staff worked collaboratively with us when we needed help meeting requirements. They saw the value of Neighborhood Health Plan's participation, and they wanted to work with us to make it happen.
>
> **Carla Bettano,** Vice President for Business Development, Neighborhood Health Plan

In Massachusetts, the success of the health exchange requires ongoing collaboration and close communication with state regulators. For example, products are approved for inclusion in the exchange by the Connector Board, but they must also be licensed by DOI in order to be sold in the state. Coordinating with DOI to ensure that products approved for sale on the exchange receive timely regulatory approval or will be able to do so is a challenge, and competing demands from both agencies is sometimes a source of frustration for some carriers.

2. Engaging carriers in the process results in policy decisions that can be more effectively implemented.

Health insurance carriers have a clear stake in how the ACA is implemented in each state. To some, this might suggest that they should be kept at arm's length during planning efforts related to the health insurance exchange and defining requirements for participating carriers. To others, this suggests that carriers are valued partners who need to be consulted early and often to ensure that they are on board with proposed changes.

In Massachusetts, health insurance carriers are viewed as critical to the success of the Connector. Connector Board and staff agree that carriers should be engaged actively throughout the process – and they acknowledge that this is a goal they have not always achieved. For example, in developing the 2009 RFR, the Connector included data reporting requirements that virtually none of the participating carriers could meet. This required hastily called meetings, negotiations, and revisions to the RFR to be more realistic in its expectations for carriers.

One way to ensure adequate input from carriers is to allow enough time for consultation while developing the exchange and requirements for the products to be offered. Although Massachusetts developed its standardized product design approach in a compressed time period of about two months, most stakeholders agree that truly effective consultation with carriers would require a significantly longer planning period.

3 For a brief summary of these market reforms, please see DOI's 2010 Membership Report of the Massachusetts Individual/Small Employer Markets for Health Coverage (June 14, 2011).

Earn the Respect of Health Insurance Carriers.

Although some tension between carriers and state health exchanges is healthy and warranted, states probably will be more successful in negotiations if they are trusted by carriers as knowledgeable and credible. Patrick Holland, former Chief Financial Officer at the Connector, offers a few tips to gain and keep credibility:

- Provide information and data to support proposed changes, especially if the changes pose a burden on carriers.
- Establish realistic timelines and meet them.
- Over-communicate.
- Always be focused on "tending to the relationship."
- Only ask for data that you really need and will use in the course of running your exchange.

Exchanges need to recognize that selling health insurance is a complicated business and, at the end of the day, carriers have many different constituents and customers to satisfy, notes Kaitlyn Kenney, Director of Policy and Research at the Connector. A successful health exchange will understand that dynamic and help carriers think through how their interests align for the benefit of the consumer, she says.

Like any important relationship, there is sometimes conflict, tension, and difficulty, according to Holland. "In working through those thorny issues, the exchange can build trust and credibility," he says.

States may also want to consider infusing carrier perspectives and expertise throughout the process of developing their health exchanges. In Massachusetts, recruiting former industry employees to join the Connector staff was essential to helping understand both business and technical challenges to implementing the exchange.

3. Transparency in decision making can sustain support and minimize opposition.

In Massachusetts, having a clear, transparent process and documenting decisions were critical in maintaining credibility and broad support for implementation of health reform, as well as avoiding litigation over decisions that adversely affected health insurance carriers. This was especially important in the context of choosing carriers to receive the "Seal of Approval" that allows them to offer their products through the exchange.

For each RFR process, a detailed memo describing the bidding and scoring process was prepared by Connector staff and submitted to the Connector's Board. The staff's recommendations were discussed at a public meeting, where final decisions were made. (See 2007 Seal of Approval Memo and 2010 Seal of Approval Memo.)

Conclusion

The ACA provides states with significant flexibility in implementing their health insurance exchanges, including defining the health products that may be offered to consumers through the exchange. In Massachusetts, the Connector perceived its role as supporting consumers in making *meaningful, informed decisions* in selecting carriers and products that provide the best value for their unique needs. To do this, Massachusetts chose to: 1) ensure that products offered through the exchange meet high standards for quality and value; 2) create tiers of products to help consumers identify the carriers and products that best meet their needs; and 3) limit the number of carriers that are allowed to participate in the exchange.

Beginning in 2009, Massachusetts also standardized product designs across each tier of coverage to support easier consumer comparisons of costs and value. Standardization includes cost-sharing requirements for those benefits

determined through research to be most important to consumers: annual deductibles; annual out-of-pocket maximums, and copayments for doctor's visits, emergency room visits, generic prescriptions, and hospital stays.

Through this process, Massachusetts has learned several valuable lessons, including the importance of establishing the role of the health exchange as a marketplace for carriers and products that meet quality and access standards; engaging health insurance carriers in policy decision-making; involving staff who have experience, knowledge, and credibility in the health insurance industry; and ensuring transparency in decisions affecting consumers and carriers.

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THE COMMONWEALTH OF MASSACHUSETTS

HEALTH INSURANCE CONNECTOR AUTHORITY

ONE ASHBURTON PLACE, ROOM 805

BOSTON, MASSACHUSETTS 02108

REQUEST FOR RESPONSES

HEALTH BENEFIT PLANS

DECEMBER 6, 2006

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SECTION I – INTRODUCTION

The Commonwealth Health Insurance Connector Authority (the "Connector" or the "Authority") is a body politic and corporate and a public instrumentality of The Commonwealth of Massachusetts (the "Commonwealth"). The Connector is established pursuant to Chapter 176Q of the Massachusetts General Laws, as amended from time to time ("c. 176Q" or the "Connector Governing Act"), as added by Section 101 of Chapter 58 of the Acts of 2006 ("c. 58" or the "Health Care Reform Act of 2006"), and is an independent public entity not subject to the supervision and control of any other office, department, commission, board, bureau, agency or political subdivision of the Commonwealth.

The Connector is governed by a ten member public-private Board, comprised of four ex-officio members -- the Secretary of Administration and Finance, who serves as chair of the Board, the Director of Medicaid, the Executive Director of the Group Insurance Commission, and the Commissioner of Insurance -- and six members of the public, three appointed by the Governor and three appointed by the Attorney General. Public sector members encompass a range of interests and expertise, including organized labor, employee health benefits, consumers, small business, actuarial science, and health economics.

The purpose of the Authority is to administer the Commonwealth Health Insurance Connector, as set forth in the Health Care Reform Act of 2006, the main purpose of which is to facilitate the availability, choice and adoption of private health insurance plans to eligible individuals and small groups as described in c. 176Q.

To meet this responsibility, the Connector administers a publicly-subsidized health insurance program for individuals without access to employer-sponsored health insurance and with family income at or below 300% of the federal poverty level (FPL). In addition to the administration of government-subsidized health benefit plans for eligible low-income residents, the Connector must also facilitate the development and offering of affordable commercial health insurance products (without public subsidy) to individuals and small groups. Eligible small groups include any business, sole proprietorship, labor union, educational, professional, civic, trade, church, not-for-profit or social organizations or firms, corporations, partnerships or associations actively engaged in business that on at least 50 percent of its working days during the preceding year employed at least one but not more than 50 employees.

Commercial health plans will be offered for sale through the Connector beginning May 1, 2007 and will have an effective date of coverage beginning July 1, 2007. To meet these deadlines, the Connector is issuing this Request for Responses (RFR) to health insurance carriers that contain guidelines and procedural rules, with responses to be submitted by health insurance carriers to the Connector by January 16, 2007. The Connector will review the submissions and determine which health benefit plans meet the criteria to be awarded the Connector's "Seal of Approval" and are selected to be offered for purchase by individuals and groups through the Connector.

SECTION II – OVERVIEW OF THE RFR

A. PURPOSE/OBJECTIVES OF THE RFR

The Connector is responsible for facilitating the development and marketing of a choice of quality, affordable health insurance products to eligible individuals and groups. The purpose of this RFR is to solicit fully insured health insurance product proposals from commercial health insurers licensed to do business in the Commonwealth. The Connector envisions offering four distinct types of health insurance products from a limited number of health insurance carriers: (1) "Premier" plans with limited out-of-pocket cost sharing by enrollees; (2) "Value" plans with higher out-of-pocket costs at the point of service; (3) "Minimum Creditable Coverage" plans representing the highest level of cost-sharing that will satisfy the individual mandate for health insurance coverage in Massachusetts; and (4) Young Adults Plans, to be offered solely through the Connector to individual, non-group purchasers ages 19 to 26. Each of these plan types is described further in Section IV of this RFR.

The Connector will serve as the distribution channel for those products that best meet the criteria set forth in this RFR and that the Board of the Connector determines to be the most appropriate for inclusion in a package of health benefit plans to be offered for sale through the Connector. Plans selected by the Board will be designated with the Connector's Seal of Approval. With the exception of the Young Adults Plans, the selected products will be made available to all individuals and small groups that meet the eligibility rules set forth in c. 58, c. 176J, and further defined in Section III of this RFR.

Because the Connector will offer for purchase a number of health insurance products from multiple insurers, the Connector will utilize the services of an intermediary, also referred to in c. 58 as a Sub-Connector, to provide a range of administrative functions typically handled internally or outsourced by insurance carriers operating in the small group market. These services will include, but not be limited to, pre-and post-enrollment customer service, benefits explanation, and premium quoting, billing, collection, remittance and reconciliation, and eligibility verification and re-enrollment. These activities are discussed further in Section III of this RFR and described in greater detail in the Sub-Connector's RFR issued on December 6, 2006 by the Connector Authority.

B. KEY CRITERIA

While the selection criteria are listed in Section VI of this RFR, of particular interest to the Connector are affordable health insurance products that encourage members to use quality, cost-effective doctors and hospitals, that engage consumers by providing actionable information about differences in cost and quality of care, and that reward members for adopting and maintaining healthy lifestyles. While the Connector, through this RFR, provides guidance and limitations with regard to the plan designs requested, our intent is to encourage health insurance carriers to develop and offer innovative plan designs that more effectively and efficiently deliver care to the residents of the Commonwealth.

SECTION II – OVERVIEW OF THE RFR (CONTINUED)

C. TERM OF THE ENGAGEMENT

The Connector will award its Seal of Approval and agree to offer such health plans for one year, renewable annually thereafter, unless notice of intent to terminate is provided by the Connector at least 90 days in advance of the next renewal date. The initial term of this engagement is for the plan year that begins July 1, 2007 and ends June 30, 2008. The Connector reserves the right, in its sole discretion, annually to renew or eliminate product offerings and insurance carriers; the Connector also reserves the right annually to add one or more carriers and/or product offerings to the portfolio of plans made available through the Connector. The annual renewal date may change to correspond with the open enrollment date for non-group coverage pursuant to discussions with the Division of Insurance (see Section III, "Enrollment Period," page 9).

SECTION III – PROGRAM REQUIREMENTS

Please note that you will be asked to confirm that you will comply with the program requirements in Response Form A.

A. RULES OF PLAN PARTICIPATION

Pursuant to c. 58, carriers that meet the following criteria are required to submit health benefit plans for the Connector's consideration:

> A carrier that, as of the close of calendar year 2005, had a combined total of 5,000 or more eligible employees and eligible dependents who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its license under c. 175, c. 176A, c. 176B or c. 176G;
>
> A carrier that as of the close of calendar year 2006, had a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its license under c. 175, c. 176A, c. 176B or c. 176G;
>
> However, neither an eligible individual or eligible employee, nor an eligible dependent, shall be considered to be enrolled in a health benefit plan issued pursuant to its authority under c. 175, c. 176A or c. 176B if the health benefit plan is sold, issued, delivered, made effective or renewed to said eligible employee or eligible dependent as a supplement to a health benefit plan subject to licensure under c. 176G.

The Connector will also consider health benefit plans from carriers that do not meet the above enrollment criteria but are otherwise licensed pursuant to c. 175, c. 176A, c. 176B or c. 176G.

As described further in Section IV of this RFR, carriers must submit for consideration the requisite number of health benefit plans under each of the three main plan levels (Premier, Value and Minimum Creditable Coverage).

For the Young Adults Plan, as described further in sub-section E of Section III and Section IV of this RFR, only those carriers that meet the following criteria, pursuant to c. 58, as amended, are allowed to submit a Young Adults Plan for the Connector's consideration:

> A carrier that, as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its license under c. 175, c. 176A, c. 176B or c. 176G.

SECTION III – PROGRAM REQUIREMENTS (CONTINUED)

The Connector is not obligated to grant its Seal of Approval to any carrier's product offerings, regardless of the carrier's small group and non-group enrollment. The Connector will -- based on the selection criteria summarized in this RFR and a determination by the Board of the appropriate range of product offerings that will best meet the needs of the target population -- offer to eligible individuals and small groups a set of product offerings from a limited number of carriers.

The Connector will only offer for sale products from carriers that satisfy the selection criteria for each of the three plan levels (Premier, Value and Minimum Creditable Coverage); and no carrier offered for sale through the Connector will be allowed to limit their product offerings to any particular health benefit plan or specific plan level.

B. DOI REVIEW AND APPROVAL OF NEW PRODUCTS AND RATE FILINGS

Products developed for the Connector that are not currently licensed in the Commonwealth must be submitted to the Division of Insurance for its review and approval. Carriers are strongly encouraged to review informally with DOI staff any new plan designs that are being submitted for the Connector's consideration but have not yet been approved by the Division. The Connector will work closely with DOI in an attempt to expedite the review process. However, the Connector will not recommend that the Connector Board issue its Seal of Approval to any health insurance product that is not either licensed by the Division or that has not received informal approval from the Division.

All filing requirements of the DOI shall apply to products offered through the Connector.

Carriers must cover all mandated benefits (i.e., a health service or category of health service provider) required by the carrier's licensing or other statute to include in its health benefit plan.

C. RATING METHODOLOGY

Carriers submitting health benefit plans to the Connector must abide by M.G.L. c. 176J, as amended, and all applicable rating regulations issued by the Division of Insurance (211 CMR 66.00 – Small Group Health Insurance) pursuant to the newly merged small group and non-group markets.

All rating factors applicable to the merged small and non-group markets that are in effect or that will take effect on July 1, 2007 may be used by carriers when rating products offered for sale through the Connector.

SECTION III – PROGRAM REQUIREMENTS (CONTINUED)

Carriers must utilize the same rating methodology for products distributed through the Connector to individuals that they use for products offered to individuals outside the Connector.

D. UNDERWRITING/ELIGIBILITY/FUNDING

Only individuals and small employers (those with 50 or fewer employees) may purchase group benefits through the Connector.

Employers that offer their eligible employees health benefit plans purchased through the Connector will not be allowed to offer to their benefits-eligible employees an alternative health benefit plan sponsored by the employer that may be purchased outside the Connector.

For those employees not eligible to participate in employer-sponsored health benefit plans, employers may establish as part of their Section 125 program a means to facilitate payroll deductions for non-group premium payments through the Connector. This provision will apply without regard to whether the employer's benefits-eligible employees are purchasing health benefit plans through the Connector, and without regard to the number of employees in the group.

Small employers offering group benefits through the Connector shall select a "benchmark" plan.

Employers that agree to pay at least 50 percent of the monthly premium for a "benchmark" plan at a given benefit level (i.e., Premier, Value or Minimum Creditable Coverage), shall restrict the choice of their employees to product offerings in the selected plan level.

Employers that contribute less than 50 percent of the monthly premium for a "benchmark" plan will not qualify as group insurance and therefore will not be able to restrict the choices of their employees, should any of them purchase non-group coverage through the Connector.

Individual purchasers will be allowed to select from any of the plan choices offered through the Connector.

No health benefit plan shall be offered through the Connector that excludes an individual from coverage because of race, color, religion, national origin, sex, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income, or age.

Only health benefit plans that have been authorized by the Commissioner of Insurance and underwritten by a carrier may be offered through the Connector.

SECTION III – PROGRAM REQUIREMENTS (CONTINUED)

Pursuant to c. 176J, carriers will be required to enroll any person who meets the requirements of an "eligible individual" into a health plan offered by the Connector if such person requests coverage within 63 days of termination of any prior creditable coverage. However, individuals that purchase insurance through the Connector and subsequently drop coverage prior to the end of the plan year shall not be allowed to enroll in a different health plan offered through the Connector until the completion of the plan year in which the individual was previously enrolled.

It is anticipated that the Connector will allow individuals to switch plans and/or to newly purchase a plan through the Connector during an annual open enrollment period, to be determined.

Carriers shall otherwise abide by eligibility, preexisting condition provisions, and waiting period provisions pursuant to c. 176J.

The Connector will retain a percentage of each carrier's health insurance premium for each of the products offered for sale through the Connector, in an amount to be determined, to cover the Connector's cost of marketing, enrollment and other administrative tasks performed on behalf of the health plans. Details regarding the funds flow and percentage of premium will be determined prior to the carriers' submission of proposals to the Connector.

E. YOUNG ADULTS PLAN

The Young Adults Plan may only be offered for sale through the Connector, and may only be purchased by individuals age 19 to 26, inclusive, who shall remain eligible for coverage under the Young Adults Plan through the last day of the month in which the individual turns 27.

The Young Adults Plan will be available only as individual coverage. No other coverage basis will be allowed for this plan type.

The Young Adults Plan will only be sold on an individual, non-group basis and will not be offered for sale as part of employer-sponsored insurance.

F. MARKETING

The Connector's target market are: (1) uninsured individuals, (2) small employers that do not currently offer group health benefits, and (3) individual employees not eligible for group insurance benefits, who want to buy health insurance through a section 125 payroll deduction program.

SECTION III – PROGRAM REQUIREMENTS (CONTINUED)

All carriers will be expected to actively market products available through the Connector and participate in joint marketing efforts with the Connector, including co-branding and establishing direct links between the Connector's web site and the carriers' web site and customer service representatives. Carriers shall propose how they plan to market the Connector as a distribution channel for the plans they propose to sell through the Connector.

Selected carriers will be expected to have available marketing and enrollment materials in advance of the May 1, 2007 open enrollment date. By April 1, mock-up marketing and enrollment materials shall be submitted for review by the Connector on a file and use basis.

All use of the Connector's marks shall be subject to the review and approval by the Connector.

G. CUSTOMER SERVICE

The Connector will contract with a third-party entity, also referred to as a Sub-Connector, to handle enrollment, premium billing and collection, monthly reconciliation, and other such sales and administrative functions, and to provide individuals, employers and brokers with information about the health benefit plans available through the Connector.

Carriers will be expected to have available customer service representatives during normal business hours to assist members and respond to inquiries from potential enrollees, and to coordinate customer service between their own representatives and the Sub-Connector's representatives.

H. DISTRIBUTION REQUIREMENTS AND ROLE OF SUB-CONNECTOR

The Connector will subcontract with an entity responsible for a range of administrative services, many of which are typically handled by health insurance carriers. These services will include some or all of the functions and services on behalf of the Connector related to:

- Pre- and post-enrollment customer service
- Eligibility and enrollment
- Premium quoting
- Monthly premium billing, collection and remittance to carriers, including bundling payments to the carriers from multiple employers and individuals
- Section 125 program administration/coordination with employers
- Notifications to individuals and employers regarding eligibility and enrollment status, late payment and non-payment of premium, and cancellation of coverage
- Payments to brokers/agents

SECTION III – PROGRAM REQUIREMENTS (CONTINUED)

The Connector will require selected carriers to enter into a relationship with the vendor selected to handle these administrative functions in order to achieve administrative savings and reduce duplication of services.

All carriers must be able to accept eligibility data in HIPAA 834 format.

I. REPORTING REQUIREMENTS

Within 30 days following the end of the month, carriers with products offered through the Connector shall submit enrollment reports, in a mutually agreeable format, for each product purchased through the Connector.

Carriers will be required to submit summary premium and claims data on a regular basis to a data management and analysis firm designated by the Connector.

J. ENROLLMENT PERIOD

The initial enrollment period for health insurance products offered through the Connector will begin on May 1, 2007, for an initial effective date of July 1, 2007. For small group buyers, the enrollment period will remain open throughout the year, with effective dates on the first of the month following completion of a group's enrollment process. For non-group buyers, the enrollment period will remain open for new entrants through January 1, 2008. Thereafter, the Connector will work with the DOI and the health insurance carriers to establish an "anniversary date," on which all non-group purchasers of Connector health insurance products will renew. However, the Connector and carriers marketing through the Connector will accept non-group enrollees who have newly qualified for non-group coverage because of moving into the state, turning 19, losing dependent coverage, aging out of a Young Adults Plan, losing group health insurance, or other such reasons established by the Connector, throughout the year.

SECTION IV – PLAN DESIGN PARAMETERS

To facilitate comparison shopping among a broad set of plan choices, to drive value, and to minimize risk selection, the Connector will offer a limited number of carriers, with each carrier required to offer products in all three plan levels -- Premier, Value and Minimum Creditable Coverage. In addition, carriers meeting the participation criteria for the Young Adults Plan, pursuant to c. 58 as amended, may also offer a Young Adults Plan, subject to approval by the Connector.

While the Connector recognizes that monthly premiums, out-of-pocket expenses and/or provider networks will vary across each of the three plan levels -- and to a limited extent across products within each plan level -- all products must provide reasonably comprehensive coverage of health services, including preventive and primary care, emergency services, hospitalization benefits, ambulatory patient services and mental health. In addition, the Premier and Value plans must include coverage of prescription drugs, although a limited formulary is allowed in all of the plan levels and other benefit differences that do not eliminate "reasonably comprehensive coverage" may be allowed.

As part of the RFR submission, carriers will need to indicate all differences in medical services or providers covered in the Premier plan that are not also covered in their Value and Minimum Creditable Coverage plans.

For those carriers with products that are selected to be offered through the Connector, the Connector anticipates working with all of the carriers to develop a standardized "evidence of coverage" template for all Connector products.

With the exception of the Young Adults Plan, the Connector will not approve any health benefit plan that includes an annual, per sickness or lifetime benefits maximum. In addition, no product offering that includes a fee schedule for medical services (e.g., plan maximum benefit of $500 per day for inpatient care, or $50 per office visit, etc.) will be approved by the Connector.

PREMIER PLAN

The Premier plan design is based on a comprehensive small group product offering, with limited point-of-service cost sharing. The plan design features listed on the next page must be replicated by all carriers submitting proposals in response to this RFR. Carriers may offer this product as an HMO, PPO, or POS.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

PREMIER PLAN DESIGN PARAMETERS

SERVICE	CO-PAYMENT
Outpatient Medical Care	
Office Visits/Routine checkups/Well-child visits	$10
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	No charge
X-rays/Labs	No charge
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	No charge
Prescription Drugs	
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$10/$25/$45
Mail order (Up to 90-days supply)	$20/$50/$135
Emergency Care	$50[1]
Inpatient Mental Health & Substance Abuse (non-biologically based up to 60 days per calendar year)	No charge
Outpatient Mental Health & Substance Abuse (non-biologically based up to 24 visits per calendar year)	$10
Rehabilitation Services	
Inpatient SNF/rehab (100 day max)	No charge
Short-term outpatient rehab (60 visits per calendar year)	$10
Other Benefits	
Ambulance (emergency only)	No charge
Durable Medical Equipment (up to $1,500 per year)	No charge
Hospice	No charge
Vision (one exam every 24 months)	$10

All services are subject to a determination of medical necessity.

All Massachusetts mandated benefits must be covered.

As the Connector would like to encourage more innovative plan designs that encompass -- to the greatest extent possible -- the preferred plan design features detailed in Section V of this RFR, carriers are also required to submit an alternative Premier plan design that is actuarially equivalent (+/- 5%) to the plan design noted above. This alternative plan design must cover the same medical services but need not replicate the benefits (cost-sharing), so long as the estimated value of claims covered under this design is within 5% of the covered claims projected for the Premier plan. For example, a second plan design might increase emergency room charges and/or specialist visit co-payments, decrease primary care and/or generic drug co-payments, offer a more limited provider network, and/or enhance wellness/fitness benefits. Each carrier must complete Response Form B of this RFR.

[1] Co-pay only applies to the use of emergency room services for non-emergency conditions that do not result in an inpatient confinement.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

VALUE PLAN

The Value plan's relative value should be approximately 80 percent of the Premier plan. Carriers are required to submit three product offerings at the Value plan level. However, to encourage a wide range of product offerings under this plan level, the relative value of the plan designs may be between 72.5% and 87.5% of the Premier plan. Carriers are allowed to offer any combination of plans within this relative value range.

If possible, one product offering should be an HMO, one product offering a PPO, and at least one product offering should include a select or tiered provider network (preferably including both physicians and hospitals). The Connector recognizes, however, that many carriers do not currently offer all three plan designs, and therefore carriers will not be required to submit an HMO, PPO and limited or tiered network product offering. Each carrier must complete Response Form C of this RFR.

MINIMUM CREDITABLE COVERAGE PLAN

The relative value of Minimum Creditable Coverage plans should be 60% of the Premier plan, plus or minus 2 percent. Carriers are required to submit two product offerings at this benefit level, and the Connector encourages carriers to consider submitting for consideration products that provide some preventive/primary care services prior to a deductible. These products should be priced two ways; (1) based on the assumption that a prescription drug benefit is required; and (2) based on the assumption that a prescription drug benefit is not required. For the products that include a drug benefit, carriers will be allowed to limit drug coverage and/or apply an up-front deductible prior to the drug coverage taking effect.

In addition to the products described above, carriers must also propose a health benefit plan that carries an average individual premium of $320. Carriers should price this product using an age rating factor of 1.0, no rating adjustment related to SIC/industry classification, and that this is the Minimum Creditable Coverage plan. Each carrier must complete Response Form D of this RFR.

YOUNG ADULTS PLAN

Carriers that meet the participation requirements of c. 58 for submission of a Young Adults Plan may propose one health benefit plan, to be offered through the Connector, with and without prescription drug coverage, to individuals age 19 to 26, inclusive. A carrier's Young Adults Plan must provide the same coverage and benefits as one of their Minimum Creditable Coverage plans approved by the Connector, except that carriers may impose benefit limits per illness or accident. Any proposed benefit limit must be at least $50,000 per illness or accident. The Connector anticipates the Division of Insurance promulgating regulations that are consistent with this definition of the minimum standard for a Young Adults Plan. Carriers wishing to offer a Young Adults Plan must complete Response Form E.

SECTION V – PREFERRED PLAN DESIGN FEATURES

The following plan design features are of interest to the Connector. Carriers should either include these features as part of their product offerings or briefly explain why they have chosen not to do so at this time. *Please note that you will be asked to address each of the Preferred Plan Design Features for each of your product offerings in Response Form G.*

A. SELECT, HIGH-PERFORMANCE NETWORKS

If properly designed, limited provider networks -- preferably including both physicians and hospitals -- can be an effective way of reducing monthly premiums without sacrificing coverage or restricting access. The Health Reform Act of 2006 indicates a preference for select, high-performance networks, and the Connector strongly encourages carriers to offer a health benefit plan with a provider network that rewards members for using cost-efficient, quality providers, including the use of community-based hospitals for routine procedures. In developing select or tiered networks, carriers must abide by the current minimum standard of at least one in-network general, full-service hospital within each Massachusetts county in the proposed service area. For each zip code in the proposed service area, enrollees must have access to at least two primary care physicians with open panels within a 15-mile radius or 30-minutes of travel time.

B. CENTERS OF EXCELLENCE

While the majority of care is relatively routine in nature and can be appropriately delivered at licensed in-network facilities across the Commonwealth, more complex conditions and procedures likely demand a higher level of sophistication and expertise than might be available at certain in-network facilities. Recognizing this, the Connector encourages carriers to consider offering enrollees -- particularly for health benefit plans with limited hospital networks -- the opportunity to access designated Centers of Excellence for specific conditions or procedures. These procedures commonly include organ transplants, bone marrow transplants, stem cell treatments, select cardiac procedures, in vitro fertilization services and certain types of cancer treatments.

In addition, the Leapfrog Group[2] has identified a select number of high-risk procedures for which volume -- the number of procedures of a given type a hospital performs each year -- has been demonstrated to positively affect outcomes. For limited networks, allowing members to access tertiary facilities that have more experience treating select complex conditions and performing certain procedures should also be considered an important part of the plan design. For health benefit plans that do not include a limited network of hospitals, carriers should consider including plan design features that reward the use of, or otherwise steer members to, Centers of Excellence for complex conditions and procedures.

[2] Launched in November 2000, The Leapfrog Group is a voluntary national program, funded by large employers and foundations, aimed at mobilizing employer purchasing power to encourage transparency and easy access to health care information, as well as reward hospitals that have a proven record of high quality care.

SECTION V – PREFERRED PLAN DESIGN FEATURES (CONTINUED)

C. INNOVATIVE PHARMACY MANAGEMENT

With pharmaceutical expenses comprising approximately 15-20 percent of medical expenses, the Connector is interested in plan designs that utilize innovative pharmacy management programs. The Connector seeks programs that allow for meaningful choice among drug therapies, but encourage members to use the least costly alternative available.

Carriers are encouraged to propose plan designs that incorporate value and choice within the pharmacy benefit. For example:

- a plan design that offers generic drug coverage with a modest co-payment while utilizing co-insurance for brand name drugs; or
- a pharmacy program that requires enrollees to utilize first-line drug therapies before more intensive second line pharmaceuticals will be covered; or
- prior authorization for drugs in certain classes; or
- a tightly managed, closed formulary; or
- a fourth tier for drugs that treat only minor illnesses and/or provide only minor symptomatic relief; or
- a waiting period before new-to-market drugs are covered.

D. CONSUMER ENGAGEMENT, INCLUDING TRANSPARENCY OF HEALTH CARE COST AND QUALITY DATA, AND WEB-BASED DECISION SUPPORT TOOLS

To engage consumers and heighten their understanding of the health care system -- in particular, the variation in cost across providers and differences in quality among providers -- carriers should demonstrate a commitment to providing enrollees with meaningful and actionable information regarding health care cost and quality. While the Commonwealth has established a Health Care Cost and Quality Council to promote high quality, safe, effective, timely, efficient, equitable and patient-centered health care, it is incumbent upon health insurance carriers -- which have access to robust data sets that can be used to measure both cost and quality -- to make available to consumers comparative cost and quality information by facility, clinician and/or physician practice group, including information related to patient safety and member satisfaction.

E. HSA OPTION WITH HIGH DEDUCTIBLE HMO

The Health Reform Act directs the Commissioner of Insurance to approve high deductible HMO plans that include a deductible up to the maximum annual IRS-established health savings account contribution, which will be $2,850 for individual coverage and $5,650 for family coverage in CY 2007. As one of its Minimum Creditable Coverage plans, carriers are encouraged to offer a high deductible health plan, as defined by the IRS, with the option -- at the subscriber's option -- of self-funding an HSA.

SECTION V – PREFERRED PLAN DESIGN FEATURES (CONTINUED)

F. WELLNESS INCENTIVES AND MEDICAL MANAGEMENT PROGRAMS

The Connector is interested in offering health benefit plans that promote primary care, wellness incentives and medical management programs. Carriers are encouraged to include plan design features that reward members for completing health risk assessments, participating in disease and case management programs, when appropriate, and actually changing their eating, exercise, smoking and/or other life-style habits.

G. PREVENTIVE AND FLEX BENEFITS FOR CHRONIC CONDITIONS

For enrollees with chronic conditions, carriers should consider, for example, offering programs that provide for reduced office visit co-payments or co-insurance or lower prescription drug co-payments. Other types of flexible benefits might allow additional pre-deductible office visits subject to a co-payment for members with chronic conditions that are enrolled in a health benefit plan that has an annual deductible.

SECTION VI – CRITERIA FOR HEALTH PLAN SELECTION

The criteria below will be used to evaluate each carrier's product offerings.

A. Evidence of the Attractiveness/Marketability of the Plan Design

B. Proposed Premiums

C. Financial Access (i.e., Cost-Sharing)

D. Provider Access and Proposed Network

E. Breadth of Geographic Coverage

F. Quality of Care, Including Metrics for Selecting and Encouraging Members to Utilize High-Quality, Cost-Effective Providers, and Designating Centers of Excellence for Complex Procedures

G. Success in Meeting Preferred Plan Design Features

H. Availability of Decision-Support Tools to Help Members Access Care, Monitor Health Status, and Reward Members for Adopting and Maintaining a Healthy Lifestyle

I. Effectiveness of Cost-Management Tools, Including Use of Health Risk Assessments (HRAs) and Predictive Modeling

J. Financial Strength of the Carrier

K. Commitment of the Carrier to Serving the Small and Non-Group Markets in Massachusetts

L. Commitment to Market the Plans through the Connector

The Connector, in its evaluation of a carrier's product offerings, will take into consideration each of these criteria in terms of the carrier's full slate of health benefit plans offered to the Connector in determining which plan designs and which carriers will receive the Connector's Seal of Approval.

SECTION VII – REQUIRED ELEMENTS OF THE PROPOSAL

A. TRANSMITTAL LETTER

The Transmittal Letter should contain a summary or executive overview of the carrier's proposal and should be signed by an individual authorized to bind the firm contractually. The letter must also provide the name, title, address, and telephone and fax numbers of the respondent's corporate contact for the proposed plan. The Connector will assume this individual will be available to respond to requests for additional information if necessary.

B. SUMMARY INFORMATION FOR EACH PLAN DESIGN

For each health benefit plan offered, the carrier must prepare summary information that describes the coverage in layman's terms and specifies co-payments, co-insurance, deductibles and any limitations related to coverage. The summary information must include, but should not be limited to, the following categories:

- Service area
- Primary Care Physician (PCP) requirements and referrals
- Urgent care and emergency room services
- Out-of-pocket maximum
- Covered services and applicable cost-sharing requirements, including:
  - Outpatient care/office visits
  - Emergency room visits
  - Diagnostic testing
  - Durable medical equipment
  - Ambulatory surgery
  - Inpatient care
    - Acute
    - Skilled nursing and rehabilitative care
  - Mental health and substance abuse
    - Biologically based conditions
      - Outpatient care/office visits
      - Inpatient care
    - Non-biologically based conditions
      - Outpatient care/office visits
      - Inpatient care
  - Prescription drug benefit

For each plan design, carriers should complete the applicable plan design worksheet (Response Forms B-E).

SECTION VII – REQUIRED ELEMENTS OF THE PROPOSAL (CONTINUED)

C. PROVIDER DIRECTORY FOR EACH HEALTH BENEFIT PLAN

For each health benefit plan offered, carriers should submit in electronic format a listing of in-network providers by practice specialty and location/zip code. A separate file should be included that lists the name and location/zip code of in-network hospitals.

D. FULL RATING FORMULA FOR EACH PLAN DESIGN

Carriers will need to make arrangements to provide to the Connector's consultant a complete rating table for each product offered so that plan premiums can be calculated and compared across plans.

In addition, the Connector's third party administrator (i.e., Sub-Connector) -- an entity that has not yet been chosen -- will need a complete rating table for each product offered by the Connector. This rating table will need to be capable of generating quotes on a regular basis. Carriers' products offered through the Connector will be required to provide a rating table to the Sub-Connector, and carriers will be required to provide updates to the rating table throughout the contract period.

E. PREMIUMS

For each product offered, carriers must list the monthly premium, assuming non-group purchase and no rating adjustment based on industry/SIC code, for each of the demographic categories, geographic regions and coverage categories listed in the table on the following page. Premiums should reflect an April 1, 2007 effective date of coverage.

SECTION VII – REQUIRED ELEMENTS OF THE PROPOSAL (CONTINUED)

DEMOGRAPHIC CATEGORIES, GEOGRAPHIC REGIONS AND COVERAGE CATEGORIES	BOSTON	WORCESTER	SPRINGFIELD
Single male, age:			
28 years old			
35 years old			
47 years old			
56 years old			
Single female, age			
28 years old			
35 years old			
47 years old			
56 years old			
Two adults			
28 yr old w/30 yr old spouse			
35 yr old w/38 yr old spouse			
47 yr old w/47 yr old spouse			
56 yr old w/63 yr old spouse			
Single male w/one child			
28 years old			
35 years old			
47 years old			
56 years old			
Single female w/one child			
28 years old			
35 years old			
47 years old			
56 years old			
Married couple w/two children			
28 yr old w/30 yr old spouse			
35 yr old w/38 yr old spouse			
47 yr old w/47 yr old spouse			
56 yr old w/63 yr old spouse			

SECTION VII – REQUIRED ELEMENTS OF THE PROPOSAL (CONTINUED)

Carriers must also provide the rating factor used for each geographic region in the Commonwealth using the rate table below.

ZIP CODES	RATING FACTOR
010 through 013	
014 through 016	
017 through 020	
018 through 019	
021 through 022 and 024	
023 and 027	
026 through 026	

F. ACTUARIAL OPINION

Every carrier must file with the Connector a copy of an actuarial opinion that the carrier's rating methodologies and rates comply with the requirements of M.G.L. c. 176J and 211 CMR 66.00, as required by the Division of Insurance. The actuarial opinion must also state that the carrier's rates are consistent with the level of benefits and premiums proposed for the Connector (e.g., Value level plans must have a relative value between 72.5% and 87.5% of the Premier plan).

The actuarial certification must be signed by a member of the American Academy of Actuaries based upon the person's examination, including a review of the appropriate records, of the actuarial assumptions and methods used by the carrier in establishing premium rates for health benefit plans offered by the carrier to be sold through the Connector.

Every carrier must maintain at its principal place of business a complete and detailed description of its rating practices including information and documentation which demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions, are in accordance with sound actuarial principles, and comply with the provisions of 211 CMR 66.00. This information must be made available to the Connector upon request, but will remain confidential.

For products offered through the Connector, every carrier shall notify the Connector regarding any material changes or additions to the actuarial methodology at least 30 days prior to the effective date of the change or addition and provide the same information, including any changes to the rating table, to the Connector's third party administrator (i.e., Sub-Connector).

SECTION VII – REQUIRED ELEMENTS OF THE PROPOSAL (CONTINUED)

G. DISCUSSION OF PREFERRED PLAN DESIGN FEATURES

For each of the preferred plan design features listed in Section V of this RFR, carriers should briefly describe how the proposed health benefit plan incorporates each of the preferred plan design features. For proposed health benefit plans that do not include a particular feature, carriers should briefly discuss the reasons for omitting that design feature. Carriers must complete Response Form G.

H. PRODUCT LICENSURE BY THE DIVISION OF INSURANCE

For each product offering, carriers must either confirm that the product is licensed for sale in the Commonwealth or discuss the status of the product filing and any feedback that the carrier has received from the Division of Insurance regarding the proposed, but not yet licensed, plan design.

I. SALES AND MARKETING PLAN

For the products proposed for the Connector, carriers should briefly describe their sales and market plan.

J. MASSACHUSETTS SMALL AND NON-GROUP ENROLLMENT

On Response Form F of this RFR, carriers must complete the small and non-group membership information for each product offered and purchased in Massachusetts, as of 12/31/05 and for the most recent month for which membership information is available (e.g., November 30, 2006).

SECTION VIII – TIMELINE AND PROCESS FOR SUBMISSION AND SELECTION

Proposals must be submitted to:

Mr. Bob Carey
Director of Planning and Development
Commonwealth Health Insurance Connector Authority
One Ashburton Place
Room 805
Boston, Massachusetts 02108

Mr. Carey can be contacted at:

617-573-1719
Robert.Carey@massmail.state.ma.us

Two (2) unbound, unpunched originals, so identified, plus six (6) bound copies, must be received at the Connector offices by 4:00 p.m. on Tuesday, January 16, 2007.

The proposal must include the following elements:

1) Transmittal Letter
2) Summary information for each proposed plan design
3) Plan design worksheet for each proposed plan design
4) Pricing worksheet for each proposed plan design
5) Provider directory in electronic format for each proposed plan design
6) Actuarial opinion for each proposed plan design
7) Preferred plan design features response form for each proposed plan design
8) Product licensure confirmation/explanation
9) Sales and marketing plan
10) Small and non-group membership details by product

A bidders conference will be held on Tuesday, December 12 starting at 9:30 AM at the McCormack State Office Building in Boston, One Ashburton Place, 21st Floor. Interested vendors are invited to attend, and Connector staff will be available to respond to questions regarding this RFR. In addition, vendors may also submit written questions to Bob Carey via email at robert.carey@massmail.state.ma.us or via the mailing address listed above. Questions will be accepted through Friday, December 15th at 5:00 PM. All questions and answers will be posted on the Connector web site no later than Wednesday, December 20th.

SECTION VIII – TIMELINE AND PROCESS FOR SUBMISSION AND SELECTION (CONTINUED)

SCHEDULE (SUBJECT TO REVISION)

DATE	ACTIVITY
December 5, 2006	RFR Issued
December 12, 2006	Q&A Session With Interested Vendors
January 16, 2007	Proposals Due to the Connector
TBD	Connector Review of Proposals Connector Meetings with Insurers
March 8, 2007	Health Benefit Plans' Recommendations Presented to Connector Board for Review And Approval
May 1, 2007	Open Enrollment Begins
July 1, 2007	***Connector Plans' Effective Date of Coverage***

SECTION IX – RESPONSE FORMS

RESPONSE FORM A – PROGRAM REQUIREMENTS

A. RULES OF PLAN PARTICIPATION

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

RULES OF PLAN PARTICIPATION	CONFIRMATION OR EXPLANATION
1. Pursuant to c. 58, please confirm that you will submit the following criteria for the Connector's consideration: A carrier that, as of the close of calendar year 2005, had a combined total of 5,000 or more eligible employees and eligible dependents who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses pursuant to its license under c. 175, c. 176A, c. 176B or c. 176G;	
A carrier that as of the close of calendar year 2006, had a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its license under c. 175, c. 176A, c. 176B or c. 176G;	
However, neither an eligible individual or eligible employee, nor an eligible dependent, shall be considered to be enrolled in a health benefit plan issued pursuant to its authority under c. 175, c. 176A or c. 176B if the health benefit plan is sold, issued, delivered, made effective or renewed to said eligible employee or eligible dependent as a supplement to a health benefit plan subject to licensure under c. 176G.	
2. Confirm that your company will submit for consideration the requisite number of health benefit plans under each of the three main plan levels (Premier, Value and Minimum Creditable Coverage).	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

A. RULES OF PLAN PARTICIPATION

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

RULES OF PLAN PARTICIPATION	CONFIRMATION OR EXPLANATION
3. For the Young Adults Plan, please confirm that your company will meet the following criteria, pursuant to c. 58, as amended for the Connector's consideration:	
A carrier that, as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its license under c. 175, c. 176A, c. 176B or c. 176G.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

B. DOI REVIEW AND APPROVAL OF NEW PRODUCTS AND RATE FILINGS

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

DOI REVIEW AND APPROVAL OF NEW PRODUCTS AND RATE FILINGS	CONFIRMATION OR EXPLANATION
1. Confirm that you will cover all mandated benefits (i.e., a health service or category of health service provider) required by the carrier's licensing or other statute to include in its health benefit plan.	

C. RATING METHODOLOGY

RATING METHODOLOGY	CONFIRMATION OR EXPLANATION
1. Confirm that you will utilize the same rating methodology for products distributed through the Connector to individuals that you use for products offered to individuals outside the Connector.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

D. UNDERWRITING/ELIGIBILITY/FUNDING

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

UNDERWRITING/ELIGIBILITY/FUNDING	CONFIRMATION OR EXPLANATION
1. Confirm that only individuals and small employers (those with 50 or fewer employees) may purchase group benefits through the Connector.	
2. Confirm that employers that offer their eligible employees health benefit plans purchased through the Connector will not be allowed to offer to their benefits-eligible employees an alternative health benefit plan sponsored by the employer that may be purchased outside the Connector.	
3. Confirm that for those employees not eligible to participate in employer-sponsored health benefit plans, employers may establish as part of their Section 125 program a means to facilitate payroll deductions for non-group premium payments through the Connector. This provision will apply without regard to whether the employer's benefits-eligible employees are purchasing health benefit plans through the Connector, and without regard to the number of employees in the group.	
4. Confirm that employers that agree to pay at least 50 percent of the monthly premium for a "benchmark" plan at a given benefit level (i.e., Premier, Value or Minimum Creditable Coverage), shall restrict the choice of their employees to product offerings in the selected plan level.	
5. Confirm that employers contribute less than 50 percent of the monthly premium for a "benchmark" plan will not qualify as group insurance and therefore will note be able to restrict the choices of their employees, should any of them purchase non-group coverage through the Connector.	
6. Confirm that individual purchasers will be allowed to select from any of the plan choices offered through the Connector.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

D. UNDERWRITING/ELIGIBILITY/FUNDING (CONTINUED)

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

UNDERWRITING/ELIGIBILITY/FUNDING	CONFIRMATION OR EXPLANATION
7. Confirm that no health benefit plan shall be offered through the Connector that excludes an individual from coverage because of race, color, religion, national origin, sex, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income, or age.	
8. Confirm that only health benefit plans that have been authorized by the Commissioner of Insurance and underwritten by a carrier may be offered through the Connector.	
9. Confirm your understanding that the Connector will retain a percentage of each carrier's health insurance premium for each of the products offered for sale through the Connector, in an amount to be determined, to cover the Connector's cost of marketing, enrollment and other administrative tasks performed on behalf of the health plans.	
10. Pursuant to c. 176J, confirm that you will enroll any person who meets the requirements of an "eligible individual" into a health plan offered by the Connector if such person requests coverage within 63 days of termination of any prior creditable coverage. However, individuals that purchase insurance through the Connector and subsequently drop coverage prior to the end of the plan year shall not be allowed to enroll in a different health plan offered through the Connector until the completion of the plan year in which the individual was previously enrolled.	
11. Confirm that you will abide by eligibility, preexisting condition provisions, and waiting period provisions pursuant to c. 176J.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

E. YOUNG ADULTS PLAN

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

YOUNG ADULTS PLAN	CONFIRMATION OR EXPLANATION
1. Confirm that the Young Adults Plan may only be offered for sale through the Connector, and may only be purchased by individuals age 19 to 26, inclusive, who shall remain eligible for coverage under this plan through the last day of the month in which the individual turns 27.	
2. Confirm that the Young Adults Plan will be available only as individual coverage. No other coverage basis will be allowed for this plan type.	
3. Confirm that the Young Adults Plan will only be sold on an individual, non-group basis and will not be offered for sale as part of employer-sponsored insurance.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

F. MARKETING

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

MARKETING	CONFIRMATION OR EXPLANATION
1. Confirm that you will actively market products available through the Connector and participate in joint marketing efforts with the Connector, including co-branding and establishing direct links between the Connector's web site and the carriers' web site and customer service representatives. Carriers shall propose how they plan to market the Connector as a distribution channel for the plans they propose to sell through the Connector.	
2. Confirm that, if selected, you will have marketing and enrollment materials available in advance of the May 1, 2007 open enrollment date, and that mock-ups of these materials will be submitted for review by the Connector on a file and use basis by April 1.	
3. Confirm that all use of the Connector's marks shall be subject to the review and approval by the Connector staff.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

G. CUSTOMER SERVICE

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

CUSTOMER SERVICE	CONFIRMATION OR EXPLANATION
1. Please confirm your understanding that the Connector will contract with a third-party entity, also referred to as a Sub-Connector, to handle enrollment, premium billing and collection, monthly reconciliation, and other such sales and administrative functions, and to provide individuals, employers and brokers with information about the health benefit plans available through the Connector.	
2. Please confirm that you will have available customer service representatives during normal business hours to assist members and respond to inquiries from potential enrollees, and to coordinate customer service between their own representatives and the Sub-Connector's representatives.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

H. DISTRIBUTION REQUIREMENTS AND ROLE OF SUB-CONNECTOR(S)

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

DISTRIBUTION REQUIREMENTS AND ROLE OF SUB-CONNECTOR(S)	CONFIRMATION OR EXPLANATION
1. Please confirm your understanding that the Connector will subcontract with an entity or entities responsible for a range of administrative services, many of which are typically handled by health insurance carriers. These services will include: ▪ Pre- and post-enrollment customer service ▪ Eligibility and enrollment ▪ Premium quoting ▪ Monthly premium billing, collection and remittance to carriers, including bundling payments to the carriers from multiple employers and individuals ▪ Section 125 program administration/coordination with employers ▪ Notifications to individuals and employers regarding eligibility and enrollment status, late payment and non-payment of premium, and cancellation of coverage ▪ Payments to brokers/agents	
2. Confirm that if you are selected to participate in the Connector that you will enter into a relationship with the vendor selected to handle administrative functions on behalf of the Connector.	
3. Please confirm that you will accept eligibility data in HIPAA 834 format.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

I. REPORTING REQUIREMENTS

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

REPORTING REQUIREMENTS	CONFIRMATION OR EXPLANATION
1. Please confirm that if you are selected as a carrier with products offered through the Connector, you shall submit enrollment reports, in a mutually agreeable format, for each product purchased through the Connector.	
2. Please confirm that you may be required to submit summary premium and claims data on a regular basis to a data management and analysis firm designated by the Connector.	

J. ENROLLMENT PERIOD

ENROLLMENT PERIOD	CONFIRMATION OR EXPLANATION
1. Please confirm that you will work with the Connector to establish an "anniversary date," on which all Connector health insurance products will renew.	
2. Please confirm that you will accept non-group enrollees who have newly qualified for non-group coverage because of moving into the state, turning 19, losing dependent coverage, aging out of a Young Adults Plan, losing group health insurance, or other such reasons established by the Connector, throughout the year.	

MEMORANDUM

To: Commonwealth Health Insurance Connector Authority

From: Jon Kingsdale, Executive Director
Bob Carey, Director of Planning and Development

Re: Staff Recommendation for Health Insurance Carriers for Commonwealth Choice

Date: March 3, 2007

Executive Summary

Ten health insurance carriers submitted proposals in response to the Connector Authority's December 2006 Request for Responses (RFR). Based on review and scoring of these ten sets of health benefit plans by staff, outside actuaries and benefits consultants, staff recommends that the Board approve the selection of seven health insurance companies to participate in the first year of the Commonwealth Choice program. As the scoring summary on the following page indicates, these seven carriers achieved scores that clearly distinguish them from the other three applicants.

Market research conducted on behalf of the Connector found that consumers want a choice of health plans at three different benefit levels: (1) comprehensive, first-dollar coverage, (2) middle "value" level of coverage, and (3) basic insurance protection. The health insurance companies were asked to propose benefit designs at each of these three levels of coverage. At each coverage level, consumers stated a desire to choose among four-to-five different health insurance plans. The seven carriers listed below will provide consumers throughout the Commonwealth with exactly this desired level of choice, since two will be available statewide and five will offer products in select geographic regions.

The recommended health insurers are:

- Blue Cross Blue Shield of Massachusetts (statewide plans)
- ConnectiCare
- Fallon Community Health Plan
- Harvard Pilgrim Health Care (statewide plans)
- Health New England
- Neighborhood Health Plan
- Tufts Health Plan

Taking into account the service area differences among the carriers, the majority of Commonwealth residents will have access to health benefit plans offered by four-to-five insurance companies. (Virtually everyone will have a choice of at least three insurance carriers.) The products offered will include select provider networks and all-inclusive networks; varying levels of co-payments and co-insurance; plans with deductibles and those without; economically priced products and more expensive plans.

The average uninsured resident of Massachusetts is 37 years old. He or she will be able to select among a range of basic health plans that best meets his or her needs for a monthly premium from $137 to $288. Among plans available at this level, residents may choose an annual deductible ranging from $1,000 to $2,000, or select a plan with first-dollar coverage (no annual deductible). Across all plans in every benefit level, individuals will have access to preventive care services prior to any deductible, and many plans will cover all office visits -- including mental health office visits -- prior to any deductible.

Individuals between the ages of 19 – 26 without access to employer-sponsored insurance will be able to select from "Young Adults Plans" with a monthly premium from $105 to $205. These health benefit plans, which will be sold solely through the Connector, will provide a number of affordable options for uninsured young adults, providing individuals the choice of annual deductibles ranging from $1,000 to $2,000 or no annual deductible and first-dollar coverage.

The procurement team evaluated six health benefit plans per carrier -- one premier plan, three value plans, and two basic plans. The procurement team awarded a maximum of 115 points for each health plan, which results in a total maximum score for each carrier of 690 points. The table on the following page lists the scores for all ten carriers. The pages that follow provide additional details regarding the scoring categories and criteria used by the Connector staff to evaluate each carrier's proposal.

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Carrier	Final Score
Total Points Available	**690**
Neighborhood Health Plan	635
Tufts Health Plan	614
Health New England	602
Fallon Community Health Plan	596
Blue Cross Blue Shield of Massachusetts	583
ConnectiCare	549
Harvard Pilgrim Health Care	543
Average Score of Top Seven Carriers	588
United HealthCare	464
The MEGA Life and Health Insurance Company	447
Mid-West National Life Insurance Company	447
Average Score of Bottom Three Carriers	452

Background

The Commonwealth Health Insurance Connector Authority issued a Request for Reponses (RFR) on December 6, 2006 to solicit proposals for fully insured health insurance products from commercial insurers licensed to do business in the Commonwealth. The Connector requested carrier proposals for four distinct types of health insurance products: (1) premier plans, with limited out-of-pocket cost sharing by enrollees; (2) value plans, with lower monthly premiums and higher out-of-pocket costs at the point of service; (3) basic plans, representing the lowest monthly premiums and highest level of member cost-sharing, which were initially established as the minimum amount of coverage needed to satisfy the individual mandate; and (4) a Young Adults Plan, which was designed as a more limited benefit to be offered solely through the Connector to individual, non-group purchasers ages 19 to 26 who did not have access to employer-sponsored insurance.

The Connector will offer products that best meet the criteria set forth in the RFR and that the Board of the Connector determines to be most appropriate for inclusion in a package of health benefit plans to be sold by the Connector. Plans selected by the Board will be designated with the Connector's Seal of Approval. With the exception of the Young Adults Plans, the selected products will be made available to individuals and small groups that meet the eligibility rules set forth in c. 58, c. 176J, as further defined by the Connector.

The RFR was posted on the Connector's web site (www.mass.gov/connector) and the state's procurement web site (www.comm-pass.com) on December 6, 2006, with proposals due on January 16, 2007. A bidders conference was held on December 12, 2006 to allow interested vendors the opportunity to ask questions of Connector staff regarding the RFR. All questions and answers were documented and posted on both web sites on December 20, 2006.

Ten carriers submitted proposals and all met the threshold criteria established by the Connector (e.g., forms completed, transmittal letter signed, appropriate number of products offered at each benefit level). In addition to the information submitted to the Connector, carriers also submitted rate tables and/or rating discs to the Connector's actuarial consultant, Charles DeWeese, who was assisted by Bela Gorman and Tony van Werkhooven, each of whom are actuaries with extensive experience in the Massachusetts health insurance market. The Connector also utilized the services of Boston Benefit Partners, LLC as a consultant for this procurement.

After reviewing the proposals, staff briefed the Board's Policy Committee and the full Board on plan designs and the average premium levels of the basic products submitted by the carriers. The Board then directed staff to request that carriers review the basic plan designs and the proposed premiums, and that carriers resubmit two basic plan designs, one that included prescription drug coverage and one that did not cover prescription drugs, pending a decision by the Board later this spring with regard to standards for

minimum creditable coverage. These resubmissions, along with revised premiums for the premier and value level plans, were submitted by the carriers to the Connector on February 16, 2007. Based on these final plan designs and premiums, Connector staff evaluated the proposals using the scoring categories and criteria discussed below.

Scoring Categories and Criteria

The following scoring categories and criteria were used by Connector staff to evaluate each carrier's submission:

Category	Points
Cost Proposal	
Individual Premium and Estimated Cost Sharing	30
Composite Premium	10
Subtotal – Cost Proposal	**40 points**
Technical Proposal	
Plan Designs and Preferred Features	30
Marketing Plan and Marketability	20
Network Access and Geographic Coverage	15
Key Program Elements	10
Subtotal – Technical Proposal	**75 points**
Total Available Points per Plan Design	**115 points**[1]
Total Available Points per Carrier (6 plan designs)	**690 points**[2]

[1] The scoring methodology also included a "Best Value" category that was designed to provide the procurement team with the flexibility to reward carriers, for example, who submitted particularly innovative plan designs or unique marketing proposals, or to reward carriers whose portfolio of plan designs were consistently strong. While several carriers did include innovative plan designs, unique marketing proposals and consistently strong portfolio of plans, the procurement team agreed that the other sections of the scoring criteria adequately captured these parts of the carriers' submissions, and therefore there was no need to award any "Best Value" points.

[2] The scoring methodology evaluated the following six plan designs: one premier plan, three value plans, and two basic plans, one with drug coverage and one without drug coverage. The Young Adults Plans were evaluated but not scored in this process.

Cost Proposal – Scoring Overview

The evaluation of cost included both premiums and member cost-sharing for each product offered. Within each benefit level (i.e., premier, value and basic), each carrier's products were compared to all other carriers' products in that benefit level, and points were awarded based on the relative cost of each product. For example, carrier X's premier level proposal was compared to all premier level proposals; carrier X's value level proposal was compared to all value level proposals; and carrier X's basic proposal was compared to all basic proposals.

Individual Premium and Estimated Cost Sharing (30 Points)

An evaluation of the individual premiums and estimated member cost sharing comprised the majority of the points (30 out of 40) available in the Cost Proposal section. These points were calculated separately for each benefit level (i.e., premier, value and basic). For each product offered, each carrier's monthly premium for a 37-year-old individual was annualized and added to an estimate of average member cost sharing for a market basket of services. The 37-year-old individual premium was chosen because it best represents the age of the average uninsured person in the Commonwealth. In addition, staff calculated a weighted premium to account for the concentration of the state's population in eastern Massachusetts.

A "market basket" of services (e.g., office visits, inpatient admissions, outpatient surgery, emergency room visits, and prescription drugs) and the frequency with which a member may use those services was developed utilizing summary claims data from the Massachusetts small group market, which is routinely provided to the Commonwealth's Division of Insurance. These data were useful in providing staff with an estimate of the utilization of services for an average insured individual in today's small group market.

However, since the data do not include all of the medical services that may involve member cost sharing, the procurement team worked with its consultants to augment the small group data in order to estimate average annual out-of-pocket expenses. For each benefit level and plan, an estimate of average annual out-of-pocket expenses was developed and added to the annual individual premium for a 37-year-old to generate a total expected average cost for each health benefit plan.

It is important to note that actual out-of-pocket expenses will vary, based on the health of the individual and the types of services used. These estimates are designed only for the purposes of comparing health benefit plans with different types of cost sharing (e.g., deductibles, co-payments, co-insurance). The estimate is not intended to project costs for the Connector's target market.

Using a relative value formula to award points within each benefit level, the health plan with the lowest total expected cost (i.e., individual premium plus estimated average out-

of-pocket expenses) was awarded 30 points, and all other health benefit plans in the benefit level were awarded points based on their total expected cost vis-à-vis the lowest cost product.

Using products offered in the value level as an example, the formula below illustrates the manner by which points were assigned for this portion of the cost evaluation.

> Fallon monthly weighted individual premium for 37-year-old = $222.00
> + Fallon estimated average monthly out-of-pocket expenses = $45.00
> = Fallon total expected cost = $267.00
> Fallon awarded 30 points
>
> Neighborhood monthly weighted individual premium for 37-year-old = $225.00
> + Neighborhood estimated average monthly out-of-pocket expenses = $52.00
> = Neighborhood total expected cost = $277.00
> Neighborhood's total expected cost as a percentage of Fallon's = 104%
> 30 points divided by 104% = 28.8 points

Composite Premium (10 Points)

A composite premium -- based on the monthly premiums for various demographic categories (e.g., single age 37, two adults ages 56 and 63, parents both age 47 with two children, etc.) across three geographic regions (i.e., eastern, central and western) -- was also calculated for each health benefit plan. The weighting of the composite premium was based on the demographic and geographic distribution of the combined Massachusetts small group and non-group markets. This composite represents of rate basis types, taking into account individual, individual plus one, and family premiums.

After the composite premiums for all products were developed, points were awarded based on the relative cost of a health benefit plan's composite premium compared to the lowest cost health plan's composite premium within each benefit level.

For example, the health benefit plan in the value level with the lowest composite premium was awarded ten points, while all other health plans in the value level were awarded points based on their cost in relation to the lowest cost product. This same calculation was performed separately for the premier and basic level plans.

Using the value level as an example, the formula below illustrates the manner by which points were assigned for this portion of the cost evaluation.

Fallon Direct Care Premium Saver Basic II composite premium = $530.77
Fallon Direct Care Premium Saver Basic II awarded 10 points

Neighborhood's value B Plan composite premium = $540.03
NHP's value B premium as a percentage of Fallon's premium = 102%
10 points divided by 102% = 9.8 points

Technical Proposal – Scoring Overview

Plan Design and Preferred Features

This section included an evaluation of each carrier's product offerings and overall plan designs, as well as an analysis of seven specific plan design features of interest to the Connector. A carrier could receive up to thirty points per plan design in this category. The seven preferred features include:

- Select, high-performance network
- Centers of excellence for complex conditions or procedures
- Innovative pharmacy management
- Consumer engagement
- HSA option with high-deductible health plan[3]
- Wellness incentives and medical management
- Preventive and flex benefits for chronic conditions

In response to the Connector's request for products that utilize a select, high-performance network, a number of carriers offered health benefit plans that utilize a select provider network. In addition to Fallon Community Health Plan -- which has offered a select network for several years -- Neighborhood Health Plan, Tufts Health Plan, and Health New England also proposed select networks that will allow individuals to purchase plans with lower monthly premiums without facing higher point-of-service cost-sharing.

For example, in the value level, the procurement team recommends that the Connector offer Fallon's Direct Care and Select Care plans, which have identical benefit designs but use different networks. Because the Direct Care plan has a more limited provider network, residents of central Massachusetts can save 13 percent on their monthly premiums without any increase in member cost-sharing.

[3] Given the uncertainty over whether the Connector would offer HSA-compatible plans, staff did not award points to carriers that offered an HSA option with a high-deductible health plan.

In the area of consumer engagement, carriers were awarded additional points for initiatives that encourage members to become more actively involved in their medical care, including making available cost and quality information about the variability in provider performance and costs. One carrier noted the promotion of web-based tools that include a "Cost of Care Estimator" that helps members understand the cost of different treatment options, as well as a link to the Massachusetts Health Quality Partners' (MHQP) web site for information on measures of quality of care by provider groups. Another carrier referenced particular features on its web site which help members choose "quality" hospitals, doctors and specialists.

In addition to the procurement team's review of the plan designs, Connector staff provided staff at the Division of Insurance with copies of all of the carriers' product offerings for the Division's review. Division of Insurance staff have also met individually with those carriers that have proposed new plan designs, which have not yet been licensed by the Division. While the initial review of these new product offerings did not reveal any major issues that could lead to the Division disallowing the sale of the new products in the Massachusetts market, the Connector will not offer for sale any plan design that has not been licensed for sale in the Commonwealth by the Division of Insurance.

Marketing Plan and Marketability

This category included an evaluation of each carrier's proposed marketing plan for its Commonwealth Choice products, as well as the overall marketability of the products being offered to the Connector. Staff looked for marketing plans that demonstrated an understanding of the role of the Connector, articulated a well-developed strategy to reach the target market, and displayed commitment from the carrier to devote resources to promote Commonwealth Choice and the carrier's health benefit plans.

Some carriers' responses clearly stood out from others. One carrier described a multi-lingual community outreach and media campaign, emphasizing the importance of having insurance and general health awareness, as well as the carrier's commitment to working with its community partners and health centers. This carrier also discussed outreach efforts to target markets -- including a special focus on uninsured individuals between the ages of 18 – 34 -- using a combination of traditional and nontraditional media and community outreach to generate awareness at the grassroots. Several carriers explicitly stated in their proposals that adding new plan participants via the Connector represented an important corporate growth strategy.

With regard to the marketability analysis, staff evaluated the products being proposed by the carrier in terms of whether the plan designs offered were being purchased in today's health insurance market or, for new plan designs offered by the carrier, whether the design features (e.g., co-payments, co-insurance, deductibles) seemed reasonable given the premiums and the target market. In general, staff concluded that most of the proposed plans appeared to have marketplace appeal. Some plans, however, were so expensive that they seemed unlikely to attract consumer interest.

Network Access and Geographic Coverage

This section reviewed each carrier's provider network(s) utilizing network criteria of one hospital per county and at least two PCPs with open panels within a 15-mile radius or 30 minutes of travel time within each zip code in the service area. In addition, carriers offering a comprehensive network that served every Massachusetts county were awarded additional points.

The Geo-Access analysis included an evaluation of the carrier's service area, with points awarded based on the percentage of zip codes in the service area that the carrier indicated had access to at least two PCPs with open panel within a 15-mile radius or 30 minutes of travel time.

Plans scoring highest in this category had large, broad networks, extending to all geographic regions of the Commonwealth. Some plans with smaller, more tightly managed networks, did not receive as many scoring points in this category. In general, the Connector staff was pleased that virtually all Commonwealth residents would have excellent access to a wide range of carriers and plan designs.

Key Program Elements

This section asked carriers to confirm or otherwise explain their ability to address a series of program elements in the following areas:

- Rules of Plan Participation
- DOI Review and Approval of New Products and Rate Filings
- Rating Methodology
- Underwriting/Eligibility/Funding
- Young Adults Plan
- Marketing
- Customer Service
- Distribution Requirements and Coordination with the Sub-Connector
- Reporting Requirements
- Effective Date of May 1st

A carrier received credit for each key program element that was confirmed or, if not confirmed, that was adequately explained. Carriers that were unable to confirm a key program element, or carriers that equivocated in their response, received lower scores. In general, carriers confirmed the entire list of key program elements included in the RFR. Given the Connector's tight timetable for implementation, carrier ability to adequately address these key program elements is very important for the success of Commonwealth Choice.

Where a carrier's response hurt its score, the response usually included the carrier making an equivocal statement or caveat. For example, carriers were asked to confirm that "if selected to participate in the Connector that [they] will enter into a relationship with the vendor [i.e., Sub-Connector] selected to handle administrative functions on behalf of the Connector." While most carriers confirmed that they would enter into a relationship with the Sub-Connector, one carrier noted that it "will use its best efforts to enter into a relationship with the vendor selected…subject to terms of the sub-connector relationship being reasonably acceptable to [the carrier]." In this instance the carrier was not awarded a point.

In another area of the "*Key Program Elements*" section, carriers were asked to confirm that they would offer a Young Adults Plan. While carriers were not required to offer a Young Adults Plan, the Connector's preference is to offer Young Adults Plans from as many carriers as possible. The two carriers that did not submit a product designed specifically for young adults did not receive points for the three questions pertaining to the Young Adults Plan in this section of the RFR.

The benefit structure of the Young Adults Plans is comparable to each carrier's basic level plan, with the exception that some carriers' Young Adults Plan, like the Commonwealth's qualified student health insurance program (QSHIP), cap coverage at no less than $50,000 per episode or per year.

Carriers' Scores

The table on the following page summarizes the final scores for all ten carriers that submitted proposals to the Connector.

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FORM AGREEMENT

BETWEEN

THE COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY (CONNECTOR)

AND

_____ (CARRIER)

Dated as of May 1, 2007

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This Agreement (Agreement) is entered into this 1st day of May, 2007 (Effective Date) by and between the Commonwealth Health Insurance Connector Authority (the Connector), with offices at 100 City Hall Plaza, Boston, MA 02108, and _____ (Carrier), a corporation with principal offices at _____.

WHEREAS, the Connector is the state authority responsible for the administration of the Commonwealth Health Insurance Connector Authority, as set forth in Chapter 58 of the Acts of 2006 (the Health Care Reform Act), one purpose of which is to facilitate the development and offering of a choice of affordable commercial health insurance products (without public subsidy) to eligible individuals (including certain employees participating in so-called Section 125 payroll deduction programs) and eligible small groups through the Connector, as described in M.G.L. c. 176Q, called the Commonwealth Choice Program;

WHEREAS, the Connector will begin offering coverage under the Commonwealth Choice Program to eligible individuals and eligible small groups beginning May 1, 2007, with an effective date of coverage beginning July 1, 2007;

WHEREAS, the Connector has entered into an agreement with an intermediary organization (the Sub-Connector), to provide a broad range of third party administrative services to assist the Connector with the implementation and operation of the Commonwealth Choice Program;

WHEREAS, on December 6, 2006 the Connector issued a Request for Responses for licensed carriers to file commercial health insurance products with the Connector which could attain the Connector's seal of approval to be offered through the Connector (Seal of Approval), and Connector subsequently issued amendments to the Request for Responses (such Request for Responses, as amended, to be known as the "RFR"); Carrier submitted responses to the RFR (RFR Responses) dated _____ ; and the RFR and RFR Responses are hereby incorporated into this Agreement by this reference; and

WHEREAS, based on Carrier's RFR Responses, the Connector has given its Seal of Approval to certain of Carrier's products, further described herein, to be offered through the Connector, and Carrier desires to make such products available through the Connector in accordance with the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the mutual covenants and agreements set forth in this Agreement, Carrier and the Connector agree as follows:

ARTICLE I. DEFINITIONS

Terms, when capitalized in this Agreement, are defined as provided below:

Administrative Fee. An administrative fee, expressed as a percent of premium, charged to Carrier and collected by the Sub-Connector to compensate for certain administrative services and broker commissions.

Affiliate. An organization that owns and/or controls, is owned and/or controlled by or on behalf of, or is under common ownership and/or control with Carrier. As used in this definition, "control" means the possession of or entitlement to, the legal power to direct or approve, or cause the direction or approval of the management and/or policies of an organization, through voting rights, contract rights, voting securities or otherwise.

Change in Control. A consolidation or merger of Carrier with or into any entity; a sale, transfer or other disposition of all or substantially all of the assets of Carrier; or an acquisition by any entity, or group of entities acting in concert, of beneficial ownership of 20 percent or more (or such lesser percentage that constitutes Control) of the outstanding voting securities or other ownership interests of Carrier.

Commonwealth Choice Health Plan. A Health Benefit Plan, including a Young Adult Plan as defined in M.G.L. c. 176J, underwritten by a Carrier that has received the Connector's Seal of Approval to be offered through the Connector.

Commonwealth Health Insurance Connector Authority or the **Connector** means the entity established pursuant to M.G.L. c. 176Q, § 2.

Contract Year. Each twelve (12) month period, commencing July 1 and ending June 30.

Covered Persons. Persons enrolled in a Commonwealth Choice Health Plan and entitled to coverage thereunder.

Division of Insurance (DOI). The Massachusetts Division of Insurance.

Eligible Individuals. Eligible Individual is defined in M.G.L. c. 176Q.

Eligible Small Groups. Eligible Small Group is defined in M.G.L. c. 176Q.

Evidence of Coverage (EOC). The document containing a detailed description of covered services, conditions, limitations, exclusions, and other terms and conditions of coverage under each Commonwealth Choice Health Plan.

Health Benefit Plan. An HMO, PPO or POS plan of health benefits that has been approved by the DOI as complying with M.G.L. c. 176J and other applicable laws and regulations to be offered to Eligible Individuals and Eligible Small Groups.

Seal of Approval. A designation by the Connector that a Health Benefit Plan has met the Connector's standards regarding quality, value and, if applicable, health care delivery network design.

Sub-Connector. An intermediary organization with which the Connector contracts to provide a broad range of administrative services related to the Commonwealth Choice Program.

ARTICLE II. REPRESENTATIONS AND WARRANTIES

Carrier represents and warrants the following as of the Effective Date of this Agreement and shall immediately provide written notice to the Connector of any changes in the representations and warranties as stated below:

2.1. Corporate Status. Carrier is a corporation duly organized, validly existing and in good standing under the laws of the Commonwealth of Massachusetts.

2.2. License. Carrier is licensed as an insurer under M.G.L c. 175; as a nonprofit hospital service corporation under M.G.L c. 176A; as a nonprofit medical service corporation under M.G.L c. 176B; or as a health maintenance organization under M.G.L c. 176G.

2.3. Managed Care Accreditation. If applicable, Carrier has a current managed care accreditation under M.G.L. c. 1760 and 211 CMR 52:00 *et seq*.

2.4. Eligibility to Participate in the Commonwealth Choice Program. Carrier meets the eligibility requirements in the RFP and in M.G.L. chapters 176J and 176Q to offer Health Benefit Plans through the Connector.

2.5. Compliance with Laws. Carrier is in compliance with all applicable federal and state laws and regulations in connection with this Agreement and its obligations hereunder, including but not limited to, M.G.L. chapters 175, 176A, 176B and 176G, as applicable; M.G.L. chapters 176I, 176J, 176O and 176Q; M.G.L. c. 151E, section 2 (Anti-Boycott); P.L. 103-3 (1993) (Federal Family and Medical Leave Act); P.L. 99-272,Title XXII of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA); P.L. 104-191 (the Health Insurance Portability and Accountability Act of 1996, or HIPAA); Chapter 143 of the Acts of 1999 (HMO Insolvency Law) and Chapter 141 of the Acts of 2000.

2.6. Commonwealth Choice Health Plans. Carrier's Commonwealth Choice Health Plans made available through the Connector pursuant to this Agreement have been approved for sale by the DOI as in compliance with all requirements of M.G.L. c. 176J and all other applicable state laws and regulations; and satisfy the Connector's selection criteria as set forth in the RFR for each of the Connector's plan benefit levels.

2.7. Insolvency Protection. Carrier has and shall maintain insolvency protection, acceptable to the DOI, to protect Covered Persons, the Connector, the Sub-Connector and the Commonwealth of Massachusetts from incurring liability for the payment of any fees that are the legal obligation of the Carrier; and protect Covered Persons from the unavailability of covered health services resulting from the Carrier's insolvency, bankruptcy or other financial impairment.

2.8. Litigation. Carrier represents and warrants that there is no outstanding litigation, arbitrated matter or other dispute to which Carrier is a party which, if decided unfavorably to Carrier, would reasonably be expected to have a material adverse effect on Carrier's ability to fulfill its obligations under this Agreement.

ARTICLE III. CARRIER OBLIGATIONS

In addition to its other specific obligations provided elsewhere in this Agreement, Carrier's obligations under this Agreement shall be as follows:

3.1. Commonwealth Choice Health Plans.

A. Carrier shall make available for purchase through the Connector, beginning May 1, 2007, the Commonwealth Choice Health Plans listed in Appendix A to Eligible Individuals and Eligible Small Groups, for coverage effective dates beginning July 1, 2007.

B. Carrier shall (1) establish premium rates for each of its Commonwealth Choice Health Plans in accordance with the rating methodology previously submitted to Connector's consultant as part of Carrier's RFR Responses; (2) provide Sub-Connector with a complete rating table capable of generating premium quotes, with updates at least 60 days in advance of the effective date of the changes ("update due date"), for each of its Commonwealth Choice Health Plans; (3) notify the Connector and Sub-Connector regarding any material changes or additions to its actuarial methodology at least thirty (30) days prior to any update due date; and (4) with respect to its Commonwalth Choice Health Plans, offer up to the following four rate basis type categories: single, two adults, one adult and one or more children, and two adults and one or more children***;*** provided, however, that nothing in this section shall affect the number or types of rate basis types Carrier offers with respect to its health plans sold outside the Connector.

C. Carrier shall not put any limitations on enrollment in its Commonwealth Choice Health Plans other than those specifically permitted by applicable laws and regulations.

3.2. Sub-Connector Contract.

A. Carrier acknowledges that (1) the Connector has delegated a broad range of administrative responsibilities to a Sub-Connector pursuant to an agreement dated February 9, 2007 (Sub-Connector Contract); (2) the Sub-Connector Contract sets forth the terms and conditions pursuant to which the Sub-Connector shall uniformly offer and administer all Commonwealth Choice Health Plans to Eligible Individuals and Eligible Small Groups through the Connector; and (3) the Sub-Connector Contract, as amended from time to time, is hereby incorporated by this reference into this Agreement.

B. Carrier hereby agrees to make its Commonwealth Choice Health Plans available through the Connector in accordance with all terms and conditions of the Sub-Connector Contract, as amended from time to time, that (1) reasonably relate to the manner in which Commonwealth Choice Health Plans are offered and administered by the Sub-Connector; or (2) necessarily depend upon Carrier's assent and cooperation in order to effectuate the uniform administration of all Commonwealth Choice Health Plans. The aforementioned terms and conditions include, but are not limited to, those addressing: (1) customer service (including benefits explanation); (2) eligibility verification, eligibility determinations and changes in eligibility; (3) enrollment, re-enrollment, lock-in period, common renewal anniversary date, and terminations; (4) premium quoting, premium billing, premium collection, remittance of premium to Carrier, and premium reconciliation; (5) marketing of Commonwealth Choice Health Plans; (6) acceptance of voice and electronic signatures; and (7) the development of additional administrative policies and procedures not specifically set forth in the Sub-Connector Contract. In the event the Sub-Connector Contract is amended, Carrier will be provided notice of such amendment. If such amendment has an adverse material financial impact on Carrier that is reasonably demonstrated to Connector, Carrier shall have the option on ninety (90) days prior written notice to the Connector to terminate this Agreement.

C. Carrier agrees to fully cooperate with the Sub-Connector in Sub-Connector's marketing and administration of Carrier's Commonwealth Choice Health Plans. For purposes of this Section, using a standard of commercial reasonableness, this cooperation will include, but is not limited to: (1) providing information necessary to enable Sub-Connector to reasonably carry out all its responsibilities under the Sub-Connector Contract; (2) assenting to Connector and Sub-Connector policies and procedures related to the

administration of Commonwealth Choice Health Plans, for example, by accepting a universal enrollment form; (3) accommodating future changes in Sub-Connector's administrative policies and procedures in order to achieve administrative efficiencies, such as enhanced automation of business processes and transactions; (4) participating in meetings with the Connector, Sub-Connector and other organizations or government agencies; and (5) training Sub-Connector staff on the features of Carrier's Commonwealth Choice Health Plans. Carrier shall notify Connector of any disputes between Carrier and Sub-Connector that have not been resolved within a reasonable period of time.

D. Carrier acknowledges and agrees to all the following:

(1) Sub-Connector's monthly premium remittance to Carrier shall consist of premium actually collected net of the Administrative Fee set forth in Schedule I;

(2) Sub-Connector (a) will use its best efforts to collect premium from Covered Persons and employer groups in accordance with its premium collection policies and procedures; (b) shall retroactively terminate Covered Persons, for whom premium remains uncollected, in accordance with its termination policies and procedures; (c) as part of its premium collection and termination policies and procedures, shall provide Carrier with monthly premium collection and termination reports sufficient for Carrier to identify Covered Persons who are in arrears for more than the time period permitted by Sub-Connector's policies and procedures; and (d) shall provide Carrier with copies of its premium collection and termination policies and procedures;

(3) In the event Sub-Connector fails to terminate Covered Persons for nonpayment of premium in accordance with its termination policies and procedures, Carrier shall terminate such Covered Persons, and seek to collect outstanding premium, if any, from such Covered Persons or employer groups, as applicable, in accordance with applicable law. Connector and Sub-Connector shall fully cooperate with Carrier with respect to records and processes necessary for Carrier to effectuate such terminations; and

(4) Carrier assumes all credit risk for nonpayment of premiums by Covered Persons and small groups and under no circumstances shall Sub-Connector or Connector be responsible to Carrier for uncollected premium.

3.3. Customer Service. Carrier shall have available customer service representatives during normal business hours to assist potential enrollees and Covered Persons, and to coordinate customer service between Carrier's own representatives and Sub-Connector's Commonwealth Choice Customer Service Center.

3.4. Marketing.

A. Carrier shall actively market its Commonwealth Choice Health Plans as mutually agreed upon by Carrier and Connector. Active marketing may include, but is not limited to, the following: (1) as part of Carrier's overall company marketing plan, developing and conducting ongoing marketing campaigns to raise awareness and educate the public about the Health Care Reform Act and the availability of Carrier's Commonwealth Choice Health Plans through the Connector; (2) co-branding such marketing campaigns and related materials consistent with Connector's branding style requirements; (3)

conducting such co-branded marketing campaigns (a) through advertisements in print, radio and in other media; and (b) through written and electronic communications sent to Carrier's members, employers, participating providers and brokers, such as newsletters, brochures and on Carrier's website; (4) including on Carrier's website direct links to Connector and Sub-Connector websites; and (5) including in such marketing campaigns the Sub-Connector's toll-free TTY telephone number for hearing impaired persons.

B. Carrier may participate in other joint marketing efforts with the Connector.

C. Carrier shall submit to the Connector, for pre-approval by the Connector, copies of marketing materials developed to market, or to enable the Connector and Sub-Connector to publicize and market, Carrier's Commonwealth Choice Health Plans. Connector shall review Carrier's proposed marketing material within 10 business days of receipt; provided, however, that approval of marketing material shall not be unreasonably denied, and provided further that such material shall be deemed approved in the event Connector does not complete its review and notify Carrier of its approval, rejection or desired modifications within this period. Carrier and Connector agree to work cooperatively to develop mutually agreeable additional guidelines for Connector's review and approval of marketing materials.

D. Each party's use of the other party's trademarks, brand names, seals, logos and similar instruments (hereinafter "brand symbols") shall be subject to prior review and approval by the other party, provided, however, that such approval shall not be unreasonably denied. Carrier and Connector agree to work cooperatively to develop mutually agreeable additional guidelines for their review and approval of brand symbol usage.

E. Carrier shall designate in writing a Marketing Executive who is authorized and empowered to represent the Carrier with respect to Carrier's marketing of its Commonwealth Choice Health Plans. Such Marketing Executive will work cooperatively with Connector on marketing and joint marketing plans and initiatives.

3.5. Evidence of Coverage.

A. Carrier will design, print and issue to Covered Persons, at its own expense, an Evidence of Coverage (EOC) which has been approved by the DOI, for each Commonwealth Choice Health Plan made available pursuant to this Agreement. Each DOI-approved EOC, as amended and approved by the DOI from time to time, is incorporated herein by this reference.

B. Carrier shall administer its Commonwealth Choice Health Plans in accordance with all the terms and conditions of the applicable EOC.

C. Carrier shall notify Connector of any proposed changes to the Evidences of Coverage at the time such proposed changes are submitted to the DOI for review and approval.

D. Carrier agrees to cooperate with Connector over time to develop a standardized EOC template for all Commonwealth Choice Health Plans offered through the Connector.

3.6. Participating Providers.

A. Carrier shall make a Provider Directory available to Covered Persons and prospective Covered Persons, on its website and in print format, as required by applicable laws and regulations, consisting of a list of providers participating in its Commonwealth Choice Health Plans.

B. Carrier agrees to ensure adequate numbers of open physician panels in its network of participating providers.

3.7. Appeals and Grievances. Carrier shall have an appeals and grievance procedure for Covered Persons that complies with M.G.L. c. 1760 and 105 CMR 128.00.

3.8. Cost/Quality Information. Carrier shall make available to Covered Persons the same comparative cost and quality information that it currently makes available to its non-Commonwealth Choice Health Plan enrollees. This information may include comparative data by facility, clinician and/or physician practice group, including information related to patient safety and member satisfaction.

3.9. ID Cards. Carrier shall issue identification cards to Covered Persons that are co-branded with the Connector.

3.10. Nondiscrimination.

A. Carrier shall not exclude any person from coverage under its Commonwealth Choice Health Plans because of race, color, religion, national origin, sex, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income, or age.

B. Carrier shall not treat persons enrolled in its Commonwealth Choice Health Plans differently than persons enrolled in the same Health Benefit Plans offered in the marketplace outside the Connector, except as specifically permitted by applicable laws, regulations or this Agreement.

3.11. Insurance. Carrier shall maintain, and upon request present Connector written evidence of, the following types of insurance at levels generally accepted as commercially reasonable for similarly situated carriers: statutory workers' compensation; commercial general liability insurance; professional errors and omissions liability insurance; bond/crime insurance, including blanket coverage for employee dishonesty and computer fraud, and for loss or damage arising out of or in connection with any fraudulent or dishonest acts committed by employees. Carrier shall notify Connector no less than ten days prior to any reduction or cancellation by Carrier of such insurance and immediately upon cancellation or any reduction by the insurer.

3.12. Data and Reporting Requirements. Subject to the requirements of and in compliance with applicable law and regulations, Carrier shall furnish the Connector and Sub-Connector, or their designees, such commercially reasonable and timely ad hoc or periodic reports and data, in a mutually agreeable format, as the Connector or Sub-Connector determines to be necessary to enable them to carry out their obligations under MGL c. 176Q and this Agreement, including but not limited to, financial reports; de-identified appeals and grievances related to Covered Persons; enrollment reports; cost and utilization reports; claims data on a regular basis to be sent to a data management and analysis firm

designated by the Connector; and updated listings of participating providers in electronic format.

3.13. Inspection and Retention of Records. Carrier shall permit the Connector or its designee, during regular business hours and upon reasonable notice, to examine and copy such Carrier records as may be necessary to carry out the purposes of M.G.L. c. 176Q and this Agreement, as determined by the Connector, except that protected health information shall be examined only as permitted by law. Records shall also be available for governmental regulatory agencies having recognized authority to review such records. All records maintained by Carrier in connection with this Agreement shall be retained for the period set forth in applicable records retention laws.

3.14. Rate Parity. Carrier shall utilize the same rating methodology, rate adjustment factors (including but not limited to trend factors) and rates for its Commonwealth Choice Health Plans that Carrier uses for the same Health Benefit Plans offered in the marketplace outside the Connector.

3.15. Compliance with Laws.

A. Carrier shall comply with all state and federal laws and regulations applicable to the performance of its obligations under this Agreement. Without limiting the generality of the foregoing, Carrier shall comply with M.G.L. chapters 175, 176A, 176B and 176G, as applicable; M.G.L. chapters 176I, 176J, 176O and 176Q; P.L. 99-272,Title XXII of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA); P.L. 104-191 (the Health Insurance Portability and Accountability Act of 1996 (HIPAA); Chapter 143 of the Acts of 1999 (HMO Insolvency Law), as applicable; and Chapter 141 of the Acts of 2000. Compliance under HIPAA, in part, shall mean that Carrier shall provide Covered Persons with all notices mandated by HIPAA, and will provide Certificates of Creditable Coverage to former Covered Persons.

B. Carrier shall be responsible for any fines and penalties arising from (1) its noncompliance with any law relating to its obligations under this Agreement; or (2) Connector's violation of any law or regulation which is caused by an act or omission by Carrier, unless and solely to the extent that Connector's violation resulted from Carrier's reasonable reliance on the specific written instructions or advice of the Connector's Contract Officer or his or her designee in taking the action (or omitting to take action) that caused the violation.

3.16. Change of Control or other Administrative Change. Carrier shall give Connector at least thirty (30) days prior written notice of any proposed Change in Control or of any other change affecting its organization that would be expected to materially disrupt or otherwise adversely impact Carrier's performance of its responsibilities under this Agreement.

ARTICLE IV. CONNECTOR OBLIGATIONS

In addition to its other specific obligations provided elsewhere in this Agreement, Connector's obligations under this Agreement shall be as follows:

4.1. Commonwealth Choice Health Plans. Connector shall facilitate the purchase of Carrier's Commonwealth Choice Health Plans by Eligible Individuals and Eligible Small Groups by (A) arranging for Carrier to offer its Commonwealth Choice Health Plans through the Connector in accordance with this Agreement; and (B) contracting for a Sub-Connector to perform a broad range of administrative services related to offering and uniformly administering Commonwealth Choice Health Plans through the Connector.

4.2. Marketing.

A. Connector shall establish and implement a plan for publicizing the existence of the Connector and actively promoting Commonwealth Choice Health Plans.

B. Connector shall offer Carrier the same or comparable opportunities to participate in co-marketing activities with Connector as it offers to other carriers offering Commonwealth Choice Health Plans through the Connector.

C. Connector shall, in accordance with Section 3.4C, review in advance all Commonwealth Choice marketing material developed by Carrier.

4.3. Seal of Approval.

A. Connector shall establish criteria upon which to base its granting and withdrawal of Seals of Approval.

B. As of the beginning of each Contract Year, Connector shall have the right, in its sole discretion, to (1) renew or eliminate other licensed carriers and/or one or more of their Commonwealth Choice Health Plans participating in the Commonwealth Choice Program; and (2) add other licensed carriers and/or Commonwealth Care Health Plans to the portfolio of plans made available through the Connector. At any time, Connector shall have the right to eliminate from the Commonwealth Choice Program other licensed carriers and/or their Commonwealth Choice Health Plans for cause or consistent with other contractual termination provisions.

ARTICLE V. TERM AND TERMINATION

5.1 Term. The initial term of this Agreement shall be from May 1, 2007 (Effective Date) through June 30, 2008 (Initial Term). Following the Initial Term, this Agreement shall, subject to Section 6.1, automatically renew for successive one (1) year Contract Years unless otherwise terminated as provided in Section 5.2.

5.2. Termination.

A. Non-Renewal. The Connector may terminate this Agreement by giving Carrier written notice of non-renewal delivered at least ninety (90) days prior to the expiration of the Initial Term or the then current Contract Year. Carrier may terminate this Agreement by giving written notice of non-renewal delivered at least one-hundred and eighty (180) days prior to the expiration of the Initial Term or the then current Contract Year.

B. Termination for Cause. Either party may terminate this Agreement upon breach by the other of any material term or representation in this Agreement, subject to the following notice and cure period requirements: In the event either party wishes to terminate this Agreement for cause, that party shall give the alleged breaching party thirty (30) days ("Cure Period") prior written notice, which notice shall include a description of the breach. If the alleged breaching party does not cure the breach to the satisfaction of the terminating party within the Cure Period, the terminating party shall provide the other party written notice of termination. This Agreement shall then terminate upon receipt of the written notice of termination or at such later date or under such circumstances as may be specified in such notice. In the event the Connector is the terminating party, during the Cure Period it may cease marketing Carrier's Commonwealth Choice Health Plans, discontinue new enrollments, notify existing Covered Persons and small groups that the arrangement with Carrier is terminating, and arrange for appropriate transition of Covered Persons and small groups in accordance with DOI and Connector requirements.

C. Immediate Termination. The Connector may, by giving written notice to the Carrier, terminate this Agreement immediately upon the occurrence of any of the events below:

(1) An Insolvency Event. As used herein, Insolvency Event shall mean any of the following with respect to the Carrier: (a) filing, or having filed against it, a petition for liquidation or reorganization under the United States Bankruptcy Code, as amended from time to time, or a petition to take advantage of any insolvency act or bankruptcy law; (b) admitting in writing its inability to pay its debts generally; (c) making an assignment, trust mortgage or other conveyance for the benefit of creditors; (d) making a proposal to its creditors for a composition or arrangement of its debts; (e) the appointment of a receiver, trustee or similar authority for itself or any substantial part of itself or any substantial part of its property; (f) taking any action to authorize any of the foregoing pursuant to its governing documents; (g) generally committing any act of insolvency, including the material failure to pay obligations as they become due; or (h) ceasing to conduct business as a going concern.

(2) Carrier's license, accreditations, credentials or certifications which are required to be maintained in order to carry out its obligations under this Agreement expire or are suspended, revoked or materially restricted.

(3) Carrier has engaged in conduct which materially endangers the health or safety of, or is otherwise detrimental to, Covered Persons or small groups participating in the Commonwealth Choice Program.

D. Termination for Change in Control of Carrier. In the event of a Change in Control of Carrier, other than a Change in Control pursuant to which the control of Carrier is transferred to an Affiliate of Carrier, the Connector may elect to terminate this Agreement by giving Carrier written notice of such termination within ninety (90) days after the effective date of such Change in Control.

E. Termination Due to Non-Payment. In the event Sub-Connector fails to make undisputed premium payments to Carrier in accordance with Sub-Connector's premium remittance policies and procedures, a copy of which shall be provided to Carrier, and such failure results in an adverse material financial impact to Carrier that is reasonably demonstrated by Carrier to the Connector, Carrier shall give Connector thirty (30) days ("Cure Period") prior written notice of intent to terminate this Agreement. If undisputed payments are not

remitted to Carrier within the Cure Period, Carrier shall provide Connector written notice of termination. This Agreement shall then terminate upon Connector's receipt of the written notice of termination or at such later date or under such other circumstances as may be specified in such notice.

5.3. Upon Termination of this Agreement. In the event of non-renewal or other termination of this Agreement, Carrier agrees to comply with all Connector and DOI requirements addressing transition of Covered Persons and small groups.

ARTICLE VI. ADDITIONAL TERMS AND CONDITIONS

6.1. Amendments.

A. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein.

B. Without Carrier's consent and by providing prompt notice to Carrier, Connector may amend this Agreement to enable Connector or Sub-Connector to comply with any existing or newly enacted law or regulation or with any order of any federal or state agency or court, and such amendment shall be effective as of the date the law, regulation or order becomes or became effective. If such amendment has an adverse material financial impact on Carrier that is reasonably demonstrated to Connector, Carrier shall have the option on ninety (90) days prior written notice to the Connector to terminate this Agreement.

C. The Connector may amend this Agreement annually to withdraw its Seal of Approval from any of Carrier's Commonwealth Choice Health Plans then being offered through the Connector by giving Carrier written notice of such withdrawal(s) at least ninety (90) days prior to the end of the Initial Term or the then current Contract Year. If such amendment has an adverse material financial impact on Carrier that is reasonably demonstrated to Connector, Carrier shall have the option to terminate this Agreement by sending written notice to the Connector at least seventy-five (75) days prior to the end of the Initial Term or the then current Contract Year. In the event of a withdrawal, the affected Commonwealth Choice Health Plan(s) shall no longer be offered through the Connector and Carrier shall comply with Connector and DOI requirements addressing transition of Covered Persons and small groups.

D. Any other amendment to this Agreement requires mutual consent of both parties, in the form of a written amendment, signed by both parties, and attached hereto.

6.2. Adequate Assurances. If Connector is aware of facts or circumstances that it reasonably believes would cause Carrier not to be willing or able to perform its obligations under this Agreement, Connector may request, and Carrier shall provide within a reasonably prompt period of time, in light of the circumstances, after receipt of a request, adequate assurances, acceptable to the Connector in its reasonable discretion, of Carrier's continuing ability and willingness to perform its obligations, or such portion thereof, as required by this Agreement.

6.3. Assignment. Carrier shall not assign, delegate or transfer any right, obligation or interest in this Agreement to any successor entity or other entity, without the prior written consent of the Connector.

6.4. Material Subcontractors. Carrier's material subcontractors providing services associated with this Agreement shall be subject to the same terms and conditions as the Carrier, as applicable. Carrier shall remain fully responsible for meeting all the terms and conditions of this Agreement regardless of whether Carrier subcontracts for performance of any responsibilities under this Agreement.

6.5. Independent Contractors. The parties intend to create an independent contractor relationship and nothing contained in this Agreement shall be construed to make either the Connector or Carrier partners, joint ventures, principals, agents or employees of the other. No officer, director, employee, agent, affiliate or contractor retained by Carrier to perform work related to this Agreement will be deemed to be an employee, agent or contractor of Connector. Neither party will have any right, power or authority, express or implied, to bind the other.

6.6. Limitation on Liability. The Connector shall have no liability or responsibility for Carrier's provision or arrangement of, or failure to provide or arrange for, any health care services, supplies, medications, or facilities to Covered Persons under this Agreement.

6.7 Anti-Boycott Covenant. During the time this Agreement is in effect, neither the Carrier nor any affiliated company, as hereafter defined, shall participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful by M.G.L. c. 151E, §2. Without limiting such other rights as it may have, the Connector shall be entitled to rescind this Agreement in the event of noncompliance with this section. As used herein, an affiliated company shall be any business entity directly or indirectly owning at least 51 percent of the ownership interests of the Carrier.

6.8. Counterparts. This Agreement may be executed simultaneously in two or more counterparts, each of which will be deemed an original, and all of which together will constitute one and the same instrument.

6.9. Entire Contract. This Agreement constitutes the entire agreement of the parties with respect to the subject matter hereof including all Schedules, Appendices, Exhibits, Attachments and amendments hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Agreement shall prevail notwithstanding any variances with the terms and conditions of any written or verbal communication subsequently occurring, except as otherwise provided herein.

6.10. No Third Party Enforcement. No person not executing this Agreement shall be entitled to enforce this Agreement against a party hereto regarding such party's obligations under this Agreement.

6.11. Section Headings. The headings of the Sections of this Agreement are for convenience only and will not affect the construction hereof**.**

6.12. This section is intentionally left blank.

6.13. Effect of Invalidity of Clauses. If any clause or provision of this Agreement is in conflict with any state or federal law or regulation, that clause or provision shall be null and void and any such invalidity shall not affect the validity of the remainder of this Agreement.

6.14. Waiver. The waiver by either party of any part of this Agreement or of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver in any other respect, to any other extent, or at any other time.

6.15. This section is intentionally left blank.

6.16. Carrier's Financial Condition and Corporate Structure. At the request of the Connector, the Carrier shall provide the Connector with documentation relating to organizational structure, financial structure and solvency, including but not limited to the following: the name(s) and address(es) of the (1) Carrier's parent organizations, (2) parents of such parent organizations, (3) Carrier's subsidiary organizations, and (4) subsidiaries of any organizations listed in (1), (2), or (3) herein; and the names and occupations of the members of the Board of Directors of the organizations listed in (1)-(4) herein.

6.17. Corrective Action Plan. At any point during this Agreement, if the Connector identifies, in its sole judgment, any deficiency of the Carrier's obligations under this Agreement, the Connector may require the Carrier to develop a commercially feasible corrective action plan to correct such deficiency. Carrier shall submit any such corrective action plan to the Connector and shall within three days of any written request, commence to implement such corrective action plan only as approved or modified by the Connector. Such plan may include an obligation to increase resources dedicated to correcting the deficiency.

6.18. Order of Precedence. Any ambiguity or inconsistency between or among the following documents shall be resolved by applying the following order of precedence: (A) this Agreement, including any Schedules, Appendices, Exhibits, Attachments and amendments hereto; (B) the Sub-Connector Contract; (C) the RFR; (D) Carrier's RFR Responses dated _____; and (E) Carrier's EOCs.

6.19. Contract Officers.

A. The Connector designates Patricia Andriolo-Bull as its Contract Officer. She or her designee shall be authorized and empowered to represent the Connector with respect to all matters relating to the Agreement. Such designation may be changed during the period of this Agreement only by written notice.

B. Carrier designates _____ as its Contract Officer. S/he or his/her designee shall be authorized and empowered to represent Carrier with respect to all matters relating to the implementation of this Agreement, including but not limited to integration of operations among Carrier, Connector and the Sub-Connector. Such designation may be changed during the period of this Agreement only by written notice to the Connector.

6.20. Sole and Exclusive Venue. Each party irrevocably agrees that any legal action, suit or proceeding brought by it in any way arising out of this Agreement must be brought solely and exclusively in the United States District Court for the District of Massachusetts or the Superior Court for Suffolk County located in Boston, Massachusetts and irrevocably accepts and submits to the sole and exclusive jurisdiction of each such court in personam, generally and unconditionally with respect to any action, suit or proceeding brought by it or

against it by the other party; provided, however, that this section will not prevent a party against whom any legal action, suit or proceeding is brought by the other party in the state courts of the Commonwealth of Massachusetts from seeking to remove such legal action, suit or proceeding, pursuant to applicable Federal law, to the district court of the United States for the district and division embracing the place where the action is pending in the state courts of the Commonwealth of Massachusetts, and in the event an action is so removed each party irrevocably accepts and submits to the jurisdiction of the aforesaid district court. Each party hereto further irrevocably consents to the service of process from any of such courts by mailing copies thereof by registered or certified mail, postage prepaid, to such party at its address designated pursuant to this Agreement, with such service of process to become effective thirty (30) days after such mailing.

6.21. Governing Law. This Agreement and the rights and obligations of the parties under this Agreement will be governed by and construed in accordance with the laws of the Commonwealth of Massachusetts, without giving effect to the principles thereof relating to the conflicts of laws.

6.22. Notice. Notices to the parties as to any matter under this Agreement will be sufficient if given in writing and sent by certified mail (return receipt requested), postage prepaid, or delivered in hand or an overnight delivery service with acknowledgment of receipt to:

To the Connector:

_____
Director of Commonwealth Choice
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza
Boston, MA 02108

With copies to:

Jamie Katz
General Counsel
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza
Boston, MA 02108

To the Carrier:

_____

_____

_____

_____

With copies to:

_____

_____

_____

_____

6.23. Remedies Cumulative. No right or remedy herein conferred upon or reserved to either party is intended to be exclusive of any other right or remedy, and each and every right and remedy will be cumulative and in addition to any other right or remedy under this Agreement, or under applicable law, whether now or hereafter existing.

6.24. Confidentiality.

A. To the extent permitted by applicable law, the parties agree (1) to keep all non-public information arising from or related to this Agreement confidential (Confidential Information); (2) to hold all Confidential Information related to this Agreement in confidence to the same extent and with at least the same degree of care as the party protects its own confidential or proprietary information of like kind and import, but in no event using less than a reasonable degree of care.

B. Notwithstanding the foregoing, (1) Carrier acknowledges and agrees that Connector is subject to laws that may compel Connector to disclose information, such as the Massachusetts Public Records Law and the Federal Freedom of Information Act; and (2) the parties shall be permitted to disclose relevant aspects of Confidential Information to their officers, agents, subcontractors, including but not limited to the Sub-Connector, and employees, to the extent such disclosure is reasonably necessary for the performance of their duties and obligations under this Agreement and such disclosure is not prohibited by applicable law.

6.25. Survival. Any provisions of this Agreement that contemplate performance by a party following the termination or expiration of this Agreement shall survive the termination or expiration of this Agreement, including but not limited to Sections 5.3.

6.26. Indemnification.

A. Carrier shall indemnify, and defend and hold Connector and the Commonwealth of Massachusetts, their agents, officers, employees and successors and assigns (Connector Indemnified Parties), harmless from and against, any and all liability, loss, damage, costs or expenses (including reasonable attorneys fees) suffered, incurred or sustained by Connector Indemnified Parties or to which any Connector Indemnified Parties become subject, resulting from, arising out of or relating to any claim:

(1) relating to any duties or obligations of Carrier or Carrier's subcontractors in respect of a third party, including Carrier's subcontractors, unless and solely to the extent that such claim results from Carrier's reasonable reliance on the specific written instructions or advice of the Connector Contract Officer or his or her designee in taking the action (or omitting to take the action) that gave rise to the claim;

(2) relating to the inaccuracy, untruthfulness or breach of any representation or warranty made by Carrier under this Agreement or breach of any obligation by Carrier under this Agreement;

(3) relating to personal injury (including death) or property loss or damage resulting from Carrier's or Carrier's subcontractors' acts or omissions; and

(4) relating to occurrences Carrier is required to insure against pursuant to Section 3.11 up to the insurance coverages required under Section 3.11.

B. The indemnity obligation described in this Section 6.26 shall not limit any other rights or remedies available to Connector under this Agreement.

C. Indemnification Procedures. If any third party claim arising out of or related to this Agreement is commenced against any Connector Indemnified Party, notice thereof will be given to Carrier as promptly as practicable. If, after such notice, Carrier acknowledges that Section 6.26.A of this Agreement applies with respect to such claim, then Carrier will be entitled, if it so elects, in a notice promptly delivered to the Connector Indemnified Party, but in no event less than 10 days prior to the date on which a response to such claim is due, to immediately take control of the defense and investigation of such claim and to employ and engage attorneys reasonably acceptable

to the Connector Indemnified Party to handle and defend the same, at the Carrier's sole cost and expense. The Connector Indemnified Party will cooperate, at the cost of the Carrier, in all reasonable respects with the Carrier and its attorneys in the investigation, trial and defense of such claim and any appeal arising therefrom; provided, however, that the Connector Indemnified Party may, at its own cost and expense, participate, through its attorneys or otherwise, in such investigation, trial and defense of such claim and any appeal arising therefrom. No settlement of a claim that involves a remedy other than the payment of money by Carrier will be entered into without the consent of the Connector Indemnified Party. After notice by Carrier to the Connector Indemnified Party of its election to assume full control of the defense of any such claim, the Carrier will not be liable to the Connector Indemnified Party for any legal expenses incurred thereafter by such Connector Indemnified Party in connection with the defense of that claim. If Carrier does not acknowledge that Section 2.26.A applies with respect to the claim and has therefore has not elected to assume full control over the defense of the claim, Carrier may participate in such defense, at its sole cost and expense, and the Connector Indemnified Party will have the right to defend the claim in such manner as it may deem appropriate.

6.27. Consequential Damages. Except with regard to claims indemnifiable under Section 6.26, above, or claims arising from the gross negligence or willful misconduct of a party, neither party shall be liable to the other party for any indirect, incidental, special, punitive, exemplary or consequential damages (including, without limitation, any damages arising from loss of use or lost business, revenue, profits, data or goodwill) arising in connection with this Agreement, whether in an action in contract, tort, strict liability or negligence, or other actions, even if advised of the possibility of such damages.

6.28. Ownership of Data.

A. Ownership of Connector Data. As between the Connector and Carrier, all Connector Data, as defined below, that is submitted, directly or indirectly, to Carrier by Connector shall be and will remain the property of the Connector. For purposes of Section 6.28, Connector Data means data and information created by the Connector and relating to the Connector, its directors, officers, employees and agents, technology, operations, facilities, consumer markets, products, capacities, systems, procedures, security practices, research, development, business affairs, ideas, concepts, innovations, inventions, designs, business methodologies, improvements, trade secrets, copyrightable subject matter and other proprietary information. Without the Connector's approval (in its sole discretion), the Connector Data will not be (1) used by Carrier or its subcontractors other than in connection with carrying out its obligations under this Agreement; (2) disclosed, sold, assigned, leased or otherwise provided to third parties by Carrier or its subcontractors other than in connection with carrying out its obligations under this Agreement; or (3) commercially exploited by or on behalf of Carrier or its subcontractors. Carrier hereby irrevocably assigns, transfers and conveys, and will cause its subcontractors to assign, transfer and convey, to the Connector without further consideration all of its and their right, title and interest in and to the Connector Data. Upon request by the Connector, Carrier will execute and deliver, and will cause its subcontractors and agents to execute and deliver, any documents that may be necessary or desirable under any law to preserve, or enable the Connector to enforce, its rights with respect to the Connector Data.

B. Ownership of Carrier Data. As between the Connector and Carrier, all Carrier Data, as defined below, that is submitted, directly or indirectly, to Connector by Carrier shall be and will remain the property of the Carrier. For purposes of Section 6.28, Carrier Data means data and information created by the Carrier and relating to the Carrier, its directors, officers, employees and agents, covered members, technology, operations, facilities, consumer markets, products, capacities, systems, procedures, security practices, research, development, business affairs, ideas, concepts, innovations, inventions, designs, business methodologies, improvements, trade secrets, copyrightable subject matter and other proprietary information. Without the Carrier's approval (in its sole discretion), the Carrier Data will not be (1) used by Connector or its subcontractors other than in connection with carrying out its obligations under this Agreement; (2) disclosed, sold, assigned, leased or otherwise provided to third parties by Connector or its subcontractors other than in connection with carrying out its obligations under this Agreement; or (3) commercially exploited by or on behalf of Connector or its subcontractors. Connector hereby irrevocably assigns, transfers and conveys, and will cause its subcontractors to assign, transfer and convey, to the Carrier without further consideration all of its and their right, title and interest in and to the Carrier Data. Upon request by the Carrier, Connector will execute and deliver, and will cause its subcontractors and agents to execute and deliver, any documents that may be necessary or desirable under any law to preserve, or enable the Carrier to enforce, its rights with respect to the Carrier Data.

6.29. HIPAA Compliance.

A. Carrier acknowledges that it is a covered entity, as defined in 45 CFR 160.103.

B. With respect to the use and disclosure of "protected health information" between the parties, as that term is defined in 45 CFR 160. 103, to the extent it is determined that one party is or must become a "business associate" of the other, as that term is defined in 45 CFR 160.103, the parties agree to enter into a business associate contract that meets the applicable requirements of 45 CFR 164.504(e).

6.30. Arbitration. In the event a dispute between the parties arises out of, or is related to, this Agreement, the parties shall meet and negotiate in good faith to attempt to resolve the dispute. If after at least twenty (20) days following the date one party has sent written notice of the dispute to the other party, the dispute is not resolved, and if either party wishes to pursue the dispute, it shall be submitted to binding arbitration. In no event shall arbitration be initiated more than 6 months following the sending of written notice of the dispute. Any arbitration proceeding under this Agreement shall be conducted in the Commonwealth of Massachusetts according to the rules of the American Arbitration Association. The arbitrators shall have no authority to award any punitive or exemplary damages, or to vary or ignore the terms of this Agreement, and shall be bound by controlling law.

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SIGNATURE PAGE

IN WITNESS THEREOF, the parties have executed this Agreement as of the day/year stated below:

The Commonwealth of Massachusetts
Health Insurance Connector Authority

By:_____

Name: _____

Title: _____

Date: _____

_____
(Carrier)

By: _____

Name: _____

Title: _____

Date: _____

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APPENDIX A

COMMONWEALTH CHOICE HEALTH PLANS

Carrier shall make available for purchase through the Connector the following Commonwealth Choice Health Plans:

1. _____
2. _____
3. _____
4. _____

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SCHEDULE I
ADMINISTRATIVE FEE

The Administrative Fee for the period July 1, 2007

Commonwealth Health Insurance Connector Authority

Your Connection to Good Health

Commonwealth Choice
Plan and Product Design Options

April, 2009

CommonwealthConnector

Goal

- Test plan design variations among the Gold, Silver and Bronze tiers, as well as other product design options
  - Include product preferences in the Seal of Approval process
- Held 5 focus groups and surveyed 7,200 Commonwealth Choice members (1,200 respondents/16% response rate)
- Focus groups consisted of -
  - 3 Commonwealth Choice member groups
  - 2 non-member groups

CommonwealthConnector

Overview (cont.)

- **Member Focus Group Participants –**
  - **33 participants – most have been members since the rollout of Commonwealth Choice**
  - **22 enrolled in a Bronze Plan; 8 in a Silver Plan and 3 in a Gold Plan**
  - **Average age was 48**
  - **Range of occupations – independent contractor, retired, photographer, attorney, unemployed, massage therapist, computer consultant**
- **Most only revisit the website at renewal time**
- **Customer Service Representatives are "amazing"**

CommonwealthConnector

Overview (cont.)

- **Non-member Focus Group participants –**
  - **19 participants**
  - **Most covered through individual policies (e.g., Midwest Alliance, HPHC, MegaLife, BCBS)**
  - **Average age was 42**
  - **Range of occupations – sales rep, caterer, nurse, small business owner, stylist, IT tech**
- **Most had never heard of the Connector previously**

CommonwealthConnector

Overview (cont.)

- **Both member and non-member focus group participants expressed the following -**
  - **Little concept of how deductibles and coinsurance work**
  - **A strong desire for website decision support tools (66% of survey respondents rated this feature as extremely and very favorable)**
    - **Allow users to input various episodes of care by plan design; this would help users better understand the intricacies of plan design options and how the dollars work**

CommonwealthConnector

Gold Product Options

	Gold Core	Gold Option A
Deductible	N/A	N/A
Out of Pocket Maximum	N/A	N/A
PCP OV Copay	$15	$20
Specialist Visit Copay	$25	$30
Inpatient Copay	$100/admission	$150/admission
Outpatient Copay	$100	$150
ER Copay	$75	$75
Prescription Rx		
Tier 1 (generic)	$10	$15
Tier 2 (preferred)	$20	$30
Tier 3 (non-preferred)	$45	$50
MRI Scan Copay	$0	$25
MH/SA	$15 copay $100 per admission	$20 copay $100 per admission
Monthly Individual Premium	$550	$520 (-$30/mo)
Episode of Care Cost	$135	$195 (+$60)

CommonwealthConnector

Gold Plan Options

- **One a scale of 1 to 5, please rank your product preference for the Gold plans with 1 being the least desirable and 5 being the most desirable**

	Core	Option A
Member Avg	3.2	3.5
Non-Member Avg	3.8	2.8
Combined Avg	3.4	3.2
Survey Preferences	38%	62%

- **Comments –**
  - **"Believe in any monthly savings, so I would switch to Option A"; "I am healthy, so the risk is worth it"; "Take premium difference and save"**
  - **"Isn't the Gold Core Plan aimed at reducing exposure in the first place? Willing to have higher premium for Gold Core Plan"; "Option A is not worth having higher OV and Rx copays"; "Option A is a worse deal if you have a chronic condition"**

CommonwealthConnector

Silver Product Options

	Silver Core	Silver Option A	Silver Option B
Deductible	N/A	N/A	$1,000/$2,000
Out of Pocket Maximum	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000
PCP OV Copay	$25	$25	$25
Specialist Visit Copay	$25	$35	$40
Inpatient Copay	$500/admission	$750/admission	N/A
Outpatient Copay	$250	$500	N/A
ER Copay	$100	$100	$150
Prescription Rx Deductible	$250/$500	N/A	N/A
Tier 1 (generic)	$15	$15	$15
Tier 2 (preferred)	50% coinsurance after deductible	$30	$30
Tier 3 (non-preferred)	50% coinsurance after deductible	$50	$50
MRI Scan Copay	$0	$25	$50
MH/SA	$25 copay $250 per admission	$25 copay $250 per admission	$25 copay $500 admission
Monthly Individual Premium	$400	$393 (-$7)	$347 (-$53)
Episode of Care Cost	$540	$800 (+$260)	$1,055 (+$515)

Silver Plan Options

- **One a scale of 1 to 5, please rank your product preference for the Silver plans with 1 being the least desirable and 5 being the most desirable**

	Core	Option A	Option B
Member Avg	2.0	3.6	3.7
Non-member Avg	2.3	2.3	4.3
Combined Avg	2.1	3.2	3.9
Survey Preferences	24%	44%	32%

- **Comments –**
  - **"Prefer not to deal with deductibles"; "Under Core plan, Rx costs would kill me; more peace of mind knowing what fixed Rx costs are"; "Always have gone with no deductible plans due to unknown"; "Rather take on more monthly premium than a deductible"**
  - **"Go with B, take the risk and incur savings"; "Main reason to have insurance is for catastrophic events – go with B"; Having deductible depends on your health. If healthy person, hedge bet"; "Extra savings worth plan"**

CommonwealthConnector

Bronze Product Options

	Bronze Core	Bronze Option A	Bronze Option B
Deductible	$1,500/$3,000	$2,000/$4,000	$250/$500
Out of Pocket Maximum	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000
OV Copay - PCP	$25	$30	$40
Specialist Visit Copay	$40	$50	$60
Inpatient Coinsurance	20% after deductible	20% after deductible	35% after deductible
Outpatient Coinsurance	20% after deductible	20% after deductible	35% after deductible
ER Copay	$100	$150	$200
Prescription Rx Deductible	$100/$200	$250/$500	$250/$500
Tier 1 (generic)	$15	$15	$15
Tier 2 (preferred)	20% coins after deductible	50% coins after deductible	50% coinsurance
Tier 3 (non-preferred)	20% coins after deductible	50% coins after deductible	50% coinsurance
MRI Scan	20% coins after deductible	20% coins after deductible	35% coinsurance
MH/SA	$30 copay 20% coins after deductible	$30 copay 20% coins after deductible	$25 copay 35% coins after deductible
Monthly Individual Premium	$300	$265 (-$35)	$221 (-$79)
Episode of Care Cost	$2,655	$3,065 (+$410)	$2,687 (+$32)

CommonwealthConnector

Bronze Plan Options

- One a scale of 1 to 5, please rank your product preference for the Bronze plans with 1 being the least desirable and 5 being the most desirable

	Core	Option A	Option B
Member Avg	3.2	2.0	3.9
Non-member Avg	3.9	2.4	2.7
Combined Avg	3.5	2.2	3.5
Survey Preferences	40%	12%	48%

- Comments –
  - "To save $35/month under Option A, value of increase in deductible is not worth it"; "Savings you will get will be put toward Rx coinsurance"; "A is not worth it – rolling the dice"; "Not enough value"
  - "Like the low deductible with Option B – only have to worry about OOP max"; "Savings of $80/month is hugh"; "If I manage to stay out of the hospital, Option B would be great – 50% Rx coinsurance is scary though"; "Monthly savings is worth the gamble"

CommonwealthConnector

PPO Option

- **One a scale of 1 to 5, please rank your preference for a PPO plan where out of network care is covered and the premium is 10% higher than an HMO plan**

	PPO Plan
Member Avg	2.7
Non-member Avg	3.5
Combined Avg	3.0
Survey Preferences	38% approve; 62% disapprove

- **Comments –**
  - **"I firmly believe that PPOs should be offered to all members – HMOs are a ripoff"; "Considerable savings of 25 to 30% would sweeten this"; "If saved 15 to 20% might be acceptable"; "Being able to go to a Specialist without going through my PCP would be worth 5 to 10% more"**

One Plan Design/One Carrier

- **One a scale of 1 to 5, please rank your preference for ONE plan design in each Tier with only ONE carrier for each plan, with a premium discount**

	One Plan
Member Avg	1.2
Non-member Avg	1.6
Combined Avg	1.3
Survey Preferences	49% rated as non-favorable

- **Comments –**
  - **"I worry this would create a marketplace that does not accept this one carrier, but I like the lack of confusion"; "Uncompetitive"; "If it were free"; "I think that more plans are better"; "Savings would need to be 75%"; "No thanks – no choice"; "You've got to be kidding"**

CommonwealthConnector

One Plan Design/5 Carriers

- One a scale of 1 to 5, please rank your preference for ONE plan design in each Tier with FIVE carriers competing on the same plan design

	One Plan/5 Carriers
Member Avg	3.4
Non-member Avg	3.7
Combined Avg	3.5
Survey Preferences	72% rated as extremely & very favorable

- Comments –
  - "Wouldn't everyone choose the cheapest plan?"; "Like more options, but competition is good"; "Feel it would simplify decision making"; "I like the competitive nature"; "It's kind of like GEICO for health insurance"

CommonwealthConnector

3 Plan Designs/5 Carriers

- One a scale of 1 to 5, please rank your preference for THREE plan designs in each Tier with FIVE carriers competing on the three plan design options

	Three Plans/5 Carriers
Member Avg	4.0
Non-member Avg	4.0
Combined Avg	4.0
Survey Preferences	68% rated as extremely & very favorable

- Comments –
  - "This really gives me a choice"; "Still possibly expensive and confusing"; "Hooray for the free market"; "This is the best of all – the most options within each Tier; "This seems like the best option for patients to compare and choose plans – standardized information"; "More choice = better fit to each individual situation/medical condition"

CommonwealthConnector

Summary

- Gold Option A is preferred largely due to lower monthly premium of $30
- Silver Option A and B preferred, largely due to lower monthly premiums of $7 and $53 respectively
  - No Rx deductible is strongly preferred under both options
  - Medical deductible in Option B is concerning to many, but monthly savings appear to outweigh concern
- Bronze Core and Option B preferred, largely due to lower deductibles and lower premium for Option B ($79/month)
- Offering a PPO option is not a strong preference, largely due to higher monthly premium

CommonwealthConnector

Summary (cont.)

- Offering one plan design and one carrier is highly unfavorable
- Offering one plan design and five carriers is more favorable
- Offering three plan designs and five carriers is the most favorable
  - While offering a lot of choice was seen as positive, many felt that too much choice could be confusing as well – strong sentiment to keep things simple

Commonwealth Choice CY 2010 Seal of Approval

Patrick Holland, Chief Financial Officer

Board of Directors Meeting
April 9, 2009

Agenda

- Timeline of Process
- Goals of Seal of Approval (SoA)
- Staff recommendations for RFR
  - Term of carrier contract
  - Carrier participation requirements
  - Benefit Designs

CY 2010 CommChoice Seal of Approval (SOA) BOD Agenda Topics

Board Meeting	Agenda
February 26, 2009 - **Done**	• Review draft of Choice SOA timeline and process
March 12, 2009 - **Done**	• Overview of Choice model • Present overview of SOA Goals • Review uptake of current enrollment data
April 9, 2009 - Today	• Review Choice SOA carrier specifications

CY 2010 CommChoice SOA BOD Agenda Topics (cont)

Board Meeting	Agenda
May 14, 2009	• Brief update on RFR process
June 11, 2009	• Detailed discussion of staff evaluations of carrier responses
June 23, 2009	• BOD Vote to award SOA to selected carriers

CY 2010 Commonwealth Choice SOA Carrier Timeline

Date	Activity
April 10, 2009 (Tentative)	RFR Issued
April 22, 2009 (Tentative)	Q&A with Carriers
May 11, 2009	Proposals due from Carriers
May 12 through June 9, 2009	Finalizing responses with Carriers
June 12 – 19, 2009	Incorporating BOD Feedback
June 23, 2009	Vote on Carrier Selection
November 1, 2009	Open Enrollment
January 1, 2010	Effective Date of new Benefit Designs

Goals of SoA Process

- Select and offer high value plans
- Align choice of plan designs and carriers with consumer demand
- Enhance simplicity of consumer shopping experience
- Minimize risk selection
  - Inside and outside of the Heath Connector
  - Among participating health plans
- Maintain continuity of coverage for existing ~21,000 Commonwealth Choice members

RFR Recommendations

- Term of Carrier Contract
  - Two year term beginning January 1, 2010
  - Option to extend 12 Months (Connector's sole discretion)
  - Ability to add/modify, close or delete benefit designs periodically throughout term of contract

RFR Recommendations (con't)

- Carrier participation requirements
  - Must respond to all proposed benefit designs
  - Continue to encourage "Select" or "Tiered" networks
    - However, must also propose broadest HMO network if desiring to use a "Select" network
  - If awarded SoA, carrier required to participate in all tiers and products

RFR Recommendations (con't)

- Benefit Designs
  - Based on research of Commonwealth Choice members and non-members, RFR reflects;
    - Demand for choice of benefit designs and carriers
    - Balanced with need to make shopping experience easier
  - Price transparency also rated high by consumers
    - Influential on carrier price-point
  - Structure and refinement of RFR reflects nearly two years of experience with exchange model

RFR Recommendations (con't)

- Benefit Designs (con't)
  - The following staff recommendations reflect three broad objectives as a result of the member research;
    - Solicit benefit designs that allow for greater transparency of price and simplify the purchasing experience
    - Limit the number of benefit designs, while continuing to provide the level of choice expected by consumers
    - Minimize member disruption by offering benefit designs that closely match our most popular offerings

RFR Recommendations (con't)

- Gold Tier
  - One uniform benefit design and cost-sharing
  - Two unique benefit designs to be priced by carriers
    - One maintains cost sharing levels of current "Gold" offering
    - Second benefit design developed in response to survey and focus groups

Gold Benefit Designs

Plan feature / Service	Gold Plan A	Gold Plan B
Annual Deductible	None	None
Annual Out-of-Pocket Maximum	Unlimited	Unlimited
Outpatient Medical Care		
PCP Office Visit	$15	$20
Specialist Office Visit	$25	$30
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$100	$150
Diagnostic X-rays/Labs	No charge	$25
Inpatient Medical Care		
Room and Board (includes deliveries/surgeries/x-rays/labs)	$100	$150
Prescription Drugs		
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$10/$25/$45	$15/$30/$50
Mail order (Up to 90-days supply)	$20/$50/$135	$30/$60/$150
Emergency Care	$75	$75
Inpatient Mental Health (non-biologically based conditions)	$100	$150
Outpatient Mental Health (non-biologically based conditions)	$10	$20
Rehabilitation Services		
Inpatient SNF/rehab	$100	$150
Other Benefits		
Ambulance (emergency only)	No charge	No charge
Durable Medical Equipment	No charge	No charge
Vision	$25	$30

RFR Recommendations (con't)

- Silver Tier
  - Moving from 11 unique benefit designs to 3
  - The 3 designs are reflective of our most popular benefit designs
  - Number of benefit designs selected to-be-determined after evaluation of responses

Silver Benefit Designs

PLAN FEATURE / SERVICE	SILVER PLAN DESIGN A	SILVER PLAN DESIGN B	SILVER PLAN DESIGN C
Annual Deductible	None	$500 (ind) / $1,000 (fam)	$1,000 (ind) / $2,000 (fam)
Annual Out-of-Pocket Maximum	$2,000 (ind) / $4,000 (Fam)	$2,000 (ind) / $4,000 (fam)	$2,000 (ind) / $4,000 (fam)
Outpatient Medical Care			
PCP Office Visit	$25	$20	$20
Specialist Office Visit	$25	$20	$20
Outpatient Surgery	$500	$0 after deductible	$0 after deductible
Diagnostic X-rays/Labs	$0	$0 after deductible	$0 after deductible
Inpatient Medical Care			
Room and Board (includes deliveries/surgeries/x-rays/labs)	$500	$0 after deductible	$0 after deductible
Prescription Drugs			
Prescription Drug Deductible	$250 (ind) / $500 (fam) applies to Tiers 2 and 3 only	None	None
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/ 50% co-insurance after the Rx deductible/ 50% co-insurance after the Rx deductible	$15/$35/$60	$15/$30/$50
Mail order (Up to 90-days supply)	$30 50% co-insurance after the Rx deductible/ 50% co-insurance after the Rx deductible	$30/$70/$120	$30/$60/$150
Emergency Care	$100	$100	$100 after deductible
Inpatient Mental Health (non-biologically based conditions)	$500	$0 after deductible	$0 after deductible
Outpatient Mental Health (non-biologically based conditions)	$25	$20	$20
Rehabilitation Services			
Inpatient SNF/rehab	$500	$0 after deductible	$0 after deductible
Other Benefits			
Ambulance (emergency only)	No charge	$0 after deductible	$0 after deductible
Durable Medical Equipment	No charge	$0 after deductible	$0 after deductible
Vision	$25	$20	$20

RFR Recommendations (con't)

- Bronze Tier
  - Requesting price-point for 3 benefit designs
  - 2 of the designs reflective of our most popular benefit designs
  - 1 is developed with market input and has an annual deductible that is between our 2 most popular

Bronze Benefit Designs

PLAN FEATURE / SERVICE	BRONZE PLAN A	BRONZE PLAN B	BRONZE PLAN C
Annual Deductible	$2,000 (ind) / $4,000 (fam)	$250 (ind) / $500 (fam)	$1,000 (ind) / $2,000 (fam)
Annual Out-of-Pocket Maximum	$5,000 (ind) / $10,000 (fam)	$5,000 (ind) / $10,000 (fam)	$5,000 (ind) / $10,000 (fam)
Outpatient Medical Care			
PCP Office Visit	$25	$25	$25
Specialist Office Visit	$25	$40	$25
Outpatient Surgery	20% co-insurance after deductible	35% co-insurance after deductible	20% co-insurance after deductible
Diagnostic X-rays/Labs	20% co-insurance after deductible	35% co-insurance after deductible	20% co-insurance after deductible
Inpatient Medical Care			
Room and Board (includes deliveries/surgeries/x-rays/labs)	20% co-insurance after deductible	35% co-insurance after deductible	20% co-insurance after deductible
Prescription Drugs			
Prescription Drug Deductible	$100 (ind) / $200 (fam)	$250 (ind) / $500 (fam) applies to Tiers 2 and 3 only	$100 (ind) / $200 (fam)
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15 after Rx deductible/ 50% co-insurance after Rx deductible 50% co-insurance after Rx deductible	$15/ 50% co-insurance after Rx deductible 50% co-insurance after Rx deductible	$15/$30/$50
Mail order (Up to 90-days supply)	$30 after Rx deductible/ 50% co-insurance after Rx deductible 50% co-insurance after Rx deductible	$30/ 50% co-insurance after Rx deductible 50% co-insurance after Rx deductible	$30/$60/$150
Emergency Care	$100 after deductible	$150	$100
Inpatient Mental Health (non-biologically based conditions)	20% co-insurance after deductible	35% co-insurance after deductible	20% co-insurance after deductible
Outpatient Mental Health (non-biologically based conditions)	$25	$25	$25
Rehabilitation Services			
Inpatient SNF/rehab	20% co-insurance after deductible	35% co-insurance after deductible	20% co-insurance after deductible
Other Benefits			
Ambulance (emergency only)	20% co-insurance after deductible	35% co-insurance after deductible	20% co-insurance after deductible
Durable Medical Equipment	$0	35% co-insurance after deductible	$0
Vision	$25	$15	$25

RFR Recommendations (con't)

- Young Adults Plan
  - Requesting response for 2 benefit designs
  - With and without Rx Coverage
  - Requesting impact on price of excluding an annual benefit maximum
    - Benefit maximum is currently offered in all but one offering

Young Adults Plan Benefit Design

PLAN FEATURE / SERVICE	YOUNG ADULTS PLAN A	YOUNG ADULTS PLAN B
Annual Deductible	$250	$2,000
Annual Out-of-Pocket Maximum	$5,000	$5,000
Outpatient Medical Care		
PCP Office Visit	$25	$25
Specialist Office Visit	$25	$25
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	30% co-insurance after deductible	20% co-insurance after deductible
Diagnostic X-rays/Labs	30% co-insurance after deductible	20% co-insurance after deductible
Inpatient Medical Care		
Room and Board (includes deliveries/surgeries/x-rays/labs)	30% co-insurance after deductible	20% co-insurance after deductible
Prescription Drugs		
Prescription Drug Deductible	None	$250 (for Retail Tiers 2 and 3 only)
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/ 50% co-insurance/ 50% co-insurance	$15/ 50% co-insurance after Rx deductible 50% co-insurance after Rx deductible
Mail order (Up to 90-days supply)	$30 / 50% co-insurance/ 50% co-insurance	$30/ 50% co-insurance 50% co-insurance
Emergency Care	$250	$250
Inpatient Mental Health (non-biologically based conditions)	30% co-insurance after deductible	20% co-insurance after deductible
Outpatient Mental Health (non-biologically based conditions)	$25	$25
Rehabilitation Services		
Inpatient SNF/rehab	30% co-insurance after deductible	20% co-insurance after deductible
Other Benefits		
Ambulance (emergency only)	30% co-insurance after deductible	20% co-insurance after deductible
Durable Medical Equipment	30% co-insurance after deductible	20% co-insurance after deductible
Vision	$10	$25

RFR Recommendations (con't)

- PPO Design
  - Due to need to offer coverage to small groups with out-of-area employees, requiring the following;
    - Broadest HMO Network offered by Carriers
    - Discussion with carriers as to most efficient manner to meet this need

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COMMONWEALTH

HEALTH INSURANCE CONNECTOR AUTHORITY

100 CITY HALL PLAZA, 6TH FLOOR

BOSTON, MASSACHUSETTS 02108

REQUEST FOR RESPONSES

HEALTH BENEFIT PLANS – SEAL OF APPROVAL

APRIL 13, 2009

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TABLE OF CONTENTS (CONTINUED)

SECTION I – INTRODUCTION

The Commonwealth Health Insurance Connector Authority (the "Health Connector" or the "Authority") is a body politic and corporate and a public instrumentality of The Commonwealth of Massachusetts (the "Commonwealth"). The Health Connector was established pursuant to Chapter 176Q of the Massachusetts General Laws, as amended from time to time ("c. 176Q" or the "Connector Governing Act"), as added by Section 101 of Chapter 58 of the Acts of 2006 ("c. 58" or the "Health Care Reform Act of 2006"), and is an independent public entity not subject to the supervision and control of any other office, department, commission, board, bureau, agency, or political subdivision of the Commonwealth.

The Health Connector is governed by a ten member public-private Board, comprised of four ex-officio members -- the Secretary of Administration and Finance, who serves as chair of the Board, the Director of Medicaid, the Executive Director of the Group Insurance Commission, and the Commissioner of Insurance -- and six members of the public, three appointed by the Governor and three appointed by the Attorney General. Public sector members encompass a range of interests and expertise, including organized labor, employee health benefits, consumers, small business, actuarial science, and health economics.

The purpose of the Health Connector, as set forth in the Health Care Reform Act of 2006, is to administer a publicly subsidized health insurance program as well as to facilitate the availability, choice and adoption of private health insurance plans to eligible individuals and small groups as described in c. 176Q.

To meet these responsibilities, the Health Connector administers Commonwealth Care (CommCare), a publicly-subsidized health insurance program for individuals without access to employer-sponsored health insurance and with family income at or below 300% of the federal poverty level (FPL). In addition to the administration of CommCare, the Health Connector also facilitates the development and offering of affordable commercial health insurance products (without public subsidy) to individuals, families, and small groups through the Commonwealth Choice (CommChoice) program. The CommChoice program administers products for four market segments: the Individual/Non-Group plan, the Young Adults plan, the Voluntary Plan, and the Contributory Plan.

In response to this Request For Responses (RFR), the Health Connector will review carrier submissions to determine which health benefit plans meet the criteria to be awarded the Health Connector's "Seal of Approval" and are selected to be offered for purchase by individuals and small groups through the Health Connector's CommChoice program. Commercial health plans selected will be offered for sale through the Health Connector's CommChoice program beginning November 1, 2009 and will have an effective date of coverage beginning January 1, 2010. To meet these deadlines, the Health Connector is issuing to health insurance carriers this RFR, which contains guidelines and procedural rules. Responses are to be submitted by health insurance carriers to the Connector by **May 11, 2009**.

SECTION II – OVERVIEW OF THE RFR

A. PURPOSE/OBJECTIVES OF THE RFR

The Health Connector is responsible for facilitating the development and marketing of a choice of quality, affordable health insurance products to eligible individuals and small groups. The purpose of this RFR is to solicit fully insured health insurance product proposals from commercial health insurers licensed to do business in the Commonwealth.

The Health Connector plans to continue to offer through its CommChoice program the following health insurance products: (1) "Gold" plans with limited out-of-pocket cost sharing by enrollees; (2) "Silver" plans with higher out-of-pocket costs; (3) "Bronze" plans representing the highest level of cost-sharing that will satisfy the individual mandate for health insurance coverage in Massachusetts (i.e., Minimum Creditable Coverage); and (4) Young Adults Plans, to be offered solely through the Health Connector to individual, non-group purchasers ages 18 to 26. In addition, the Health Connector requests a response from carriers to offer options for covering employees of a small employer group who live outside of the carrier's HMO service area, whether through another HMO with a broader service area, or a "wrap-around" Preferred Provider Organization ("PPO") for out-of-area coverage, or an alternative PPO benefit plan, or another "solution." Each of these plan types is described further in Section IV of this RFR.

The Health Connector will serve as a distribution channel for those products that best meet the criteria set forth in this RFR and that the Board of Directors of the Health Connector determines to be the most appropriate for inclusion in a package of health benefit plans to be offered for sale through the Health Connector's CommChoice program. Plans selected by the Board will be designated with the Health Connector's Seal of Approval. With the exception of the Young Adults Plans, the selected products will be made available to all individuals and small groups that meet the eligibility rules set forth in c. 58, c. 176J, and further defined in Section III of this RFR.

Because the Health Connector will offer for purchase a number of health insurance products from multiple insurers, the Health Connector will utilize the services of an intermediary, also referred to in c. 58 as a "Sub-Connector," to provide a range of administrative functions typically handled internally or outsourced by insurance carriers operating in the small and non-group markets. These services will include, but not be limited to, pre-and post-enrollment customer service, benefits explanation, and premium quoting, billing, collection, remittance and reconciliation, and eligibility verification and renewals. These activities are discussed further in Section III of this RFR.

SECTION II – OVERVIEW OF THE RFR (CONTINUED)

B. KEY CRITERIA

Of particular interest to the Health Connector are affordable health insurance products that encourage members to use quality, cost-effective doctors and hospitals that engage consumers by providing actionable information about differences in cost and quality of care, and that reward members for adopting and maintaining healthy lifestyles. While the Health Connector, provides guidance and limitations with regard to the plan designs requested, our intent is to encourage health insurance carriers to develop and offer innovative plan designs that more effectively and efficiently deliver care to the residents of the Commonwealth.

C. TERM OF THE ENGAGEMENT

The Health Connector will award its Seal of Approval and agree to offer such health plans for a term of one year beginning January 1, 2010 and ending December 31, 2010 with two 12 month extension options (at the Health Connector's sole discretion). The Health Connector reserves the right periodically to modify benefit designs, including adding new plan designs and deleting and closing existing benefit designs. The decision to modify benefit designs at a time other than during the Health Connector's annual renewal period will be determined at the sole discretion of the Health Connector.

SECTION III – PROGRAM REQUIREMENTS

Please note that you will be asked to confirm that you will comply with the program requirements in Response Form A.

A. RULES OF PLAN PARTICIPATION

Pursuant to c. 58, carriers that meet the following criteria are required to submit health benefit plans for the Health Connector's consideration:

> Effective January 1, 2007, a carrier that marketed a health benefit plan subject to M.G.L. c. 176J, and as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its license under c. 175, c. 176A, c. 176B or c. 176G;
>
> However, neither an eligible individual or eligible employee, nor an eligible dependent, shall be considered to be enrolled in a health benefit plan issued pursuant to its authority under c. 175, c. 176A or c. 176B if the health benefit plan is sold, issued, delivered, made effective or renewed to said eligible employee or eligible dependent as a supplement to a health benefit plan subject to licensure under c. 176G.

The Health Connector will also consider health benefit plans from carriers that do not meet the above enrollment criteria but are otherwise licensed pursuant to c. 175, c. 176A, c. 176B or c. 176G.

As described further in Section IV of this RFR, carriers must submit for consideration the requisite number of health benefit plans under each of the three main plan benefit levels (Gold, Silver and Bronze) and a benefit designed to cover out-of-area employees.

For the Young Adults Plan, as described further in sub-section E of Section III and Section IV of this RFR, only those carriers that meet the following criteria, pursuant to c. 58, as amended, are allowed to submit a Young Adults Plan for the Health Connector's consideration:

> A carrier that, as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its license under c. 175, c. 176A, c. 176B or c. 176G.

SECTION III – PROGRAM REQUIREMENTS (CONTINUED)

The Health Connector is not obligated to grant its Seal of Approval to any carrier's product offerings, regardless of the carrier's small group and non-group enrollment. The Health Connector will -- based on the selection criteria summarized in this RFR and a determination by the Board -- offer to eligible individuals and small groups a set of product offerings from a limited number of carriers.

The Health Connector will only offer for sale through its CommChoice program products from carriers that satisfy the selection criteria for each of the three plan benefit levels (Gold, Silver and Bronze), Young Adults Plans, and a benefit design for employees residing out-of-area; and no carrier will be allowed to limit its product offerings to any particular health benefit plan or specific plan level unless approved by the Health Connector in its sole discretion.

B. DOI REVIEW AND APPROVAL OF NEW PRODUCTS AND RATE FILINGS

Only health benefit plans authorized by the Commissioner of Insurance and underwritten by a carrier may be offered through the CommChoice program.

Products developed for the Health Connector not currently licensed in the Commonwealth must be submitted to the Division of Insurance (DOI) for its review and approval. Carriers are strongly encouraged to review informally with DOI staff any new plan designs being submitted for the Health Connector's consideration but have not yet been approved by DOI. The Health Connector will work closely with DOI in an attempt to expedite the review process. However, the Health Connector will not recommend that the Connector Board issue its Seal of Approval to any health insurance product that is not either licensed by DOI or that has not received its informal approval.

All filing requirements of the DOI shall apply to products offered through the CommChoice program.

Carriers must cover all mandated benefits (e.g., a health service or category of health service provider) required by the carrier's licensing or other statute to include in its health benefit plan.

C. RATING METHODOLOGY

Carriers submitting health benefit plans to the Health Connector must abide by M.G.L. c. 176J, as amended, and all applicable rating regulations issued by the Division of Insurance (211 CMR 66.00 – Small Group Health Insurance) pursuant to the merged small group and non-group market.

SECTION III – PROGRAM REQUIREMENTS (CONTINUED)

Carriers must utilize the same rating methodology for products distributed through the Health Connector that they use for products offered outside the Health Connector. The Health Connector will administer its CommChoice small group product offering (the Contributory Plan) consistent with the state's small group rating rules. Policies and procedures developed for the Contributory Plan are designed to be applied consistently and uniformly for all participating carriers. The Health Connector will consult and coordinate with DOI in order to administer CommChoice in accordance with DOI's interpretation of the small group rating rules and their application to CommChoice.

Products distributed through the Health Connector may not use SIC code adjustments in non-group rating. In addition, products distributed through the Health Connector's CommChoice program will use the following four-tier rate basis types: single, 2-person, single + child(ren), and family.

D. COMMCHOICE PRODUCT DESCRIPTION

The CommChoice program is a health insurance exchange that brings together non-group subscribers and employees and private health insurance carriers for the purchase of high quality, good value health benefit plans. The CommChoice program is comprised of four products, the Individual/Non-Group plan, the Young Adults Plan, the Voluntary Plan, and the Contributory Plan.

Non-group subscribers may purchase any health benefit plan offered through the CommChoice program that is available where they live. Young adults may purchase a non-group policy, or they may select one of the Young Adults Plans offered specifically to young adults 18-26 years of age without dependents.

Small employer groups (those with 50 or fewer eligible employees) may offer eligible employees health benefit plans purchased through the CommChoice program. Coverage for these eligible employees is currently offered on a pilot basis through the Contributory Plan product. Small employer groups select a "benchmark health plan" offered by CommChoice at a specific plan benefit level (e.g., "Silver"), and agree to pay at least 50 percent of an eligible employee's monthly premium and at least 25 percent of any eligible employee's eligible dependent's monthly premium as determined for the benchmark plan. The benefit-eligible employees may select the employer's benchmark plan or any of the other health benefit plans available to them within the benchmark plan's benefit level. Additionally, these small employer groups are not permitted to offer their benefits-eligible employees separate or competing employer-sponsored health insurance coverage.

SECTION III – PROGRAM REQUIREMENTS (CONTINUED)

The CommChoice Voluntary Plan allows employer groups (of any size) to offer their employees who are ineligible to participate in their employer-sponsored health benefit plan a means to purchase non-group health benefit plans on a pre-tax basis. Employer groups may establish through their Section 125 plan the means to facilitate payroll deductions for non-group health insurance premium payments. This is not group health insurance and there is no employer contribution as part of this arrangement. There are no restrictions as to the selection of alternative health plans that the employer group may allow benefits-ineligible employees to purchase through their Section 125 programs.

The Health Connector will retain the greater of 4.5% of the premium collected or $12 per subscriber per month when premium is collected to cover its cost of marketing, customer support, enrollment, premium billing, collection and reconciliation, broker commissions, and other administrative tasks performed on behalf of the health plans.

E. YOUNG ADULTS PLAN

The Young Adults Plan may only be offered for sale through the CommChoice program, and it may only be purchased by individuals age 18 to 26, inclusive, who shall remain eligible for coverage under the Young Adults Plan until the anniversary of enrollment (i.e., renewal date) following the individual's 27th birthday.

The Young Adults Plan will be available only as individual coverage. No other coverage basis will be allowed for this plan type.

The Young Adults Plan will only be sold on an individual, non-group basis and will not be offered for sale as part of employer-sponsored insurance.

F. MARKETING

The Health Connector's target markets are: (1) uninsured individuals and families, (2) young adults ages 18 – 26, (3) small employers not currently offering group health benefits to their employees, and (4) employees not eligible for group insurance benefits, who are able to buy health insurance through a Section 125 payroll deduction program.

All carriers will be expected to actively market products available through the CommChoice program and to participate in joint marketing efforts with the Health Connector, including co-branding and establishing mutual relationships in website links and customer service representatives. Carriers shall propose a marketing plan which details how they will market CommChoice products.

SECTION III – PROGRAM REQUIREMENTS (CONTINUED)

Selected carriers will be expected to create marketing and enrollment materials in advance of the November 1, 2009 open enrollment date. By September 15, draft marketing and enrollment materials shall be submitted for review by the Health Connector on a file-and-use basis. Final marketing and enrollment materials must be finalized and delivered to the Health Connector by October 1, 2009.

All use of the Health Connector's marks shall be subject to the review and approval by the Health Connector.

G. CUSTOMER SERVICE

The Health Connector will contract with a third-party entity, also referred to as a Sub-Connector, to handle customer service, enrollment, premium billing and collection, monthly reconciliation, and other such sales and administrative functions, and to provide individuals, employers, employees, and brokers with information about the health benefit plans available through CommChoice.

Carriers will be expected to have available customer service representatives available during normal business hours to assist members, to respond to inquiries from potential enrollees, and to coordinate customer service between their own representatives, Health Connector, and the Sub-Connector's representatives.

H. DISTRIBUTION REQUIREMENTS AND ROLE OF SUB-CONNECTOR

The Health Connector will subcontract with a Sub-Connector for a range of administrative services, many of which are typically handled by health insurance carriers. These services will include some or all of the functions and services on behalf of the Health Connector related to:

- Pre- and post-enrollment customer service
- Eligibility and enrollment
- Premium quoting
- Monthly premium billing, collection and remittance to carriers, including bundling payments to the carriers from multiple employers and individuals
- Section 125 program administration/coordination with employers
- Notifications to individuals and employers regarding eligibility and enrollment status, late payment and non-payment of premium, and cancellation of coverage
- Payments to brokers/agents
- Coverage renewal

SECTION III – PROGRAM REQUIREMENTS (CONTINUED)

The Health Connector will require selected carriers to enter into a relationship with the applicable vendor to handle these administrative functions in order to achieve administrative savings and reduce duplication of services.

During the Seal of Approval contractual period, the Health Connector reserves the right to modify or change its administrative agreements with the Sub-Connector and/or procure a different, or additional, Sub-Connector vendor. The Health Connector will require that selected carriers work collaboratively, and in a timely fashion, with the Health Connector and any/all Sub-Connector vendors to ensure continuous, smooth operation of all administrative functions.

All carriers offering health benefit plans through the CommChoice program must be able to accept enrollment data in a HIPAA 834 format and financial data in a HIPAA 820 format.

The Health Connector will work with each CommChoice carrier to build and maintain the processes, file formats and technology deemed necessary for the transmission of enrollment, financial, and other essential data between the Sub-Connector and the carriers. This includes any existing requirements at the time of the Seal of Approval contracting process, and any state or federally mandated data collection and reporting changes. All other changes desired by the carriers will be viewed as discretionary; and they must be included in a formal request to the Health Connector and Sub-Connector, subject to additional reimbursement by the carriers.

I. REPORTING REQUIREMENTS

As part of this RFR submission, if applicable, carriers are required to submit claims data for CommChoice members. An extract, format to be determined, is required for all members enrolled as of December 31, 2008 for all services incurred as a CommChoice member. In addition, for carriers awarded the SoA, a quarterly schedule will be determined for future claims submissions.

In addition, as part to this RFR submission, carriers will also be required to submit a file of the Medical Loss Ratio (MLR) for both CommChoice specific business (if applicable) and total Massachusetts' based non-group and small group business for the periods ending March 31, 2009, December 31, 2008, and December 31, 2007. The Health Connector will also require from those carriers awarded the SoA a monthly electronic file, format and field layout to-be-determined, of participating physicians and hospitals. This file will include unique identifiers such as the NPI for physicians and the first extract will be required with final marketing materials on October 1, 2009.

SECTION III – PROGRAM REQUIREMENTS (CONTINUED)

J. ENROLLMENT PERIOD

Initial enrollment for: (1) eligible individual subscribers and their eligible dependents in the non-group product and Voluntary Plan product, (2) eligible young adults in the Young Adults Plan product, and (3) eligible small employer groups and their benefits-eligible employees (and their eligible dependents, if applicable) will begin on November 1, 2009, for an initial effective date of January 1, 2010.

The Health Connector and carriers offering health benefit plans through CommChoice will enroll:

(1) Eligible individual subscribers and their eligible dependents in the non-group product. Coverage is effective on the 1st day of every month, and may be renewed 12 months after the initial enrollment date. Individual subscribers and their eligible dependents (if applicable) in the non-group product may not change their existing CommChoice coverage at any other time during their 12 month coverage period unless they experience a qualifying event as permitted by the Health Connector;

(2) Eligible young adults in the Young Adults Plan product. Coverage is effective on the 1st day of every month, and may be renewed 12 months after the initial enrollment date, unless the individual has turned 27. Young Adults Plan subscribers may not change their existing CommChoice coverage at any other time during their 12 month coverage period unless they experience a qualifying event as permitted by the Health Connector ;

(3) Voluntary Plan employer groups and their employees (and their eligible dependents, if applicable) that purchase non-group coverage. Coverage is effective on the 1st day of every month and may be renewed on the 12 month anniversary date of the employer group's enrollment. Employees and their eligible dependents (if applicable) may not enroll at any other time during the 12 month coverage period unless they experience a qualified change in status as permitted by the Health Connector; and

(4) Eligible small employer groups and their benefits-eligible employees (and their eligible dependents, if applicable). Coverage is effective on the 1st day of every month and may be renewed on the 12 month anniversary date of the employer group's enrollment. Eligible employees and their eligible dependents (if applicable) may not enroll at any other time during the 12 month coverage period unless they experience a qualified change in status as permitted by the Health Connector.

Existing CommChoice members and employer groups that are scheduled to renew coverage on or after January 1, 2010 may also enroll in health benefit plans chosen through this RFR upon their anniversary date.

SECTION IV – PLAN DESIGN PARAMETERS

To facilitate comparison shopping ease among a broad set of plan choices, to drive value, and to minimize risk selection, the Health Connector will offer a limited number of carriers, with each carrier required to offer products in all three plan benefit levels – Gold, Silver, Bronze - and a PPO design. In addition, carriers meeting the participation criteria for the Young Adults Plan, pursuant to c. 58 as amended, may also offer a Young Adults Plan, subject to approval by the Health Connector.

With the exception of the Young Adults Plan, the Health Connector will not approve any health benefit plan that includes an annual, per sickness or lifetime benefits maximum. In addition, no product offering that includes a fee schedule for medical services (e.g., plan maximum benefit of $500 per day for inpatient care, or $50 per office visit, etc.) will be approved by the Health Connector. (Please note: all plans must comply with 956 CMR 5.00, the Minimum Creditable Coverage Regulations.[1])

Unless otherwise indicated, all co-payments in the benefit design specifications are per visit, per inpatient stay, or (in the case of same-day surgery) per procedure. In instances where a plan design includes a deductible, the cost-sharing column of the table describes if a particular service is subject to the deductible. For example, in the Silver Benefits Level, Plan Design B indicates that there is a $500 individual deductible and that a PCP office visit requires a $20 co-pay. As indicated in this table, a member visiting a PCP must provide a $20 co-pay, but does not have to first satisfy the deductible. However, if a member in this same plan design has outpatient surgery, this service will be subject to the deductible.

A. GOLD PLAN

The Gold plan designs are based on a comprehensive small group product offering, with limited point-of-service cost sharing. The plan design features listed on the next page must be replicated by all carriers submitting proposals in response to this RFR. This plan should rely on a carrier's broadest HMO network.

[1] Please click here to access the Minimum Creditable Coverage Regulations. Please note, effective January 1, 2010 these Regulations require coverage of the following "broad range" of medical services: Ambulatory patient services, including outpatient, day surgery and related anesthesia; Diagnostic imaging and screening procedures, including x-rays; Emergency services; Hospitalization (including at a minimum, inpatient acute care services which are generally provided by an acute care hospital for covered benefits in accordance with the member's subscriber certificate or plan description); Maternity and newborn care; Medical/surgical care, including preventive and primary care; Mental health and substance abuse services; Prescription drugs; and Radiation therapy and chemotherapy.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

GOLD PLAN DESIGN PARAMETERS

The Health Connector requests the carriers submit two Gold plan options according to each of the following plan designs. After reviewing all proposals, the Health Connector will select one plan design to be offered at the Gold level.

Plan Design A[2] - Gold Benefit Level

PLAN FEATURE / SERVICE	CO-PAYMENT
Annual Deductible	None
Annual Out-of-Pocket Maximum	Unlimited
Outpatient Medical Care	
PCP Office Visit	$15
Specialist Office Visit	$25
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$100
Diagnostic X-rays/Labs	No charge
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	$100
Prescription Drugs	
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$10/$25/$45
Mail order (Up to 90-days supply)	$20/$50/$135
Emergency Care	$75[3]
Inpatient Mental Health (non-biologically based conditions)	$100
Outpatient Mental Health (non-biologically based conditions)	$15
Rehabilitation Services	
Inpatient SNF/rehab	$100
Other Benefits	
Ambulance (emergency only)	No charge
Durable Medical Equipment	No charge
Vision	$25

[2] For those carriers currently offering products through CommChoice, Gold Option A corresponds to the plan design parameters required by the Health Connector for Gold plans with an effective date of coverage of July 1, 2008 as part of the 2008 renewal.

[3] Co-payment waived if ER visit results in hospital admission.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

Plan Design B – Gold Benefit Level

PLAN FEATURE / SERVICE	CO-PAYMENT
Annual Deductible	None
Annual Out-of-Pocket Maximum	Unlimited
Outpatient Medical Care	
PCP Office Visit	$20
Specialist Office Visit	$30
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$150
Diagnostic X-rays/Labs	$25
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	$150
Prescription Drugs	
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/$30/$50
Mail order (Up to 90-days supply)	$30/$60/$150
Emergency Care	$75[4]
Inpatient Mental Health (non-biologically based conditions)	$150
Outpatient Mental Health (non-biologically based conditions)	$20
Rehabilitation Services	
Inpatient SNF/rehab	$150
Other Benefits	
Ambulance (emergency only)	No charge
Durable Medical Equipment	No charge
Vision	$30

All services are subject to a determination of medical necessity.

All Massachusetts mandated benefits must be covered.

[4] Co-payment waived if ER visit results in hospital admission.

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SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

B. SILVER PLAN

Carriers are required to submit three product offerings at the Silver plan benefit level according to the design parameters detailed below. These plans should rely on a carrier's broadest HMO network, but a carrier should indicate if it is able and interested in offering this plan with a "select" network. In preparing your response, please rank the plan designs (first, second, and third) in terms of preference for offering them through the Health Connector. In addition, please provide the value of each plan design relative to Gold Plan Design A and B (e.g., 80%).

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

Plan Design A – Silver Benefit Level

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	None
Annual Out-of-Pocket Maximum	$2,000 (ind) / $4,000 (fam)
Outpatient Medical Care	
PCP Office Visit	$25
Specialist Office Visit	$25
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$500
Diagnostic X-rays/Labs	$0
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	$500
Prescription Drugs	
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/ 50% co-insurance / 50% co-insurance
Mail order (Up to 90-days supply)	$30 50% co-insurance / 50% co-insurance
Emergency Care	$100[5]
Inpatient Mental Health (non-biologically based conditions)	$0
Outpatient Mental Health (non-biologically based conditions)	$25
Rehabilitation Services	
Inpatient SNF/rehab	$500
Other Benefits	
Ambulance (emergency only)	No charge
Durable Medical Equipment	No charge
Vision	$25

[5] Co-payment waived if ER visit results in hospital admission.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

Plan Design B – Silver Benefit Level

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$500 (ind) / $1,000 (fam)
Annual Out-of-Pocket Maximum	$2,000 (ind) / $4,000 (fam)
Outpatient Medical Care	
PCP Office Visit	$20
Specialist Office Visit	$20
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$0 after deductible
Diagnostic X-rays/Labs	$0 after deductible
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	$0 after deductible
Prescription Drugs	
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/$35/$60
Mail order (Up to 90-days supply)	$30/$70/$120
Emergency Care	$100[6]
Inpatient Mental Health (non-biologically based conditions)	$0
Outpatient Mental Health (non-biologically based conditions)	$20
Rehabilitation Services	
Inpatient SNF/rehab	$0 after deductible
Other Benefits	
Ambulance (emergency only)	$0 after deductible
Durable Medical Equipment	$0 after deductible
Vision	$20

[6] Co-payment waived if ER visit results in hospital admission.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

Plan Design C – Silver Benefit Level

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$1,000 (ind) / $2,000 (fam)
Annual Out-of-Pocket Maximum	$2,000 (ind) / $4,000 (fam)
Outpatient Medical Care	
PCP Office Visit	$20
Specialist Office Visit	$20
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$0 after deductible
Diagnostic X-rays/Labs	$0 after deductible
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	$0 after deductible
Prescription Drugs Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/$30/$50
Mail order (Up to 90-days supply)	$30/$60/$150
Emergency Care	$100 after deductible[7]
Inpatient Mental Health (non-biologically based conditions)	$0 after deductible
Outpatient Mental Health (non-biologically based conditions)	$20
Rehabilitation Services	
Inpatient SNF/rehab	$0 after deductible
Other Benefits	
Ambulance (emergency only)	$0 after deductible
Durable Medical Equipment	$0 after deductible
Vision	$20

[7] Co-payment waived if ER visit results in hospital admission.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

C. BRONZE PLAN

Carriers are required to submit three Bronze product offerings. In responding, the carrier should rank the plan designs (first, second, and third) in terms of preference for offering them through the Health Connector. These plans should rely on a carrier's broadest HMO network, but a carrier should indicate if it is able and interested in offering this plan with a "select" network. In addition, please provide the value of each plan design relative to Gold Plan Designs A and B (e.g., 80%).

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

Plan Design A – Bronze Benefit Level

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$250 (ind) / $500 (fam)
Annual Out-of-Pocket Maximum	$5,000 (ind) / $10,000 (fam)
Outpatient Medical Care	
PCP Office Visits	$25
Specialist Office Visit	$40
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	35% co-insurance after deductible
Diagnostic X-rays/Labs	35% co-insurance after deductible
Inpatient Medical Care Room and Board (includes deliveries/surgeries/x-rays/labs)	35% co-insurance after deductible
Prescription Drugs Prescription Drug Deductible	$250 (ind) / $500 (fam) applies to Tiers 2 and 3 only
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/ 50% co-insurance after Rx deductible 50% co-insurance after Rx deductible
Mail order (Up to 90-days supply)	$30/ 50% co-insurance after Rx deductible 50% co-insurance after Rx deductible
Emergency Care	$150[8]
Inpatient Mental Health (non-biologically based conditions)	35% co-insurance after deductible
Outpatient Mental Health (non-biologically based conditions)	$25
Rehabilitation Services Inpatient SNF/rehab	35% co-insurance after deductible
Other Benefits Ambulance (emergency only)	35% co-insurance after deductible
Durable Medical Equipment	35% co-insurance after deductible
Vision	$15

[8] Co-payment waived if ER visit results in hospital admission.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

Plan Design B – Bronze Benefit Level

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$1,000 (ind) / $2,000 (fam)
Annual Out-of-Pocket Maximum	$5,000 (ind) / $10,000 (fam)
Outpatient Medical Care	
PCP Office Visit	$25
Specialist Office Visit	$40
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	25% co-insurance after deductible
Diagnostic X-rays/Labs	25% co-insurance after deductible
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	25% co-insurance after deductible
Prescription Drugs	
Prescription Drug Deductible	$100 (ind) / $200 (fam)
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/$30/$50
Mail order (Up to 90-days supply)	$30/$60/$150
Emergency Care	$150 after deductible[9]
Inpatient Mental Health (non-biologically based conditions)	25% co-insurance after deductible
Outpatient Mental Health (non-biologically based conditions)	$25
Rehabilitation Services	
Inpatient SNF/rehab	25% co-insurance after deductible
Other Benefits	
Ambulance (emergency only)	25% co-insurance after deductible
Durable Medical Equipment	$0
Vision	$25

[9] Co-payment waived if ER visit results in hospital admission.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

Plan Design C – BRONZE BENEFIT LEVEL

For "Plan Design C" only, it is required that the carrier make available, as part of this benefit design, a Health Savings Account (HSA).

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$2,000 (ind) / $4,000 (fam)
Annual Out-of-Pocket Maximum	$5,000 (ind) / $10,000 (fam)
Outpatient Medical Care	
PCP Office Visit	$25
Specialist Office Visit	$25
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	20% co-insurance after deductible
Diagnostic X-rays/Labs	20% co-insurance after deductible
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	20% co-insurance after deductible
Prescription Drugs	
Prescription Drug Deductible	$100 (ind) / $200 (fam)
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15 after Rx deductible/ 50% co-insurance after Rx deductible 50% co-insurance after Rx deductible
Mail order (Up to 90-days supply)	$30 after Rx deductible/ 50% co-insurance after Rx deductible 50% co-insurance after Rx deductible
Emergency Care	$100 after deductible[10]
Inpatient Mental Health (non-biologically based conditions)	$0
Outpatient Mental Health (non-biologically based conditions)	$25
Rehabilitation Services	
Inpatient SNF/rehab	20% co-insurance after deductible
Other Benefits	
Ambulance (emergency only)	20% co-insurance after deductible
Durable Medical Equipment	$0
Vision	$25

[10] Co-payment waived if ER visit results in hospital admission.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

D. YOUNG ADULTS PLAN

Carriers that meet the participation requirements of c. 58 for submission of a Young Adults Plan are required to propose two health benefit plans according to the parameters outlined below. These plans should be offered both with and without prescription drug coverage to individuals' ages 18 to 26, inclusive. Carriers are asked to respond to both of these options and to indicate the price differential between inclusion or exclusion of an annual benefit limit. The Health Connector is also interested in meaningful price point differences at various benefit maximum differences. Specifically, the Health Connector requests the price points for the same health plan benefit package but with a $50,000, $100,000, $250,000 or no annual benefit maximum.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

Plan Design A – Young Adults Plan

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$250
Annual Out-of-Pocket Maximum	$5,000
Outpatient Medical Care	
PCP Office Visit	$25
Specialist Office Visit	$25
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	30% co-insurance after deductible
Diagnostic X-rays/Labs	30% co-insurance after deductible
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	30% co-insurance after deductible
Prescription Drugs	
Prescription Drug Deductible	None
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/ 50% co-insurance/ 50% co-insurance
Mail order (Up to 90-days supply)	$30 / 50% co-insurance/ 50% co-insurance
Emergency Care	$250[11]
Inpatient Mental Health (non-biologically based conditions)	30% co-insurance after deductible
Outpatient Mental Health (non-biologically based conditions)	$25
Rehabilitation Services	
Inpatient SNF/rehab	30% co-insurance after deductible
Other Benefits	
Ambulance (emergency only)	30% co-insurance after deductible
Durable Medical Equipment	30% co-insurance after deductible
Vision	$10

[11] Co-payment waived if ER visit results in hospital admission.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

Plan Design B – Young Adults Plan

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$2,000
Annual Out-of-Pocket Maximum	$5,000
Outpatient Medical Care	
PCP Office Visit	$25
Specialist Office Visit	$25
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	20% co-insurance after deductible
Diagnostic X-rays/Labs	20% co-insurance after deductible
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	20% co-insurance after deductible
Prescription Drugs	
Prescription Drug Deductible	$250 (for Retail Tiers 2 and 3 only)
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/ 50% co-insurance after Rx deductible 50% co-insurance after Rx deductible
Mail order (Up to 90-days supply)	$30/ 50% co-insurance 50% co-insurance
Emergency Care	$250[12]
Inpatient Mental Health (non-biologically based conditions)	20% co-insurance after deductible
Outpatient Mental Health (non-biologically based conditions)	$25
Rehabilitation Services	
Inpatient SNF/rehab	20% co-insurance after deductible
Other Benefits	
Ambulance (emergency only)	20% co-insurance after deductible
Durable Medical Equipment	20% co-insurance after deductible
Vision	$25

[12] Co-payment waived if ER visit results in hospital admission.

SECTION V – PREFERRED PLAN DESIGN FEATURES

The following plan design features are of interest to the Health Connector. Carriers should either include these features as part of their product offerings or briefly explain why they have chosen not to do so at this time. *Please note that you will be asked to address each of the Preferred Plan Design Features for each of your product offerings in Response Form G.*

A. SELECT, HIGH-PERFORMANCE NETWORKS

Limited provider networks -- preferably including both physicians and hospitals -- can be an effective way of reducing monthly premiums without sacrificing coverage or restricting access. The Health Reform Act of 2006 indicates a preference for select, high-performance networks, and the Health Connector strongly encourages carriers to offer a health benefit plan with a provider network that rewards members for using cost-efficient, quality providers, including the use of community-based hospitals for routine procedures. In developing select or tiered networks, carriers must abide by the current minimum standard of at least one in-network general, full-service hospital within each Massachusetts County in the proposed service area. For each zip code in the proposed service area, enrollees must have access to at least two primary care physicians with open panels within a 15-mile radius or 30-minutes of travel time.

B. CENTERS OF EXCELLENCE

While the majority of care is relatively routine in nature and can be appropriately delivered at licensed in-network facilities across the Commonwealth, more complex conditions and procedures likely demand a higher level of sophistication and expertise. Recognizing this, the Health Connector encourages carriers to consider offering enrollees -- particularly for health benefit plans with limited hospital networks -- the opportunity to access designated Centers of Excellence for specific conditions or procedures. These procedures commonly include organ transplants, bone marrow transplants, stem cell treatments, select cardiac procedures, in vitro fertilization services and certain types of cancer treatments.

In addition, the Leapfrog Group[13] has identified a select number of high-risk procedures for which volume -- the number of procedures of a given type a hospital performs each year -- has been demonstrated to positively affect outcomes. For limited networks, allowing members to access tertiary facilities that have more experience treating select complex conditions and performing certain procedures should also be considered an important part of the plan design. For health benefit plans that do not include a limited network of hospitals, carriers should

[13] Launched in November 2000, The Leapfrog Group is a voluntary national program, funded by large employers and foundations, aimed at mobilizing employer purchasing power to encourage transparency and easy access to health care information, as well as reward hospitals that have a proven record of high quality care.

SECTION V – PREFERRED PLAN DESIGN FEATURES (CONTINUED)

consider including plan design features that reward the use of, or otherwise steer members to, Centers of Excellence for complex conditions and procedures.

C. CONSUMER ENGAGEMENT, INCLUDING TRANSPARENCY OF HEALTH CARE COST AND QUALITY DATA, AND WEB-BASED DECISION SUPPORT TOOLS

To engage consumers and heighten their understanding of the variation in cost across providers and differences in quality among providers, carriers should demonstrate a commitment to providing enrollees with meaningful and actionable information regarding health care cost and quality. While the Commonwealth has established a Health Care Quality and Cost Council to promote high quality, safe, effective, timely, efficient, equitable and patient-centered health care, it is incumbent upon health insurance carriers -- which have access to robust data sets that can be used to measure both cost and quality -- to make available to consumers comparative cost and quality information by facility, clinician and/or physician practice group, including information related to patient safety and member satisfaction.

D. HSA OPTION WITH HIGH DEDUCTIBLE HMO

The Health Reform Act directs the Commissioner of Insurance to approve high deductible HMO plans that include a deductible up to the maximum annual IRS-established health savings account contributions for 2010. As one of its Minimum Creditable Coverage plans, carriers are encouraged to offer a high deductible health plan, as defined by the IRS[14], with the option -- at the subscriber's option -- of self-funding an HSA.

E. WELLNESS INCENTIVES AND MEDICAL MANAGEMENT PROGRAMS

The Health Connector is interested in carriers offering value-added benefits that promote primary care, wellness incentives and medical management programs. Carriers are encouraged to include plan design features that reward members for completing health risk assessments, participating in appropriate disease and case management programs, and providing other programs to change their eating, exercise, smoking, and/or other life-style habits.

F. PREVENTIVE AND FLEX BENEFITS FOR CHRONIC CONDITIONS

For enrollees with chronic conditions, carriers should consider, for example, offering programs that provide for reduced office visit co-payments or co-insurance or lower prescription drug co-payments. Other types of flexible benefits might allow additional pre-deductible office visits

[14] See 26 U.S.C. § 223.

SECTION V – PREFERRED PLAN DESIGN FEATURES (CONTINUED)

subject to a co-payment for members with chronic conditions that are enrolled in a health benefit plan that has an annual deductible.

SECTION VI – REQUIRED ELEMENTS OF THE PROPOSAL

A. TRANSMITTAL LETTER

The Transmittal Letter should contain a summary or executive overview of the carrier's proposal and should be signed by an individual authorized to bind the firm contractually. The letter must also provide the name and contact information for the RFR respondent. The Health Connector will assume this individual will be available to respond to requests for additional information if necessary.

B. SUMMARY INFORMATION FOR EACH PLAN DESIGN

For each health benefit plan proposed, the carrier must prepare summary information that describes the coverage in layman's terms and specifies co-payments, co-insurance, deductibles and any limitations related to coverage. The summary information must include, but should not be limited to, the following categories:

- Service area
- Primary Care Physician (PCP) requirements and referrals
- Urgent care and emergency room services
- Out-of-pocket maximum
- Covered services and applicable cost-sharing requirements, including:
  - Outpatient care/office visits
  - Emergency room visits
  - Diagnostic testing
  - Durable medical equipment
  - Ambulatory surgery
  - Inpatient care
    - Acute
    - Skilled nursing and rehabilitative care
  - Mental health and substance abuse
    - Biologically based conditions
      - Outpatient care/office visits
      - Inpatient care
    - Non-biologically based conditions
      - Outpatient care/office visits
      - Inpatient care
  - Prescription drug benefit

For each plan design, carriers should complete the applicable plan design worksheet (Response Forms B-E). If a carrier has an existing plan that meets these plan design parameters, they should include the summary plan document (i.e., schedule of benefits) for that plan.

SECTION VI – REQUIRED ELEMENTS OF THE PROPOSAL (CONTINUED)

C. PROVIDER DIRECTORY FOR EACH HEALTH BENEFIT PLAN

For each health benefit plan proposed, carriers should submit in electronic format a listing of in-network providers by practice specialty and location/zip code. A separate file should be included that lists the name and location/zip code of in-network hospitals.

D. FULL RATING FORMULA FOR EACH PLAN DESIGN

Carriers will need to make arrangements to provide to the Health Connector's consultant a complete rating table for each product offered so that plan premiums can be calculated and compared across plans.

In addition, the Health Connector's third party administrator (i.e., Sub-Connector) will need a complete rating table for each product offered by the Health Connector. This rating table will need to be capable of generating quotes on a regular basis for both non-group and small-group rating. Carriers' products offered through the Health Connector will be required to provide a rating table to the Sub-Connector, and carriers will be required to provide updates to the rating table throughout the contract period.

E. PREMIUMS

For each product offered, carriers must list the monthly premium, assuming non-group purchase and no rating adjustment based on industry/SIC code, for each of the demographic categories, geographic regions and coverage categories listed in the table on the following page. Premiums should reflect a January 1, 2010 effective date of coverage.

SECTION VI – REQUIRED ELEMENTS OF THE PROPOSAL (CONTINUED)

DEMOGRAPHIC CATEGORIES, GEOGRAPHIC REGIONS AND COVERAGE CATEGORIES	BOSTON (02108)	WORCESTER (01601)	SPRINGFIELD (01089)
Single male, age:			
25 years old			
35 years old			
45 years old			
55 years old			
Single female, age			
25 years old			
35 years old			
45 years old			
55 years old			
Two adults			
28 yr old w/30 yr old spouse			
35 yr old w/38 yr old spouse			
47 yr old w/47 yr old spouse			
56 yr old w/63 yr old spouse			
Single male w/one child			
28 years old			
35 years old			
47 years old			
56 years old			
Single female w/one child			
28 years old			
35 years old			
47 years old			
56 years old			
Married couple w/two children			
28 yr old w/30 yr old spouse			
35 yr old w/38 yr old spouse			
47 yr old w/47 yr old spouse			
56 yr old w/63 yr old spouse			

SECTION VI – REQUIRED ELEMENTS OF THE PROPOSAL (CONTINUED)

Carriers must also provide the rating factor used for each geographic region in the Commonwealth using the rate table below.

ZIP CODES	RATING FACTOR
010 through 013	
014 through 016	
017 through 020	
018 through 019	
021 through 022 and 024	
023 and 027	
025 through 026	

F. ACTUARIAL OPINION

Every carrier must file with the Health Connector a copy of an actuarial opinion that the carrier's rating methodologies and rates comply with the requirements of M.G.L. c. 176J and 211 CMR 66.00, as required by the Division of Insurance.

The actuarial certification must be signed by a member of the American Academy of Actuaries based upon the person's examination, including a review of the appropriate records, of the actuarial assumptions and methods used by the carrier in establishing premium rates for health benefit plans offered by the carrier to be sold through the Health Connector.

Every carrier must maintain at its principal place of business a complete and detailed description of its rating practices including information and documentation which demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions, are in accordance with sound actuarial principles, and comply with the provisions of 211 CMR 66.00. This information must be made available to the Health Connector upon request, but will remain confidential.

Every carrier shall notify the Health Connector regarding any material changes or additions to the actuarial methodology at least 120 days prior to the effective date of the change or addition and provide the same information, including any changes to the rating table, to the Health Connector.

SECTION VI – REQUIRED ELEMENTS OF THE PROPOSAL (CONTINUED)

G. DISCUSSION OF PREFERRED PLAN DESIGN FEATURES

For each of the preferred plan design features listed in Section V of this RFR, carriers should briefly describe how the proposed health benefit plan incorporates each of the preferred plan design features. For proposed health benefit plans that do not include a particular feature, carriers should briefly discuss the reasons for omitting that design feature. Carriers must complete Response Form G.

H. PRODUCT LICENSURE BY THE DIVISION OF INSURANCE

For each product offering, carriers must either confirm that the product is licensed for sale in the Commonwealth or discuss the status of the product filing and any feedback that the carrier has received from the Division of Insurance regarding the proposed, but not yet licensed, plan design.

I. SALES AND MARKETING PLAN

Carriers should briefly describe their sales and marketing plan and how they will differentiate their marketing efforts for Health Connector products.

J. MASSACHUSETTS SMALL AND NON-GROUP ENROLLMENT

On Response Form F of this RFR, carriers must complete the small and non-group membership information for each product offered and purchased in Massachusetts. Carriers should provide monthly enrollment data from the period from January 1, 2008 through December 31, 2008. In addition, carriers should report enrollment for the most recent month for which membership information is available (e.g., March 31, 2009).

As noted on Response Form F, the Health Connector is requiring this data at the benefit design level so identifiers which allow this type of analysis are required.

SECTION VII – TIMELINE AND PROCESS FOR SUBMISSION AND SELECTION

Proposals must be submitted to:

Mr. Patrick Holland
Chief Financial Officer
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza, 6th Floor
Boston, Massachusetts 02108

Mr. Holland can be contacted at:

617-933-3058
Patrick.Holland@state.ma.us

Two (2) unbound, unpunched originals, so identified, plus six (6) bound copies, must be received at the Health Connector offices by 3:00 p.m. on Friday, May 15, 2009.

The proposal must include the following elements:

1) Transmittal Letter
2) Summary information for each required plan design
3) Plan design worksheet for each required plan design
4) Pricing worksheet for each required plan design
5) Provider directory in electronic format for each required plan design
6) Actuarial opinion for each required plan design
7) Preferred plan design features response form for each required plan design
8) Product licensure confirmation/explanation
9) Sales and marketing plan
10) Small and non-group membership details

A bidders conference will be held on April 22, 2009. Interested vendors are invited to attend. Health Connector staff will be available to respond to questions regarding this RFR. In addition, vendors may also submit written questions to the Health Connector at connector.rfr.questions@state.ma.us or via the mailing address listed above. Questions will be accepted through April 24, 2009. All questions and answers will be posted on the Health Connector web site, www.MaHealthConnector.org, no later than April 29, 2009.

SECTION VII – TIMELINE AND PROCESS FOR SUBMISSION AND SELECTION (CONTINUED)

SCHEDULE

DATE	ACTIVITY
April 13, 2009	RFR Issued
April 22, 2009	Q&A Session With Interested Vendors
May 11, 2009	Proposals Due to the Health Connector by 3:00 p.m.
May 16 through June 19	Health Connector review of carrier proposals and Meetings with Carriers
June 23, 2009	Health Benefit Plans' Recommendations Presented to Connector Board for Review And Approval
November 1, 2009	Open Enrollment Begins
January 1, 2010	***Connector Plans' Effective Date of Coverage***

SECTION VIII – RESPONSE FORMS

RESPONSE FORM A – PROGRAM REQUIREMENTS

A. RULES OF PLAN PARTICIPATION

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

RULES OF PLAN PARTICIPATION	CONFIRMATION OR EXPLANATION
1. Pursuant to c. 58, please confirm that you will submit the following criteria for the Health Connector's consideration: A carrier that, as of the close of any preceding calendar year, had a combined total of 5,000 or more eligible employees and eligible dependents who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses pursuant to its license under c. 175, c. 176A, c. 176B or c. 176G;	
However, neither an eligible individual or eligible employee, nor an eligible dependent, shall be considered to be enrolled in a health benefit plan issued pursuant to its authority under c. 175, c. 176A or c. 176B if the health benefit plan is sold, issued, delivered, made effective or renewed to said eligible employee or eligible dependent as a supplement to a health benefit plan subject to licensure under c. 176G.	
2. Confirm that your company will submit for consideration the requisite number of health benefit plans under each of the three main plan benefit levels (Gold, Silver, Bronze) as well as a PPO design.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

A. RULES OF PLAN PARTICIPATION

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

RULES OF PLAN PARTICIPATION	CONFIRMATION OR EXPLANATION
3. For the Young Adults Plan, please confirm that your company will meet the following criteria, pursuant to c. 58, as amended for the Health Connector's consideration:	
A carrier that, as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its license under c. 175, c. 176A, c. 176B or c. 176G.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

B. DOI REVIEW AND APPROVAL OF NEW PRODUCTS AND RATE FILINGS

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

DOI REVIEW AND APPROVAL OF NEW PRODUCTS AND RATE FILINGS	CONFIRMATION OR EXPLANATION
1. Confirm that you will cover all mandated benefits (i.e., a health service or category of health service provider) required by the carrier's licensing or other statute to include in its health benefit plan.	

C. RATING METHODOLOGY

RATING METHODOLOGY	CONFIRMATION OR EXPLANATION
1. Confirm that you will utilize the same rating methodology for products distributed through the Health Connector that you use for products offered outside the Health Connector.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

D. COMMCHOICE PRODUCT DESIGN

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

COMMCHOICE PRODUCT DESIGN	CONFIRMATION OR EXPLANATION
1. Confirm your understanding that only eligible small employers (those with 50 or fewer eligible employees) may purchase small group health insurance coverage through the Health Connector's CommChoice program.	
2. Confirm your understanding that employers that offer their eligible employees health benefit plans purchased through the Health Connector's CommChoice program will not be allowed to offer to their benefits-eligible employees any separate or competing employer-sponsored health insurance coverage.	
3. Confirm your understanding that for those employees not eligible to participate in employer-sponsored health benefit plans, employers may establish as part of their Section 125 program a means to facilitate payroll deductions for non-group premium payments through CommChoice. This provision will apply without regard to whether the employer's benefits-eligible employees are purchasing health benefit plans through CommChoice, and without regard to the number of employees in the group.	
4. Confirm your understanding that eligible small employers that agree to pay at least 50 percent of the monthly premium for a "benchmark" plan at a given benefit level (i.e., Gold, Silver or Bronze), shall restrict the choice of their employees to product offerings in the selected plan benefit level.	
5. Confirm your understanding that employers that do not contribute the minimum amount of the monthly premium for a "benchmark" plan will not qualify for a Contributory Plan through CommChoice, and employees will not be eligible for group insurance coverage through CommChoice.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

D. COMMCHOICE PRODUCT DESIGN (CONTINUED)

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

COMMCHOICE PRODUCT DESIGN	CONFIRMATION OR EXPLANATION
6. Confirm your understanding that non-group purchasers will be allowed to select from any of the plan choices offered through the Health Connector's CommChoice program.	
7. Confirm your understanding that no health benefit plan shall be offered through the Health Connector that excludes an individual from coverage because of race, color, religion, national origin, sex, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income, or age.	
8. Confirm your understanding that only health benefit plans that have been authorized by the Division of Insurance and underwritten by a carrier may be offered through the Health Connector.	
9. Confirm your understanding that the Health Connector will retain the higher of 4.5% of premium collected or $12.00 per subscriber for each of the products offered for sale through the Health Connector, to cover the Health Connector's cost of marketing, enrollment and other administrative tasks performed on behalf of the health plans.	
10. Confirm that you will abide by CommChoice program policies and procedures.	
11. Confirm your understanding that CommChoice non-group purchasers that subsequently drop coverage prior to the end of the plan year shall not be allowed to enroll in a different health plan offered through CommChoice until the completion of the plan year in which the individual was previously enrolled.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

E. YOUNG ADULTS PLAN

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

YOUNG ADULTS PLAN	CONFIRMATION OR EXPLANATION
1. Confirm that the Young Adults Plan may only be offered for sale through the Health Connector's CommChoice program, and may only be purchased by individuals ages 18 to 26, inclusive, without access to employer sponsored insurance, who shall remain eligible for coverage under this plan until the anniversary date (i.e., renewal date) following the individual's 27th birthday.	
2. Confirm that the Young Adults Plan will be available only as individual coverage. No other coverage basis will be allowed for this plan type.	
3. Confirm that the Young Adults Plan will only be sold on a non-group basis and will not be offered for sale as part of employer-sponsored insurance.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

F. MARKETING

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

MARKETING	CONFIRMATION OR EXPLANATION
1. Confirm that you will create a detailed marketing plan (which outlines roles and responsibilities) and participate in joint marketing efforts with the Health Connector, including co-branding and establishing direct links between the Health Connector's web site and the carriers' web site and customer service representatives. Carriers shall propose how they plan to market the Health Connector as a distribution channel for the plans they propose to sell through CommChoice.	
2. Confirm that, if selected, you will have marketing and enrollment materials available in advance of the November 1, 2009 open enrollment date, and that a draft of these materials will be submitted for review by the Health Connector on a file and use basis by September 15, 2009 and finalized by October 1, 2009.	
3. Confirm that all use of the Health Connector's marks shall be subject to the review and approval by the Health Connector staff.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

G. CUSTOMER SERVICE

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

CUSTOMER SERVICE	CONFIRMATION OR EXPLANATION
1. Please confirm your understanding that the Health Connector will contract with a third-party entity, also referred to as a Sub-Connector, to handle customer service, enrollment, premium billing and collection, monthly reconciliation, and other such sales and administrative functions, and to provide individuals, employers, employees, and brokers with information about the health benefit plans available through CommChoice.	
2. Please confirm that you will have available customer service representatives during normal business hours to assist members and respond to inquiries from potential enrollees, and to coordinate customer service between their own representatives and the Sub-Connector's representatives.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

H. DISTRIBUTION REQUIREMENTS AND ROLE OF SUB-CONNECTOR(S)

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

DISTRIBUTION REQUIREMENTS AND ROLE OF SUB-CONNECTOR(S)	CONFIRMATION OR EXPLANATION
1. Please confirm your understanding that the Health Connector will subcontract with an entity or entities responsible for a range of administrative services, many of which are typically handled by health insurance carriers. These services will include: ▪ Pre- and post-enrollment customer service ▪ Eligibility and enrollment ▪ Premium quoting ▪ Monthly premium billing, collection and remittance to carriers, including bundling payments to the carriers from multiple employers and individuals ▪ Section 125 program administration/coordination with employers ▪ Notifications to individuals and employers regarding eligibility and enrollment status, late payment and non-payment of premium, and cancellation of coverage ▪ Payments to brokers/agents ▪ Renewals	
2. Confirm that if you are selected to participate in the Health Connector that you will enter into a relationship with the vendor selected to handle administrative functions on behalf of the Health Connector.	
3. Please confirm that you will accept eligibility data in HIPAA 834 format.	
4. Please confirm that you will accept financial data in HIPAA 820 format.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

I. REPORTING REQUIREMENTS

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

REPORTING REQUIREMENTS	CONFIRMATION OR EXPLANATION
1. Please confirm that you may be required to submit rate data to the Health Connector, in a mutually agreeable format, for each product sold through CommChoice.	
2. Please confirm that you may be required to submit summary premium and claims data on a regular basis to the Health Connector or a Health Connector designated third-party.	

J. ENROLLMENT PERIOD

ENROLLMENT PERIOD	CONFIRMATION OR EXPLANATION
1. Please confirm that you will accept CommChoice membership as reported in the Health Connector's enrollment files to carriers (based on the enrollment period description outlined in Section III, J (Program Requirements, Enrollment Period)).	

RESPONSE FORM B – GOLD PLAN DESIGN WORKSHEET

In the tables below, confirm that you will be able to match each of the features of the Gold Plan Design A and B by writing "confirm" in the column labeled "Your Gold Design Plan A (or B)." If you cannot match a plan design provision, please provide a brief summary of the benefit you are able to provide in the space provided, or if necessary on a separate attachment.

PLAN FEATURE / SERVICE	GOLD PLAN DESIGN A	YOUR GOLD DESIGN PLAN A
Annual Deductible	None	
Annual Out-of-Pocket Maximum	Unlimited	
Outpatient Medical Care		
PCP Office Visit	$15	
Specialist Office Visit	$25	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$100	
Diagnostic X-rays/Labs	No charge	
Inpatient Medical Care		
Room and Board (includes deliveries/surgeries/x-rays/labs)	$100	
Prescription Drugs		
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$10/$25/$45	
Mail order (Up to 90-days supply)	$20/$50/$135	
Emergency Care	$75[15]	
Inpatient Mental Health (non-biologically based conditions)	$100	
Outpatient Mental Health (non-biologically based conditions)	$15	
Rehabilitation Services		
Inpatient SNF/rehab	$100	
Other Benefits		
Ambulance (emergency only)	No charge	
Durable Medical Equipment	No charge	
Vision	$25	

[15] Co-payment waived if ER visit results in hospital admission.

PLAN FEATURE / SERVICE	GOLD PLAN DESIGN B	YOUR GOLD DESIGN PLAN B
Annual Deductible	None	
Annual Out-of-Pocket Maximum	Unlimited	
Outpatient Medical Care		
PCP Office Visit	$20	
Specialist Office Visit	$30	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$150	
Diagnostic X-rays/Labs	$25	
Inpatient Medical Care		
Room and Board (includes deliveries/surgeries/x-rays/labs)	$150	
Prescription Drugs		
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/$30/$50	
Mail order (Up to 90-days supply)	$30/$60/$150	
Emergency Care	$75[16]	
Inpatient Mental Health (non-biologically based conditions)	$150	
Outpatient Mental Health (non-biologically based conditions)	$20	
Rehabilitation Services		
Inpatient SNF/rehab	$150	
Other Benefits		
Ambulance (emergency only)	No charge	
Durable Medical Equipment	No charge	
Vision	$30	

[16] Co-payment waived if ER visit results in hospital admission.

RESPONSE FORM B – GOLD PLAN DESIGN WORKSHEET (CONTINUED)

In the table below, for each proposed product design at the Gold level, please estimate the percentage of medical expenses that will be covered for an average enrollee. That is, for the average person, how much of his/her total medical expenses do you estimate will be covered by the health plan.

	GOLD PLAN DESIGN	GOLD PLAN DESIGN A	GOLD PLAN DESIGN B
Percentage of average medical expenses for an insured individual covered by the proposed plan design			
Relative Value	100%		

RESPONSE FORM C – SILVER PLAN DESIGN WORKSHEET

In the tables below, confirm that you will be able to match each of the features of the Silver Plan Design A, B, or C by writing "confirm" in the column labeled "Your Silver Design Plan A (B, or C)." If you cannot match a plan design provision, please provide a brief summary of the benefit you are able to provide in the space provided, or if necessary on a separate attachment. At the end of the table, indicate the relative value of each plan design in comparison to "Your Gold Plan Design A and B Plans."

PLAN FEATURE / SERVICE	SILVER PLAN DESIGN A	YOUR SILVER PLAN DESIGN A
Annual Deductible	None	
Annual Out-of-Pocket Maximum	$2,000 (ind) / $4,000 (fam)	
Outpatient Medical Care		
PCP Office Visit	$25	
Specialist Office Visit	$25	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$500	
Diagnostic X-rays/Labs	$0	
Inpatient Medical Care		
Room and Board (includes deliveries/surgeries/x-rays/labs)	$500	
Prescription Drugs		
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/ 50% co-insurance / 50% co-insurance	
Mail order (Up to 90-days supply)	$30 50% co-insurance / 50% co-insurance	
Emergency Care	$100[17]	
Inpatient Mental Health (non-biologically based conditions)	$0	
Outpatient Mental Health (non-biologically based conditions)	$25	
Rehabilitation Services		
Inpatient SNF/rehab	$500	
Other Benefits		
Ambulance (emergency only)	No charge	
Durable Medical Equipment	No charge	
Vision	$25	

[17] Co-payment waived if ER visit results in hospital admission.

PLAN FEATURE / SERVICE	SILVER PLAN DESIGN B	YOUR SILVER PLAN DESIGN B
Annual Deductible	$500 (ind) / $1,000 (fam)	
Annual Out-of-Pocket Maximum	$2,000 (ind) / $4,000 (fam)	
Outpatient Medical Care		
PCP Office Visit	$20	
Specialist Office Visit	$20	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$0 after deductible	
Diagnostic X-rays/Labs	$0 after deductible	
Inpatient Medical Care		
Room and Board (includes deliveries/surgeries/x-rays/labs)	$0 after deductible	
Prescription Drugs		
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/$35/$60	
Mail order (Up to 90-days supply)	$30/$70/$120	
Emergency Care	$100[18]	
Inpatient Mental Health (non-biologically based conditions)	$0	
Outpatient Mental Health (non-biologically based conditions)	$20	
Rehabilitation Services		
Inpatient SNF/rehab	$0 after deductible	
Other Benefits		
Ambulance (emergency only)	$0 after deductible	
Durable Medical Equipment	$0 after deductible	
Vision	$20	

[18] Co-payment waived if ER visit results in hospital admission.

PLAN FEATURE / SERVICE	SILVER PLAN DESIGN C	YOUR SILVER PLAN DESIGN C
Annual Deductible	$1,000 (ind) / $2,000 (fam)	
Annual Out-of-Pocket Maximum	$2,000 (ind) / $4,000 (fam)	
Outpatient Medical Care		
PCP Office Visit	$20	
Specialist Office Visit	$20	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$0 after deductible	
Diagnostic X-rays/Labs	$0 after deductible	
Inpatient Medical Care		
Room and Board (includes deliveries/surgeries/x-rays/labs)	$0 after deductible	
Prescription Drugs		
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/$30/$50	
Mail order (Up to 90-days supply)	$30/$60/$150	
Emergency Care	$100 after deductible[19]	
Inpatient Mental Health (non-biologically based conditions)	$0 after deductible	
Outpatient Mental Health (non-biologically based conditions)	$20	
Rehabilitation Services		
Inpatient SNF/rehab	$0 after deductible	
Other Benefits		
Ambulance (emergency only)	$0 after deductible	
Durable Medical Equipment	$0 after deductible	
Vision	$20	

[19] Co-payment waived if ER visit results in hospital admission.

RESPONSE FORM C – SILVER PLAN DESIGN WORKSHEET

In the table below, indicate the relative value of each plan design relative to the value of "Your Gold Plan Design A and B Plans."

	SILVER PLAN DESIGN A	SILVER PLAN DESIGN B	SILVER PLAN DESIGN C
Percentage of average medical expenses for an insured individual covered by the proposed plan design			
Relative Value (compared to "Your Gold Plan Design A Plan")			
Relative Value (compared to "Your Gold Plan Design B Plan")			

RESPONSE FORM D – BRONZE (MINIMUM CREDITABLE COVERAGE) PLAN DESIGN WORKSHEET

In the tables below, confirm that you will be able to match each of the features of the Bronze Plan Design A, B, and C by writing "confirm" in the column labeled "Your Bronze Plan Design A (or B, or C)." If you cannot match a plan design provision, please provide a brief summary of the benefit you are able to provide in the space provided, or if necessary on a separate attachment. At the end of the table, indicate the relative value of each plan design relative to "Your Gold Plan Design A and B Plans."

PLAN FEATURE / SERVICE	BRONZE PLAN DESIGN A	YOUR BRONZE PLAN DESIGN A
Annual Deductible	$250 (ind) / $500 (fam)	
Annual Out-of-Pocket Maximum	$5,000 (ind) / $10,000 (fam)	
Outpatient Medical Care PCP Office Visits	$25	
Specialist Office Visit	$40	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	35% co-insurance after deductible	
Diagnostic X-rays/Labs	35% co-insurance after deductible	
Inpatient Medical Care Room and Board (includes deliveries/surgeries/x-rays/labs)	35% co-insurance after deductible	
Prescription Drugs Prescription Drug Deductible	$250 (ind) / $500 (fam) applies to Tiers 2 and 3 only	
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15 / 50% co-insurance after Rx deductible/ 50% co-insurance after Rx deductible	
Mail order (Up to 90-days supply)	$30 / 50% co-insurance after Rx deductible/ 50% co-insurance after Rx deductible	
Emergency Care	$150[20]	
Inpatient Mental Health (non-biologically based conditions)	35% co-insurance after deductible	
Outpatient Mental Health (non-biologically based conditions)	$25	
Rehabilitation Services Inpatient SNF/rehab	35% co-insurance after deductible	
Other Benefits Ambulance (emergency only)	35% co-insurance after deductible	
Durable Medical Equipment	35% co-insurance after deductible	
Vision	$15	

[20] Co-payment waived if ER visit results in hospital admission.

PLAN FEATURE / SERVICE	BRONZE PLAN DESIGN B	YOUR BRONZE PLAN DESIGN B
Annual Deductible	$1,000 (ind) / $2,000 (fam)	
Annual Out-of-Pocket Maximum	$5,000 (ind) / $10,000 (fam)	
Outpatient Medical Care		
PCP Office Visit	$25	
Specialist Office Visit	$40	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	25% co-insurance after deductible	
Diagnostic X-rays/Labs	25% co-insurance after deductible	
Inpatient Medical Care		
Room and Board (includes deliveries/surgeries/x-rays/labs)	25% co-insurance after deductible	
Prescription Drugs		
Prescription Drug Deductible	$100 (ind) / $200 (fam)	
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/$30/$50	
Mail order (Up to 90-days supply)	$30/$60/$150	
Emergency Care	$150 after deductible[21]	
Inpatient Mental Health (non-biologically based conditions)	25% co-insurance after deductible	
Outpatient Mental Health (non-biologically based conditions)	$25	
Rehabilitation Services		
Inpatient SNF/rehab	25% co-insurance after deductible	
Other Benefits		
Ambulance (emergency only)	25% co-insurance after deductible	
Durable Medical Equipment	$0	
Vision	$25	

[21] Co-payment waived if ER visit results in hospital admission.

PLAN FEATURE / SERVICE	BRONZE PLAN DESIGN C	YOUR BRONZE PLAN DESIGN C
Annual Deductible	$2,000 (ind) / $4,000 (fam)	
Annual Out-of-Pocket Maximum	$5,000 (ind) / $10,000 (fam)	
Outpatient Medical Care		
PCP Office Visit	$25	
Specialist Office Visit	$25	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	20% co-insurance after deductible	
Diagnostic X-rays/Labs	20% co-insurance after deductible	
Inpatient Medical Care		
Room and Board (includes deliveries/surgeries/x-rays/labs)	20% co-insurance after deductible	
Prescription Drugs		
Prescription Drug Deductible	$100 (ind) / $200 (fam)	
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15 after Rx deductible/ 50% co-insurance after Rx deductible/ 50% co-insurance after Rx deductible	
Mail order (Up to 90-days supply)	$30 after Rx deductible/ 50% co-insurance after Rx deductible/ 50% co-insurance after Rx deductible	
Emergency Care	$100 after deductible[22]	
Inpatient Mental Health (non-biologically based conditions)	$0	
Outpatient Mental Health (non-biologically based conditions)	$25	
Rehabilitation Services		
Inpatient SNF/rehab	20% co-insurance after deductible	
Other Benefits		
Ambulance (emergency only)	20% co-insurance after deductible	
Durable Medical Equipment	$0	
Vision	$25	

[22] Co-payment waived if ER visit results in hospital admission.

RESPONSE FORM D – BRONZE (MINIMUM CREDITABLE COVERAGE) PLAN DESIGN WORKSHEET (CONTINUED)

In the table below, indicate the value of each plan design relative to "Your Gold Plan Design A and B Plans."

	BRONZE (MCC) PLAN DESIGN A	BRONZE (MCC) PLAN DESIGN B	BRONZE (MCC) PLAN DESIGN C
Percentage of average medical expenses for an insured individual covered by the proposed plan design			
Relative Value (compared to "Your Gold Plan Design A Plan")			
Relative Value (compared to "Your Gold Plan Design B Plan")			

RESPONSE FORM E – YOUNG ADULTS PLAN DESIGN WORKSHEET

In the tables below, confirm that you will be able to match each of the features of the Young Adults Plan Design A or B by writing "confirm" in the column labeled "Your Young Adults Plan Design A (or B)." If you cannot match a plan design provision, please provide a brief summary of the benefit you are able to provide in the space provided, or if necessary on a separate attachment. In the table below, please provide a brief summary of the benefit you are offering in the space provided, or if necessary on a separate attachment. For each column, provide your proposed cost-sharing arrangements for each of the services listed. At the end of the table, indicate the relative value of the plan design, with and without a drug benefit, compared to "Your Gold Plan Design A and B Plans."

PLAN FEATURE / SERVICE	YOUNG ADULTS PLAN DESIGN A	YOUR YOUNG ADULTS PLAN DESIGN A
Annual Deductible	$250	
Annual Out-of-Pocket Maximum	$5,000	
Outpatient Medical Care PCP Office Visit	$25	
Specialist Office Visit	$25	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	30% co-insurance after deductible	
Diagnostic X-rays/Labs	30% co-insurance after deductible	
Inpatient Medical Care Room and Board (includes deliveries/surgeries/x-rays/labs)	30% co-insurance after deductible	
Prescription Drugs Prescription Drug Deductible	None	
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/ 50% co-insurance/ 50% co-insurance	
Mail order (Up to 90-days supply)	$30 / 50% co-insurance/ 50% co-insurance	
Emergency Care	$250[23]	
Inpatient Mental Health (non-biologically based conditions)	30% co-insurance after deductible	
Outpatient Mental Health (non-biologically based conditions)	$25	
Rehabilitation Services Inpatient SNF/rehab	30% co-insurance after deductible	
Other Benefits Ambulance (emergency only)	30% co-insurance after deductible	
Durable Medical Equipment	30% co-insurance after deductible	
Vision	$10	

[23] Co-payment waived if ER visit results in hospital admission.

RESPONSE FORM E – YOUNG ADULTS PLAN DESIGN WORKSHEET (CONTINUED)

PLAN FEATURE / SERVICE	YOUNG ADULTS PLAN DESIGN B	YOUR YOUNG ADULTS PLAN DESIGN B
Annual Deductible	$2,000	
Annual Out-of-Pocket Maximum	$5,000	
Outpatient Medical Care		
PCP Office Visit	$25	
Specialist Office Visit	$25	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	20% co-insurance after deductible	
Diagnostic X-rays/Labs	20% co-insurance after deductible	
Inpatient Medical Care		
Room and Board (includes deliveries/surgeries/x-rays/labs)	20% co-insurance after deductible	
Prescription Drugs		
Prescription Drug Deductible	$250 (for Retail Tiers 2 and 3 only)	
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/50% co-insurance after Rx deductible/ 50% co-insurance after Rx deductible	
Mail order (Up to 90-days supply)	$30/50% co-insurance/ 50% co-insurance	
Emergency Care	$250[24]	
Inpatient Mental Health (non-biologically based conditions)	20% co-insurance after deductible	
Outpatient Mental Health (non-biologically based conditions)	$25	
Rehabilitation Services		
Inpatient SNF/rehab	20% co-insurance after deductible	
Other Benefits		
Ambulance (emergency only)	20% co-insurance after deductible	
Durable Medical Equipment	20% co-insurance after deductible	
Vision	$25	

[24] Co-payment waived if ER visit results in hospital admission.

RESPONSE FORM E – YOUNG ADULTS PLAN DESIGN WORKSHEET (CONTINUED)

In the table below, indicate the percentage of average medical expenses covered for an individual under the proposed plan design as well as the value of each plan design relative to "Your Gold Plan Design B Plan." In addition, please provide an estimate of the impact of a $50,000, $100,000, $250,000 as compared to no annual benefit maximum on the monthly premium on a per member per month (PMPM) basis.

	YOUNG ADULTS PLAN DESIGN A	YOUNG ADULTS PLAN DESIGN B
Percentage of average medical expenses for an insured individual covered by the proposed plan design		
Relative Value (compared to "Your Gold Plan Design A Plan")		
Relative Value (compared to "Your Gold Plan Design B Plan")		
Incremental change in monthly premium (Per member per month) due to inclusion of $50,000 Benefit Maximum.		
Incremental change in monthly premium (Per member per month) due to inclusion of $100,000 Benefit Maximum.		
Incremental change in monthly premium (Per member per month) due to inclusion of $250,000 Benefit Maximum.		

RESPONSE FORM F – MASSACHUSETTS SMALL AND NON-GROUP MEMBERSHIP BY PRODUCT

In the table below, please provide a membership count (i.e., lives covered), by product, for your small (< 51 eligible subscribers) and non-group sales in Massachusetts, by month for the period from January 1, 2008 through December 31, 2008 and updated through the most recent month for which a membership count is available (e.g., March 31, 2009). Please provide the Health Connector the name and summary plan documents (i.e., schedule of benefits) for your twenty most popular small/non-group products.

PRODUCT NAME AND BRIEF DESCRIPTION (E.G., STANDARD HMO W/$15 OFFICE VISIT CO-PAYMENT AND $250 INPATIENT CO-PAYMENT, OR STANDARD HMO W/$1,000 DEDUCTIBLE, OR PPO W/$1,000 DEDUCTIBLE, ETC.)	MEMBERSHIP AS OF JANUARY 31, 2008		MEMBERSHIP AS OF FEBRUARY 28, 2008		MEMBERSHIP AS OF MARCH 31, 2008		MEMBERSHIP AS OF APRIL 30, 2008		MEMBERSHIP AS OF MAY 31, 2008		MEMBERSHIP AS OF JUNE 30, 2008	
	NON-GROUP	SMALL GROUP	NON-GROUP	SMALL GROUP	NON-GROUP	SMALL GROUP	NON-GROUP	SMALL GROUP	NON-GROUP	SMALL GROUP	NON-GROUP	SMALL GROUP

RESPONSE FORM F – MASSACHUSETTS SMALL AND NON-GROUP MEMBERSHIP BY PRODUCT (CONTINUED)

PRODUCT NAME AND BRIEF DESCRIPTION (E.G., STANDARD HMO W/$15 OFFICE VISIT CO-PAYMENT AND $250 INPATIENT CO-PAYMENT, OR STANDARD HMO W/$1,000 DEDUCTIBLE, OR PPO W/$1,000 DEDUCTIBLE, ETC.)	MEMBERSHIP AS OF JULY 31, 2008		MEMBERSHIP AS OF AUGUST 31, 2008		MEMBERSHIP AS OF SEPTEMBER 30, 2008		MEMBERSHIP AS OF OCTOBER 31, 2008		MEMBERSHIP AS OF NOVEMBER 30, 2008		MEMBERSHIP AS OF DECEMBER 31, 2008		MOST RECENT MEMBERSHIP COUNT (INDICATE MONTH)	
	NON-GROUP	SMALL GROUP	NON-GROUP	SMALL GROUP	NON-GROUP	SMALL GROUP	NON-GROUP	SMALL GROUP	NON-GROUP	SMALL GROUP	NON-GROUP	SMALL GROUP	NON-GROUP	SMALL GROUP

RESPONSE FORM G – PREFERRED PLAN DESIGN FEATURES

In the table below, for each product offering, carriers should discuss how the proposed plan design incorporates the preferred plan design features described in Section V of this RFR. If the proposed plan design does not include a preferred feature, carriers should discuss why they have chosen not to include the particular feature in their proposal.

1. Select, High-Performance Networks
2. Centers of Excellence

RESPONSE FORM G – PREFERRED PLAN DESIGN FEATURES (CONTINUED)

In the table below, for each product offering, carriers should discuss how the proposed plan design incorporates the preferred plan design features described in Section V of this RFR. If the proposed plan design does not include a preferred feature, carriers should discuss why they have chosen not to include the particular feature in their proposal.

3. Consumer Engagement
4. HSA Option with High Deductible HMO Plan

RESPONSE FORM G – PREFERRED PLAN DESIGN FEATURES (CONTINUED)

In the table below, for each product offering, carriers should discuss how the proposed plan design incorporates the preferred plan design features described in Section V of this RFR. If the proposed plan design does not include a preferred feature, carriers should discuss why they have chosen not to include the particular feature in their proposal.

5. Wellness Incentives and Medical Management Programs
6. Preventive and Flex Benefits for Chronic Conditions

The Commonwealth of Massachusetts
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza, 6th Floor
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DEVAL PATRICK
Governor

TIM MURRAY
Lieutenant Governor

LESLIE KIRWAN
Board Chair

JON M. KINGSDALE
Executive Director

To: Board of Directors, Commonwealth Health Insurance Connector Authority

From: Patrick Holland, Chief Financial Officer

Date: June 19, 2009

cc: Jon Kingsdale, Rosemarie Day, Jamie Katz, Kevin Counihan, Kaitlyn Kenney, Debra Hayes

Re: Commonwealth Choice Seal of Approval Recommendations for Calendar Year 2010

The Health Connector released a Request for Responses (RFR) on April 13, 2009 to determine which health insurance carriers meet criteria established by the RFR to be awarded the Health Connector's "Seal of Approval" (SoA) and thereby offered for purchase by individuals and small groups through the Health Connector's CommChoice program. Benefit designs developed as part of this RFR will be available to purchasers November 1, 2009 for a January 1, 2010 effective date of coverage.

The SoA is an important designation awarded by the Health Connector, as it indicates that carriers selected meet certain standards regarding quality and value and are willing to work with the Health Connector to offer individuals and small groups, high value, cost effective health benefit plans. In addition, all plans awarded the Health Connector's SoA meet the state's Minimum Creditable Coverage (MCC) requirements. This memo summarizes the RFR process and identifies staff recommendations for awarding the SoA.

Executive Summary

Under the Board's direction and guidance, the Health Connector embarked on a substantial change to the CommChoice model for the 2010 RFR. Rather than rely on carriers to select benefit designs to be sold through the Health Connector based on broad actuarial value ranges, we are standardizing the benefit designs on each tier. We selected these standard benefit designs based on the popularity of CommChoice plans currently offered, the ability of new designs to moderate premium increases, and market research on preferred benefit designs and degree of choice, while trying to minimize the member disruption from making plan design changes. We then requested carriers to price to the standard benefit designs. In structuring choice in this manner, we expect to encourage transparency in monthly premiums across carriers, simplify the shopping experience, and reduced the number of different plan designs a consumer will need to understand and evaluate.

As a result of the RFR process, staff is recommending that nine plan designs be offered by seven health insurance carriers, which include the six incumbent carriers and the addition of CeltiCare Health Plan of Massachusetts. The breakdown of plan designs across tiers include one gold, three silver, three bronze and two young adult plans. (In addition, one carrier will offer both a broad and select provider network on all tiers except gold.)

In recommending this suite of plan designs we believe we have met the five goals identified at our February 26th Board meeting. These goals are:

- Select and offer high value plans
- Align choice of plan designs and carriers with consumer demand
- Enhance simplicity of shopping experience
- Minimize risk selection inside and outside the Health Connector, as well as among participating health plans and,
- Maintain continuity of coverage for the existing members

We will be re-designing the website and shopping experience to help lead consumers through a comparison and choice of standardized benefit designs, so that they can choose one benefit design at a time to focus on, and then readily compare and shop premiums, network and other relevant information across carriers for that single, standardized set of benefits.

Key Recommendations

Insurance Carriers

Based on the quality of the carriers' initial RFR responses, results of the Procurement Management Team (PMT) review and subsequent collaboration of all carriers in working with the Health Connector to resolve various differences that emerged throughout the SoA process, staff is recommending retention of the existing six carriers and the addition of CeltiCare Health Plan of Massachusetts. CeltiCare Health Plan is a newly formed carrier that has also been recently approved by the Board to provide health insurance to Commonwealth Care members. Its proposal for Commonwealth Choice is very price competitive, representing one of the lower priced options on every tier.

The availability of the recommended carriers, by geographic region, is noted on *Attachment A*. Changes to the current geographic availability will be the introduction of CeltiCare in Boston and Worcester.

Available Benefit Designs

As discussed with Board members at the June 11th meeting, the specific plan designs recommended for 2010 are Gold B, Silver A, Silver B, Silver C, Bronze A, Bronze B (newly proposed at the June 11th Board meeting), Bronze C, Young Adults A with and without Rx and Young Adults B with and without Rx. Please see *Attachment B* for a summary of the specific benefit designs and member cost sharing. (Please note that Attachment B does not provide a comprehensive summary of all benefits covered by a plan, but highlights those service categories subject to standardization per the Health Connector's RFR.)

In addition, for the Young Adults plan designs, based on Board input and the relatively high price differential in moving from benefit maximums to no-benefit maximums, we are proposing that carriers be allowed to determine if they will incorporate a benefit maximum, and if so, the amount of the maximum, as long as the benefit maximum is not less than $50,000 annually. This $50,000 corresponds with the minimum standards for Qualified Student Health Insurance

Plans; should those regulations change, staff recommends that the Board consider altering the Young Adults plan as well.

Non-standard service categories

As noted at our June 11th Board meeting, we are also recommending that carriers be allowed, at their option, to provide the following member value-added services:

- Waiver of member cost sharing for preventive services
- For the YAP B plan design, offer three PCP office visits subject to a co-pay and all subsequent office visits subject to the deductible
- Modify inpatient mental health as long as the plan design is consistent with mental health parity regulations

In addition, due to differences in how carrier claims payment systems define and adjudicate durable medical equipment, we will allow carriers to maintain their existing plan design for the durable medical equipment benefit.

Out of Area Coverage Solutions

Due to the difficulty in melding the standardization approach with the variety of approaches carriers employ to meet the needs of small employers, we have an Out of Area Coverage solution from some carriers, continue to discuss possible options with a few carriers and will not have a solution for yet a few other carriers. This is an area of need for the Health Connector that we will continue to explore, but we will mostly likely have limited options for small employers needing this type of solution in 2010.

Revised Bronze Plan Design B

Due to positive feedback from the Board on June 11th, the Health Connector developed an alternative Bronze B plan design which includes co-pay cost sharing features for medical and pharmacy services, rather than a coinsurance structure. Rather than be limited to only coinsurance plan designs on the Bronze tier, the alternative Bronze B will allow for a lower premium, while maintaining co-pays. In addition, again based on Board feedback, we are pleased to report that in working with our actuaries and preliminary feedback from carriers, the monthly premium for this alternative Bronze B plan design is, on average, below the Bronze A, which was a stated goal of the Board at our June 11th meeting.

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Attachment A

Availability of the Recommended Carriers

Carrier	Boston	Worcester	Springfield	Hyannis	Pittsfield
HPHC	√	√	√	√	√
BCBSMA	√	√	√	√	√
THP	√	√		√	
HNE			√		√
CeltiCare	√	√		√	
NHP	√	√	√		
FCHP*	√	√	√		√
*Based on Broad Network offering (Select Network excludes Boston and Springfield Region)					

Attachment B:
Health Connector Recommended Benefit Designs

Gold Plan Design B

PLAN FEATURE / SERVICE	CO-PAYMENT
Annual Deductible	None
Annual Out-of-Pocket Maximum	Unlimited
Outpatient Medical Care	
PCP Office Visit	$20
Specialist Office Visit	$30
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$150
Diagnostic X-rays/Labs	$25
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	$150
Prescription Drugs	
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/$30/$50
Mail order (Up to 90-days supply)	$30/$60/$150
Emergency Care	$75[1]
Inpatient Mental Health (non-biologically based conditions)	$150
Outpatient Mental Health (non-biologically based conditions)	$20
Rehabilitation Services	
Inpatient SNF/rehab	$150
Other Benefits	
Ambulance (emergency only)	No charge
Vision	$30

[1] Co-payment waived if ER visit results in hospital admission.

Silver Plan Design A

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	None
Annual Out-of-Pocket Maximum	$2,000 (ind) / $4,000 (fam)
Outpatient Medical Care	
PCP Office Visit	$25
Specialist Office Visit	$25
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$500
Diagnostic X-rays/Labs	$0
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	$500
Prescription Drugs	
Prescription Drug Deductible	$250 (ind) / $500 (fam) applies to Tiers 2 and 3 only
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/ 50% co-insurance/ 50% co-insurance
Mail order (Up to 90-days supply)	$30 50% co-insurance/ 50% co-insurance
Emergency Care	$100[2]
Inpatient Mental Health (non-biologically based conditions)	$500
Outpatient Mental Health (non-biologically based conditions)	$25
Rehabilitation Services	
Inpatient SNF/rehab	$500
Other Benefits	
Ambulance (emergency only)	No charge
Vision	$25

[2] Co-payment waived if ER visit results in hospital admission.

Silver Plan Design B

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$500 (ind) / $1,000 (fam)
Annual Out-of-Pocket Maximum	$2,000 (ind) / $4,000 (fam)
Outpatient Medical Care	
PCP Office Visit	$20
Specialist Office Visit	$20
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$0 after deductible
Diagnostic X-rays/Labs	$0 after deductible
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	$0 after deductible
Prescription Drugs	
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/$35/$60
Mail order (Up to 90-days supply)	$30/$70/$120
Emergency Care	$100[3]
Inpatient Mental Health (non-biologically based conditions)	$0 after deductible[4]
Outpatient Mental Health (non-biologically based conditions)	$20
Rehabilitation Services	
Inpatient SNF/rehab	$0 after deductible
Other Benefits	
Ambulance (emergency only)	$0 after deductible
Vision	$20

[3] Co-payment waived if ER visit results in hospital admission.
[4] Health Connector recommended, but this service category is not one for which we will require standardization.

Silver Plan Design C

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$1,000 (ind) / $2,000 (fam)
Annual Out-of-Pocket Maximum	$2,000 (ind) / $4,000 (fam)
Outpatient Medical Care	
PCP Office Visit	$20
Specialist Office Visit	$20
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$0 after deductible
Diagnostic X-rays/Labs	$0 after deductible
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	$0 after deductible
Prescription Drugs	
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/$30/$50
Mail order (Up to 90-days supply)	$30/$60/$150
Emergency Care	$100 after deductible[5]
Inpatient Mental Health (non-biologically based conditions)	$0 after deductible[6]
Outpatient Mental Health (non-biologically based conditions)	$20
Rehabilitation Services	
Inpatient SNF/rehab	$0 after deductible
Other Benefits	
Ambulance (emergency only)	$0 after deductible
Vision	$20

[5] Co-payment waived if ER visit results in hospital admission.
[6] Health Connector recommended, but this service category is not one for which we will require standardization.

Bronze Plan Design A

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$250 (ind) / $500 (fam)
Annual Out-of-Pocket Maximum	$5,000 (ind) / $10,000 (fam)
Outpatient Medical Care	
PCP Office Visits	$25
Specialist Office Visit	$40
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	35% co-insurance after deductible
Diagnostic X-rays/Labs	35% co-insurance after deductible
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	35% co-insurance after deductible
Prescription Drugs	
Prescription Drug Deductible	$250 (ind) / $500 (fam) applies to Tiers 2 and 3 only
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/ 50% co-insurance after Rx deductible 50% co-insurance after Rx deductible
Mail order (Up to 90-days supply)	$30/ 50% co-insurance after Rx deductible 50% co-insurance after Rx deductible
Emergency Care	$150[7]
Inpatient Mental Health (non-biologically based conditions)	35% co-insurance after deductible[8]
Outpatient Mental Health (non-biologically based conditions)	$25
Rehabilitation Services	
Inpatient SNF/rehab	35% co-insurance after deductible
Other Benefits	
Ambulance (emergency only)	35% co-insurance after deductible
Vision	$15

[7] Co-payment waived if ER visit results in hospital admission.
[8] Health Connector recommended, but this service category is not one for which we will require standardization.

Bronze Plan Design B (per revised specifications)

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$2,000 (ind) / $4,000 (fam)
Annual Out-of-Pocket Maximum	$5,000 (ind) / $10,000 (fam)
Outpatient Medical Care	
PCP Office Visit	$30
Specialist Office Visit	$45
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$250 after deductible
Diagnostic X-rays/Labs	$0 after deductible
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	$500 after deductible
Prescription Drugs (generic/preferred brand/non-preferred brand)	$250 (Tiers 2 and 3 only)/ $500 (Tiers 2 and 3 only)
Retail (Up to 30-days supply)	$10 /$30 after Rx deductible/$50 after Rx deductible
Mail order (Up to 90-days supply)	$20 /$60 after Rx deductible/$90 after Rx deductible
Emergency Care	$150 after deductible[9]
Inpatient Mental Health (non-biologically based conditions)	$500 after deductible[10]
Outpatient Mental Health (non-biologically based conditions)	$30
Rehabilitation Services	
Inpatient SNF/rehab	$500 after deductible
Other Benefits	
Ambulance (emergency only)	$0 after deductible
Vision	$30

[9] Co-payment waived if ER visit results in hospital admission.
[10] Health Connector recommended, but this service category is not one for which we will require standardization.

Bronze Plan Design C
HSA compliant

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$2,000 (ind) / $4,000 (fam)
Annual Out-of-Pocket Maximum	$5,000 (ind) / $10,000 (fam)
Outpatient Medical Care	
PCP Office Visit	$25 after deductible
Specialist Office Visit	$25 after deductible
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	20% co-insurance after deductible
Diagnostic X-rays/Labs	20% co-insurance after deductible
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	20% co-insurance after deductible
Prescription Drugs	
(generic/preferred brand/non-preferred brand)	After Deductible
Retail (Up to 30-days supply)	$15/50%/50%
Mail order (Up to 90-days supply)	$30/50%/50%
Emergency Care	$100 after deductible[11]
Inpatient Mental Health (non-biologically based conditions)	$0 after deductible[12]
Outpatient Mental Health (non-biologically based conditions)	$25 after deductible
Rehabilitation Services	
Inpatient SNF/rehab	20% co-insurance after deductible
Other Benefits	
Ambulance (emergency only)	20% co-insurance after deductible
Vision	$25 after deductible

[11] Co-payment waived if ER visit results in hospital admission.
[12] Health Connector recommended, but this service category is not one for which we will require standardization.

Young Adults Plan Design A

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$250
Annual Out-of-Pocket Maximum	$5,000
Outpatient Medical Care	
PCP Office Visit	$25
Specialist Office Visit	$25
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	30% co-insurance after deductible
Diagnostic X-rays/Labs	30% co-insurance after deductible
Inpatient Medical Care Room and Board (includes deliveries/surgeries/x-rays/labs)	30% co-insurance after deductible
Prescription Drugs	
Prescription Drug Deductible	None
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/ 50% co-insurance/ 50% co-insurance
Mail order (Up to 90-days supply)	$30 / 50% co-insurance/ 50% co-insurance
Emergency Care	$250[13]
Inpatient Mental Health (non-biologically based conditions)	30% co-insurance after deductible[14]
Outpatient Mental Health (non-biologically based conditions)	$25
Rehabilitation Services	
Inpatient SNF/rehab	30% co-insurance after deductible
Other Benefits	
Ambulance (emergency only)	30% co-insurance after deductible
Vision	$10

[13] Co-payment waived if ER visit results in hospital admission.
[14] Health Connector recommended, but this service category is not one for which we will require standardization.

Young Adults Plan Design B

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$2,000
Annual Out-of-Pocket Maximum	$5,000
Outpatient Medical Care	
PCP Office Visit	$25
Specialist Office Visit	$25
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	20% co-insurance after deductible
Diagnostic X-rays/Labs	20% co-insurance after deductible
Inpatient Medical Care	
Room and Board (includes deliveries/surgeries/x-rays/labs)	20% co-insurance after deductible
Prescription Drugs	
Prescription Drug Deductible	$250 (for Retail Tiers 2 and 3 only)
Retail (Up to 30-days supply) (generic/preferred brand/non-preferred brand)	$15/ 50% co-insurance after Rx deductible 50% co-insurance after Rx deductible
Mail order (Up to 90-days supply)	$30/ 50% co-insurance 50% co-insurance
Emergency Care	$250[15]
Inpatient Mental Health (non-biologically based conditions)	20% co-insurance after deductible[16]
Outpatient Mental Health (non-biologically based conditions)	$25
Rehabilitation Services	
Inpatient SNF/rehab	20% co-insurance after deductible
Other Benefits	
Ambulance (emergency only)	20% co-insurance after deductible
Vision	$25

[15] Co-payment waived if ER visit results in hospital admission.
[16] Health Connector recommended, but this service category is not one for which we will require standardization.

Commonwealth Choice

July 2011
Seal of Approval

Board of Directors Meeting
January 13, 2011

Agenda

- Overview of current CommChoice status
- Goals of July 2011 Seal of Approval (SoA)
- Staff recommendations for RFR
  - Length of health plan contracts
  - Health plan participation requirements
  - Updates to standardization model
  - YAP updates
  - Administrative and supplemental fee
  - Other items
- Timeline

Overview

- All existing CommChoice health plans signed six-month contracts for CommChoice participation from January 1 – June 30, 2011

- Key terms (maintain "steady state"):
  - Health plans must offer their current standardized plan designs in the Gold, Silver, Bronze and YAP levels (if applicable)
  - Health plans will be granted the flexibility to participate in both our non-group and small group (i.e. Business Express) programs or just the non-group program
  - Commitment from health plans not currently participating in Business Express to make a good faith effort to negotiate their participation by July 1, 2011
  - Contract maintained the reduced administrative fee of 3.5% implemented July 1, 2010

Goals of July 2011 SoA

- Robust carrier participation in small business health insurance program (and continued participation in non-group program)
  - All health plans participating in Business Express
- Enhance the shopping experience for individuals and small businesses, while maintaining the benefits of standardization
- Balance the need for consumer / small business choice with the desire for a streamlined shopping experience and product portfolio
- Begin transition to compliance with PPACA requirements (i.e., Young Adult Plans)
- Provide stability while the Health Connector is planning for changes required by national health reform

RFR Recommendations

Length of Health Plan Contracts

- 18-month term beginning July 1, 2011 through December 31, 2012

- Rationale:
  - This approach provides the Health Connector and health plans stability while we engage in planning for changes required by national health reform

  - This approach also recognizes the resource, administrative and operational investments associated with the procurement process that are required of the Health Connector and health plans

Health Plan Participation Requirements

1. Health plans are required to participate in all product offerings (non-group and small group)
   - This includes individual/non-group, Young Adult Plan* (YAP), Business Express (BE), Voluntary Plan (VP) and Contributory Plan (CP) renewals

2. Health plans must continue to offer products that meet the standardized plan design specifications in all benefit tiers on the broadest commercial provider network available to the health plan
   - Health plans are encouraged to also offer "select / limited" network product(s) that meet the standardized plan benefit designs

* For health plans with over 5,000 enrollees

Updates to Standardization
Consumer Focus Groups

- 5 Focus Groups – 27 Participants – December 2010

- Objectives
  - Solicit opinions about benefit standardization
  - Prioritization of existing standardized benefit categories
  - Reaction to possible reduction in benefit plan design options

- Key Findings
  - Members largely supportive of standardization
  - 8 of existing 12 standardized benefit categories viewed as important to remain standardized
  - Strong interest in simple, actionable decision support tools
  - 3-8 plan design options were optimal
  - Health Connector is meeting the objective of creating easy-to-use Health Insurance Exchange

Updates to Standardization
Carrier Feedback

- The Health Connector also solicited input from all participating health plans to review the existing standardization model to identify possible enhancements or modifications
  - Most health plans were not supportive of introducing a new set of standardized products because of added administrative costs and operational impacts
  - Most health plans supported more flexibility in plan design and streamlining the number of plans offered through CommChoice

Updates to Standardization
Guiding Principles

- The guiding principles used to develop recommendations reflect three broad objectives, informed by consumer focus groups and health plan feedback:
  - Maintain standardized benefit designs that allow for price transparency and simplify the shopping experience
  - Streamline the number of benefit designs, while continuing to provide the level of choice expected by consumers and small businesses
  - Minimize member disruption and health plan administrative costs by offering benefit designs that match our current offerings

Updates to Standardization
Plan Design Recommendations

- We do not recommend introducing a new set of standardized plan designs

- To streamline the CommChoice product portfolio, we recommend removing the Silver Medium benefit package
  - Health plans will be required to offer Silver Medium as a renewal option to existing Silver Medium members until enrollment threshold merits closure and transition to comparable products;
  - Existing members have the option to stay in their existing plan or select a new plan upon renewal

- Maintenance of all other existing products at Gold, Silver, and Bronze levels

Updates to Standardization
Plan Design Recommendations

- Rationale for eliminating Silver Medium:
  - Streamlines Health Connector product portfolio and supports administrative simplification efforts
  - Silver Medium is not a top selling plan design
    - Enrollment in current Silver Medium is about 1,800 paid subscribers (or 6% of total CommChoice enrollment)
  - Silver Low provides a very similar plan design option
  - Eliminating alternative plan designs has more significant impacts on the range of consumer choice
    - In Bronze tier, Bronze High has significantly lower deductible than Bronze Medium or Low and is a top seller
    - Bronze Medium and Bronze Low provide important product diversity:
      - Both have $2,000 (ind)/$4,000 (fam) deductibles, but Bronze Medium relies on co-pays while Bronze Low relies on co-insurance

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Updates to Standardization

Plan Design Recommendations

Commonwealth Choice: Tier Overview								
Tier		Gold	Silver High	Silver Medium	Silver Low	Bronze High	Bronze Medium	Bronze Low
Annual deductible (also called the "deductible")		None	None	$500 per individual $1,000 per family	$1,000 per individual $2,000 per family	$250 per individual $500 per family	$2,000 per individual $4,000 per family	$2,000 per individual $4,000 per family
Annual Out-of-Pocket Maximum		None	$2,000 per individual $4,000 per family	$2,000 per individual $4,000 per family	$2,000 per individual $4,000 per family	$5,000 per individual $10,000 per family	$5,000 per individual $10,000 per family	$5,000 per individual $10,000 per family
Primary Care Provider (PCP) office visit		$20 copay	$25 copay	$20 copay	$20 copay	$25 copay	$30 copay	annual deductible, then $25 copay
Diagnostic x-ray or laboratory test		$25 copay	$0 copay	annual deductible, then $0 copay	annual deductible, then $0 copay	annual deductible, then 35% co-insurance	annual deductible, then $0 copay	annual deductible, then 20% co-insurance
Outpatient surgery		$150 copay	$500 copay	annual deductible, then $0 copay	annual deductible, then $0 copay	annual deductible, then 35% co-insurance	annual deductible, then $250 copay	annual deductible, then 20% co-insurance
Hospitalization		$150 copay	$500 copay	annual deductible, then $0 copay	annual deductible, then $0 copay	annual deductible, then 35% co-insurance	annual deductible, then $500 copay	annual deductible, then 20% co-insurance
Prescription drug deductible (also called the "Rx deductible")		None	None	None	None	$250 per individual $500 per family (for Tiers 2 and 3; for Retail and Mail order)	$250 per individual $500 per family (for Tiers 2 and 3; for Retail and Mail order)	None (but the annual deductible does apply to prescription drugs)
Prescription drugs (Rx)	Retail	Tier 1: $15 copay	Tier 1: $15 copay	Tier 1: $15 copay	Tier 1: $15 copay	Tier 1: $15 copay	Tier 1: $10 copay	Tier 1: annual deductible, then $15 copay
		Tier 2: $30 copay	Tier 2: 50% co-insurance	Tier 2: $35 copay	Tier 2: $30 copay	Tier 2: Rx deductible, then 50% co-insurance	Tier 2: Rx deductible, then $30 copay	Tier 2: annual deductible, then 50% co-insurance
		Tier 3: $50 copay	Tier 3: 50% co-insurance	Tier 3: $60 copay	Tier 3: $50 copay	Tier 3: Rx deductible, then 50% co-insurance	Tier 3: Rx deductible, then $50 copay	Tier 3: annual deductible, then 50% co-insurance
	Mail order	Tier 1: $30 copay	Tier 1: $30 copay	Tier 1: $30 copay	Tier 1: $30 copay	Tier 1: $30 copay	Tier 1: $20 copay	Tier 1: annual deductible, then $30 copay
		Tier 2: $60 copay	Tier 2: 50% co-insurance	Tier 2: $70 copay	Tier 2: $60 copay	Tier 2: Rx deductible, then 50% co-insurance	Tier 2: Rx deductible, then $60 copay	Tier 2: annual deductible, then 50% co-insurance
		Tier 3: $150 copay	Tier 3: 50% co-insurance	Tier 3: $120 copay	Tier 3: $150 copay	Tier 3: Rx deductible, then 50% co-insurance	Tier 3: Rx deductible, then $90 copay	Tier 3: annual deductible, then 50% co-insurance
Emergency room		$75 copay	$100 copay	$100 copay	annual deductible, then $100 copay	$150 copay	annual deductible, then $150 copay	annual deductible, then $100 copay
Other benefits		All carriers are fully-insured and cover all mandated state benefits. Coverage and cost-sharing for benefits other than those listed above may vary from one plan to another within a single tier.						

This plan design would no longer be sold to new purchasers.

Updates to Standardization
Benefit Category Recommendations

- Based on consumer and health plan feedback, we recommend removing the following service categories from our standardization specifications:
  - Inpatient Skilled Nursing Facility (SNF)
  - Office Visit for Outpatient Mental Health
  - Routine Vision
  - Ambulance

- The Health Connector will review coverage and cost-sharing for all services (including those highlighted above) as part of the SoA process

- This change will provide health plans more flexibility with regard to plan design without undermining the core benefits of standardization

Updates to Standardization
Benefit Category Recommendations

- The following benefit categories will continue to be standardized (i.e. prescribed cost-sharing):
  - Annual deductible
  - Annual out of pocket maximum
  - PCP office visit
  - Diagnostic x-ray or laboratory test
  - Outpatient surgery
  - Hospitalization
  - Rx Deductible
  - Rx (Retail – Tier 1, 2 and 3)
  - Rx (Mail order – Tier 1, 2 and 3)
  - Emergency room

YAP Updates

- Current YAP waiver expires in September 2011
- Seek a waiver for renewing YAP enrollees (to mitigate dramatic premium increases)
- To help determine YAP product offering:
  - Request health plans to provide premium pricing for existing YAP plan designs but with no annual limit
  - Request health plans to provide premium pricing for a YAP plan design that is a high deductible health plan with no annual limit
  - Request health plans indicate their preference
  - Make recommendation to Board based on info. received
- Consider delaying implementation of any new YAP products until October 2011

YAP Plan Designs

Commonwealth Choice: YAP Overview				
Tier		**YAP High**	**YAP Low**	**YAP (High Deductible Health Plan)**
Annual deductible		$250 per individual	$2,000 per individual	$3,050 per individual
Annual Out-of-Pocket		$5,000 per individual	$5,000 per individual	$5,950 per individual
Primary Care Provider (PCP) office visit		$25 copay	$25 copay	annual deductible, then $25 copay
Diagnostic x-ray or laboratory test		annual deductible, then 30% co-insurance	annual deductible, then 20% co-insurance	annual deductible, then 20% co-insurance
Outpatient surgery		annual deductible, then 30% co-insurance	annual deductible, then 20% co-insurance	annual deductible, then 20% co-insurance
Hospitalization		annual deductible, then 30% co-insurance	annual deductible, then 20% co-insurance	annual deductible, then 20% co-insurance
Prescription drug deductible		None	$250 per individual (for Tiers 2 and 3; for Retail only)	None (but the annual deductible applies to prescription drugs)
Prescription drugs (Rx)	**Retail**	**Tier 1:** $15 copay	**Tier 1:** $15 copay	**Tier 1:** annual deductible, then $15 copay
		Tier 2: 50% co-insurance	**Tier 2:** Rx deductible, then 50% co-insurance	**Tier 2:** annual deductible, then 50% co-insurance
		Tier 3: 50% co-insurance	**Tier 3:** Rx deductible, then 50% co-insurance	**Tier 3:** annual deductible, then 50% co-insurance
	Mail order	**Tier 1:** $30 copay	**Tier 1:** $30 copay	**Tier 1:** annual deductible, then $30 copay
		Tier 2: 50% co-insurance	**Tier 2:** 50% co-insurance	**Tier 2:** annual deductible, then 50% co-insurance
		Tier 3: 50% co-insurance	**Tier 3:** 50% co-insurance	**Tier 3:** annual deductible, then 50% co-insurance
Emergency room		$250 copay	$250 copay	annual deductible, then $100 copay
Other benefits		All carriers are fully-insured and cover all mandated state benefits. Coverage and cost-sharing for benefits other than those listed above may vary from one plan to another within a single tier.		

No Annual Limit on any of the Young Adult Plan designs.

Administrative and Supplemental Fees

- Contract will maintain the reduced administrative fee (3.5%) implemented July 1, 2010

- We recommend removing the $10 PSPM supplemental fee that is charged to small groups with group sizes of 1-5 as of July 1, 2011
  - Rationale:
    - This is an appropriate policy to minimize costs for small businesses
    - Ensures Health Connector shopping experience is no more expensive than any other distribution channel
    - Health Connector is equipped to manage fiscal impact through Business Express membership growth and budget discipline

Other Items

- A wellness subsidy program for eligible small businesses will be implemented by July 1, 2011 as required by Chapter 288, and integrated with the Business Express product

- As part of the Business Transfer Agreement between the Health Connector and SBSB, Phase II of the conversion of small group accounts from SBSB will occur in April 2012

- The Health Connector is planning to implement a provider search tool which will provide consumers the ability to narrow their plan options by providers when they shop online through CommChoice

Timeline

Date	Activity
1/14/2011	• Issue RFR
1/26/2011	• Q&A with health plans
2/11/2011	• Proposals due from health plans
2/14/2011 – 3/31/2011	• Finalize responses with health plans
4/1/2011 – 4/8/2011	• Incorporate Board feedback
4/14/2011	• Present Health Connector staff evaluation and recommendations of health plan responses • Board vote on health plan selection; award SoA
5/1/2011	• Start enrollment for 7/1/2011 coverage
7/1/2011	• Effective date of July 2011 SoA plans
10/1/2011 (Tentative)	• Coverage effective date if new YAP plan designs

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COMMONWEALTH

HEALTH INSURANCE CONNECTOR AUTHORITY

100 CITY HALL PLAZA, 6TH FLOOR

BOSTON, MASSACHUSETTS 02108

REQUEST FOR RESPONSES

HEALTH BENEFIT PLANS – SEAL OF APPROVAL

JANUARY 14, 2011

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SECTION I – INTRODUCTION

The Commonwealth Health Insurance Connector Authority (the "Health Connector" or the "Authority") was established by the landmark Massachusetts health reform law of 2006, known as Chapter 58. The mission of the Health Connector is to connect Massachusetts residents with affordable health insurance. The Health Connector is an independent public authority governed by a ten-member board, comprised of government officials and members of the public, representing a range of interests and expertise that includes organized labor, employee health benefits, consumers, small business, actuarial science, and health economics.

In order to accomplish its mission, the Health Connector serves as an exchange, administering a number of programs that facilitate enrollment in health insurance plans for Massachusetts individuals and small businesses. Commonwealth Choice ("CommChoice") is one of its key programs. CommChoice is a program that enables eligible individuals and small groups to shop for and select from a variety of affordable commercial health insurance products. Shoppers can find these plans through the Health Connector's award-winning website, www.MaHealthConnector.org. The CommChoice program markets health plans to two market segments, non-group and small group, through five specialized products: the Individual/Non-Group Plan, the Young Adults Plan, the Voluntary Plan, Business Express, and the Contributory Plan.

SECTION II – OVERVIEW OF THE RFR

A. PURPOSE/OBJECTIVES OF THE RFR

The purpose of this Request For Responses (RFR) is to obtain proposals from health insurance Carriers ("Carriers") to offer plans for sale through CommChoice. The Health Connector will review Carrier submissions to determine which health benefit plans meet the criteria to be awarded the "Seal of Approval" (SoA). Plans that are given the SoA will be offered for purchase by individuals and small groups through the Health Connector's CommChoice program. SoA plans will be offered for sale May 1, 2011 and will have an effective date of coverage beginning July 1, 2011. To meet these deadlines, responses to this RFR must be submitted by Carriers to the Health Connector by **February 11, 2011**.

The Health Connector plans to continue to offer the following benefit levels: (1) "Gold" plans with limited out-of-pocket cost sharing by enrollees; (2) "Silver" plans with higher out-of-pocket costs; (3) "Bronze" plans representing the highest level of cost-sharing that will meet the Health Connector's minimum creditable coverage standards.

The Health Connector will serve as a distribution channel for those products that best meet the criteria set forth in this RFR and that the Health Connector's Board determines to be the most appropriate for inclusion in a package of health benefit plans to be offered for sale through the CommChoice program. Plans selected by the Board will be designated with the Health Connector's SoA. With the exception of the Young Adults Plans, the selected products will be made available to all individuals and small groups that meet the eligibility rules set forth in c. 58, c. 176J, and further defined in Section III of this RFR.

B. COMMCHOICE PRODUCT DESCRIPTION

The CommChoice program enables non-group subscribers and employees to purchase high quality, good value health benefit plans from private health insurance Carriers. The CommChoice program is comprised of five products: the Individual/Non-Group Plan, the Young Adults Plan, the Voluntary Plan, Business Express, and the Contributory Plan.

The Health Connector's target markets are: (1) uninsured individuals and families, (2) young adults ages 18 – 26, (3) small employers not currently offering group health benefits to their employees, and (4) employees not eligible for group insurance benefits, who are able to buy health insurance through a Section 125 payroll deduction program.

Eligible individuals may purchase any **Individual/Non-group** health benefit plan offered through the CommChoice program that is available where they live. Young adults may purchase a non-group policy, or they may select one of the Young Adults Plans offered specifically to young adults 18-26 years of age, inclusive, without dependents.

SECTION II – OVERVIEW OF THE RFR (CONTINUED)

The **Young Adults Plan** may only be offered for sale through the CommChoice program, and it may only be purchased by individuals age 18 to 26, inclusive, who shall remain eligible for coverage under the Young Adults Plan until the anniversary of enrollment (i.e., renewal date) following the individual's 27th birthday. The Young Adults Plan will only be sold on an individual, non-group basis as individual coverage. No other coverage basis will be allowed for this plan type and it may not be offered for sale as part of employer-sponsored insurance.

The CommChoice **Voluntary Plan** allows employer groups (of any size) to offer their employees who are ineligible to participate in their employer-sponsored health benefit plan a means to purchase non-group health benefit plans on a pre-tax basis. Employer groups may establish through their Section 125 plan the means to facilitate payroll deductions for non-group health insurance premium payments. This is not group health insurance and there is no employer contribution as part of this arrangement. There are no restrictions as to the selection of alternative health plans that the employer group may allow benefits-ineligible employees to purchase through their Section 125 programs.

Small employer groups (those with 50 or fewer eligible employees) may offer eligible employees health benefit plans purchased through the CommChoice program. Coverage for these eligible employees is currently offered through **Business Express** and, only on a renewal basis, through the **Contributory Plan** product.

Small employer groups enrolling in the Business Express product select a single health benefit plan offered by CommChoice for all benefit-eligible employees.

Small employer groups enrolled in the Contributory Plan product select a "benchmark health plan" offered by CommChoice at a specific plan benefit level (e.g., "Silver"). The benefit-eligible employees may select the employer's benchmark plan or any of the other health benefit plans available to them within the benchmark plan's benefit level.

Additionally, small employer groups enrolled in Business Express or the Contributory Plan are not permitted to offer their benefits-eligible employees separate or competing employer-sponsored health insurance coverage.

In April 2012, employer groups enrolled through the Small Business Service Bureau, Inc. intermediary business that choose to renew may be renewed through the Health Connector's Business Express program. Carriers awarded the SoA will be required to recognize those transferring employer groups as renewing groups and, accordingly, must offer those groups the same privileges and benefits as other similarly situated renewing groups.

In accordance with Ch. 288 of the Acts of 2010 ("Chapter 288"), the Health Connector will offer a wellness program for qualifying Business Express employer groups. Participating employer groups may be eligible for a premium credit upon the successful completion of the wellness program.

SECTION II – OVERVIEW OF THE RFR (CONTINUED)

C. SELECTION CRITERIA

To create a "level playing field" for participating Carriers and sufficient choice of products for individuals and small businesses, while facilitating ease of plan comparison and shopping, the following criteria will be used in evaluating carrier responses:

- Carrier participation in all CommChoice product offerings (i.e. Individual/Family, YAP, (if eligible to offer YAPs; see Section IIIA for more details), Voluntary Plan, Business Express, and renewals for the Contributory Plan);
- Carriers offer all standardized benefit packages for all plan benefit levels (Gold, Silver Bronze) as defined in Section IV of this RFR for all CommChoice product offerings;
- Carriers offer all health insurance products on the broadest commercial provider network available to the carrier; and
- Carriers offer health insurance products that offer good value for consumers while providing comprehensive benefits.

While the Health Connector provides guidance with regard to the plan designs requested, our intent is to encourage health insurance Carriers to effectively and efficiently deliver care to the residents of the Commonwealth.

The Health Connector is not obligated to grant its SoA to any carrier's product offerings, regardless of the carrier's small group and non-group enrollment. The Health Connector will -- based on the selection criteria summarized in this RFR and a determination by the Board -- offer to eligible individuals and small groups a set of product offerings from a limited number of Carriers.

D. TERM OF THE ENGAGEMENT

The Health Connector will award its SoA and agree to offer such health plans for a term of eighteen (18) months beginning July 1, 2011 and ending December 31, 2012 with one 12 month extension (at the Health Connector's option). The Health Connector may propose changes to benefit designs at the start of the extension period, including adding new plan designs and deleting and closing existing benefit designs. The decision to *modify* benefit designs during the contract term, must be approved by the Health Connector, as set forth in more detail in Section 3.1.B of the template contract (Attachment A).. Carriers may, however, submit a request on a semi-annual basis to *close* any existing benefit designs that are currently offered to new or renewing subscribers on a semi-annual basis to the Health Connector. The Health Connector will review these requests and make a good faith determination as to ceasing sales or renewals for this product based upon the information presented in the request; however, closure of a plan design available to new purchasers would require all Carriers to close the specified plan in an effort to maintain the objective of a "level playing field" as described above.

SECTION III – PROGRAM REQUIREMENTS

Please note that you will be asked to confirm that you will comply with the program requirements in Response Form A.

A. RULES OF ELIGIBILITY

1. Participation in CommChoice Seal of Approval

Pursuant to M.G.L. c. 176J, § 3(c)(2) and (d)(2), Carriers that meet the following criteria are required to submit health benefit plans for the Health Connector's consideration:

> As of January 1, 2007, a carrier that as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its license under chapter 176G, shall be required annually to file a plan with the connector for its consideration, which could attain the connector seal of approval; provided however, the plan shall be filed no later than October 1 of any calendar year.
>
> As of January 1, 2007, a carrier that as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its authority under chapter 175, 176A or 176B, shall be required annually to file a plan with the connector for its consideration, which could attain the connector seal of approval; provided however, the plan shall be filed no later than October 1 of any calendar year.

The Health Connector will also consider health benefit plans from Carriers that do not meet the above criteria but are otherwise licensed pursuant to c. 175, c. 176A, c. 176B or c. 176G and wish to submit plans.

2. Eligibility to Offer Young Adult Plans

Only those Carriers that meet the following criteria, pursuant to M.G.L. c. 176J, § 10, are allowed to submit a Young Adults Plan for the Health Connector's consideration:

> Such plans shall only be offered by a carrier that, as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its license under chapter 175, chapter 176A, chapter 176B or chapter 176G. Further, such plans shall only be offered through the commonwealth health insurance connector as defined in chapter 176Q. Premium rates for young adult plans shall be consistent with section 3.

B. Rules of Participation

The Health Connector will offer for sale through its CommChoice program only products from Carriers that satisfy the selection criteria for each of the three plan benefit levels (Gold, Silver and Bronze), and Young Adults Plans (if eligible).

No Carrier will be allowed to limit its product offerings to any particular CommChoice product or set of CommChoice products, or any health benefit plan or specific plan level unless approved by the Health Connector in its sole discretion. In addition, if a Carrier wishes to offer one of the standardized plan benefit packages with a limited provider network, that Carrier must also offer that same product with its broadest commercial provider network.

During the first half of calendar year 2011, the Health Connector will be performing work to include a provider search function in its website to enhance the shopping experience for individuals who are selecting health plans. Carriers that offer plans through CommChoice will be expected periodically to provide updated provider network information for inclusion in this provider search function.

C. DOI Review and Approval of New Products and Rate Filings

Only health benefit plans authorized by the Commissioner of Insurance and underwritten by a carrier may be offered through the CommChoice program.

Products developed for the Health Connector not currently licensed in the Commonwealth must be submitted to the Division of Insurance (DOI) for its review and approval. Carriers are strongly encouraged to review informally with DOI staff any new plan designs that are being submitted for the Health Connector's consideration but have not yet been approved by DOI. The Health Connector will work closely with DOI in an attempt to expedite the review process. However, the Health Connector will not recommend that the Board issue its SoA to any health insurance product that is not licensed by DOI or has not received DOI's informal approval.

All filing requirements of the DOI, including the rate filing requirements under Chapter 176J as amended by Chapter 288, shall apply to products offered through the CommChoice program.

Carriers must cover all mandated benefits (e.g., a health service or category of health service provider) required by the carrier's licensing or other statute to include in its health benefit plan.

D. Rating Methodology

Carriers submitting health benefit plans to the Health Connector must abide by M.G.L. c. 176J, as amended, and all applicable rating regulations issued by the DOI (211 CMR 66.00 – Small Group Health Insurance) pursuant to the merged small group and non-group market.

SECTION III – PROGRAM REQUIREMENTS (CONTINUED)

Carriers must utilize the same rating methodology for products distributed through the Health Connector that they use for products offered outside the Health Connector. The Health Connector will administer its CommChoice small group product offerings (Business Express and the Contributory Plan) consistent with the state's small group rating rules. Policies and procedures developed for Business Express and the Contributory Plan are designed to be applied consistently and uniformly for all participating Carriers. The Health Connector will consult and coordinate with DOI in order to administer CommChoice in accordance with DOI's interpretation of the small group rating rules and their application to CommChoice.

Products distributed through the Health Connector may not use SIC code adjustments in non-group rating. In addition, products distributed through the Health Connector's CommChoice program will use the following four-tier rate basis types: single, 2-person, single + child(ren), and family.

E. HEALTH PLAN BENEFIT DOCUMENTS

As explained in Section III(K) below, enrollment will commence on May 1, 2011 for a July 1, 2011 effective date. SoA Carriers will be expected to create health plan benefit and enrollment materials in advance of May 1, 2011. By March 15, draft health plan benefit and enrollment materials shall be submitted for review by the Health Connector on a file-and-use basis. Final health plan benefit and enrollment materials must be finalized and delivered to the Health Connector by April 1, 2011.

F. MARKETING

All Carriers will be expected to actively market products available through the CommChoice program and to participate in joint marketing efforts with the Health Connector, including co-branding and establishing mutual relationships in website links and customer service representatives. Carriers shall propose a marketing plan which details how they will market CommChoice products.

All use of the Health Connector's name, marks or logos in marketing materials shall be subject to the prior review and approval by the Health Connector.

G. HEALTH CONNECTOR ADMINISTRATIVE FEE

The Health Connector will retain the greater of 3.5% of the premium collected or $12 per subscriber per month when premium is collected to cover its cost of marketing, customer support, enrollment, premium billing, collection and reconciliation, broker commissions, and other administrative tasks performed on behalf of the health plans.

SECTION III – PROGRAM REQUIREMENTS (CONTINUED)

H. CUSTOMER SERVICE

The Health Connector will contract with a third-party entity, also referred to as a Sub-Connector, to handle customer service, enrollment, premium billing and collection, monthly reconciliation, and other such sales and administrative functions, and to provide individuals, employers, employees, and brokers with information about the health benefit plans available through CommChoice.

Carriers will be expected to have available customer service representatives during normal business hours to assist members, to respond to inquiries from potential enrollees, and to coordinate customer service between their own representatives, the Health Connector, and the Sub-Connector's representatives.

I. DISTRIBUTION REQUIREMENTS AND ROLE OF SUB-CONNECTOR

The Health Connector will subcontract with a Sub-Connector for a range of administrative services, many of which are typically handled by health insurance Carriers. These services will include some or all of the functions and services on behalf of the Health Connector related to:

- Pre- and post-enrollment customer service
- Eligibility and enrollment
- Premium quoting
- Monthly premium billing, collection and remittance to Carriers, including bundling payments to the Carriers from multiple employers and individuals
- Section 125 program administration/coordination with employers
- Notifications to individuals and employers regarding eligibility and enrollment status, late payment and non-payment of premium, and cancellation of coverage
- Payments to brokers/agents
- Coverage renewal

The Health Connector will require Carriers to collaborate with the Sub-Connector to handle these administrative functions in order to achieve administrative savings and reduce duplication of services.

During the SoA contractual period, the Health Connector reserves the right to modify or change its administrative agreements with the Sub-Connector and/or procure a different, or additional, Sub-Connector vendor. The Health Connector will require that Carriers work collaboratively, and in a timely fashion, with the Health Connector and any/all Sub-Connector vendors to ensure continuous, smooth operation of all administrative functions.

SECTION III – PROGRAM REQUIREMENTS (CONTINUED)

All Carriers offering health benefit plans through the CommChoice program must be able to accept enrollment data in a HIPAA 834 format and financial data in a HIPAA 820 format.

The Health Connector will work with each CommChoice Carrier to build and maintain the processes, file formats and technology deemed necessary for the transmission of enrollment, financial, and other essential data between the Sub-Connector and the Carriers. This includes any existing requirements at the time of the SoA contracting process, and any state or federally mandated data collection and reporting changes. All other changes desired by the Carriers will be viewed as discretionary; and they must be included in a formal request to the Health Connector and Sub-Connector, subject to additional reimbursement by the Carriers.

J. REPORTING REQUIREMENTS

The Health Connector has the authority to request from Carriers awarded the SoA, in a format to be determined, an extract of claims data for all CommChoice members enrolled as of December 31, 2010 for all services incurred as a CommChoice member. Pending implementation and availability of data through the All Payer Claims Database (APCD), the Health Connector will make a good faith effort to work in conjunction with the Division of Health Care Finance and Policy to obtain the necessary information, but otherwise will request data directly from Carriers.

In addition, the Health Connector also has the right to require Carriers awarded the SoA to submit a file of the Medical Loss Ratio (MLR) for both CommChoice specific business (if applicable) and total Massachusetts' based non-group and small group business for the periods ending December 31, 2009, and December 31, 2010. When possible, the Health Connector will work in conjunction with other state agencies to obtain the requisite data.

To support the provider search function, the Health Connector will also require from those Carriers awarded the SoA a monthly electronic file, format and field layout to-be-determined, of participating physicians and hospitals. This file will include unique identifiers such as the NPI for physicians and the first extract will be required with final marketing materials on April 1, 2011.

K. ENROLLMENT PERIOD

Initial enrollment for: (1) eligible individual subscribers and their eligible dependents in the non-group product and Voluntary Plan product, (2) eligible young adults in the Young Adults Plan product, and (3) eligible small employer groups and their benefits-eligible employees (and their eligible dependents, if applicable) will begin on May 1, 2011, for an initial effective date of July 1, 2011.

SECTION III – PROGRAM REQUIREMENTS (CONTINUED)

The Health Connector and Carriers offering health benefit plans through CommChoice will enroll:

(1) Eligible individual subscribers and their eligible dependents in the non-group product in accordance with Chapter 288 and Division of Insurance rules. Coverage is effective on the 1st day of every month.

(2) Eligible young adults in the Young Adults Plan product in accordance with Chapter 288 and Division of Insurance rules. Coverage is effective on the 1st day of every month.

(3) Voluntary Plan employer groups and their employees (and their eligible dependents, if applicable) that purchase non-group coverage. Coverage is effective on the 1st day of every month and may be renewed on the 12 month anniversary date of the employer group's enrollment. Employees and their eligible dependents (if applicable) may not enroll at any other time during the 12 month coverage period unless they experience a qualified change in status as determined by the Health Connector; and

(4) Eligible small employer groups and their benefits-eligible employees (and their eligible dependents, if applicable). Coverage is effective on the 1st day of every month. Eligible employees and their eligible dependents (if applicable) may not enroll at any other time during the 12 month coverage period unless they experience a qualified change in status as permitted by the Health Connector.

Small employer groups enrolled in the Contributory Plan and those small employers with a group size of six (6) or more enrolled through Business Express may be renewed on the 12 month anniversary date of the employer group's enrollment. Small employer groups with a group size of five (5) or less may be renewed on April 1, regardless of the employer group's original effective date of coverage.

Existing CommChoice members and employer groups that are scheduled to renew coverage on or after July 1, 2011 may also enroll in health benefit plans chosen through this RFR upon their anniversary date.

SECTION IV – PLAN DESIGN PARAMETERS

To facilitate comparison shopping ease among a broad set of plan choices, to drive value, and to minimize risk selection, the Health Connector will offer a limited number of Carriers, with each Carrier required to offer products in all three plan benefit levels – Gold, Silver, Bronze – and for all prescribed plan benefit packages. All products must rely on a Carrier's broadest commercial provider network; however, Carriers have the option and are encouraged to offer a second, limited provider network option for products. In addition, Carriers meeting the eligibility criteria for the Young Adults Plan, pursuant to c. 58 as amended, may also offer a Young Adults Plan, subject to approval by the Health Connector.

The Health Connector will not approve for new sales any health benefit plan that includes an annual, per sickness or lifetime benefits maximum. In addition, no product offering that includes a fee schedule for medical services (e.g., plan maximum benefit of $500 per day for inpatient care, or $50 per office visit, etc.) will be approved by the Health Connector. (Please note: all plans must comply with 956 CMR 5.00, the Minimum Creditable Coverage Regulations, as applicable for 2011.)

Unless otherwise indicated, all co-payments in the benefit design specifications are per visit, per inpatient stay, or (in the case of same-day surgery) per procedure. In instances where a plan design includes a deductible, the cost-sharing column of the table describes if a particular service is subject to the deductible. For example, in the Silver Benefits Level, Silver Low indicates that there is a $1,000 individual deductible and that a PCP office visit requires a $20 co-pay. As indicated in this table, a member visiting a PCP must provide a $20 co-pay, but does not have to first satisfy the deductible. However, if a member in this same plan design has outpatient surgery, this service will be subject to the deductible.

A. GOLD LEVEL PLAN

The Gold plan design is based on a comprehensive small group product offering, with limited point-of-service cost sharing. The plan design features listed on the next page must be replicated by all Carriers submitting proposals in response to this RFR.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

GOLD LEVEL PLAN DESIGN PARAMETERS

The Health Connector requests the Carriers submit one Gold plan according to the following plan design parameters. Please note: for Carriers currently participating in the CommChoice program, this plan design corresponds to the plan design currently sold in the Gold level.

Gold Level Plan Design

PLAN FEATURE / SERVICE	CO-PAYMENT
Annual Deductible	None
Annual Out-of-Pocket Maximum	None
Outpatient Medical Care PCP Office Visit	$20
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$150
Diagnostic x-rays or Laboratory Tests	$25
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	$150
Prescription Drugs Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$15/$30/$50
Mail order (Up to 90-days supply)	$30/$60/$150
Emergency Room	$75[1]

All services are subject to a determination of medical necessity.

All Massachusetts mandated benefits must be covered.

[1] Co-payment waived if ER visit results in hospital admission.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

B. SILVER LEVEL PLANS

Carriers are required to submit two product offerings at the Silver plan benefit level according to the plan design parameters detailed below. Please note: for Carriers currently participating in the CommChoice program, these plan designs correspond to the Silver High and Silver Low plan designs currently sold in the Silver level.

Silver Level Plan Design – Silver High

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	None
Annual Out-of-Pocket Maximum	$2,000 (ind) / $4,000 (fam)
Outpatient Medical Care PCP Office Visit	$25
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$500
Diagnostic x-rays or Laboratory Tests	$0
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	$500
Prescription Drugs Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$15/ 50% co-insurance / 50% co-insurance
Mail order (Up to 90-days supply)	$30 50% co-insurance / 50% co-insurance
Emergency Room	$100[2]

[2] Co-payment waived if ER visit results in hospital admission.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

Silver Level Plan Design - Silver Low

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$1,000 (ind) / $2,000 (fam)
Annual Out-of-Pocket Maximum	$2,000 (ind) / $4,000 (fam)
Outpatient Medical Care PCP Office Visit	$20
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$0 after deductible
Diagnostic x-rays or Laboratory Tests	$0 after deductible
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	$0 after deductible
Prescription Drugs Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$15/$30/$50
Mail order (Up to 90-days supply)	$30/$60/$150
Emergency Room	$100 after deductible[3]

[3] Co-payment waived if ER visit results in hospital admission.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

C. BRONZE LEVEL PLANS

Carriers are required to submit three Bronze product offerings. Please note: for Carriers currently participating in the CommChoice program, these plan designs correspond to the Bronze High, Medium, and Low plan designs currently sold in the Bronze level.

Bronze Level Plan Design– Bronze High

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$250 (ind) / $500 (fam)
Annual Out-of-Pocket Maximum	$5,000 (ind) / $10,000 (fam)
Outpatient Medical Care PCP Office Visits	$25
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	35% co-insurance after deductible
Diagnostic x-rays or Laboratory Tests	35% co-insurance after deductible
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	35% co-insurance after deductible
Prescription Drugs Prescription Drug Deductible	$250 (ind) / $500 (fam) applies to Tiers 2 and 3 only
Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$15/ 50% co-insurance after Rx deductible 50% co-insurance after Rx deductible
Mail order (Up to 90-days supply)	$30/ 50% co-insurance after Rx deductible 50% co-insurance after Rx deductible
Emergency Room	$150[4]

[4] Co-payment waived if ER visit results in hospital admission.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

Bronze Level Plan Design – Bronze Medium

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$2,000 (ind) / $4,000 (fam)
Annual Out-of-Pocket Maximum	$5,000 (ind) / $10,000 (fam)
Outpatient Medical Care PCP Office Visit	$30
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$250 after deductible
Diagnostic x-rays or Laboratory Tests	$0 after deductible
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	$500 after deductible
Prescription Drugs Prescription Drug Deductible	$250 (ind) / $500 (fam) (applies to Tiers 2 and 3 only)
Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$10/ $30 after Rx deductible/ $50 after Rx deductible
Mail order (Up to 90-days supply)	$20/ $60 after Rx deductible/ $90 after Rx deductible
Emergency Room	$150 after deductible[5]

[5] Co-payment waived if ER visit results in hospital admission.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

Bronze Level Plan Design – Bronze Low

For "Bronze Low," it is required that the carrier make available, as part of this benefit design, a Health Savings Account (HSA).

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$2,000 (ind) / $4,000 (fam)
Annual Out-of-Pocket Maximum	$5,000 (ind) / $10,000 (fam)
Outpatient Medical Care PCP Office Visit	$25 after deductible
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	20% co-insurance after deductible
Diagnostic x-rays or Laboratory Tests	20% co-insurance after deductible
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	20% co-insurance after deductible
Prescription Drugs Prescription Drug Deductible	None (the annual deductible applies to prescription drugs)
Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$15 after deductible/ 50% co-insurance after deductible 50% co-insurance after deductible
Mail order (Up to 90-days supply)	$30 after deductible/ 50% co-insurance after deductible 50% co-insurance after deductible
Emergency Room	$100 after deductible[6]

[6] Co-payment waived if ER visit results in hospital admission.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

D. YOUNG ADULTS LEVEL PLANS

Carriers that meet the participation requirements of c. 58 for submission of a Young Adults Plan are required to propose three health benefit plans according to the parameters outlined below. These plans should be offered to individuals' ages 18 to 26, inclusive.

Two of these plans should be offered both with and without prescription drug. Please note: for Carriers currently participating in the CommChoice program, these two plan designs correspond to the YAP High and YAP Low plan designs currently sold in the Young Adult Plan level, but without the allowance of an Annual Benefit Limit.

The Health Connector requests Carriers submit information regarding if, and how many, individuals reached the annual benefit limit of a Young Adult Plan, if applicable, since the inception of these plans.

Carriers are also requested to provide feedback with respect to the development of a Health Savings Account (HSA) compatible High Deductible Health Plan (HDHP) for Young Adults, as detailed below. Carriers would be required to facilitate access to an HSA for interested purchasers. This product would only be available with prescription drug coverage. The Health Connector requests premium prices for all of these products.

Additionally, Carriers should provide the Health Connector feedback as to any administrative, operational, member satisfaction, or other concerns you may have relative to the development and sale of this product. Please also rank these three Young Adult Products in terms of your preference for offering them.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

Young Adult Plan Design – Young Adult Plan High (offered with and without Prescription Drug Coverage)

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$250
Annual Out-of-Pocket Maximum	$5,000
Outpatient Medical Care PCP Office Visit	$25
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	30% co-insurance after deductible
Diagnostic x-rays or Laboratory Tests	30% co-insurance after deductible
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	30% co-insurance after deductible
Prescription Drugs Prescription Drug Deductible	None
Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$15/ 50% co-insurance/ 50% co-insurance
Mail order (Up to 90-days supply)	$30 / 50% co-insurance/ 50% co-insurance
Emergency Room	$250[7]

[7] Co-payment waived if ER visit results in hospital admission.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

Young Adult Plan Design – Young Adult Plan Low (offered with and without Prescription Drug Coverage)

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$2,000
Annual Out-of-Pocket Maximum	$5,000
Outpatient Medical Care PCP Office Visit	$25
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	20% co-insurance after deductible
Diagnostic x-rays or Laboratory Tests	20% co-insurance after deductible
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	20% co-insurance after deductible
Prescription Drugs Prescription Drug Deductible	$250 (applies to Retail Tiers 2 and 3 only)
Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$15/ 50% co-insurance after Rx deductible 50% co-insurance after Rx deductible
Mail order (Up to 90-days supply)	$30/ 50% co-insurance 50% co-insurance
Emergency Room	$250[8]

[8] Co-payment waived if ER visit results in hospital admission.

SECTION IV – PLAN DESIGN PARAMETERS (CONTINUED)

Young Adults Plan Design – HSA-Compatible HDHP

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$3,050
Annual Out-of-Pocket Maximum	$5,950
Outpatient Medical Care PCP Office Visit	$25 after deductible
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	20% co-insurance after deductible
Diagnostic x-rays or Laboratory Tests	20% co-insurance after deductible
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	20% co-insurance after deductible
Prescription Drugs Prescription Drug Deductible	None (the annual deductible applies to prescription drugs)
Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$15 after deductible/ 50% co-insurance after deductible/ 50% co-insurance after deductible
Mail order (Up to 90-days supply)	$30 after deductible/ 50% co-insurance after deductible/ 50% co-insurance after deductible
Emergency Room	$100 after deductible[9]

[9] Co-payment waived if ER visit results in hospital admission.

SECTION V – REQUIRED ELEMENTS OF THE PROPOSAL

A. SUBMISSION REQUIREMENTS

Proposals must be submitted to:

Mr. Roni Mansur
Director, Commonwealth Choice
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza, 6th Floor
Boston, Massachusetts 02108

Mr. Mansur can be contacted at:

617-933-3039
Roni.Mansur@state.ma.us

Two (2) unbound, unpunched originals, so identified, plus six (6) bound copies, must be received at the Health Connector offices by 3:00 p.m. on February, 11, 2011.

The proposal must include the following elements:

1) Transmittal Letter
2) Summary information for each required plan design (Response Form A)
3) Plan design and actuarial value worksheet for each required plan design (Response Forms B - E)
4) Pricing worksheet for each required plan design
5) Provider directory in electronic format for each required plan design
6) Actuarial opinion for each required plan design
7) Product licensure confirmation/explanation
8) Sales and marketing plan
9) Small and non-group membership details (Response Form F)

B. TRANSMITTAL LETTER

The Transmittal Letter should contain a summary or executive overview of the Carrier's proposal and should be signed by an individual authorized to bind the firm contractually. The letter must also provide the name and contact information for the RFR respondent. The Health Connector will assume this individual will be available to respond to requests for additional information if necessary.

SECTION V – REQUIRED ELEMENTS OF THE PROPOSAL (CONTINUED)

A template contract for participation in the CommChoice program is attached as Attachment A to this RFR. Carriers who submit responses to this RFR should indicate in their transmittal letter that they are willing to enter into this contract as written, or subject to such revisions as they identify in their response. Carriers with existing contracts should indicate a willingness to enter into a renewal of their existing contract, with any updates required for this contract period (as indicated in redlined text in Attachment A), or subject to such revisions as they identify in their response. All contracts, whether new contracts or renewals, must contain a provision requiring Carrier participation in all product lines and benefit levels, as stated in Section 3.1.B of the template contract (Attachment A).

C. SUMMARY INFORMATION FOR EACH PLAN DESIGN

For each health benefit plan proposed, the carrier must prepare summary information that describes the coverage in layperson's terms and specifies co-payments, co-insurance, deductibles and any limitations related to coverage. The summary information must include, but should not be limited to, the following categories:

- Service area
- Primary Care Physician (PCP) requirements and referrals
- Urgent care and emergency room services
- Out-of-pocket maximum
- Covered services and applicable cost-sharing requirements, including:
  - Outpatient care/office visits
  - Emergency room visits
  - Ambulance
  - Diagnostic testing
  - Durable medical equipment
  - Ambulatory surgery
  - Inpatient care
    - Acute
    - Skilled nursing and rehabilitative care
  - Mental health and substance abuse
    - Biologically based conditions
      - Outpatient care/office visits
      - Inpatient care
    - Non-biologically based conditions
      - Outpatient care/office visits
      - Inpatient care
  - Prescription drug benefit
  - Routine Vision

For each plan design, Carriers should complete the applicable plan design worksheet (Response Forms B-E). If a carrier has an existing plan that meets these plan design parameters, they should include the summary plan document (i.e., schedule of benefits) for that plan.

SECTION V – REQUIRED ELEMENTS OF THE PROPOSAL (CONTINUED)

D. PROVIDER DIRECTORY FOR EACH HEALTH BENEFIT PLAN

For each health benefit plan proposed, Carriers should submit in electronic format a listing of in-network providers by practice specialty and location/zip code. A separate file should be included that lists the name and location/zip code of in-network hospitals.

E. FULL RATING FORMULA FOR EACH PLAN DESIGN

The Health Connector reserves the right to request Carriers provide to the Health Connector's consultant a complete rating table for each product offered so that plan premiums can be calculated and compared across plans.

In addition, the Health Connector's third party administrator (i.e., Sub-Connector) will need a complete rating table for each product offered by the Health Connector. This rating table will need to be capable of generating quotes on a regular basis for both non-group and small-group rating. Carriers' products offered through the Health Connector will be required to provide a rating table to the Sub-Connector, and Carriers will be required to provide updates to the rating table throughout the contract period.

F. PREMIUMS

For each product offered, Carriers must list the monthly premium, assuming non-group purchase and no rating adjustment based on industry/SIC code, for each of the demographic categories, geographic regions and coverage categories listed in the table on the following page. Estimated premiums should reflect a July 1, 2011 effective date of coverage.

SECTION V – REQUIRED ELEMENTS OF THE PROPOSAL (CONTINUED)

DEMOGRAPHIC CATEGORIES, GEOGRAPHIC REGIONS AND COVERAGE CATEGORIES	BOSTON (02108)	WORCESTER (01601)	SPRINGFIELD (01089)
Single individual, age:			
25 years old			
35 years old			
45 years old			
55 years old			
Two adults			
28 yr old w/30 yr old spouse			
35 yr old w/38 yr old spouse			
47 yr old w/47 yr old spouse			
56 yr old w/63 yr old spouse			
Single individual w/one child			
28 years old			
35 years old			
47 years old			
56 years old			
Married couple w/two children			
28 yr old w/30 yr old spouse			
35 yr old w/38 yr old spouse			
47 yr old w/47 yr old spouse			
56 yr old w/63 yr old spouse			

SECTION V – REQUIRED ELEMENTS OF THE PROPOSAL (CONTINUED)

Carriers must also provide the rating factor used for each geographic region in the Commonwealth using the rate table below.

ZIP CODES	RATING FACTOR
010 through 013	
014 through 016	
017 through 020	
018 through 019	
021 through 022 and 024	
023 and 027	
025 through 026	

G. ACTUARIAL OPINION

Every carrier must file with the Health Connector a copy of an actuarial opinion that the carrier's rating methodologies and rates comply with the requirements of M.G.L. c. 176J, as amended by Chapter 288, and 211 CMR 66.00, as required by the DOI.

The actuarial certification must be signed by a member of the American Academy of Actuaries based upon the person's examination, including a review of the appropriate records, of the actuarial assumptions and methods used by the carrier in establishing premium rates for health benefit plans offered by the carrier to be sold through the Health Connector.

Every carrier must maintain at its principal place of business a complete and detailed description of its rating practices including information and documentation which demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions, are in accordance with sound actuarial principles, and comply with the provisions of 211 CMR 66.00. This information must be made available to the Health Connector upon request, but will remain confidential.

Every carrier shall notify the Health Connector regarding any material changes or additions to the actuarial methodology prior to the effective date of the change or addition and provide the same information, including any changes to the rating table, to the Health Connector. See Section 3.1.C of the template contract, attached as Attachment A to this RFR, or the corresponding section of carrier's existing contract for details.

SECTION V – REQUIRED ELEMENTS OF THE PROPOSAL (CONTINUED)

H. PRODUCT LICENSURE BY THE DIVISION OF INSURANCE

For each product offering, Carriers must either confirm that the product is licensed for sale in the Commonwealth or discuss the status of the product filing and any feedback that the carrier has received from the DOI regarding the proposed, but not yet licensed, plan design.

I. SALES AND MARKETING PLAN

Carriers should briefly describe their sales and marketing plan and how they will differentiate their marketing efforts for Health Connector products.

J. MASSACHUSETTS SMALL AND NON-GROUP ENROLLMENT

On Response Form F of this RFR, Carriers must complete the small and non-group membership information for each product offered and purchased in Massachusetts. Carriers should provide monthly enrollment data from the period from January 1, 2010 through December 31, 2010.

As noted on Response Form F, the Health Connector is requiring this data at the benefit design level so identifiers which allow this type of analysis are required.

SECTION VI – TIMELINE AND PROCESS FOR SUBMISSION AND SELECTION

A bidders conference will be held on January 26, 2011 from 9:00 – 11:00 am. Interested vendors are invited to attend. Health Connector staff will be available to respond to questions regarding this RFR. In addition, vendors may also submit written questions to the Health Connector at connector.rfr.questions@state.ma.us or via the mailing address listed above. Questions will be accepted through January 28, 2011. All questions and answers will be posted on the Comm-Pass website no later than February 2, 2011.

SCHEDULE

DATE	ACTIVITY
January 14, 2011	RFR Issued
January 26, 2011	Q&A Session With Interested Vendors
February 11, 2011	Proposals Due to the Health Connector by 3:00 p.m.
February 14 through April 8, 2011	Health Connector review of carrier proposals and Meetings with Carriers
April 14, 2011	Health Benefit Plans' Recommendations Presented to Connector Board for Review And Approval
May 1, 2011	Open Enrollment Begins
July 1, 2011	***Connector Plans' Effective Date of Coverage***

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SECTION VII – RESPONSE FORMS

RESPONSE FORM A – PROGRAM REQUIREMENTS

A. RULES OF ELIGIBILITY

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

RULES OF ELIGIBILITY	CONFIRMATION OR EXPLANATION
1. Please confirm that you are a carrier that, as of the close of 2010, had a combined total of 5,000 or more eligible employees and eligible dependents who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses pursuant to its license under c. 175, c. 176A, c. 176B or c. 176G; provided that neither an eligible individual or eligible employee, nor an eligible dependent, shall be considered to be enrolled in a health benefit plan issued pursuant to its authority under c. 175, c. 176A or c. 176B if the health benefit plan is sold, issued, delivered, made effective or renewed to said eligible employee or eligible dependent as a supplement to a health benefit plan subject to licensure under c. 176G.	
2. For the Young Adults Plan, please confirm that your company will meet the following criteria, pursuant to c. 58, as amended for the Health Connector's consideration: A carrier that, as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its license under c. 175, c. 176A, c. 176B or c. 176G.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

B. RULES OF PARTICIPATION

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

RULES OF PARTICIPATION	CONFIRMATION OR EXPLANATION
1. Confirm that your company will submit for consideration the requisite number of standardized benefit packages under each of the three main plan benefit levels (Gold, Silver, Bronze).	
2. Please confirm that your understanding that the Health Connector will only offer for sale through its CommChoice program products from Carriers that satisfy the selection criteria for each of the three plan benefit levels (Gold, Silver and Bronze), and Young Adults Plans (if eligible).	
3. Confirm your understanding that the Health Connector will not permit any carrier to limit its product offerings to any particular CommChoice product or set of CommChoice products, or any standardized health benefit package or specific plan benefit level unless approved by the Health Connector in its sole discretion.	
4. Confirm your understanding that Carriers wishing to offer one of the standardized plan benefit packages with a limited provider network must also offer that same product with the carrier's broadest commercial provider network.	
5. Confirm that you will periodically provide updated provider network information for inclusion in this provider search function.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

C. COMMCHOICE PRODUCT DESIGN

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

COMMCHOICE PRODUCT DESIGN	CONFIRMATION OR EXPLANATION
1. Confirm your understanding that only eligible small employers (those with 50 or fewer eligible employees) may purchase small group health insurance coverage through the Health Connector's CommChoice program.	
2. Confirm your understanding that employers that offer their eligible employees health benefit plans purchased through the Health Connector's CommChoice program will not be allowed to offer to their benefits-eligible employees any separate or competing employer-sponsored health insurance coverage.	
3. Confirm your understanding that small employer groups enrolling in the Business Express product select a single health benefit plan offered by CommChoice for all benefit-eligible employees.	
4. Confirm your understanding that small employer groups enrolling in the Contributory Plan product select a "benchmark health plan" offered by CommChoice at a specific plan benefit level (e.g., "Silver"). The benefit-eligible employees may select the employer's benchmark plan or any of the other health benefit plans available to them within the benchmark plan's benefit level.	
5. Confirm your understanding that Carriers will be required to recognize those employer groups enrolled through the Small Business Service Bureau Inc. intermediary business that choose to renew through Business Express as renewing groups and, accordingly, must offer those groups the same privileges and benefits as other similarly situated renewing groups.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

C. COMMCHOICE PRODUCT DESIGN (CONTINUED)

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

COMMCHOICE PRODUCT DESIGN (CONTINUED)	CONFIRMATION OR EXPLANATION
6. Confirm your understanding that for those employees not eligible to participate in employer-sponsored health benefit plans, employers may establish as part of their Section 125 program a means to facilitate payroll deductions for non-group premium payments through CommChoice. This provision will apply without regard to whether the employer's benefits-eligible employees are purchasing health benefit plans through CommChoice, and without regard to the number of employees in the group.	
7. Confirm your understanding that non-group purchasers will be allowed to select from any of the plan choices offered through the Health Connector's CommChoice program.	
8. Confirm that the Young Adults Plan may only be offered for sale through the Health Connector's CommChoice program, and may only be purchased by individuals ages 18 to 26, inclusive, without access to employer sponsored insurance with a contribution of at least 33 percent, who shall remain eligible for coverage under this plan until the anniversary date (i.e., renewal date) following the individual's 27th birthday.	
9. Confirm that the Young Adults Plan will be available only as individual coverage. No other coverage basis will be allowed for this plan type.	
10. Confirm that the Young Adults Plan will only be sold on a non-group basis and will not be offered for sale as part of employer-sponsored insurance.	

C. COMMCHOICE PRODUCT DESIGN (CONTINUED)

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

COMMCHOICE PRODUCT DESIGN (CONTINUED)	CONFIRMATION OR EXPLANATION
11. Confirm your understanding that no health benefit plan shall be offered through the Health Connector that excludes an individual from coverage because of race, color, religion, national origin, sex, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income, or age.	
12. Confirm your understanding that only health benefit plans that have been authorized by the Division of Insurance and underwritten by a carrier may be offered through the Health Connector.	
13. Confirm that you will abide by CommChoice program policies and procedures.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

D. DOI REVIEW AND APPROVAL OF NEW PRODUCTS AND RATE FILINGS

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

DOI REVIEW AND APPROVAL OF NEW PRODUCTS AND RATE FILINGS	CONFIRMATION OR EXPLANATION
1. Confirm that you will cover all mandated benefits (i.e., a health service or category of health service provider) required by the carrier's licensing or other statute to include in its health benefit plan.	

E. RATING METHODOLOGY

RATING METHODOLOGY	CONFIRMATION OR EXPLANATION
1. Confirm that you will utilize the same rating methodology for products distributed through the Health Connector that you use for products offered outside the Health Connector.	

F. HEALTH CONNECTOR ADMINISTRATIVE FEE

HEALTH CONNECTOR ADMINISTRATIVE FEE	CONFIRMATION OR EXPLANATION
1. Confirm your understanding that the Health Connector will retain the higher of 3.5% of premium collected or $12.00 per subscriber for each of the products offered for sale through the Health Connector, to cover the Health Connector's cost of marketing, enrollment and other administrative tasks performed on behalf of the health plans.	

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RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

G. HEALTH PLAN BENEFIT MATERIALS

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

HEALTH PLAN BENEFIT MATERIALS	CONFIRMATION OR EXPLANATION
1. Confirm that, if selected, you will have health plan benefit and enrollment materials available in advance of the May 1, 2011 enrollment date, and that a draft of these materials will be submitted for review by the Health Connector on a file and use basis by March 15, 2011and finalized by April 1, 2011.	

H. MARKETING

HEALTH PLAN BENEFIT MATERIALS	CONFIRMATION OR EXPLANATION
1. Confirm that you will create a detailed marketing plan (which outlines roles and responsibilities) and participate in joint marketing efforts with the Health Connector, including co-branding and establishing direct links between the Health Connector's web site and the Carriers' web site and customer service representatives. Carriers shall propose how they plan to market the Health Connector as a distribution channel for the plans they propose to sell through CommChoice.	
2. Confirm that all use of the Health Connector's marks shall be subject to the review and approval by the Health Connector staff.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

I. CUSTOMER SERVICE

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

CUSTOMER SERVICE	CONFIRMATION OR EXPLANATION
1. Please confirm your understanding that the Health Connector will contract with a third-party entity, also referred to as a Sub-Connector, to handle customer service, enrollment, premium billing and collection, monthly reconciliation, and other such sales and administrative functions, and to provide individuals, employers, employees, and brokers with information about the health benefit plans available through CommChoice.	
2. Please confirm that you will have available customer service representatives during normal business hours to assist members and respond to inquiries from potential enrollees, and to coordinate customer service between their own representatives and the Sub-Connector's representatives.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

J. DISTRIBUTION REQUIREMENTS AND ROLE OF SUB-CONNECTOR(S)

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

DISTRIBUTION REQUIREMENTS AND ROLE OF SUB-CONNECTOR(S)	CONFIRMATION OR EXPLANATION
1. Please confirm your understanding that the Health Connector will subcontract with an entity or entities responsible for a range of administrative services, many of which are typically handled by health insurance Carriers. These services will include: ▪ Pre- and post-enrollment customer service ▪ Eligibility and enrollment ▪ Premium quoting ▪ Monthly premium billing, collection and remittance to Carriers, including bundling payments to the Carriers from multiple employers and individuals ▪ Section 125 program administration/coordination with employers ▪ Notifications to individuals and employers regarding eligibility and enrollment status, late payment and non-payment of premium, and cancellation of coverage ▪ Payments to brokers/agents ▪ Renewals	
2. Confirm that if you are selected to participate in the Health Connector that you will enter into a relationship with the vendor selected to handle administrative functions on behalf of the Health Connector.	
3. Please confirm that you will accept eligibility data in HIPAA 834 format.	
4. Please confirm that you will accept financial data in HIPAA 820 format.	

RESPONSE FORM A – PROGRAM REQUIREMENTS (CONTINUED)

K. REPORTING REQUIREMENTS

If you are able to comply with the consideration, write 'Confirmed', and/or provide the information requested.

REPORTING REQUIREMENTS	CONFIRMATION OR EXPLANATION
1. Please confirm that you may be required to submit rate data to the Health Connector, in a mutually agreeable format, for each product sold through CommChoice.	
2. Please confirm that you may be required to submit summary premium and claims data on a regular basis to the Health Connector or a Health Connector designated third-party.	

L. ENROLLMENT PERIOD

ENROLLMENT PERIOD	CONFIRMATION OR EXPLANATION
1. Please confirm that you will accept CommChoice membership as reported in the Health Connector's enrollment files to Carriers (based on the enrollment period description outlined in Section III, J (Program Requirements, Enrollment Period)).	

RESPONSE FORM B – GOLD PLAN DESIGN WORKSHEET

In the tables below, confirm that you will be able to match each of the features of the Gold Level Plan Design by writing "confirm" in the column labeled "Gold Level Plan Design." If you cannot match a plan design provision, please provide a brief summary of the benefit you are able to provide in the space provided, or if necessary on a separate attachment.

PLAN FEATURE / SERVICE	GOLD LEVEL PLAN DESIGN	YOUR GOLD LEVEL PLAN DESIGN
Annual Deductible	None	
Annual Out-of-Pocket Maximum	None	
Outpatient Medical Care PCP Office Visit	$20	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$150	
Diagnostic x-rays or Laboratory Tests	$25	
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	$150	
Prescription Drugs Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$15/$30/$50	
Mail order (Up to 90-days supply)	$30/$60/$150	
Emergency Room	$75[10]	

[10] Co-payment waived if ER visit results in hospital admission.

RESPONSE FORM B – GOLD PLAN DESIGN WORKSHEET (CONTINUED)

In the table below, please provide the actuarial value of the Gold level plan design. That is, please provide an estimate of the percentage of medical expenses that will be covered by the health plan for an average enrollee.

	GOLD LEVEL PLAN DESIGN
Percentage of average medical expenses covered by the health plan for an average enrollee in the proposed plan design.	

RESPONSE FORM C – SILVER PLAN DESIGN WORKSHEET

In the tables below, confirm that you will be able to match each of the features of the Silver High and Silver Low by writing "confirm" in the column labeled "Silver Level Plan Design – Silver High (or Low)." If you cannot match a plan design provision, please provide a brief summary of the benefit you are able to provide in the space provided, or if necessary on a separate attachment. At the end of the table, indicate the actuarial value of each plan design."

A. SILVER HIGH PLAN LEVEL

PLAN FEATURE / SERVICE	SILVER LEVEL PLAN DESIGN – SILVER HIGH	YOUR SILVER LEVEL PLAN DESIGN – SILVER HIGH
Annual Deductible	None	
Annual Out-of-Pocket Maximum	$2,000 (ind) / $4,000 (fam)	
Outpatient Medical Care PCP Office Visit	$25	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$500	
Diagnostic x-rays or Laboratory Tests	$0	
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	$500	
Prescription Drugs Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$15/ 50% co-insurance / 50% co-insurance	
Mail order (Up to 90-days supply)	$30 50% co-insurance / 50% co-insurance	
Emergency Room	$100[11]	

[11] Co-payment waived if ER visit results in hospital admission.

RESPONSE FORM C – SILVER PLAN DESIGN WORKSHEET (CONTINUED)

B. SILVER LOW PLAN LEVEL

PLAN FEATURE / SERVICE	SILVER LEVEL PLAN DESIGN – SILVER LOW	YOUR SILVER LEVEL PLAN DESIGN – SILVER LOW
Annual Deductible	$1,000 (ind) / $2,000 (fam)	
Annual Out-of-Pocket Maximum	$2,000 (ind) / $4,000 (fam)	
Outpatient Medical Care PCP Office Visit	$20	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$0 after deductible	
Diagnostic x-rays or Laboratory Tests	$0 after deductible	
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	$0 after deductible	
Prescription Drugs Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$15/$30/$50	
Mail order (Up to 90-days supply)	$30/$60/$150	
Emergency Room	$100 after deductible[12]	

[12] Co-payment waived if ER visit results in hospital admission.

RESPONSE FORM C – SILVER PLAN DESIGN WORKSHEET (CONTINUED)

In the table below, please provide the actuarial value of each of the Silver Level Plan Designs.

	SILVER LEVEL PLAN DESIGN – SILVER HIGH	SILVER LEVEL PLAN DESIGN – SILVER LOW
Percentage of average medical expenses covered by the health plan for an average enrollee in the proposed plan design.		

RESPONSE FORM D – BRONZE LEVEL PLAN DESIGN WORKSHEET

In the tables below, confirm that you will be able to match each of the features of the Bronze Level Plan Designs (High, Medium, and Low) by writing "confirm" in the column labeled "Your Bronze Level Plan Design High (or Medium, or Low)." If you cannot match a plan design provision, please provide a brief summary of the benefit you are able to provide in the space provided, or if necessary on a separate attachment. At the end of the table, indicate the actuarial value of each plan design.

A. BRONZE HIGH PLAN LEVEL

PLAN FEATURE / SERVICE	BRONZE PLAN DESIGN – BRONZE HIGH	YOUR BRONZE PLAN DESIGN – BRONZE HIGH
Annual Deductible	$250 (ind) / $500 (fam)	
Annual Out-of-Pocket Maximum	$5,000 (ind) / $10,000 (fam)	
Outpatient Medical Care PCP Office Visits	$25	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	35% co-insurance after deductible	
Diagnostic x-rays or Laboratory Tests	35% co-insurance after deductible	
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	35% co-insurance after deductible	
Prescription Drugs Prescription Drug Deductible	$250 (ind) / $500 (fam) applies to Tiers 2 and 3 only	
Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$15 / 50% co-insurance after Rx deductible/ 50% co-insurance after Rx deductible	
Mail order (Up to 90-days supply)	$30 / 50% co-insurance after Rx deductible/ 50% co-insurance after Rx deductible	
Emergency Room	$150[13]	

[13] Co-payment waived if ER visit results in hospital admission.

RESPONSE FORM D – BRONZE LEVEL PLAN DESIGN WORKSHEET (CONTINUED)

B. BRONZE MEDIUM PLAN LEVEL

PLAN FEATURE / SERVICE	BRONZE PLAN DESIGN – BRONZE MEDIUM	YOUR BRONZE PLAN DESIGN – BRONZE MEDIUM
Annual Deductible	$2,000 (ind) / $4,000 (fam)	
Annual Out-of-Pocket Maximum	$5,000 (ind) / $10,000 (fam)	
Outpatient Medical Care PCP Office Visit	$30	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	$250 after deductible	
Diagnostic x-rays or Laboratory Tests	$0 after deductible	
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	$500 after deductible	
Prescription Drugs Prescription Drug Deductible	$250 (ind) / $500 (fam) (applies to Tiers 2 and 3 only)	
Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$10/ $30 after Rx deductible/ $50 after Rx deductible	
Mail order (Up to 90-days supply)	$20/ $60 after Rx deductible/ $90 after Rx deductible	
Emergency Room	$150 after deductible[14]	

[14] Co-payment waived if ER visit results in hospital admission.

RESPONSE FORM D – BRONZE LEVEL PLAN DESIGN WORKSHEET (CONTINUED)

C. BRONZE LOW PLAN LEVEL

PLAN FEATURE / SERVICE	BRONZE PLAN DESIGN – BRONZE LOW	YOUR BRONZE PLAN DESIGN – BRONZE LOW
Annual Deductible	$2,000 (ind) / $4,000 (fam)	
Annual Out-of-Pocket Maximum	$5,000 (ind) / $10,000 (fam)	
Outpatient Medical Care PCP Office Visit	$25 after deductible	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	20% co-insurance after deductible	
Diagnostic x-rays or Laboratory Tests	20% co-insurance after deductible	
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	20% co-insurance after deductible	
Prescription Drugs Prescription Drug Deductible	None (the annual deductible applies to prescription drugs)	
Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$15 after deductible/ 50% co-insurance after deductible/ 50% co-insurance after deductible	
Mail order (Up to 90-days supply)	$30 after deductible/ 50% co-insurance after deductible/ 50% co-insurance after deductible	
Emergency Room	$100 after deductible[15]	

[15] Co-payment waived if ER visit results in hospital admission.

RESPONSE FORM D – BRONZE LEVEL PLAN DESIGN WORKSHEET (CONTINUED)

In the table below, please provide the actuarial value of each Bronze Level plan design.

	BRONZE LEVEL PLAN DESIGN – BRONZE HIGH	BRONZE LEVEL PLAN DESIGN – BRONZE MEDIUM	BRONZE LEVEL PLAN DESIGN – BRONZE LOW
Percentage of average medical expenses covered by the health plan for an average enrollee in the proposed plan design.			

RESPONSE FORM E – YOUNG ADULTS PLAN DESIGN WORKSHEET

In the tables below, confirm that you will be able to match each of the features of the Young Adults Plan Design High, or Low, or HSA-Compatible HDHP by writing "confirm" in the column labeled "Your Young Adults Plan Design High (or Low or HSA-Compatible HDHP)." If you cannot match a plan design provision, please provide a brief summary of the benefit you are able to provide in the space provided, or if necessary on a separate attachment. At the end of the table, indicate the actuarial value of the plan design, with and without a drug benefit (only Young Adult Plan High and Low would be available without prescription drug coverage).

RESPONSE FORM E – YOUNG ADULTS PLAN DESIGN WORKSHEET (CONTINUED)

A. YAP HIGH PLAN LEVEL

PLAN FEATURE / SERVICE	YOUNG ADULTS LEVEL PLAN DESIGN - HIGH	YOUR YOUNG ADULTS LEVEL PLAN DESIGN - HIGH
Annual Deductible	$250	
Annual Out-of-Pocket Maximum	$5,000	
Outpatient Medical Care PCP Office Visit	$25	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	30% co-insurance after deductible	
Diagnostic x-rays or Laboratory Tests	30% co-insurance after deductible	
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	30% co-insurance after deductible	
Prescription Drugs Prescription Drug Deductible	None	
Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$15/ 50% co-insurance/ 50% co-insurance	
Mail order (Up to 90-days supply)	$30 / 50% co-insurance/ 50% co-insurance	
Emergency Room	$250[16]	

[16] Co-payment waived if ER visit results in hospital admission.

RESPONSE FORM E – YOUNG ADULTS PLAN DESIGN WORKSHEET (CONTINUED)

A. YAP LOW PLAN LEVEL

PLAN FEATURE / SERVICE	YOUNG ADULTS LEVEL PLAN DESIGN - LOW	YOUR YOUNG ADULTS LEVEL PLAN DESIGN - LOW
Annual Deductible	$2,000	
Annual Out-of-Pocket Maximum	$5,000	
Outpatient Medical Care PCP Office Visit	$25	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	20% co-insurance after deductible	
Diagnostic x-rays or Laboratory Tests	20% co-insurance after deductible	
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	20% co-insurance after deductible	
Prescription Drugs Prescription Drug Deductible	$250 (applies to Retail Tiers 2 and 3 only)	
Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$15/ 50% co-insurance after Rx deductible/ 50% co-insurance after Rx deductible	
Mail order (Up to 90-days supply)	$30/ 50% co-insurance/ 50% co-insurance	
Emergency Room	$250[17]	

[17] Co-payment waived if ER visit results in hospital admission.

RESPONSE FORM E – YOUNG ADULTS PLAN DESIGN WORKSHEET (CONTINUED)

PLAN FEATURE / SERVICE	YAP LEVEL PLAN DESIGN – HSA-COMPATIBLE HDHP	YOUR YAP LEVEL PLAN DESIGN – HSA-COMPATIBLE HDHP
Annual Deductible	$3,050	
Annual Out-of-Pocket Maximum	$5,950	
Outpatient Medical Care PCP Office Visit	$25 after deductible	
Outpatient Surgery (OP Hospital/Ambulatory Surgery Centers)	20% co-insurance after deductible	
Diagnostic x-rays or Laboratory Tests	20% co-insurance after deductible	
Inpatient Hospitalization Room and Board (includes deliveries/surgeries/x-rays/labs)	20% co-insurance after deductible	
Prescription Drugs Prescription Drug Deductible	None (the annual deductible applies to prescription drugs)	
Retail (Up to 30-days supply) (Tier 1/Tier 2/Tier 3)	$15 after deductible/ 50% co-insurance after deductible/ 50% co-insurance after deductible	
Mail order (Up to 90-days supply)	$30 after deductible/ 50% co-insurance after deductible/ 50% co-insurance after deductible	
Emergency Room	$100 after deductible[18]	

PLEASE CONFIRM THAT THE CARRIER IS ABLE TO FACILITATE ACCESS TO AN HSA.

[18] Co-payment waived if ER visit results in hospital admission.

RESPONSE FORM E – YOUNG ADULTS PLAN DESIGN WORKSHEET (CONTINUED)

In the table below, please provide the actuarial value of each of the proposed Young Adult Plan Level plan designs.

	YOUNG ADULT LEVEL PLAN DESIGN - HIGH	YOUNG ADULTS LEVEL PLAN DESIGN - LOW	YOUNG ADULTS LEVEL PLAN DESIGN – HSA-COMPATIBLE HDHP
Percentage of average medical expenses covered by the health plan for an average enrollee in the proposed plan design.	With Prescription Drug Coverage: Without Prescription Drug Coverage:	With Prescription Drug Coverage: Without Prescription Drug Coverage:	With Prescription Drug Coverage:

RESPONSE FORM F – MASSACHUSETTS SMALL AND NON-GROUP MEMBERSHIP BY PRODUCT

In the table below, please provide a membership count (i.e., lives covered), by product, for your small (< 51 eligible subscribers) and non-group sales in Massachusetts, by month for the period from January 1, 2010 through December 31, 2010. Please provide the Health Connector the name and summary plan documents (i.e., schedule of benefits) for your twenty most popular small/non-group products.

PRODUCT NAME AND BRIEF DESCRIPTION (E.G., STANDARD HMO W/$15 OFFICE VISIT CO-PAYMENT AND $250 INPATIENT CO-PAYMENT, OR STANDARD HMO W/$1,000 DEDUCTIBLE, OR PPO W/$1,000 DEDUCTIBLE, ETC.)	MEMBERSHIP AS OF JANUARY 31, 2010		MEMBERSHIP AS OF APRIL 30, 2010		MEMBERSHIP AS OF JULY 31, 2010		MEMBERSHIP AS OF OCTOBER 30, 2010		MEMBERSHIP AS OF DECEMBER 31, 2010	
	NON-GROUP	SMALL GROUP	NON-GROUP	SMALL GROUP	NON-GROUP	SMALL GROUP	NON-GROUP	SMALL GROUP	NON-GROUP	SMALL GROUP

Commonwealth Choice
July 2011
Seal of Approval

Roni Mansur
Director of Commonwealth Choice

Kaitlyn Kenney
Director of Policy and Research and National Health Care Reform Coordinator

Board of Directors Meeting
April 14, 2011

Agenda

- Background
- Timeline
- RFR specifications
- PMT review process
- PMT scoring results
- Young Adult Plan analysis and recommendations
- Staff Seal of Approval recommendation

Commonwealth Choice

At its core, the Commonwealth Choice model is a more consumer friendly, transparent, and competitive market structure

Easy to use Website	Standardized Benefits	Organized Consumer Choice	Trusted and objective source of information	Administrative Functions
• Easy to shop • Easy to enroll	• Allows "apples – to - apples" comparison	• Gold, Silver, Bronze and YAP product tiers • Seven carriers	• Plans sold through the Connector have to be awarded "Seal of Approval"	• Connector centralizes key administrative functions (e.g. processing applications, billing, collecting payments, call center, waiver process)

- **Better value for consumers through greater transparency and comparison shopping**
- **Healthy competition among carriers that results in lower costs through greater efficiency**

Background

- Currently, the existing CommChoice health plans are engaged in a six-month contract with the Health Connector for them to participate in the program from January 1 – June 30, 2011

- Health plans were required to maintain a "steady state":
  - Health plans offered the current standardized plan designs in the Gold, Silver, Bronze and YAP (if applicable) levels
  - Flexibility to participate in the Health Connector's non-group and small group programs or just the non-group program
  - Health plans not currently participating in Business Express committed to make a good faith effort to negotiate their participation for the next Seal of Approval
  - Maintain the reduced administrative fee of 3.5% implemented on July 1, 2010

Background

- Goals of July 2011 Seal of Approval
  - Participation of all CommChoice health plans in Business Express
  - Enhance the shopping experience for individuals and small businesses, while maintaining the benefits of standardization
    - Small group wellness subsidies
    - Removal of $10 supplemental fee for small businesses with 1-5 employees
  - Begin transition to compliance with PPACA requirements (i.e., Young Adult Plans)
  - Provide stability while the Health Connector is planning for changes required by national health reform

Timeline

Date	Activity
1/14/2011	• Issue RFR
1/26/2011	• Q&A with health plans
2/11/2011 or 2/18/2011 (extension upon request)	• Responses due from health plans
2/14/2011 – 3/9/2011	• PMT review of responses
3/14/2011 – 4/8/2011	• Finalize responses with health plans
4/14/2011	• Present Health Connector staff evaluation and recommendations of health plan responses • Board vote on health plan selection; award SoA
4/15/2011-4/21/2011	• Execute contracts with health plans
5/1/2011	• Start enrollment for 7/1/2011 coverage
7/1/2011	• Effective date of July 2011 SoA plans

RFR Specifications
Contract Term

- 18-month contract: July 1, 2011-December 31, 2012
  - Provides the Health Connector and health plans stability allowing parties to plan for national health reform
  - Alleviates administrative and operational investments that need to be made by both parties related to implementation of Seal of Approval requirements (e.g. plan benefit changes)
  - BMCHP is a new entrant in Commonwealth Choice targeting an initial implementation date of 1/1/2012

RFR Specifications
Product Offering

- Health plans continue to be required to participate in all benefit tiers and offer products that comply with CommChoice standardization specifications
  - The Health Connector closed the Silver Medium benefit package for new sales
  - The Health Connector removed standardized member cost sharing for inpatient skilled nursing facility, office visit for outpatient mental health, routine vision, and ambulance

RFR Specifications
Standardized Benefits

Commonwealth Choice: Tier Overview *(For plans effective: July 1, 2011)*							
Tier		**Gold** (i.e. Gold B)	**Silver High** (i.e. Silver A)	**Silver Low** (i.e. Silver C)	**Bronze High** (i.e. Bronze A)	**Bronze Medium** (i.e. Bronze B)	**Bronze Low** (i.e. Bronze C)
Annual deductible (also called the "deductible")		None	None	$1,000 per individual $2,000 per family	$250 per individual $500 per family	$2,000 per individual $4,000 per family	$2,000 per individual $4,000 per family
Annual Out-of-Pocket Maximum		None	$2,000 per individual $4,000 per family	$2,000 per individual $4,000 per family	$5,000 per individual $10,000 per family	$5,000 per individual $10,000 per family	$5,000 per individual $10,000 per family
Primary Care Provider (PCP) office visit		$20 copay	$25 copay	$20 copay	$25 copay	$30 copay	annual deductible, then $25 copay
Diagnostic x-ray or laboratory test		$25 copay	$0 copay	annual deductible, then $0 copay	annual deductible, then 35% co-insurance	annual deductible, then $0 copay	annual deductible, then 20% co-insurance
Outpatient surgery		$150 copay	$500 copay	annual deductible, then $0 copay	annual deductible, then 35% co-insurance	annual deductible, then $250 copay	annual deductible, then 20% co-insurance
Hospitalization		$150 copay	$500 copay	annual deductible, then $0 copay	annual deductible, then 35% co-insurance	annual deductible, then $500 copay	annual deductible, then 20% co-insurance
Prescription drug deductible (also called the "Rx deductible")		None	None	None	$250 per individual $500 per family (for Tiers 2 and 3; for Retail and Mail order)	$250 per individual $500 per family (for Tiers 2 and 3; for Retail and Mail order)	None (but the annual deductible does apply to prescription drugs)
Prescription drugs (Rx)	**Retail**	**Tier 1:** $15 copay	**Tier 1:** $15 copay	**Tier 1:** $15 copay	**Tier 1:** $15 copay	**Tier 1:** $10 copay	**Tier 1:** annual deductible, then $15 copay
		Tier 2: $30 copay	**Tier 2:** 50% co-insurance	**Tier 2:** $30 copay	**Tier 2:** Rx deductible, then 50% co-insurance	**Tier 2:** Rx deductible, then $30 copay	**Tier 2:** annual deductible, then 50% co-insurance
		Tier 3: $50 copay	**Tier 3:** 50% co-insurance	**Tier 3:** $50 copay	**Tier 3:** Rx deductible, then 50% co-insurance	**Tier 3:** Rx deductible, then $50 copay	**Tier 3:** annual deductible, then 50% co-insurance
	Mail order	**Tier 1:** $30 copay	**Tier 1:** $30 copay	**Tier 1:** $30 copay	**Tier 1:** $30 copay	**Tier 1:** $20 copay	**Tier 1:** annual deductible, then $30 copay
		Tier 2: $60 copay	**Tier 2:** 50% co-insurance	**Tier 2:** $60 copay	**Tier 2:** Rx deductible, then 50% co-insurance	**Tier 2:** Rx deductible, then $60 copay	**Tier 2:** annual deductible, then 50% co-insurance
		Tier 3: $150 copay	**Tier 3:** 50% co-insurance	**Tier 3:** $150 copay	**Tier 3:** Rx deductible, then 50% co-insurance	**Tier 3:** Rx deductible, then $90 copay	**Tier 3:** annual deductible, then 50% co-insurance
Emergency room		$75 copay	$100 copay	annual deductible, then $100 copay	$150 copay	annual deductible, then $150 copay	annual deductible, then $100 copay

RFR Specifications
Network Configuration

- Health plans must offer all products on their broadest commercial provider network
  - For July 1, 2011, Tufts will be offering all SOA products on their broadest commercial network
- Health plans could offer limited network product(s) that comply with CommChoice standardization, in conjunction with a broad network product
  - Fallon will continue to offer a limited network (in conjunction with their broad network) for all Silver and Bronze plans
  - Harvard Pilgrim has indicated that they will offer a limited network (in conjunction with their broad network) on the Bronze High and Bronze Medium benefit packages in 2012

RFR Specifications
Business Express

- The Health Connector has reached an agreement with BCBSMA for participation in Business Express with a planned implementation date of between 10/1/2011 and 12/1/2011
  - An operational / technology solution has been developed that addresses issues that prevented BCBSMA from participating in Business Express in the past
- Other currently non-participating health plans have indicated that they will participate in Business Express when BCBSMA participates
  - All health plans awarded the Seal of Approval would be required to participate in Business Express no later than the time that BCBSMA is "on the shelf"
- All participating health plans will enjoy a reduced administrative fee of 2.5% for Business Express
- Cancellation of phase II of the Business Transfer Agreement with the Small Business Service Bureau

PMT Review Process

- The Health Connector received responses to the SoA RFR from nine health plans
- A cross-functional team of seven Health Connector staff members constituted the Procurement Management Team (PMT) that reviewed and scored the RFR responses
- The responses were scored on three levels:
  - Level 1: Compliance with RFR submission requirements
  - Level 2: Compliance with CommChoice program requirements
  - Level 3: Adherence to CommChoice standardization parameters

PMT Scoring Results

- The PMT determined that 8 of the 9 health plans that submitted responses to the CommChoice Seal of Approval RFR satisfied the requirements of all three scoring levels:
  - Blue Cross Blue Shield of Massachusetts
  - BMC HealthNet Plan
  - CeltiCare Health Plan
  - Fallon Community Health Plan
  - Harvard Pilgrim Health Plan
  - Health New England
  - Neighborhood Health Plan
  - Tufts Health Plan

YAP Analysis

- To help determine YAP product offering the RFR requested that the health plans:
  - Indicate their product preference
  - Provide premium pricing for existing YAP plan designs with no annual limit
  - Provide premium pricing for a YAP plan design that is a high deductible health plan with no annual limit

YAP Analysis
Benefit Designs

Commonwealth Choice: YAP Overview				
Tier		**YAP High**	**YAP Low**	**YAP (High Deductible Health Plan)**
Annual deductible		$250 per individual	$2,000 per individual	$3,050 per individual
Annual Out-of-Pocket		$5,000 per individual	$5,000 per individual	$5,950 per individual
Primary Care Provider (PCP) office visit		$25 copay	$25 copay	annual deductible, then $25 copay
Diagnostic x-ray or laboratory test		annual deductible, then 30% co-insurance	annual deductible, then 20% co-insurance	annual deductible, then 20% co-insurance
Outpatient surgery		annual deductible, then 30% co-insurance	annual deductible, then 20% co-insurance	annual deductible, then 20% co-insurance
Hospitalization		annual deductible, then 30% co-insurance	annual deductible, then 20% co-insurance	annual deductible, then 20% co-insurance
Prescription drug deductible		None	$250 per individual (for Tiers 2 and 3; for Retail only)	None (but the annual deductible applies to prescription drugs)
Prescription drugs (Rx)	**Retail**	**Tier 1:** $15 copay	**Tier 1:** $15 copay	**Tier 1:** annual deductible, then $15 copay
		Tier 2: 50% co-insurance	**Tier 2:** Rx deductible, then 50% co-insurance	**Tier 2:** annual deductible, then 50% co-insurance
		Tier 3: 50% co-insurance	**Tier 3:** Rx deductible, then 50% co-insurance	**Tier 3:** annual deductible, then 50% co-insurance
	Mail order	**Tier 1:** $30 copay	**Tier 1:** $30 copay	**Tier 1:** annual deductible, then $30 copay
		Tier 2: 50% co-insurance	**Tier 2:** 50% co-insurance	**Tier 2:** annual deductible, then 50% co-insurance
		Tier 3: 50% co-insurance	**Tier 3:** 50% co-insurance	**Tier 3:** annual deductible, then 50% co-insurance
Emergency room		$250 copay	$250 copay	annual deductible, then $100 copay
Other benefits		All carriers are fully-insured and cover all mandated state benefits. Coverage and cost-sharing for benefits other than those listed above may vary from one plan to another within a single tier.		

No Annual Limit on any of the Young Adult Plan designs.

YAP Analysis

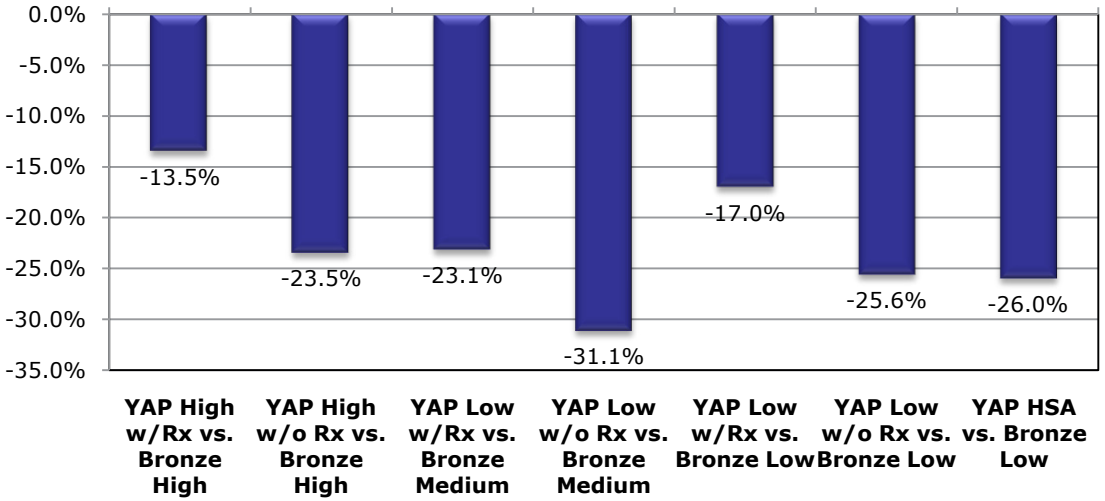
- Most health plans indicated a preference for maintenance of existing plan designs vs. creation of the new HSA compatible plan

- Reasons included:
  - Concerns regarding HSA take-up by this population
  - Administrative and operational ease
  - Limited differentiation between YAP Low and YAP HSA

YAP Analysis
Premium Pricing

- In general, YAPs without annual limits still compare favorably to Bronze plans from a pricing perspective

Composite Average July 2011 Premiums: YAP vs. Bronze Level Plans*



*This includes data for health plans that are eligible to offer YAPs and that submitted rates for YAPs without an annual limit.

- Based on premium data submitted by health plans, the increase in premium for YAPs without the annual limits are projected to be on average about 17-18%, which includes the impact of both premium trend and the removal of the annual limit

YAP Analysis
Recommendations

- Maintain existing benefit designs without an annual limit; do not pursue the HSA plan design
- Carriers may choose to implement the removal of the annual limit to new purchasers as of 7/1/11 or 10/1/11
- To gradually phase out limits for existing members, seek a waiver for enrollees in existing YAPs with annual limits
  - Mitigates significant premium increase at renewal
  - More than half (56%) of YAP enrollees are ages 25+ so will phase out of product within two years
  - Experience to date suggests most members enrolled for 9-11 months

SoA Recommendation

- Based on the scoring of the PMT and subsequent follow-up meetings with the health plans responding to the RFR, the staff of the Health Connector recommends that the Seal of Approval be awarded to the following health plans, contingent on final agreement on contracts, for the period beginning July 1, 2011 and ending December 31, 2012:
  - Blue Cross Blue Shield of Massachusetts
  - BMC Health Net Plan
  - CeltiCare Health Plan
  - Fallon Community Health Plan
  - Harvard Pilgrim Health Plan
  - Health New England
  - Neighborhood Health Plan
  - Tufts Health Plan

Attachment A – SoA July 2011 Template Contract

FORM AGREEMENT

BETWEEN

THE COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY (HEALTH CONNECTOR)

AND

(CARRIER)

Dated as of July 1, 2011

TABLE OF CONTENTS

This Agreement (Agreement) is made effective this 1st day of July, 2011 (Effective Date) by and between the Commonwealth Health Insurance Connector Authority (the Health Connector), with offices at 100 City Hall Plaza, Boston, MA 02108, and ___ (Carrier), a corporation with principal offices at [address].

WHEREAS, the Health Connector is an independent public state authority established under Chapter 58 of the Acts of 2006 (the Health Care Reform Act), one purpose of which is to facilitate the development and offering of a choice of affordable commercial health insurance products (without public subsidy) to eligible individuals (including certain employees participating in so-called Section 125 payroll deduction programs) and eligible small groups through the Health Connector, as described in M.G.L. c. 176Q, called the Commonwealth Choice Program;

WHEREAS, on January 14, 2011the Health Connector issued a Request for Responses for licensed carriers to file commercial health insurance products with the Health Connector which could attain the Health Connector's Seal of Approval to be offered through the Health Connector (Seal of Approval;

WHEREAS, based on Carrier's Responses, the Health Connector awards its Seal of Approval to certain of Carrier's products, further described herein, to be offered through the Health Connector, and Carrier desires to make such products available through the Health Connector to eligible individuals and eligible small groups through the Health Connector's nongroup and small group product offerings in accordance with the terms and conditions of this Agreement and until such time as the Health Connector, in its sole discretion, decides to no longer offer a product through the Commonwealth Choice Program, and Carrier desires to continue to make such products available through the Health Connector to eligible individuals and eligible small groups through the Health Connector's nongroup and small group product offerings in accordance with the terms and conditions of this Agreement or until such time that the Carrier, consistent with applicable law, decides no longer to offer such products as part of its book of business; and

WHEREAS, the Health Connector will begin offering such products awarded the Health Connector's Seal of Approval to eligible individuals and eligible small groups May 1, 2011 with an effective date of coverage beginning July 1, 2011;

NOW, THEREFORE, in consideration of the mutual covenants and agreements set forth in this Agreement, Carrier and the Health Connector agree as follows:

ARTICLE I. DEFINITIONS

Terms, when capitalized in this Agreement, are defined as provided below:

Administrative Fee. An administrative fee, expressed as a percent of premium or flat dollar amount, charged to Carrier and collected by the Sub-Connector to compensate for certain administrative services and broker commissions.

Affiliate. An organization that owns and/or controls, is owned and/or controlled by or on behalf of, or is under common ownership and/or control with Carrier. As used in this definition, "control" means the possession of or entitlement to, the legal power to direct or approve, or cause the direction or approval of the management and/or policies of an organization, through voting rights, contract rights, voting securities or otherwise.

Change in Control. A consolidation or merger of Carrier with or into any entity; a sale, transfer or other disposition of all or substantially all of the assets of Carrier; or an acquisition by any entity, or group of entities acting in concert, of beneficial ownership of 20 percent or more (or such lesser percentage that constitutes Control) of the outstanding voting securities or other ownership interests of Carrier.

Commonwealth Choice Health Plan. A Health Benefit Plan, including a Young Adult Plan as defined in M.G.L. c. 176J, underwritten by a Carrier that has received the Health Connector's Seal of Approval to be offered through the Health Connector.

Commonwealth Health Insurance Connector Authority or the **Health Connector** means the entity established pursuant to M.G.L. c. 176Q, § 2.

Covered Persons. Persons enrolled in a Commonwealth Choice Health Plan and entitled to coverage thereunder.

Contract Term. The eighteen (18) month period commencing July 1, 2011, and ending December 31, 2012; if this Contract is renewed in accordance with Section 5.1, the contract term shall further include the twelve (12) month period commencing January 1, 2013 and ending December 31, 2013.

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Division of Insurance (DOI). The Massachusetts Division of Insurance.

Eligible Individuals. Eligible Individual as defined in M.G.L. c. 176Q.

Eligible Small Groups. Eligible Small Group as defined in M.G.L. c. 176Q.

Eligible Young Adults. Young Adult as defined in M.G.L. c. 176J.

Evidence of Coverage (EOC). The document containing a detailed description of covered services, conditions, limitations, exclusions, and other terms and conditions of coverage under each Commonwealth Choice Health Plan.

Health Benefit Plan. An HMO, PPO or POS plan of health benefits that has been approved by the DOI as complying with M.G.L. c. 176J and other applicable laws and regulations to be offered to Eligible Individuals, Eligible Small Groups, and Eligible Young Adults.

Seal of Approval. A designation by the Health Connector that a Health Benefit Plan has met the Health Connector's standards regarding quality, value and, if applicable, health care delivery network design.

Sub-Connector. An intermediary organization with which the Health Connector contracts to provide a broad range of administrative services related to the Commonwealth Choice Program.

ARTICLE II. REPRESENTATIONS AND WARRANTIES

Carrier represents and warrants the following as of the Effective Date of this Agreement and shall immediately provide written notice to the Health Connector of any changes in the representations and warranties as stated below:

2.1. Corporate Status. Carrier is a corporation duly organized, validly existing and in good standing under the laws of the Commonwealth of Massachusetts.

2.2. License. Carrier is licensed as a health maintenance organization under M.G.L c. 176G.

2.3. Managed Care Accreditation. If applicable, Carrier has a current managed care accreditation under M.G.L. c. 176O and 211 CMR 52:00 *et seq*.

2.4. Eligibility to Participate in the Commonwealth Choice Program. Carrier meets the eligibility requirements in Section III(A) of the RFR and in M.G.L. chapters 176J and 176Q to offer Health Benefit Plans through the Health Connector.

2.5. Compliance with Laws. Carrier is in compliance with all applicable federal and state laws and regulations related to and in connection with this Agreement and its obligations hereunder, including but not limited to, M.G.L. chapters 175, 176A, 176B and 176G, as applicable; M.G.L. chapters 176I, 176J, 176O and 176Q; M.G.L. c. 151E, section 2 (Anti-Boycott); P.L. 103-3 (1993) (Federal Family and Medical Leave Act); P.L. 99-272,Title XXII of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA); P.L. 104-191 (the Health Insurance Portability and Accountability Act of 1996, or HIPAA); Chapter 143 of the Acts of 1999 (HMO Insolvency Law); Chapter 141 of the Acts of 2000; P.L. 111-148 (the Patient Protection and Affordable Care Act); and P.L. 111-152 (the Health Care and Education Reconciliation Act of 2010).

2.6. Commonwealth Choice Health Plans. Carrier's Commonwealth Choice Health Plans made available through the Health Connector for sale to eligible individuals and eligible small groups pursuant to this Agreement have been approved for sale by the DOI as in compliance with all requirements of M.G.L. c. 176J and all other applicable state laws and regulations, including Minimum Creditable Coverage regulations; and satisfy the Health Connector's selection criteria as set forth in the RFR for each of the Health Connector's plan benefit levels and all standardized benefit packages.

2.7. Insolvency Protection. Carrier has and shall maintain insolvency protection, acceptable to the DOI, to protect Covered Persons, the Health Connector, the Sub-Connector and the Commonwealth of Massachusetts from incurring liability for the payment of any fees that are the legal obligation of the Carrier; and protect Covered Persons from the unavailability of covered health services resulting from the Carrier's insolvency, bankruptcy or other financial impairment.

2.8. Litigation. Carrier represents and warrants that there is no outstanding litigation, arbitrated matter or other dispute to which Carrier is a party which, if decided unfavorably to Carrier, would reasonably be expected to have a material adverse effect on Carrier's ability to fulfill its obligations under this Agreement.

ARTICLE III. CARRIER OBLIGATIONS

In addition to its other specific obligations provided elsewhere in this Agreement, Carrier's obligations under this Agreement shall be as follows:

3.1. Commonwealth Choice Health Plans.

A. Plans Under a Prior Seal of Approval. Carrier shall continue to make available through the Health Connector the Commonwealth Choice Health Plans listed in Appendix A, Schedule I, that were selected under a prior Seal of Approval, unless Parties mutually agree to close a Health Plan. During the Contract Term, Carrier may make changes to the Commonwealth Choice Health Plans listed in Appendix A, Schedule I, as permitted under applicable state and federal law and as approved by the Health Connector, such approval shall not be unreasonably withheld. Carrier must provide a written request to the Health Connector at least one hundred twenty (120) days prior to the proposed effective date of such change and obtain the Health Connector's written approval. The Health Connector shall review such proposed change and notify Carrier of its determination within thirty (30) days of receipt of Carrier's written request. Carrier may change the benefits or cost-sharing features of its Commonwealth Choice Health Plans listed in Appendix A, Schedule I, upon thirty (30) days prior written notice to the Health Connector if such change is required by Massachusetts or federal law and approved by the DOI in advance of implementation. Nothing in this Section 3.1.A shall prevent Carrier from making changes in the language of its Commonwealth Choice Health Plans' EOCs, provided such changes (1) are designed to improve the clarity of such documents, (2) do not change the benefits or cost-sharing features of the plans, (3) are implemented uniformly throughout all relevant plans sold by Carrier in Massachusetts, and (4) if required, are approved by the DOI in advance of implementation. Carrier will give the Health Connector at least thirty (30) days advance written notice prior to the implementation of any language changes it intends to implement in the EOCs.

B. Plans Under This Seal of Approval. Carrier will offer all standardized benefit packages for all plan benefit levels (i.e. Gold, Silver, and Bronze) on the broadest commercial provider network available to the Carrier. Carrier will offer all standardized benefit packages in all plan benefit levels to all Commonwealth Choice product offerings, (i.e., Individual/Nongroup, YAP, Voluntary Plan, Business Express, and renewals for the Contributory Plan). In addition, if a Carrier wishes to offer one of the standardized plan benefit packages with a limited provider network, that Carrier must also offer that same product with its broadest commercial provider network. Specifically, Carrier shall make available for purchase through the Health Connector, beginning on May 1, 2011, the Commonwealth Choice Health Plans that were selected under this Seal of Approval and are listed in Appendix A, Schedule II, to Eligible Individuals and Eligible Small Groups for coverage effective July 1, 2011. However, if the Health Connector delays the implementation of the Young Adult Health Plans that were selected under this Seal of Approval and are listed in Appendix A, Schedule II, the Carrier agrees to continue offering to new and renewing business its existing Young Adult Health Plans until implementation. During the Contract Term, for Carrier's Commonwealth Choice Health Plans listed in Appendix A, Schedule II, Carrier may not change those benefits or cost-sharing features specifically required in the Section IV of the RFR, and for which the Health Connector gave its Seal of Approval even if such plan(s) were offered under a prior Seal of Approval and had the same or a modified plan design. During the Contract Term, for Carrier's Commonwealth Choice Health Plans listed in Appendix A, Schedule II Carrier may change certain other benefits or cost-sharing features as set forth below,

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Carrier must provide a written request to the Health Connector at least one hundred twenty (120) days prior to the proposed effective date of such change and obtain the Health Connector's written approval; such approval shall not be unreasonably withheld. The Health Connector shall review such proposed change and notify Carrier of its determination within thirty (30) days of receipt of Carrier's written request.

a. Changes to Certain Benefit Features Permitted. Carrier may request to modify certain benefit features of its Commonwealth Choice Health Plans listed in Appendix A, Schedule II, for example: (1) ambulance; (2) routine vision; (3) outpatient mental health office visits; (4) inpatient mental health; (5) inpatient skilled nursing facility; (6) durable medical equipment; and (7) specialist co-pays ("Non-Standardized Benefit Categories").

b. Changes to Certain Cost-Sharing Features Permitted. Carrier may request to modify the following cost-sharing features of its Commonwealth Choice Health Plans listed in Appendix A, Schedule II: (1) waiver of co-payments for preventive care office visits, and (2) three co-payment only option on office visits in YAP Low plan design ("Value-Added Benefits").

c. Other Permitted Changes.

   i. Carrier may change the benefits or cost-sharing features of its Commonwealth Choice Health Plans listed in Appendix A, Schedule II, upon thirty (30) days prior written notice to the Health Connector if such change is required by Massachusetts or federal law and approved by the DOI in advance of implementation.

   ii. Nothing in this Section 3.1.B shall prevent Carrier from making changes in the language of its Commonwealth Choice Health Plans' EOCs, provided such changes (1) are designed to improve the clarity of such documents, (2) do not change the benefits or cost-sharing features of the plans, (3) are implemented uniformly throughout all relevant plans sold by Carrier in Massachusetts, and (4) if required, are approved by the DOI in advance of implementation. Carrier will give the Health Connector at least thirty (30) days advance written notice prior to the implementation of any language changes it intends to implement in the EOCs.

d. Closure of Plans. Carrier may submit a request to the Health Connector on a semi-annual basis commencing six months after the start of the Contract Term to close any existing plan listed in Appendix A, Schedule II. The Connector will review such a request and make a determination based upon the information presented in the request as well as the Health Connector's enrollment data and any additional information provided by the other participating carriers; provided, however, that closure of a plan will not be permitted unless all other carriers agree to close such plan.

C. Carrier shall (1) establish premium rates for each of its Commonwealth Choice Health Plans in accordance with the rating methodology used to develop the estimated premiums submitted to the Health Connector as part of Carrier's RFR Responses; (2) provide Sub-Connector with a complete rating table(s) capable of generating non-group and small group premium quotes as defined by the Health Connector, with updates at least seventy-five (75) days in advance of the effective date of the premium rate ("rate due date"), for

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each of its Commonwealth Choice Health Plans, provided however, that in the event Carrier fails to provide such rating table by the rate due date, Sub-Connector may continue to use rates generated by the rating table(s) currently in effect until such time as the Sub-Connector is able to update Carrier's rates using new rating table(s); (3) notify the Health Connector and Sub-Connector regarding any material changes or additions to its actuarial methodology at least thirty (30) days prior to any rate due date; and (4) with respect to its Commonwealth Choice Health Plans, provide rates for the following four rate basis type categories: single, two adults, one adult and one or more children, and two adults and one or more children***;*** provided, however, that nothing in this section shall affect the number or types of rate basis types Carrier offers with respect to its health plans sold outside the Health Connector.

D. Carrier shall not put any limitations on enrollment in its Commonwealth Choice Health Plans other than those specifically permitted by applicable laws and regulations.

E. Carrier shall process new enrollment applications within three (3) business days of receipt of complete and accurate enrollment files(s) from the Health Connector.

3.2. Sub-Connector Contract.

A. Carrier acknowledges that (1) the Health Connector has delegated a broad range of administrative responsibilities to a Sub-Connector pursuant to an agreement dated February 9, 2007, as amended, (Sub-Connector Contract); (2) the Sub-Connector Contract sets forth the terms and conditions pursuant to which the Sub-Connector shall uniformly offer and administer all Commonwealth Choice Health Plans to Eligible Individuals and Eligible Small Groups through the Health Connector; and (3) the Sub-Connector Contract, as amended from time to time, is hereby incorporated by this reference into this Agreement. The Health Connector has delivered a copy of the existing Sub-Connector Contract to Carrier, and shall deliver copies of all amendments thereof to Carrier.

B. Carrier hereby agrees to make its Commonwealth Choice Health Plans available through the Connector in accordance with all terms and conditions of the Sub-Connector Contract, as amended from time to time, that (1) reasonably relate to the manner in which Commonwealth Choice Health Plans are offered and administered by the Sub-Connector; or (2) necessarily depend upon Carrier's assent and cooperation in order to effectuate the uniform administration of all Commonwealth Choice Health Plans. The aforementioned terms and conditions include, but are not limited to, those addressing: (1) customer service (including benefits explanation); (2) eligibility verification, eligibility determinations and changes in eligibility; (3) enrollment, re-enrollment, renewal anniversary date, and terminations; (4) premium quoting, premium billing, premium collection, remittance of premium to Carrier, and premium reconciliation; (5) marketing of Commonwealth Choice Health Plans; (6) acceptance of voice and electronic signatures; and (7) the development of additional administrative policies and procedures not specifically set forth in the Sub-Connector Contract. In the event the Sub-Connector Contract is amended or the Health Connector enters into other Sub-Connector contracts, Carrier will be provided notice of such amendment or other contracts. If such amendment or other contracts has an adverse material financial impact on Carrier that is reasonably demonstrated to the Health Connector, Carrier shall have the option on ninety (90) days prior written notice to the Health Connector to terminate this Agreement.

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C. Carrier agrees to cooperate fully with the Sub-Connector in Sub-Connector's marketing and administration of Carrier's Commonwealth Choice Health Plans. For purposes of this Section, using a standard of commercial reasonableness, this cooperation will include, but is not limited to: (1) providing information necessary to enable Sub-Connector to reasonably carry out all its responsibilities under the Sub-Connector Contract; (2) assenting to Health Connector and Sub-Connector policies and procedures related to the administration of Commonwealth Choice Health Plans, for example, by accepting a universal enrollment form; (3) accommodating future changes in Sub-Connector's administrative policies and procedures in order to achieve administrative efficiencies, such as enhanced automation of business processes and transactions; (4) participating in meetings with the Health Connector, Sub-Connector and other organizations or government agencies; and (5) training Sub-Connector staff on the features of Carrier's Commonwealth Choice Health Plans. Carrier shall notify the Health Connector of any disputes between Carrier and Sub-Connector that have not been resolved within a reasonable period of time.

D. Carrier agrees to, and shall abide by, the Health Connector's policies and procedures for its Commonwealth Choice Program and its nongroup and small group product offerings through the Commonwealth Choice Program. The Health Connector will provide Carrier with a copy of the policies and procedures in effect on the date of this Agreement. Any reference in this Agreement to Sub-Connector's policies and procedures shall include the Health Connector's policies and procedures for its Commonwealth Choice Program. Carrier has entered into this Agreement based upon the Commonwealth Choice Program as such Program is structured on the date of this Agreement and based upon the policies and procedures in effect on the date of this Agreement. In the event the Health Connector revises its policies and procedures after the date hereof in a manner that will create or result in a material adverse economic or financial impact on Carrier, as determined by Carrier in its reasonable discretion and demonstrated to the Health Connector, were it to remain a part of the Commonwealth Choice Program, Carrier may terminate this Agreement upon one hundred twenty (120) days written notice to the Health Connector unless the policy or procedure is modified to avoid such an impact prior to the effective date of the termination. During the one hundred twenty (120) day notice period, Carrier agrees to continue to make available through the Health Connector the Commonwealth Choice Health Plans listed in Appendix A, Schedule I and II until the effective date of termination; and the Health Connector agrees to not implement the policies and procedures that Carriers has determined, in its reasonable discretion, and demonstrated to the Health Connector to have a material adverse economic or financial impact on Carrier. The Carrier agrees to adhere to the transition plan developed by the Health Connector in its sole discretion in accordance with section 5.3.

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E. Carrier acknowledges and agrees to all the following:

(1) Sub-Connector's monthly premium remittance to Carrier shall consist of full premium actually collected net of the Administrative Fee set forth in Appendix B;

(2) Sub-Connector (a) will use its best efforts to collect premium from Covered Persons and employer groups in accordance with its premium collection policies and procedures; (b) shall retroactively terminate Covered Persons, for whom premium remains uncollected, in accordance with its termination policies and procedures; (c) as part of its premium collection and termination policies and procedures, shall provide Carrier with

monthly premium collection and termination reports sufficient for Carrier to identify Covered Persons who are in arrears for more than the time period permitted by Sub-Connector's policies and procedures; and (d) shall provide Carrier with copies of its premium collection and termination policies and procedures;

(3) In the event Sub-Connector fails to terminate Covered Persons for nonpayment of premium in accordance with its termination policies and procedures, Carrier shall terminate such Covered Persons, and seek to collect outstanding premium, if any, from such Covered Persons or employer groups, as applicable, in accordance with applicable law. The Health Connector and Sub-Connector shall fully cooperate with Carrier with respect to records and processes necessary for Carrier to effectuate such terminations; and

(4) Carrier assumes all credit risk for nonpayment of premiums by Covered Persons and small groups and under no circumstances shall Sub-Connector or the Health Connector be responsible to Carrier for uncollected premium.

F. In the event a dispute arises between Carrier and the Health Connector (through the Sub-Connector) involving Sub-Connector's failure to collect premium or properly enroll or terminate coverage in Carrier's Commonwealth Choice Health Plans in accordance with Sub-Connector's premium collection and termination policies and procedures, Carrier shall first seek to address and resolve the matter directly with the Sub-Connector. Carrier shall notify the Health Connector of any disputes between Carrier and Sub-Connector that have not been resolved within a reasonable period of time. In such case, the Health Connector shall seek to resolve the matter with the Sub-Connector. If the matter cannot be satisfactorily resolved with the Sub-Connector: (a) the Health Connector may take additional actions to resolve the matter, including but not limited to enforcing the Sub-Connector Contract; and (b) Carrier may, if such dispute has an adverse material financial impact on Carrier, which impact is reasonably demonstrated to the Health Connector, give notice of intent to terminate this Agreement pursuant to its rights under section 5.2.A.

3.3. Customer Service. Carrier shall have available customer service representatives during normal business hours to assist potential enrollees and Covered Persons, and to coordinate customer service between Carrier's own representatives and Sub-Connector's Commonwealth Choice Customer Service Center.

3.4. Marketing.

A. Carrier shall actively market its Commonwealth Choice Health Plans as mutually agreed upon by Carrier and the Health Connector. Active marketing may include, but is not limited to, the following: (1) as part of Carrier's overall company marketing plan, developing and conducting marketing campaigns to raise awareness and educate the public about the Health Care Reform Act and the availability of Carrier's Commonwealth Choice Health Plans through the Health Connector; (2) co-branding such marketing campaigns and related materials consistent with the Health Connector's branding style requirements; (3) conducting such co-branded marketing campaigns (a) through advertisements in print, radio and in other media; and (b) through written and electronic communications sent to Carrier's members, employers, participating providers and brokers, such as newsletters, brochures and on Carrier's website; (4) including on Carrier's website direct links to the Health Connector and Sub-Connector websites; and

(5) including in such marketing campaigns the Sub-Connector's toll-free TTY telephone number for hearing impaired persons.

B. Carrier may participate in other joint marketing efforts with the Health Connector as mutually agreed to by Carrier and the Health Connector.

C. Carrier shall submit all marketing materials for Commonwealth Choice products o the Health Connector for review. Carrier and the Health Connector agree to work cooperatively to develop mutually agreeable additional guidelines for the Health Connector's review and approval of marketing materials.

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D. Each party's use of the other party's trademarks, brand names, seals, logos and similar instruments (hereinafter "brand symbols") shall be subject to prior review and approval by the other party, provided, however, that such approval shall not be unreasonably denied. Carrier and the Health Connector agree to work cooperatively to develop mutually agreeable additional guidelines for their review and approval of brand symbol usage.

E. Carrier shall designate in writing a Marketing Executive who is authorized and empowered to represent the Carrier with respect to Carrier's marketing of its Commonwealth Choice Health Plans. Such Marketing Executive will work cooperatively with the Health Connector on marketing and joint marketing plans and initiatives.

3.5. Evidence of Coverage.

A. Carrier will design, print and issue to Covered Persons, at its own expense, an Evidence of Coverage (EOC) which has been approved by the DOI, for each Commonwealth Choice Health Plan made available pursuant to this Agreement. Each DOI-approved EOC, as amended and approved by the DOI from time to time, is incorporated herein by this reference.

B. Carrier shall generate and issue a premium rate letter consistent with DOI requirements that identifies the premium to be paid by or on behalf of a Covered Person. Parties agree to work collaboratively to ensure Carrier has the information necessary to generate such premium letters.

C. Carrier shall administer its Commonwealth Choice Health Plans in accordance with all the terms and conditions of the applicable EOC.

D. No later than April 1, 2011, Carrier shall submit to the Health Connector any EOCs and health plan benefit materials used in connection with the Commonwealth Choice program. Thereafter, Carrier shall notify the Health Connector of any proposed changes to the EOC no later than ten (10) business days after such proposed changes are approved by the DOI.

3.6. Participating Providers.

A. Carrier shall make a Provider Directory available to Covered Persons and prospective Covered Persons, on its website and in print format, as required by applicable laws and

regulations, consisting of a list of providers participating in its Commonwealth Choice Health Plans.

B. Carrier agrees to ensure adequate numbers of open physician panels in its network of participating providers in accordance with the RFR.

3.7. Appeals and Grievances. Carrier shall have an appeals and grievance procedure for Covered Persons that complies with M.G.L. c. 176O and 105 CMR 128.00.

3.8. Cost/Quality Information. Carrier shall make available to Covered Persons the same comparative cost and quality information that it currently makes available to its non-Commonwealth Choice Health Plan enrollees. This information may include comparative data by facility, clinician and/or physician practice group, including information related to patient safety and member satisfaction.

3.9. ID Cards. Carrier shall issue identification cards to Covered Persons that are co-branded with the Health Connector within five (5) business days of receipt of complete and accurate enrollment information.

3.10. Nondiscrimination.

A. Carrier shall not exclude any person from coverage under its Commonwealth Choice Health Plans because of race, color, religion, national origin, sex, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income, or age.

B. Carrier shall not treat persons enrolled in its Commonwealth Choice Health Plans differently than persons enrolled in the same Health Benefit Plans offered in the marketplace outside the Health Connector, except as specifically permitted by applicable laws, regulations or this Agreement.

3.11. Insurance. Carrier shall maintain, and upon request present the Health Connector written evidence of, the following types of insurance at levels generally accepted as commercially reasonable for similarly situated carriers: statutory workers' compensation; commercial general liability insurance; professional errors and omissions liability insurance; bond/crime insurance, including blanket coverage for employee dishonesty and computer fraud, and for loss or damage arising out of or in connection with any fraudulent or dishonest acts committed by employees. Carrier shall notify the Health Connector no less than ten days prior to any reduction or cancellation by Carrier of such insurance and immediately upon cancellation or any reduction by the insurer.

3.12. Data and Reporting Requirements. Subject to the requirements of and in compliance with applicable law and regulations, Carrier shall furnish the Health Connector and Sub-Connector, or their designees, such commercially reasonable and timely ad hoc or periodic reports and data, in a mutually agreeable format, as the Health Connector or Sub-Connector determines to be necessary to enable them to carry out their obligations under MGL c. 176Q and this Agreement, including but not limited to, financial reports; de-identified appeals and grievances related to Covered Persons; enrollment reports; and cost and utilization reports. Such information shall be maintained by the Health Connector and Sub-Connector as confidential information of Carrier except as otherwise consented to by Carrier.

Upon request from the Health Connector, in a mutually agreeable format and content that can be provided at a reasonable cost to the Carrier (using the data elements in Appendix C, Schedule I as a guideline for content), the Carrier will provide to the Health Connector Claims data for Commonwealth Choice Covered Persons enrolled as of December 31, 2010. Carrier shall have thirty (30) days from the date the Health Connector and Carrier agree to format and content to submit such claims data.

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Upon request from the Connector, Carrier will work collaboratively with the Health Connector to submit a file, in a mutually agreeable format, that contains Medical Loss Ratio (MLR) data for both the Commonwealth Choice Program and total Massachusetts based non-group and small group business (using the format in Appendix C, Schedule II as a guideline for content). Carrier shall have thirty (30) days from the date the Health Connector and Carrier agree to format and content to submit such MLR data.

Carrier agrees to supply provider data to the Health Connector or its designated vendor for use in a provider search function to be accessible from the Health Connector's website. The data will contain elements requested by the Health Connector that are reasonably necessary to identify providers available to persons selecting Commonwealth Choice plans. Carrier will update the data regularly, including, but not limited to, a monthly electronic file of Carrier's participating physicians and hospitals.

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3.13. Inspection and Retention of Records. Carrier shall permit the Health Connector or its designee, during regular business hours and upon reasonable notice, to examine and copy such Carrier records as may be necessary to carry out the purposes of M.G.L. c. 176Q and this Agreement, as determined by the Health Connector, except that protected health information shall be examined only as permitted by law. Records shall also be available for governmental regulatory agencies having recognized authority to review such records. All records maintained by Carrier in connection with this Agreement shall be retained for the period set forth in applicable records retention laws. Such information shall be maintained by the Health Connector and Sub-Connector as confidential information of Carrier except as otherwise consented to by Carrier.

3.14. Rate Parity. Carrier shall utilize a comparable rating methodology, rate adjustment factors (including but not limited to trend factors) and rates for its Commonwealth Choice Health Plans that Carrier uses for the same Health Benefit Plans offered in the merged nongroup/small group marketplace outside the Health Connector.

3.15. Compliance with Laws.

A. Carrier shall comply with all state and federal laws and regulations applicable or related to the performance of its obligations under this Agreement. Without limiting the generality of the foregoing, Carrier shall comply with M.G.L. chapters 175, 176A, 176B and 176G, as applicable; M.G.L. chapters 176I, 176J, 176O and 176Q; P.L. 99-272, Title XXII of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA); P.L. 104-191 (the Health Insurance Portability and Accountability Act of 1996 (HIPAA); Chapter 143 of the Acts of 1999 (HMO Insolvency Law), as applicable; Chapter 141 of the Acts of 2000; as well as P.L. 111-148 (the Patient Protection and Affordable Care Act or PPACA); and P.L. 111-152 (the Health Care and Education Reconciliation Act of 2010 or HCERA). Compliance under HIPAA, in part, shall mean that Carrier shall

provide Covered Persons with all notices mandated by HIPAA, and will provide Certificates of Creditable Coverage to former Covered Persons.

B. Carrier shall be responsible for any fines and penalties arising from (1) its noncompliance with any law relating to its obligations under this Agreement; or (2) the Health Connector's violation of any law or regulation which is caused solely by an act or omission by Carrier, its agents, employees or subcontractors, and not any other third party, unless and solely to the extent that the Health Connector's violation resulted from Carrier's good faith reliance on or compliance with the specific written (including email) instructions or advice of the Health Connector or the Sub-Connector (provided that in the event Carrier receives contradictory instructions or advice it may only rely upon the instructions or advice of the Health Connector's Contract Officer or his or her designee, in taking the action or omitting to take action that caused the violation.)

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3.16. Change of Control or other Administrative Change. Carrier shall give the Health Connector at least thirty (30) days prior written notice of any proposed Change in Control or of any other change affecting its organization that would be expected to materially disrupt or otherwise adversely impact Carrier's performance of its responsibilities under this Agreement.

ARTICLE IV. HEALTH CONNECTOR OBLIGATIONS

In addition to its other specific obligations provided elsewhere in this Agreement, the Health Connector's obligations under this Agreement shall be as follows:

4.1. Commonwealth Choice Health Plans. The Health Connector shall facilitate the purchase of Carrier's Commonwealth Choice Health Plans by Eligible Individuals and Eligible Small Groups by (A) arranging for Carrier to offer its Commonwealth Choice Health Plans through the Health Connector in accordance with this Agreement; and (B) contracting for a Sub-Connector to perform a broad range of administrative services related to offering and uniformly administering Commonwealth Choice Health Plans through the Health Connector.

4.2. Marketing.

A. The Health Connector has established and implemented a plan for publicizing the existence of the Health Connector and actively promoting Commonwealth Choice Health Plans.

B. The Health Connector shall offer Carrier the same or comparable opportunities to participate in co-marketing activities with the Health Connector as it offers to other carriers offering Commonwealth Choice Health Plans through the Health Connector.

C. The Health Connector shall, in accordance with Section 3.4C, review Carrier's proposed marketing material within ten (10) business days of receipt; provided, however, that approval of marketing material shall not be unreasonably denied, and provided further that such material shall be deemed approved in the event the Health Connector does not complete its review and notify Carrier of its approval, rejection or desired modifications within this period. Carrier and the Health Connector agree to work cooperatively to develop mutually agreeable additional guidelines for the Health Connector's review and approval of marketing materials.

D. The Health Connector and Carrier shall work collaboratively on marketing plans for CommChoice products offered by the Health Connector.

4.3. Seal of Approval.

A. The Health Connector has established criteria upon which to base its granting and withdrawal of Seals of Approval.

B. The Health Connector shall have the right, in its sole discretion, to (1) renew or eliminate other licensed carriers and/or one or more of their Commonwealth Choice Health Plans participating in the Commonwealth Choice Program; and (2) add other licensed carriers and/or Commonwealth Choice Health Plans to the portfolio of plans made available through the Health Connector. At any time, the Health Connector shall have the right to eliminate from the Commonwealth Choice Program other licensed carriers and/or their Commonwealth Choice Health Plans for cause or consistent with other contractual termination provisions.

4.4. During the Contract Term, the Health Connector may receive a book of business consisting of certain employer groups, including groups of one subscriber, that has been transferred from the Small Business Service Bureau (the "Transferred Accounts"). In the event that, at the time of the transfer, the Carrier provides coverage to a Transferred Account, and the Carrier provides the same or substantially the same health plan through the Commonwealth Choice program as it provided to that account prior to the transfer, the Carrier will continue to provide coverage for that account through the Commonwealth Choice plan after the transfer and will treat such accounts as renewing accounts, on the same terms as before the transfer, including, without limitation, no change in the pre-transfer renewal date or in the amount credited against a subscriber's deductible. **Cooperation with Carrier Information Requests.** The Health Connector agrees to cooperate with Carrier's reasonable requests for information when Carrier requires information from the Health Connector or the Sub-Connector for the following purposes without limitation: satisfying legal reporting requirements, responding to inquiries from regulatory agencies, investigating complaints from Covered Persons, or investigating complaints or suspicions of fraud.

ARTICLE V. TERM AND TERMINATION

5.1. Term. The term of this Contract shall be the eighteen (18) month period commencing July 1, 2011 (Effective Date) and ending December 31, 2012. This Contract may be renewed, at the Health Connector's option for one additional twelve (12) month period commencing January 1, 2013 and running through December 31, 2013 In the event that the Health Connector chooses the renewal option, it shall provide Carrier with notice 120 days in advance of the expiration of the original 18-month Contract Term. The Health Connector may decide to discontinue certain products or add certain products during the 12 month renewal days, in which case it will provide Carrier with notice of such intention at the time that it notifies the Carrier of its intention to renew the Contract.

5.2. Termination.

A. Termination for Cause. Either party may terminate this Agreement upon breach by the other of any material term or representation in this Agreement, subject to the following notice and cure period requirements: In the event either party wishes to terminate this

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June 30, 2011 (Contract Term). This Agreement will not automatically renew, unless both
parties mutually agree to extend the terms of this agreement

Agreement for cause, that party shall give the alleged breaching party thirty (30) days ("Cure Period") prior written notice, which notice shall include a description of the breach. If the alleged breaching party does not cure the breach to the satisfaction of the terminating party within the Cure Period, the terminating party shall provide the other party written notice of termination. This Agreement shall then terminate upon receipt of the written notice of termination or at such later date or under such circumstances as may be specified in such notice. In the event the Health Connector is the terminating party, during the Cure Period it may cease marketing Carrier's Commonwealth Choice Health Plans, discontinue new enrollments, notify existing Covered Persons and small groups that the arrangement with Carrier is terminating, and arrange for appropriate transition of Covered Persons and small groups in accordance with DOI and Health Connector requirements.

B. Termination without Cause. Carrier and the Health Connector agree to work collaboratively to address issues that arise during the Carrier's participation in Commonwealth Choice. In the event that Carrier decides to terminate this Agreement without cause, Carrier must provide the Health Connector with ninety (90) days written notice of Carrier's intent to terminate this Agreement and the reason for its termination. The Health Connector in its sole discretion will develop a contingency plan (which provisions shall not be inconsistent with applicable federal and state law) to address termination issues including but not limited to, the run-out of membership, collection of premiums, and enrollee communications.

C. Immediate Termination. The Health Connector may, by giving written notice to the Carrier, terminate this Agreement immediately upon the occurrence of any of the events below:

(1) An Insolvency Event. As used herein, Insolvency Event shall mean any of the following with respect to the Carrier: (a) filing, or having filed against it, a petition for liquidation or reorganization under the United States Bankruptcy Code, as amended from time to time, or a petition to take advantage of any insolvency act or bankruptcy law; (b) admitting in writing its inability to pay its debts generally; (c) making an assignment, trust mortgage or other conveyance for the benefit of creditors; (d) making a proposal to its creditors for a composition or arrangement of its debts; (e) the appointment of a receiver, trustee or similar authority for itself or any substantial part of itself or any substantial part of its property; (f) taking any action to authorize any of the foregoing pursuant to its governing documents; (g) generally committing any act of insolvency, including the material failure to pay obligations as they become due; or (h) ceasing to conduct business as a going concern.

(2) Carrier's license, accreditations, credentials or certifications which are required to be maintained in order to carry out its obligations under this Agreement expire or are suspended, revoked or materially restricted.

(3) Carrier has engaged in conduct which materially endangers the health or safety of, or is otherwise detrimental to, Covered Persons or small groups participating in the Commonwealth Choice Program.

D. Termination for Change in Control of Carrier. In the event of a Change in Control of Carrier, other than a Change in Control pursuant to which the control of Carrier is transferred to an Affiliate of Carrier, the Health Connector may elect to terminate this

Agreement by giving Carrier written notice of such termination within ninety (90) days after the effective date of such Change in Control.

E. Termination Due to Non-Payment. In the event Sub-Connector fails to make undisputed premium payments to Carrier in accordance with Sub-Connector's premium remittance policies and procedures, a copy of which shall be provided to Carrier, and such failure results in an adverse material financial impact to Carrier that is reasonably demonstrated by Carrier to the Health Connector, Carrier shall give the Health Connector thirty (30) days ("Cure Period") prior written notice of intent to terminate this Agreement. If undisputed premium payments are not remitted to Carrier within the Cure Period, Carrier shall provide the Health Connector written notice of termination. This Agreement shall then terminate upon the Health Connector's receipt of the written notice of termination or at such later date or under such other circumstances as may be specified in such notice.

F. Termination Related to DOI. In the event the DOI requests or requires Carrier to terminate this Agreement, Carrier shall give Connector immediate notice of such DOI request or requirement, and Carrier may terminate this Agreement upon thirty (30) days prior written notice to the Health Connector.

5.3. Upon Termination of this Agreement. In the event of non-renewal or other termination of this Agreement, Carrier agrees to comply with all Health Connector and DOI requirements addressing transition of Covered Persons and small groups. A transition plan to be carried out by the Carrier will be developed by the Health Connector in its sole discretion (which provisions shall not be inconsistent with applicable federal and state law). Such transition plan will require the immediate discontinuance of any new sales of all of the Carrier's Commonwealth Choice Health Plans. In addition, such transition plan will require the discontinuance of all Young Adults Plan coverages (at the earliest date consistent with statutory and regulatory notice requirements). For all other nongroup and small group coverages sold through the Commonwealth Choice Program and in effect at the time of termination of this agreement, the transition plan will require the discontinuance of Carrier's other such coverage at the Covered Person's anniversary date closest to and subsequent to the termination of this Agreement. All such discontinuances will be consistent with statutory and regulatory notice requirements.

ARTICLE VI. ADDITIONAL TERMS AND CONDITIONS

6.1. Amendments.

A. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein.

B. Without Carrier's consent and by providing prompt notice to Carrier, the Health Connector may amend this Agreement to enable the Health Connector or Sub-Connector to comply with any existing or newly enacted law or regulation or with any order of any federal or state agency or court, and such amendment shall be effective as of the date the law, regulation or order becomes or became effective. If such amendment has an adverse material financial impact on Carrier that is reasonably demonstrated to the Health Connector, Carrier shall have the option on ninety (90) days prior written notice to the Health Connector to terminate this Agreement.

C. The Health Connector may amend this Agreement to withdraw its Seal of Approval from any of Carrier's Commonwealth Choice Health Plans then being offered through the Health Connector by giving Carrier written notice of such withdrawal(s) at least ninety (90) days prior to the end of the Contract Term. If such amendment has an adverse material financial impact on Carrier that is reasonably demonstrated to the Health Connector, Carrier shall have the option to terminate this Agreement by sending written notice to the Health Connector at least seventy five (75) days prior to the end of the Contract Term. In the event of a withdrawal, the affected Commonwealth Choice Health Plan(s) shall no longer be offered through the Health Connector and Carrier shall comply with the Health Connector and DOI requirements addressing transition of Covered Persons and small groups.

D. Any other amendment to this Agreement requires mutual consent of both parties, in the form of a written amendment, signed by both parties, and attached hereto.

6.2. Adequate Assurances. If the Health Connector is aware of facts or circumstances that it reasonably believes would cause Carrier not to be willing or able to perform its obligations under this Agreement, the Health Connector may request, and Carrier shall provide within a reasonably prompt period of time, in light of the circumstances, after receipt of a request, adequate reasonably requested assurances, acceptable to the Health Connector in its reasonable discretion, such acceptance not to be unreasonably withheld or delayed, of Carrier's continuing ability and willingness to perform its obligations, or such portion thereof, as required by this Agreement.

6.3. Assignment. Carrier shall not assign, delegate or transfer any right, obligation or interest in this Agreement to any successor entity or other entity, without the prior written consent of the Health Connector.

6.4. Material Subcontractors. Carrier's material subcontractors providing services associated with this Agreement shall be subject to the same terms and conditions as the Carrier, as applicable. Carrier shall remain fully responsible for meeting all the terms and conditions of this Agreement regardless of whether Carrier subcontracts for performance of any responsibilities under this Agreement.

6.5. Independent Contractors. The parties intend to create an independent contractor relationship and nothing contained in this Agreement shall be construed to make either the Health Connector or Carrier partners, joint venturor, principals, agents or employees of the other. No officer, director, employee, agent, affiliate or contractor retained by Carrier to perform work related to this Agreement will be deemed to be an employee, agent or contractor of the Health Connector. Neither party will have any right, power or authority, express or implied, to bind the other.

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6.6. Limitation on Liability. The Health Connector shall have no liability or responsibility for Carrier's arrangement of, or failure to arrange for, any health care services, supplies, medications, or facilities to Covered Persons under this Agreement.

6.7. Anti-Boycott Covenant. During the time this Agreement is in effect, neither the Carrier nor any affiliated company, as hereafter defined, shall participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful by M.G.L. c. 151E, §2. Without limiting such other rights as it may have, the Health Connector shall be entitled to

rescind this Agreement in the event of noncompliance with this section. As used herein, an affiliated company shall be any business entity directly or indirectly owning at least 51 percent of the ownership interests of the Carrier.

6.8. Counterparts. This Agreement may be executed simultaneously in two or more counterparts, each of which will be deemed an original, and all of which together will constitute one and the same instrument.

6.9. Entire Contract. This Agreement constitutes the entire agreement of the parties with respect to the subject matter hereof including all Schedules, Appendices, Exhibits, Attachments and amendments hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Agreement shall prevail notwithstanding any variances with the terms and conditions of any written or verbal communication subsequently occurring, except as otherwise provided herein.

6.10. No Third Party Enforcement. No person not executing this Agreement shall be entitled to enforce this Agreement against a party hereto regarding such party's obligations under this Agreement.

6.11. Section Headings. The headings of the Sections of this Agreement are for convenience only and will not affect the construction hereof.

6.12. Technology Functions Not Covered Under This Agreement. Carrier may submit to the Health Connector a request to perform additional technology functions not covered under the Agreement. Within ten (10) business days of receiving such request, the Health Connector will respond to Carrier in writing with cost to perform such technology functions and time line of performance of such functions. Carrier and the Health Connector shall mutually agree to cost and timeline. Once cost and timeline are mutually agreed upon, the Health Connector will amend this Agreement. Carrier reserves the right to withdraw request at any time prior to executing amendment.

6.13. Effect of Invalidity of Clauses. If any clause or provision of this Agreement is in conflict with any state or federal law or regulation, that clause or provision shall be null and void and any such invalidity shall not affect the validity of the remainder of this Agreement.

6.14. Waiver. The waiver by either party of any part of this Agreement or of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver in any other respect, to any other extent, or at any other time.

6.15. This section intentionally left blank.

6.16. Carrier's Financial Condition and Corporate Structure. At the request of the Health Connector, the Carrier shall provide the Health Connector with non-confidential documentation relating to organizational structure, financial structure and solvency, including but not limited to the following: the name(s) and address(es) of the (1) Carrier's parent organizations, (2) parents of such parent organizations, (3) Carrier's subsidiary organizations, and (4) subsidiaries of any organizations listed in (1), (2), or (3) herein; and the names and occupations of the members of the Board of Directors of the organizations listed in (1)-(4) herein.

6.17. Corrective Action Plan. At any point during this Agreement, if the Health Connector identifies, in its reasonable judgment, any deficiency of the Carrier's obligations under this Agreement or in the ability for the Health Connector to adequately offer Carrier plans, the Health Connector may require the Carrier to develop a commercially feasible corrective action plan to correct such deficiency. Carrier shall submit any such corrective action plan to the Health Connector and shall within ten (10) business days of any written request, commence to implement such corrective action plan only as approved or modified by the Health Connector. Such plan may include an obligation to increase resources dedicated to correcting the deficiency. In the event Carrier cannot correct such deficiency within the ten (10) business days, the Health Connector has the right to close all health plans listed on Appendix A, Schedule II, to new Eligible Individuals and Eligible Small Groups until such deficiency has been cured.

6.18. Order of Precedence. Any ambiguity or inconsistency between or among the following documents shall be resolved by applying the following order of precedence. With respect to issues involving the Health Connector – Carrier relationship: (A) this Agreement, including any Schedules, Appendices, Exhibits, Attachments and amendments hereto; (B) the Sub-Connector Contract; (C) Carrier's RFR Responses; (D) the RFR; and (E) Carrier's EOC's. With respect to benefit issues raised by Covered Persons: (A) Carrier's EOC's; (B) this Agreement, including any Schedules, Appendices, Exhibits, Attachments, and amendments hereto; (C) the Sub-Connector Contract; (D) Carrier's RFR Responses; and (E) the RFR.

6.19. Contract Officers.

A. The Health Connector designates Roni Mansur, Director of Commonwealth Choice, as its Contract Officer. He or his designee shall be authorized and empowered to represent the Health Connector with respect to all matters relating to the Agreement. Such designation may be changed during the period of this Agreement only by written notice.

B. Carrier designates [DESIGNEE] as its Contract Officer. S/he or his/her designee shall be authorized and empowered to represent Carrier with respect to all matters relating to the implementation of this Agreement, including but not limited to integration of operations among Carrier, the Health Connector and the Sub-Connector. Such designation may be changed during the period of this Agreement only by written notice to the Health Connector.

6.20. Sole and Exclusive Venue. Each party irrevocably agrees that any legal action, suit or proceeding brought by it in any way arising out of this Agreement must be brought solely and exclusively in the United States District Court for the District of Massachusetts or the Superior Court for Suffolk County located in Boston, Massachusetts and irrevocably accepts and submits to the sole and exclusive jurisdiction of each such court in persona, generally and unconditionally with respect to any action, suit or proceeding brought by it or against it by the other party; provided, however, that this section will not prevent a party against whom any legal action, suit or proceeding is brought by the other party in the state courts of the Commonwealth of Massachusetts from seeking to remove such legal action, suit or proceeding, pursuant to applicable Federal law, to the district court of the United States for the district and division embracing the place where the action is pending in the state courts of the Commonwealth of Massachusetts, and in the event an action is so removed each party irrevocably accepts and submits to the jurisdiction of the aforesaid district court. Each party hereto further irrevocably consents to the service of process from

any of such courts by mailing copies thereof by registered or certified mail, postage prepaid, to such party at its address designated pursuant to this Agreement, with such service of process to become effective thirty (30) days after such mailing.

6.21. Governing Law. This Agreement and the rights and obligations of the parties under this Agreement will be governed by and construed in accordance with the laws of the Commonwealth of Massachusetts, without giving effect to the principles thereof relating to the conflicts of laws.

6.22. Notice. Notices to the parties as to any matter under this Agreement will be sufficient if given in writing and sent by certified mail (return receipt requested), postage prepaid, or delivered in hand or an overnight delivery service with acknowledgment of receipt to:

To the Health Connector:

Roni Mansur
Director of Commonwealth Choice
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza
Boston, MA 02108

With copies to:

Edward DeAngelo
General Counsel
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza
Boston, MA 02108

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To the Carrier:

With copies to:

6.23. Remedies Cumulative. No right or remedy herein conferred upon or reserved to either party is intended to be exclusive of any other right or remedy, and each and every right and remedy will be cumulative and in addition to any other right or remedy under this Agreement, or under applicable law, whether now or hereafter existing.

6.24. Confidentiality.

A. To the extent permitted by applicable law, the parties agree (1) to keep all non-public information arising from or related to this Agreement confidential (Confidential Information); (2) to hold all Confidential Information related to this Agreement in confidence to the same extent and with at least the same degree of care as the party protects its own confidential or proprietary information of like kind and import, but in no event using less than a reasonable degree of care.

B. Notwithstanding the foregoing, (1) Carrier acknowledges and agrees that the Health Connector is subject to laws that may compel the Health Connector to disclose information, such as the Massachusetts Public Records Law and the Federal Freedom of Information Act; and (2) the parties shall be permitted to disclose relevant aspects of Confidential Information to their officers, agents, subcontractors, including but not limited to the Sub-Connector, and employees, to the extent such disclosure is reasonably necessary for the performance of their duties and obligations under this

Agreement and such disclosure is not prohibited by applicable law. Notwithstanding the foregoing, the parties acknowledge that certain proprietary information belonging to Carrier may not be appropriate for disclosure pursuant to subsection (1). If the Health Connector receives a request to disclose proprietary information belonging to Carrier pursuant to subsection (1), the Health Connector agrees to notify Carrier of such request prior to the disclosure of any information in order that Carrier may have sufficient opportunity to raise a timely objection, assert any available defense against disclosure, and/or seek a protective order or other appropriate remedy.

6.25. Survival. Any provisions of this Agreement that contemplate performance by a party following the termination or expiration of this Agreement shall survive the termination or expiration of this Agreement, including but not limited to Section 5.3.

6.26. Indemnification.

A. Carrier shall indemnify, and defend and hold the Health Connector and the Commonwealth of Massachusetts, their agents, officers, employees and successors and assigns (Health Connector Indemnified Parties), harmless from and against, any and all liability, loss, damage, costs or expenses (including reasonable attorneys fees) suffered, incurred or sustained by the Health Connector Indemnified Parties or to which any Health Connector Indemnified Parties become subject, resulting from, arising out of or relating to any claim:

(1) relating to any duties or obligations, under this Agreement of Carrier or Carrier's subcontractors in respect of a third party, including Carrier's subcontractors, unless and solely to the extent that such claim results from Carrier's reasonable reliance on the specific written instructions or advice of the Health Connector Contract Officer or his or her designee or the Sub-Connector in taking the action (or omitting to take the action) that gave rise to the claim;

(2) relating to the inaccuracy, untruthfulness or breach of any representation or warranty made by Carrier under this Agreement or breach of any obligation by Carrier under this Agreement;

(3) relating to personal injury (including death) or property loss or damage resulting from Carrier's or Carrier's subcontractors' acts or omissions; and

(4) relating to occurrences Carrier is required to insure against pursuant to Section 3.11 up to the insurance coverages required under Section 3.11 if such claim is based on the acts or omissions of Carrier or its subcontractor.

B. The indemnity obligation described in this Section 6.26 shall not limit any other rights or remedies available to the Health Connector under this Agreement.

C. Indemnification Procedures. If any third party claim arising out of or related to this Agreement is commenced against any Health Connector Indemnified Party, notice thereof will be given to Carrier as promptly as practicable. If, after such notice, Carrier acknowledges that Section 6.26.A of this Agreement applies with respect to such claim, then Carrier will be entitled, if it so elects, in a notice promptly delivered to the Health Connector Indemnified Party, but in no event less than ten (10) days prior to the date on which a response to such claim is due, to immediately take control of the defense

and investigation of such claim and to employ and engage attorneys reasonably acceptable to the Health Connector Indemnified Party to handle and defend the same, at the Carrier's sole cost and expense. The Health Connector Indemnified Party will cooperate, at the cost of the Carrier, in all reasonable respects with the Carrier and its attorneys in the investigation, trial and defense of such claim and any appeal arising therefrom; provided, however, that the Health Connector Indemnified Party may, at its own cost and expense, participate, through its attorneys or otherwise, in such investigation, trial and defense of such claim and any appeal arising therefrom. No settlement of a claim that involves a remedy other than the payment of money by Carrier will be entered into without the consent of the Health Connector Indemnified Party and the Carrier. After notice by Carrier to the Health Connector Indemnified Party of its election to assume full control of the defense of any such claim, the Carrier will not be liable to the Health Connector Indemnified Party for any legal expenses incurred thereafter by such Health Connector Indemnified Party in connection with the defense of that claim. If Carrier does not acknowledge that Section 6.26.A applies with respect to the claim and therefore has not elected to assume full control over the defense of the claim, Carrier may participate in such defense, at its sole cost and expense, and the Health Connector Indemnified Party will have the right to defend the claim in such manner as it may deem appropriate, at the cost and expense of Carrier.

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6.27. Consequential Damages. Except with regard to claims indemnifiable under Section 6.26, above, or claims arising from the gross negligence or willful misconduct of a party, neither party shall be liable to the other party for any indirect, incidental, special, punitive, exemplary or consequential damages (including, without limitation, any damages arising from loss of use or lost business, revenue, profits, data or goodwill) arising in connection with this Agreement, whether in an action in contract, tort, strict liability or negligence, or other actions, even if advised of the possibility of such damages.

6.28. Ownership of Data.

A. Ownership of Health Connector Data. As between the Health Connector and Carrier, all Health Connector Data, as defined below, that is submitted, directly or indirectly, to Carrier by the Health Connector shall be and will remain the property of the Health Connector. For purposes of Section 6.28, Health Connector Data means data and information created by the Health Connector and relating to the Health Connector, its directors, officers, employees and agents, technology, operations, facilities, consumer markets, products, capacities, systems, procedures, security practices, research, development, business affairs, ideas, concepts, innovations, inventions, designs, business methodologies, improvements, trade secrets, copyrightable subject matter and other proprietary information. Without the Health Connector's approval (in its sole discretion), the Health Connector Data will not be (1) used by Carrier or its subcontractors other than in connection with carrying out its obligations under this Agreement; (2) disclosed, sold, assigned, leased or otherwise provided to third parties by Carrier or its subcontractors other than in connection with carrying out its obligations under this Agreement; or (3) commercially exploited by or on behalf of Carrier or its subcontractors. Carrier hereby irrevocably assigns, transfers and conveys, and will cause its subcontractors to assign, transfer and convey, to the Health Connector without further consideration all of its and their right, title and interest in and to the Health Connector Data. Upon request by the Health Connector, Carrier will execute and deliver, and will cause its subcontractors and agents to execute and deliver, any documents that may be necessary or desirable under any law to preserve, or enable the

Health Connector to enforce, its rights with respect to the Health Connector Data. Notwithstanding the foregoing, the Carrier shall be responsible for compliance with all federal or state requirements regarding the security and privacy of Health Connector Data that is within the Carrier's custody, including with limitations the requirements of HIPAA and of M.G.L c.93H.

B. Ownership of Carrier Data. As between the Health Connector and Carrier, all Carrier Data, as defined below, that is submitted, directly or indirectly, to the Health Connector by Carrier shall be and will remain the property of the Carrier. For purposes of Section 6.28, Carrier Data means data and information created by the Carrier and relating to the Carrier, its directors, officers, employees and agents, covered members, technology, operations, facilities, consumer markets, products, capacities, systems, procedures, security practices, research, development, business affairs, ideas, concepts, innovations, inventions, designs, business methodologies, improvements, trade secrets, copyrightable subject matter and other proprietary information. Without the Carrier's approval (in its sole discretion), the Carrier Data will not be (1) used by the Health Connector or its subcontractors other than in connection with carrying out its obligations under this Agreement; (2) disclosed, sold, assigned, leased or otherwise provided to third parties by the Health Connector or its subcontractors other than in connection with carrying out its obligations under this Agreement; or (3) commercially exploited by or on behalf of the Health Connector or its subcontractors. The Health Connector hereby irrevocably assigns, transfers and conveys, and will cause its subcontractors to assign, transfer and convey, to the Carrier without further consideration all of its and their right, title and interest in and to the Carrier Data. Upon request by the Carrier, the Health Connector will execute and deliver, and will cause its subcontractors and agents to execute and deliver, any documents that may be necessary or desirable under any law to preserve, or enable the Carrier to enforce, its rights with respect to the Carrier Data.

6.29. HIPAA Compliance/Data Security Breach.

A. Carrier acknowledges that it is a covered entity, as defined in 45 CFR 160.103.

B. With respect to the use and disclosure of "protected health information" between the parties, as that term is defined in 45 CFR 160.103, to the extent it is determined that one party is or must become a "business associate" of the other, as that term is defined in 45 CFR 160.103, the parties agree to enter into a business associate contract that meets the applicable requirements of 45 CFR 164.504(e).

C. In the event that a party knows or has reason to know of (1) a breach of security (as defined by M.G.L. c. 93H) involving individually-identifiable information and/or protected health information received from the other party under this Agreement that occurred while such information was in that party's custody or control, or (2) a security breach (as defined by the American Recovery and Reinvestment Act of 2009) of unsecured protected health information received from the other party under this Agreement, while such information was in the party's custody or control, then that party shall as soon as practicable provide notice of such occurrence to the other party and shall provide any further notice and take steps to mitigate as are required by the applicable law.

6.30. Arbitration. In the event a dispute between the parties arises out of, or is related to, this Agreement, the parties shall meet and negotiate in good faith to attempt to resolve the dispute. If after at least twenty (20) days following the date one party has sent written

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notice of the dispute to the other party, the dispute is not resolved, and if either party wishes to pursue the dispute, it shall be submitted to binding arbitration. In no event shall arbitration be initiated more than six (6) months following the sending of written notice of the dispute. Any arbitration proceeding under this Agreement shall be conducted in the Commonwealth of Massachusetts according to the rules of the American Arbitration Association. The arbitrators shall have no authority to award any punitive or exemplary damages, or to vary or ignore the terms of this Agreement, and shall be bound by controlling law.

SIGNATURE PAGE

IN WITNESS THEREOF, the parties have executed this Agreement as of the day/year stated below:

The Commonwealth of Massachusetts **Health Insurance Connector Authority**	**(Carrier)**
By:_____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

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APPENDIX A

SCHEDULE I

COMMONWEALTH CHOICE HEALTH PLANS UNDER A PRIOR SEAL OF APPROVAL

Carrier shall continue to make available for renewal through the Health Connector the following Commonwealth Choice Health Plans:

1. **Gold –**
2. **Silver –**
3. **Silver –**
4. **Bronze –**
5. **Young Adult Plan –**
6. **Young Adult Plan –**

APPENDIX A

SCHEDULE II

COMMONWEALTH CHOICE HEALTH PLANS UNDER THIS SEAL OF APPROVAL

Carrier shall continue to make the following Commonwealth Choice Health Plans available for purchase through the Health Connector beginning November 1, 2010 for effective date of coverage beginning January 1, 2011:

1. **Gold -**
2. **Silver High –**
3. **Silver Low -**
4. **Bronze High –**
5. **Bronze Medium –**
6. **Bronze Low -**
7. **Young Adult Plan High -**
8. **Young Adult Plan Low -**

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APPENDIX B

ADMINISTRATIVE FEE

For new business and business renewing on or after July 1, 2011, the Administrative Fee for the period July 1, 2011 through December 31, 2012 is the greater of 3.5% of full premium collected or $12.00 per subscriber per month where premium is collected.

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APPENDIX C

SCHEDULE I

CLAIMS DATA FILE LAYOUT

Data Elements - Guideline:

The following are the data elements common to all claim types:

Administrative Fields:
- Claim Number
- Claim Type (IP, OP, Prof, Rx, Other)
- Date Paid (preferred format of all date fields: yyyymmdd)
- Group Number
- In-Network Provider vs. Out-of-Network Provider Designation
- Claim status code (e.g. denied, reversal, paid, etc)

Demographic Data:
- Subscriber Number
- Member Number
- Relationship to Subscriber Identifier (Employee, Spouse, child1, child2, etc)
- Member Birth Date
- Member Sex
- Member 3 Digit Zip Code

The following are the data elements common to Hospital Inpatient & Outpatient Facility claims only:

Provider Fields:
- Facility Number
- Type of Bill (3 digit code defining type of facility (Hospital, SNF, etc), bill classification, and bill frequency)
- Provider Type (Hospital, SNF, Surgery Center, etc; only needed if Type of Bill is not available)

SCHEDULE I

CLAIMS DATA FILE LAYOUT

Claim Fields:

- Source of Admission
- Type of Admission
- Place of Service (IP, OP, Freestanding surgicenter, etc.)
- Diagnosis Codes (primary and all secondary ICD9 codes)
- Procedure Codes (primary and all secondary ICD9 codes)
- Date of Admission (start of care date for outpatient)
- Date of Discharge (end of care date for outpatient)
- Length of Stay (IP claims only)
- ICU/CCU/PICU Days (IP claims only, but needed only if revenue codes are not available)
- Discharge Disposition (IP claims only)
- DRG (IP claims only)
- Billed Charges
- Deductible Amount
- Coinsurance Amount
- Copay Amount
- Paid Amount
- Withhold Amount
- COB Amount
- Revenue Code
- CPT Codes
- CPT Modifier
- Service Date
- Total Units of Service by Revenue Code
- Total Charges by Revenue Code

APPENDIX C

SCHEDULE I

CLAIMS DATA FILE LAYOUT

The following are the data elements specific to Professional claims only:

Provider Fields:
- Provider of Service Number
- Provider of Service Specialty

Claim Fields:
- Diagnosis Codes (primary and all secondary ICD9 codes)
- Place of Service (office, home, etc)
- Service Date
- Billed Charges
- Deductible Amount
- Coinsurance Amount
- Copay Amount
- Paid Amount
- Withhold Amount
- COB Amount
- CPT Code
- CPT Modifier
- Total Units of Service

The following are the data elements specific to Pharmacy claims only:

Claim Fields:
- NDC Number
- Prescription Fill Date
- Therapeutic Class
- Formulary Indicator
- Mail Order Indicator
- Brand or Generic Indicator
- Refill sequence
- Prescription Supply Days
- Prescription Quantity
- Billed Charges by Pharmacy
- Deductible Amount
- Coinsurance Amount
- Copay Amount
- Paid Amount
- Sales Tax
- COB Amount
- Ingredient Cost
- Dispensing Fee
- Average Wholesale Price of Prescription

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SCHEDULE I

CLAIMS DATA FILE LAYOUT

The following are the data elements relating to the Membership File:

- Group Number
- Subscriber Number
- Member Number
- Relationship to Subscriber Identifier (Employee, Spouse, child1, child2, etc)
- Member Birth Date
- Member Sex
- Member 3 Digit Zip Code
- Coverage Eligibility Date
- Coverage Termination Date

APPENDIX C

SCHEDULE II

MEDICAL LOSS RATIO TEMPLATE

	Quarter Ended March 31, 2011			Year Ended December 31, 2010			Year Ended December 31, 2009	
	Connector specific	Total NG/ Small Group		Connector specific	Total NG/ Small Group		Connector specific	Total NG/ Small Group
Total Incurred Claims - paid								
Total IBNR								
Total Claims								
Gross Premium Revenue								
Bad Debt Expense								
Net Premium Revenue								
Members								
Member Months								

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