



State of Connecticut

REQUEST FOR PROPOSAL

November 19, 2002

Table of Contents

Section I: Introduction and Background

Section II: Bid Specifications

Section III: Performance Objectives and Guarantees

Section IV: Selection Criteria

Section V: Summary Plan Designs

Section VI: Historical Financial Data

Section VII: Network Accessibility, Profile, and Disruption Analysis Exhibits

Section VIII: Financial Bid Response Exhibits

Section IX: Questionnaire
A. General
B. Medical
C. Prescription Drug
D. Dental

Appendices

SECTION I

INTRODUCTION AND BACKGROUND

INTRODUCTION

The State of Connecticut, acting through the Health Care Cost Containment Committee (“HCCCC”) and this Request for Proposal (“RFP”), is seeking the services of health plan(s) with the expertise and capability to administer its health care program for employees, retirees, and their covered dependents. The contracts with current health plans expire on June 30, 2003. It is anticipated that the new contracts, that will be effective on July 1, 2003, will be for an initial term of two years with the option of a third and fourth year.

BACKGROUND

Legislative History and Program Management

The State Comptroller is empowered by Connecticut General Statutes, Section 5-259 to arrange and procure a “group hospitalization and medical and surgical insurance plan” for employees and retirees.

The HCCCC was established through collective bargaining in 1985 and is composed of six labor representatives, six management representatives, and one neutral chairperson. It is responsible for implementing cost control measures, monitoring and improving plan quality, and initiating health promotion and wellness activities for state employees, retirees, and their eligible dependents.

Current Health Plans

Medical

On October 1, 1993, as an outcome of collective bargaining, elements of managed care were introduced into the state medical plan with the goal of restraining health care costs while maintaining access and quality of care. Current medical plans include the following:

- ✓ *Point of Service (“POS”)* - Under this option, employees elect, each time medical services are required, whether to access a network provider (and receive higher levels of plan benefits), or access a non-network provider (and receive lower levels of plan benefits). **Note that the POS plans do NOT require a referral to access network specialists.** A POS plan offering is provided through Anthem Blue Cross Blue Shield (“ABCBS”), ConnectiCare, and Health Net. ABCBS offers two POS plans, which include the State Preferred (i.e., broad network) and State Blue Care (i.e., more restrictive network) plan options.

- ✓ *Point of Enrollment Non-Gated (“POE-NG”)* - This option operates as a typical “lock-in” Health Maintenance Organization (“HMO”). That is, benefits are only available if care is rendered by a network provider. **Note that the POE-NG plans do NOT require a referral to access network specialists.** The POE-NG plan offerings are provided through ABCBS (using the same network that supports the State Blue Care POS plan), ConnectiCare, and Health Net.
- ✓ *Point of Enrollment Gated (“POE-G”)* - This option operates as a typical “lock-in” Health Maintenance Organization (“HMO”). That is, benefits are only available if care is rendered by a network provider or authorized by the plan. **Note that the POE-G plans do require a referral to access network specialists.** The POE-G plan offerings are provided through ABCBS (using the same network that supports the State Blue Care POS plan), ConnectiCare, and Health Net.
- ✓ *Out of State (“OOS”)* – This option consists of a Preferred Provider Organization (“PPO”) available to employees and retirees who reside outside of the state of Connecticut. This plan is provided through ABCBS utilizing the national BlueCard PPO network.

The plans are available to active and retired employees. Benefits for Medicare eligible retirees consist of a Medicare Carveout approach (Note some of the post 65 retirees are not eligible for Medicare). That is, the plan’s normal benefits are first determined, from which Medicare benefits are subtracted. The balance, if any, represents the plan’s liability. Medicare eligible retirees who reside outside of Connecticut participate in the Out of State BlueCard PPO on a supplemental basis.

All medical plans are provided through fully insured and non-dividend eligible (i.e., non-participating) insurance contracts.

Current Dental Plans

Current dental plans include the following:

- ✓ *Indemnity Plan* – This option is a traditional fee-for-service plan administered by ABCBS. The indemnity plan provides coverage for services according to a percentage of usual, customary and reasonable fees that vary according to the type of service(s) rendered. Members may use either participating or non-participating providers.
- ✓ *HMO Plan* – This is a State licensed HMO “lock-in” option offered by a licensed health care center whereby benefits are payable only if care is rendered by a network provider. At the time of enrollment, CIGNA HMO subscribers are furnished with a panel of providers from which they select a dentist who supplies their treatment in accordance with plan provisions. A capitated financial arrangement exists between CIGNA and panel dentists; subscribers pay a specific dollar copay amount that varies for each covered service.

All dental plans are provided through fully insured and non-dividend eligible (i.e., non-participating) insurance contracts.

SECTION II BID SPECIFICATIONS

A. Program Design Specifications

1. Premium rates are being requested on the following plans. Where multiple plans are currently offered, the plan serving as the template is indicated in parentheses. (Note that you are being asked to provide your premium rates with and without prescription drug coverage.)

Medical

Plan Designs

Active Employees and Non-Medicare Retirees

- a. POS (State Preferred with a \$10 office visit copay)
- b. POE - Non-Gated (State Preferred, in network portion with a \$5 office visit copay)
- c. POE - Gated (State Preferred, in network portion with a \$5 office visit copay)
- d. Out-of-State (State Preferred, PPO with a \$10 office visit copay)

Medicare Eligible Retirees

- e. Retirees who reside in the State: Medicare Carveout for each plan above
- f. Retirees who reside Out-of-State: A plan that supplements Medicare. As an alternative the State is seeking proposals for the Out-of-State PPO plan on a Medicare Carveout basis.

Plan design summaries are included in Section V, and complete summary plan descriptions are included in the appendices.

Eligibility

The plans will be offered to all active employees and retirees of the State of Connecticut.

Network

The Health Plan's service area must encompass the entire state of Connecticut and, ideally, include all acute care facilities in the state. This proposal also requires detailed GeoAccess mapping, whose requirements (and associated Exhibits) are outlined in Section VII.

Employee Contributions

Employee contribution methodology is based on common contribution by delivery system (i.e., POE-NG, POE-G, POS, State Preferred POS, and OOS). Note that the State may introduce a methodology by which contributions by Health Plan are adjusted to reflect the underlying risk characteristics of the enrolled population.

Prescription Drug Plan

The State is interested in pursuing prescription drug coverage under each of the following scenarios:

- ✓ Bundled with the medical coverage
- ✓ Carved out and provided directly through independent pharmacy benefit managers (“PBMs”)

In consideration of the above, Health Plans will be asked to provide premium rates including and excluding prescription drug coverage.

Dental

Please be advised that the State specifically reserves the right to cancel the dental portion of this RFP and, instead, procure the services it requires in partnership with the Department of Social Services through the ACHIEVE Initiative, a collaborative process being coordinated by the Office of Health Care Access and funded with a grant from the Robert Wood Johnson Foundation.

Plan Designs

- a. HMO
- b. Indemnity (with and without a Passive PPO network)

Managed Care

The State of Connecticut is interested in introducing an element of managed care to the dental program. In that regard, you will be asked to provide rates for the indemnity plan including a PPO network on a “passive basis” (i.e. the same plan design).

Eligibility

The plans will be offered to all full-time (and select part-time employees) active employees and retirees of the State of Connecticut.

Network

The dental HMO company must be licensed in the state of Connecticut as a health care center.

Employee Contributions

For active employees, the state contributes from 70% to 100% of the premium rate, dependent on the plan and coverage level elections; in aggregate the state contributes 79% of the total premium cost. For retired employees, the state contributes 20% of the premium cost. In addition, there are several small groups of part-time employees who are entitled to participate in the dental plan on a fully contributory basis.

2. **You are required to submit a proposal for all three medical plan options (i.e., POS, POE-NG, and POE-G) and Out-of-State PPO, if available. However, please note that you may be awarded all or a portion of the medical plans offered.**
3. Premium rates should be provided based on the following financing arrangements, coverage tiers and other financial considerations.
 - a. Fully insured and non-dividend eligible (i.e., non-participating). Under this arrangement, the health plan retains any premium surplus and absorbs any premium shortfall. Prospective rates are based on historical claims experience. (Note that you are being asked to provide your change to quoted rates if the program financing was on fully insured and dividend eligible (i.e., participating) arrangement. In addition, we are asking for reductions to quoted retention levels and any changes to claim costs if plans were offered on a self-insured basis.)
 - b. Rates are to be provided on a self-supporting basis for the following group plans:

Medical

 - ✓ Actives/Non-Medicare retirees
 - ◆ POS
 - ◆ POE Non-Gated
 - ◆ POE Gated
 - ◆ Out-of-State PPO
 - ✓ Medicare Eligible Retirees
 - ◆ POS
 - ◆ POE Non-Gated
 - ◆ POE Gated
 - ◆ Out-of-State PPO

- Dental
- ✓ Actives
 - ◆ Indemnity
 - ◆ Dental HMO
 - ✓ Retirees
 - ◆ Indemnity
 - ◆ Dental HMO
- c. The rates must be based on the following rate tier relationships:
- ✓ Employee only 1.0
 - ✓ Employee plus one dependent 2.2
 - ✓ Family 2.7
 - ✓ Family Less Employed Spouse (“FLES”) – Calculated as Family rate minus Employee only rate
- d. A multi-health plan environment.
- ✓ Medical: It is expected that eligible members will be allowed to select among multiple offerings of POS, POE-NG, and POE-G Health Plans. (Note that you are being asked to provide your reduction to quoted rates if you were awarded the entire program, consisting of POE-NG, POE-G, POS, and Out-of-State plan options, on an exclusive, sole health plan basis.)
 - ✓ Dental: Eligible members will likely be allowed to select among multiple dental HMO plans and only one indemnity dental plan.
- e. Individual medical (e.g. POS, POE-NG, POE-G, etc.) and dental (i.e. indemnity and HMO) rates are to be quoted on a standalone basis. (Note that you are being asked to provide the reduction to your quoted rates if you are awarded multiple medical or dental plans).
- f. No commissions will be payable.
- g. An effective date of July 1, 2003 with premium rates to be guarantee for two years is expected. **Premium rates must be quoted separately for each plan year (i.e., July 2003-04 and July 2004-05).** Rate guarantees beyond this time frame are encouraged.
- h. Dates of service on and after the effective date are covered.
- i. All premiums will be paid within the 30-day grace period.

B. Proposal Submission Requirements

1. This request for proposal will be posted on the internet at www.proposaltech.com. You will be contacted by a Proposaltech representative with the information regarding how to access and post your RFP responses. The website will have the following information posted:
 - Questionnaire
 - Financial Exhibits
 - Claims Experience
 - Employee demographics
 - Appendices including Summary Plan Descriptions and other pertinent information

Please complete the RFP on-line and submit your responses to **all** sections electronically by 4:30 p.m. on **Monday December 23, 2002**. Bids submitted late will not be accepted. The State or their designated representatives reserve the right in its sole discretion to eliminate any incomplete proposal.

2. Additionally, hard copies of your responses to the RFP must be completed and submitted to the Office of the State Comptroller and the office of Deloitte & Touche LLP by 4:30 p.m., **Monday December 23, 2002**. Bids arriving late will not be accepted. The State or their designated representatives reserve the right in its sole discretion to eliminate any incomplete proposal. The proposals should be placed in a sealed envelope and labeled as the "State Health Care Proposal Submission". Your written proposal, contained in a loose-leaf binder, should be submitted to the following individuals (number of copies as indicated):

Mr. Nicholas Paulish, CEBS
Firm Director
Deloitte & Touche LLP
Stamford Harbor Park
PO Box 10098
333 Ludlow Street
Stamford, CT 06902-6982

Mr. Steven Weinberger
Division Director
Office of the State Comptroller
Retirement & Benefit Services
Division
55 Elm Street
Hartford, Connecticut 06106-1775

3 copies

Original and 10 copies

3. Any exceptions to the terms, conditions, plan provisions or other requirements in any part of this RFP must be **clearly identified** on the Deviation Page included within your proposal. **This page must be signed by an authorized corporate officer who is able to contractually bind your organization.** Your proposal will be considered incomplete if the deviation page is not signed.

4. If for any reason your company decides not to submit a proposal in reply to this invitation, please contact Deloitte & Touche by telephone followed by written confirmation of declination by **Monday December 2, 2002** to the individual at the address listed in Item 3 above.
5. Any questions regarding these specifications must be submitted in writing via the website message board on www.proposaltech.com. All questions and answers will be shared with all bidders. Please submit by **Monday December 2, 2002** (questions submitted after this date may not be accepted).

In no event should questions be directed to the Office of the Comptroller or to members of the Health Care Cost Containment Committee.

6. In the proposal, each Health Plan must do the following:
 - a. Respond to the Questionnaire in hardcopy and electronically
 - i) The General Section must be answered by all Health Plans without regard to the coverages being quoted. If you need to submit more than one response to the General Section of the Questionnaire, please contact Proposal Tech to receive authorization to submit multiple responses to the General Section.
 - ii) If your organization is proposing on a subset of the requested plans (e.g., Medical/Prescription Drug only, Prescription Drug only or Dental only), the applicable Questionnaire sections must be answered, including the General Section.
 - iii) If your organization is responding to all services, please answer all sections of the Questionnaire. If a separate affiliate is being proposed for the prescription drug or dental benefits, you must complete the General Section for each organization proposed.
 - iv) If there are different responses based on plan delivery systems (e.g., POE-G, POE-NG, POS, etc.), please so indicate for each corresponding question.
 - b. Complete all requested exhibits by program type and in the requested format. This must be submitted in hardcopy and electronic format.
 - c. Provide all requested program documentation.
7. Bidders must comply with the minimum performance objectives outlined in the Performance Objectives and Guarantees Section of this proposal. Any deviations to the Performance Objectives and Guarantees Section must be noted in your Deviations from Specifications Exhibit. It is assumed that each Bidder will comply with standard industry administrative procedures (e.g. claims adjudication, EOB distribution, etc.) and thus, are not specifically addressed in this RFP.

8. Disclose any current or past (within the last two years) business relationship that may pose a conflict of interest. Include all business relationships with the State's present health plan vendors (i.e., Anthem Blue Cross Blue Shield, CIGNA, ConnectiCare, and Health Net) and consultants (i.e., Deloitte & Touche), including their parent companies, subsidiaries, or subcontractors.
9. Proposals must include a summary of the contractor's experience with affirmative action. This information is to include a summary of the contractor's affirmative action plan and the contractor's affirmative action policy statement. Section 4-114a-3(10) of the regulations of Connecticut State Agencies requires agencies to consider the following factors when awarding a contract which is subject to contract compliance requirements:
 - a. The contractor's success in implementing an affirmative action plan;
 - b. The contractor's success in developing an apprenticeship program complying with Section 46a-68-1 to 46a-68-17 of the Connecticut General Statutes, inclusive;
 - c. The contractor's promise to develop and implement a successful affirmative action plan;
 - d. The contractor's submission of EEO-1 data indicating that the composition of its work force is at or near parity when compared to the racial and sexual composition of the work force in the relevant labor market area; and
 - e. The contractor's promise to set aside a portion of the contract for legitimate small contractors and minority business enterprises, where applicable. (See Section 32-9e of the Connecticut General Statutes)

In consideration of the above, your proposal submission must contain the following:

- ✓ "Notification of Contractors" form is attached, to be read, signed, and returned by the contractor (Attachment I).
- ✓ Attached is a Contract Compliance Requirements reporting form, which the contractor must complete, sign and return; such form will be sent by OSC to the Commission on Human Rights and Opportunities (CHRO). (Attachment II)

C. Instructions to Contractors

1. Conformance - All responses to this RFP must conform to these instructions. Failure to conform may be considered appropriate cause for rejection of the response.
2. Structure of Response - Contractors must structure the responses as outlined in this RFP.
3. Exclusion of Taxes from Prices - The State of Connecticut is exempt from the payment of premium, excise, transportation, and sales taxes imposed by the Federal Government and the State. Such taxes must be excluded from quoted prices.
4. Signature and Responsible Persons - The proposal must be signed by an authorized official. The proposal must also provide the name, title, address and telephone number for individuals with authority to negotiate and contractually bind the contractor, and for those who may be contacted for the purpose of clarifying the information provided.
5. “Not to Exceed” Quotations - All premium rates will be considered as “not to exceed” quotations.
6. Premium Rates not Subject to Adjustment – There will be no adjustments to quoted premium rates after the winning bidder(s) have been announced.

D. Terms and Conditions

Any contractor responding to this RFP must be willing to adhere to the following conditions and must so state in its submission:

1. Acceptance or Rejection by the State - The State reserves the right to accept or reject any or all proposals submitted for consideration. All proposals will be kept sealed and safe until the deadline for submission has passed.
2. Conformance with Statutes - Any contract awarded as a result of this RFP must be in full compliance with all State Statutes.
3. Ownership of Proposals - Any restrictions on the use of the data contained within your RFP response must be clearly stated in the proposal itself. All proposals in response to this RFP are to be the sole property of the State, and subject to the provisions of Section 1-19 of the Connecticut General Statutes (Freedom of Information).
4. Reinsurance/Joint Administration/Joint Ventures – Any reinsurance agreements or joint administrative or joint ventures must be described in detail in your proposal and will be subject to approval by the State.
5. Finalists Site Visits – Finalists will be required to reimburse the State for out-of-pocket costs (e.g., travel, hotel, meals, etc.) incurred by State personnel and their designated representative in conducting finalists site visits.

6. Ownership of Subsequent Products - Any product, whether acceptable or unacceptable, developed under the contract awarded as a result of this RFP is to be the sole property of the State unless otherwise stated in the RFP or contract.
7. Timing and Sequence - Timing and sequence of events resulting from this RFP will ultimately be determined by the State.
8. Stability of Proposed Prices - Any price offerings from contractors must be valid for a period of two hundred and seventy (270) days from the due date of the proposals.
9. Oral Agreements - Any alleged oral agreement or arrangement made by a contractor with any agency or employee will be superseded by the written agreement.
10. Amending or Canceling Requests - The State reserves the right to amend or cancel this RFP prior to the due date and time, if it is in the best interest of the State.
11. Rejection for Default or Misrepresentation - The State reserves the right to reject the proposal of any contractor that is in default of any prior contract or for misrepresentation.
12. State's Clerical Errors in Awards - The State reserves the right to correct inaccurate awards resulting from its clerical errors.
13. Rejection of Qualified Proposals - Proposals are subject to rejection in whole or in part if they limit or modify any of the terms and conditions and/or specifications of the RFP.
14. Contractor Presentation of Supporting Evidence - A contractor, if requested, must be prepared to present evidence of experience, ability, service facilities, and financial standing necessary to satisfactorily meet the requirements set forth or implied in the proposal.
15. Changes to Proposal - No additions or changes to the original proposal will be allowed after submittal. While changes are not permitted, clarification at the request of the HCCCC may be required at the contractor's expense.
16. Collusion - By responding, the contractor implicitly states that the proposal is not made in connection with any competing contractor submitting a separate response to the RFP, and is in all respects fair and without collusion or fraud. It is further implied that the contractor did not participate in the RFP development process, had no knowledge of the specific contents of the RFP prior to the issuance of the RFP and that no employee of any state agency or member of the HCCCC participated directly or indirectly in the contractor's proposal preparation.
17. Premium Rates – Premium rates cannot be changed except on the renewal date stated in the contract. Written notice must be given to the State at least 120 days prior to a contemplated change.
18. Transfer of Records – If at some date in the future it becomes necessary to terminate the contract, you must agree to transfer to the State within 15 days of termination, all data and records necessary to administer the plan. This would include, but not be limited to:

- ✓ Employee and dependent eligibility
- ✓ 24 months of historical claims data
- ✓ Coinsurance and deductible data
- ✓ Lifetime maximum levels

E. Rights Reserved to the State

1. The Health Care Cost Containment Committee, through the Office of the Comptroller, seeks proposals for informational purposes only from prospective organizations and will not willfully omit any qualified proposers. The Office of the Comptroller shall be held harmless for any failure to solicit responses from potential bidders.
2. The State reserves the right to award in part, to reject any and all proposals in whole or in part, to waive technical defects, irregularities and omissions if, in its judgment, the best interest of the State will be served.
3. This RFP does not commit the Office of the Comptroller to award a contract, to pay any costs incurred in preparing an informational proposal for this request or to procure a contract for services or supplies.
4. The RFP process is intended to constitute a competitive negotiation, meaning a procedure for contracting for services in which (a) proposals are solicited from qualified persons, firms, or corporations by a request for proposals and (b) changes may be negotiated in proposals and prices after being submitted.
5. The Office of the Comptroller will be held harmless for any intentional or unintentional misrepresentation of the State health care program in any ensuing circumstances.
6. The Office of the Comptroller will reserve the right to be involved in the selection of and/or replacement of all key vendor staff that will represent the State health care program. The Office of the Comptroller will have authority to request the removal of vendor staff person(s) from the account with just cause and will also be included in the final interview process for candidates to replace any removed staff persons. Any changes in key staff the vendor makes must be done with 30 days notice and approval of the Office of the Comptroller.

F. Participation in the Municipal Employees Health Insurance Program

All Health Plans that are offered to State employees have a corresponding obligation to participate in the Municipal Employee Health Insurance Program (“MEHIP”). MEHIP was created by the Connecticut Legislature under Public Act Number 96-234 and became operational July 1, 1998. MEHIP is available to any entity, which is otherwise eligible to participate in the State Municipal Employees Retirement System (e.g. towns, cities, school districts, etc.) and non-profit organizations that are organized as a 501 (c) 3 and have a contract with the State. All Health Plans selected as a function of this RFP will be required to participate in the MEHIP upon its next renewal, July 1, 2003. Additional information regarding the MEHIP is included as an attachment.

G. RFP Response Timetable

Task	Completed By
Deloitte & Touche release RFPs to health plans	November 19, 2002
Health Plans submit electronic inquiries to Deloitte & Touche	December 2, 2002
Health Plans provide decline to quote to Deloitte & Touche	December 2, 2002
Deloitte & Touche provides Health Plans with responses to electronic inquiries	December 9, 2002
Health Plan proposals are due to Office of the Comptroller and Deloitte & Touche (<i>Hardcopies and Electronic Posting</i>)	December 23, 2002
Selection of Finalists	January 31, 2003
Finalists Oral Interviews	February 5, 2003
Finalists Site Visits	February 19, 2003
Final Selection	March 1, 2003
Program Introduction and Open Enrollment	May 1, 2003
Program Effective Date	July 1, 2003

SECTION III

PERFORMANCE OBJECTIVES AND GUARANTEES

PERFORMANCE OBJECTIVES

The selected bidder will be expected to perform activities within the established guidelines described in this section and standard administrative procedures.

Please review the performance objectives/criteria for bidders carefully. Any deviations from these performance objectives must be noted in the Deviations from Specifications Exhibit. Each bidder must also provide its actual 2001 and 2002 year to date results as compared to these performance objectives.

A. Account Service

- Dedicated Unit
 - ◆ The State of Connecticut will have a dedicated unit for claims processing and member services. It is preferable that the unit be housed in a facility located in the state of Connecticut.
- Account Executive
 - ◆ The Health Plan will provide a dedicated account executive.
 - ◆ The Health Plan's representatives (all levels) will be accessible to the State of Connecticut Benefit Staff via electronic mail.
- Contracts
 - ◆ Contracts, administrative agreements or amendments will be provided to the State of Connecticut within 90 calendar days after a written request for changes, by April 1 of the current year prior to standard renewal, and 45 days after initial effective date.
 - ◆ The bidder must quote the proposed plans and provide currently insured participants continued coverage on a no-loss, no-gain basis. The actively-at-work requirement is to be waived for all current participants including those individuals on COBRA continuance, and short-term and long-term disability. All individuals must be covered under the new insurance arrangements without qualification.
 - ◆ The prospective Health Plan must agree to waive all pre-existing condition exclusions for all current participants covered under the new plans.

- Eligibility
 - ◆ Pend PCP information for new members until the eligibility data is received.
 - ◆ Accept electronic transfer of eligibility data on a biweekly basis.
 - ◆ Update eligibility data within 24 hours from the time of receipt of data.
- Reports/Reporting
 - ◆ The Health Plan must maintain utilization statistics based on the desired State of Connecticut claim structure.

Monthly reports

- ◆ Premium and enrollment detail separated by plan, coverage type, and member status (e.g. active, Non-Medicare retiree, etc.)
- ◆ A paid claim listing by claim structure separated by plan, coverage type and member status, including in-network, out-of-network, and employee and dependent breakdowns.

Quarterly reports

- ◆ Medical reports detailing utilization management and network performance within 60 days of the close of the reporting period. Reports should allow for distinction between in and out-of-network utilization performance as well as participating and non-participating provider activity separately for each plan and in aggregate. Reporting should include documentation of savings associated with all individual managed care programs (e.g., provider discounts, utilization management, hospital pre-certification, etc.).
- ◆ Prescription drug reports detailing utilization and claims detail by prescription drug and volume. Reports should also provide detailed retail/mail-order and brand/generic activity on a script and claim dollar basis. Reporting should also include documentation of savings associated with all individual managed care programs (e.g., ingredient discounts, utilization management, generic substitution, formulary rebates, etc.).

Annual

- ◆ Top 10 utilized hospitals by both admissions and by claims
- ◆ Top 50 utilized physicians
- ◆ Top 25 retail and mail order drugs, separately, by cost by therapeutic category
- ◆ Tops 25 drugs by diagnosis by therapeutic category

- ◆ Large claims over \$75,000
- ◆ HEDIS reports
 - ◇ Health Plan book of business
 - ◇ State of Connecticut specific
- ◆ A final year-end accounting no later than 120 days after the end of the contract year
- ◆ An annual report for the medical and prescription drug programs as outlined in the quarterly (prescription drug) and semi-annual (medical) report sections above
- ◆ A copy of the internal audit report

Ad hoc

- ◆ The Health Plan will provide ad hoc reporting to support State of Connecticut initiatives, as necessary.

B. Customer/Member Service

- The Health Plan must communicate significant changes in Member Services (e.g. phone messages or prompts and personnel) to the State in advance. The Health Plan must receive the State's approval prior to implementing major changes (e.g. unit structure and service center).
- The Health Plan must name a Member Services' liaison to conduct problem resolution with the State's benefits staff.
- The Health Plan must attempt to diligently resolve all eligibility issues prior to referring participants to the State's benefits staff.
- The Health Plan must issue and mail ID cards within 48 hours, excluding weekends and holidays.
- Target Telephone Response
 - ◆ 100% of State calls answered live within 30 seconds.
 - ◆ Abandonment rate less than 5%.
 - ◆ 90% of customer service issues resolved on first call.

- Written Responses
 - ◆ 100% of member services inquiries will be acknowledged within 7 business days.
 - ◆ 95% of written inquiries to member services will be resolved within 30 business days.

C. Provider Network

- Health Plan must be licensed in the State of Connecticut as a health care center
- Network Turnover
 - ◆ PCP - less than 5% annually within the State of Connecticut service area (turnover is defined as any withdrawal from the network for reasons other than illness, death or quality)
 - ◆ The Health Plan will keep the State apprised of any issues/discussions surrounding their primary providers and hospitals.
 - ◆ The State must be provided with monthly notices of additions, terminations or changes in practice status (i.e. open vs. closed) of participating physicians and hospitals.
- Network Accessibility
 - ◆ Health Plan must service all counties in Connecticut and, ideally, include all acute care facilities.
 - ◆ Health Plan must meet minimum access requirements as outlined in Section VII.
 - ◆ Minimum of 85% of all PCPs within the State of Connecticut's service area must have open practices.
- Medical Network Appointment Times
 - ◆ Routine - 90% within 30 calendar days
 - ◆ Non-urgent care - 90% within 7 days
 - ◆ Urgent care - 95% within 24 hours

D. Quality

- The Health Plan and the State will develop a written patient satisfaction survey (phone surveys are not acceptable) to be administered annually to a statistically significant sample of State members. A “good” or “excellent” rating is expected from 85% of all respondents on all questions of network quality, accessibility, claims and service.

E. Claims Processing

- Health Plan must be able to administer the State’s proposed plan designs without any changes.
- The Health Plan must directly coordinate with Medicare on behalf of the retiree in processing Medicare carveout and Medicare Supplement claims.
- Audit/Quality Assurance Program
 - ◆ The Health Plan will audit a minimum of 3% to 5% of claims monthly for all plans to determine financial and procedural accuracy (internally).
 - ◆ The Health Plan will audit all claims in excess of \$20,000.
- The claims processing system must be integrated with the eligibility system.
- Indemnification of the State of Connecticut
 - ◆ The Health Plan will not charge against the experience claim payments not authorized under the Plan (except those authorized by the State of Connecticut) if such payment was the result of negligent, reckless, or willful acts or omissions by the Health Plan, its agents, officers, or employees. The State of Connecticut acknowledges that, even in the exercise of ordinary care, some unauthorized claims, few in number and small in dollar amount, will be paid. Such payments may be charged against the experience.
 - ◆ The Health Plan will indemnify, hold, and save the State of Connecticut, its agents, officers and employees harmless from liability of any nature or kind (including costs, expenses, and attorney’s fees) for harm suffered by any entity or person as a result of the negligent, reckless, or willful acts or omissions of the Health Plan, its officers, agents, or employees.
- Claims Turnaround Time
 - ◆ 95% within 10 business days
 - ◆ Pended claims not to exceed 6% - 8% of processed claims

- Claims Payment Accuracy
 - ◆ Financial - payment accuracy ratio of 99%
 - ◆ Non-financial (claim coding) - coding accuracy ratio of 98%
- Claims Office
 - ◆ The location of the claims office that pays the State's claims will not be changed without prior approval of the State.
 - ◆ The Health Plan will accept claims submitted by members via facsimile.
 - ◆ The State reserves the right to audit the claim records and other financial records of the Health Plan, as they pertain to the employee benefit program whenever it is deemed appropriate. Such audits may be performed by State personnel, or by outside auditors selected by the State. If the State performs an independent audit, then the State's audit results will be used to ascertain performance compliance.

F. Wellness Programs

- The Health Plan will meet HEDIS measurement performance standards as set by the State and the Health Plan. The standards will be based on an annual percentage increase over the Health Plan's previous year's results. Standards will include, but not be limited to:
 - ◆ Childhood Immunization Rate
 - ◆ Mammography Screening Rate
 - ◆ Pap Smear Rate
 - ◆ Prenatal Care in First Trimester
- The Health Plan will have or will be in the process of seeking NCQA Accreditation at the time of proposal response.

G. Performance Guarantees

- The Health Plan will agree to performance guarantees that are, at a minimum, the performance targets and penalties as provided in this Section, inclusive of performance guarantees in the area of implementation. The Health Plan will place 2% of annual premium at risk (15% of administrative fees in the self-insured alternative). The distribution of premium and administrative fees at risk between performance areas will be mutually agreed upon between the State and the Health Plan.

H. Financial Guarantees

- The Health Plan must provide fully insured rates for the July 2003/2004 and July 2004/2005 plan years.

I. Communications

- The Health Plan must obtain the State's approval prior to the distribution of any member communication materials.
- The Health Plan will be responsible for reviewing and updating applicable sections for the annual open enrollment materials produced by the State.
- The Health Plan will be responsible for bearing the cost of drafting (both initial and final) Summary Plan Descriptions (SPDs) for the various plans. The Health Plan will also be responsible for printing and mailing the SPDs to members.
- The Health Plan must utilize State specific forms and materials, as necessary.
- The Health Plan will provide enrollment kits including directories of participating providers.
- The Health Plan will provide all necessary materials according to a schedule stipulated by the Office of the Comptroller.

J. Technical Assistance

- On an annual or as-needed basis, the Health Plan will be expected to provide actuarial and underwriting assistance (e.g. price changes to plan).

K. Legislative Compliance Processes

- The Health Plan will administer the State program in compliance with all pertinent Connecticut statutes, regulations, and bulletins.
- The Health Plan must comply with all provisions of the Health Insurance Portability and Accountability Act of 1996, including, but not limited to:
 - ◆ Providing certificates of creditable coverage where lawfully required
 - ◆ Permitting mid-year enrollment as outlined in the special enrollment provisions
 - ◆ Compliance with HIPAA electronic transaction standards
- The Health Plan will administer the New York Health Care Reform Act requirements for all participants residing and receiving care in New York. The Health Plan will make payments on behalf of the State.

- For fully insured arrangements, the Health Plan is required to obtain prior approval from the State Insurance Department for all policy forms and rates.

L. Dental

- **In order to submit a proposal for the Dental HMO option, the bidder must be licensed as a health care center with the Insurance Department.**

PERFORMANCE GUARANTEES

The Health Plans will be expected to meet or exceed the following performance standards by category. Results below the standard level of performance will result in a financial penalty. The Health Plan will place 2% of its premium or in the case of the self-insured alternative, 15% of its administrative fees at risk. The distribution of premium/administrative fees at risk between performance areas will be mutually agreed upon between the State and the Health Plan. Performance standards should be reported and measured monthly; however, the final financial settlement will be based on the weighted average of the monthly results.

The following performance standards apply to all coverages, medical, dental, and prescription drug, unless noted otherwise in the performance standards section specific to each coverage.

Medical, Dental, and Prescription Drug

Category	Standard	Measurement
Claims Processing		
<ul style="list-style-type: none"> Claims Financial Accuracy 	99% payment accuracy ratio	Total dollars paid correctly (total dollars actually paid minus the absolute value of overpayments and underpayments) divided by total dollars that should have been paid for the audited sample.
<ul style="list-style-type: none"> Claim Coding Accuracy 	98% coding accuracy ratio	Total number of claims correctly processed divided by the total number of claims audited.
<ul style="list-style-type: none"> Claims Turnaround 	95% within 10 business days	Time from the date a claim is received to the date it is processed (i.e., paid, pending or denied) excluding weekends and holidays (clean claims only).
Customer Service		
<ul style="list-style-type: none"> Telephone Response Time 	100% within 30 seconds	Telephone system should provide statistics regarding time from call connecting to the 800# to the time it is answered by a live person.
<ul style="list-style-type: none"> Telephone Abandonment Rate 	Less than 5%	Percentage of calls in which the caller hangs up before the call is answered by a live person.
<ul style="list-style-type: none"> ID Cards 	90% mailed within 48 hours	Time from the date of receipt of each eligibility tape to the date the ID card is mailed excluding weekends and holidays.
<ul style="list-style-type: none"> Responsiveness to Written Correspondence 	100% acknowledged within 7 business days; 95% resolved within 30 business days	Time from the date the correspondence is received to the date an acknowledgement/resolution of the inquiry is mailed.
Quality		
<ul style="list-style-type: none"> Member Satisfaction 	Score of “4” or “5” on a 5-point scale by 85% of the respondents	Overall plan satisfaction by determining the percentage of State members who give a rating of “4” or “5” on a 5-point scale. The survey will be mutually agreed upon by State and the Health Plan.

Category	Standard	Measurement
Reporting		
<ul style="list-style-type: none"> Release of reports 	Provided within 45 days of the end of the reporting period	Time from the date the reporting period closes to the date the report is mailed. Reporting period close is dependent on the frequency of the specific report.
Implementation		
<ul style="list-style-type: none"> State Satisfaction 	100% satisfaction with the implementation process and corresponding activities	Measurement will be based entirely on the State’s overall satisfaction with the implementation process; however, any issues or concerns must be communicated by the State to the Health Plan and the State must have allowed time for the Health Plan to address any issues or concerns.

Medical

Category	Standard	Measurement
Provider Network		
<ul style="list-style-type: none"> PCP Turnover 	Less than 5% annually	Percentage of PCPs who left the network voluntarily during the plan year.
<ul style="list-style-type: none"> Appointment Times 	<u>Routine</u> – 90% within 30 calendar days <u>Non-urgent care</u> – 90% within 7 days <u>Urgent care</u> – 95% in 24 hours	Percentage of members who receive care within the time frames designated.
<ul style="list-style-type: none"> Open Practices 	85% of all PCPs must have open practices	Percentage of the Health Plans PCPs accepting new patients during the plan year.

Managed Dental (Passive PPO and HMO)

Category	Standard	Measurement
Provider Network		
<ul style="list-style-type: none"> Open Practices 	85% of all Generalists must have open practices	Percentage of Generalists accepting new patients during the plan year.
<ul style="list-style-type: none"> Appointment Times 	<u>Routine</u> – 90% within 30 calendar days <u>Non-urgent care</u> – 90% within 7 days <u>Urgent care</u> – 95% in 24 hours	Percentage of members who receive care within the time frames designated.

Prescription Drug

Retail and Mail Order

Category	Standard	Measurement
• Generic Substitution	35% generic ratio	Total number of generic prescriptions dispensed divided by the total number of prescriptions dispensed
• Mail Order Dispensing Accuracy	99.9% accuracy ratio	Total number of claims correctly processed divided by the total number of claims audited.
• Mail Order Turnaround	95% in 2 business days 100% in 15 business days	Time from the date a claim is received to the date it is processed (i.e. paid, pended or denied) excluding weekends and holidays (clean claims only).
• Utilization Savings	3-5 % savings	Amount saved as a result of DUR controls (including prospective, concurrent, and retrospective reviews).

SECTION IV

SELECTION CRITERIA

SELECTION CRITERIA

The State considers the following criteria to be the most critical (not listed in order of importance) in selecting a Health Plan(s) to provide and administer a managed health program and other requested services for the State and its members:

- ◆ Demonstrated long-term commitment to providing and encouraging high quality health care
- ◆ Ability to provide the State of Connecticut participants with efficient benefit administration and utilization review services.
- ◆ Accessibility on a cost-effective basis to high quality physicians, hospitals and ancillary providers, particularly those mostly highly utilized by State plan participants.
- ◆ An effective and efficient means of providing customer service support and program information to participants.
- ◆ Demonstrated ability to manage health care costs for the State and its employees and retirees.
- ◆ Interest in a long-term, mutually beneficial partnership.
- ◆ Ability to achieve cost savings for the State through competitive premiums.
- ◆ Proven track record in the areas of managed care, network management and customer service.
- ◆ Proven flexibility in reporting and communication capabilities including the ability to customize management reports and employee communications materials to meet the State's specific requirements.
- ◆ Capability to handle the retiree population including split family enrollments in the Medicare and non-Medicare programs.
- ◆ Integrated on-line systems to facilitate timely eligibility reporting and claim payments.
- ◆ Ability to provide a service area that encompasses the entire state of Connecticut.
- ◆ Ability to duplicate the State's proposed plan designs.
- ◆ Recognized commitment and dedication to affirmative action

SECTION V

SUMMARY PLAN DESIGNS

This section contains summary plan outlines of the requested health care programs.

Medical

In State Plans

- ✓ POS
- ✓ POE – Non-Gated
- ✓ POE – Gated
- ✓ Medicare Carveout for each plan above

Out-of-State Plans

- ✓ Out-of-State PPO
- ✓ A plan that supplements Medicare
- ✓ Medicare Carveout for Out-of-State PPO plan (as an alternative to the plan supplements Medicare)

Note: All Connecticut State Mandated benefits are currently included in the medical plans. It is expected that all Connecticut State Mandated benefits will continue to be included.

Dental

- ✓ Indemnity (with and without a PPO network)
- ✓ Dental HMO

Summary plan descriptions are included in the appendices.

POS Plan

Benefit Features	In-Network	Out-of-Network
Deductible		
Individual	None	\$300
Family (3 or more)	None	\$900
Out-of-Pocket Maximums		
Individual	None	\$2,000 (plus deductible)
Family	None	\$4,000 (plus deductible)
Coinsurance	None	20% of allowable charge
Lifetime Maximum	None	None
Outpatient Physician Visits	\$10 *	80%
Preventive Care	\$10 *(no copay for well-child and immunizations)	80%
Family Planning		
Oral Contraceptives	Covered under Rx	Covered under Rx
Vasectomy	100%	80%
Tubal Ligation	100%	80%
Inpatient Physician	100% (pre-cert req.)	80% (pre-cert req.)
Inpatient Hospital	100% (pre-cert req.)	80% (pre-cert req.)
Outpatient Surgical Facility	100% (pre-cert req.)	80% (pre-cert req.)
Ambulance	100% (if emergency)	100% (if emergency)
Pre-adm. Cert/Concurrent Rev	Through MD	Penalty of 20% up to \$500
Prescription Drug	\$3 generic/ \$6 brand	80%
Mental Health	Pre-cert req.	Pre-cert req
Inpatient	100%	80%

* Note that Retirees who retired prior to 6/1/1999 maintain an office visit copay of \$5

POS Plan (cont.)

Benefit Features	POS In-Network	POS Out-of-Network
Outpatient	\$10 copayment	80%
Substance Abuse	Pre-cert req.	Pre-cert req.
Detoxification	100%	80%
Inpatient	Drug: 100% Alcohol: 100%	Drug: 80% Alcohol: 80%
Outpatient	100%	80%
Skilled Nursing Facility	100%, (pre-cert req.)	80%, up to 60 days/yr. (pre-cert req.)
Home Health Care	100%, (pre-cert req.)	80%, up to 200 visits/yr. (pre-cert req.)
Hospice	100% (pre-cert req.)	80%, up to 60 days (pre-cert req.)
ST Rehab and Physical Therapy	100%	80%, up to 60 inpt. days, 30 outpt. days per cond/yr.
Diagnostic X-Ray and lab	100%	80%
Pre-Admission Testing	100%	80%
Emergency Care	100% if emergency	100% if emergency
Durable Medical Equipment	100% (pre-cert req.)	80% (pre-cert req.)
Prosthetics	100% (pre-cert req.)	80% (pre-cert req.)
Routine Eye Exam	\$15, 1 exam per year	50%, 1 exam every 2 years
Audiological Screening	\$15, 1 exam per year	80%, 1 exam per year

POE Non-Gated and POE Gated Plans

Benefit Features	POE
Deductible	
Individual	None
Family	None
Out-of-Pocket Maximums	
Individual	None
Family	None
Coinsurance	None
Lifetime Maximum	None
Outpatient Physician Visits	\$5
Preventive Care	\$5 (no copay for well-child and immunizations)
Family Planning	
Oral Contraceptives	Covered under Rx
Vasectomy	100%
Tubal Ligation	100%
Inpatient Physician	100% (pre-cert req.)
Inpatient Hospital	100% (pre-cert req.)
Outpatient Surgical Facility	100% (pre-cert req.)
Ambulance	100% (if emergency)
Pre-adm. Cert/Concurrent Rev	Through MD
Prescription Drug	\$3 generic/ \$6 brand
Mental Health	Pre-cert req.
Inpatient	100%

POE Non-Gated and POE Gated Plans (cont.)

Benefit Features	POE
Outpatient	\$5 copayment
Substance Abuse	Pre-cert req.
Detoxification	100%
Inpatient	Drug: 100% Alcohol: 100%
Outpatient	100%
Skilled Nursing Facility	100%, (pre-cert req.)
Home Health Care	100%, (pre-cert req.)
Hospice	100% (pre-cert req.)
ST Rehab and Physical Therapy	100%
Diagnostic X-Ray and lab	100%
Pre-Admission Testing	100%
Emergency Care	100% if emergency
Durable Medical Equipment	100% (pre-cert req.)
Prosthetics	100% (pre-cert req.)
Routine Eye Exam	\$15, 1 exam per year
Audiological Screening	\$15, 1 exam per year

Out of State-PPO Plan

Benefit Features	In-Network	Out-of-Network
Deductible		
Individual	None	\$300
Family (3 or more)	None	\$900
Out-of-Pocket Maximums		
Individual	None	\$2,000 (plus deductible)
Family	None	\$4,000 (plus deductible)
Coinsurance	None	20% of allowable charge
Lifetime Maximum	None	None
Outpatient Physician Visits	\$10*	80%
Preventive Care	\$10* (no copay for well-child and immunizations)	80%
Family Planning		
Oral Contraceptives	Covered under Rx	Covered under Rx
Vasectomy	100%	80%
Tubal Ligation	100%	80%
Inpatient Physician	100% (pre-cert req.)	80% (pre-cert req.)
Inpatient Hospital	100% (pre-cert req.)	80% (pre-cert req.)
Outpatient Surgical Facility	100% (pre-cert req.)	80% (pre-cert req.)
Ambulance	100% (if emergency)	100% (if emergency)
Pre-adm. Cert/Concurrent Rev	Through MD	Penalty of 20% up to \$500
Prescription Drug	\$3 generic/ \$6 brand	80%
Mental Health	Pre-cert req.	Pre-cert req.
Inpatient	100%	80%

* Note that Retirees who retired prior to 6/1/1999 maintain an office visit copay of \$5

Out of State-PPO Plan (cont.)

Benefit Features	In-Network	Out-of-Network
Outpatient	\$10 copayment	80%
Substance Abuse	Pre-cert req.	Pre-cert req.
Detoxification	100%	80%
Inpatient	Drug: 100% Alcohol: 100%	Drug: 80% Alcohol: 80%
Outpatient	100%	80%
Skilled Nursing Facility	100%, (pre-cert req.)	80%, up to 60 days/yr. (pre-cert req.)
Home Health Care	100%, (pre-cert req.)	80%, up to 200 visits/yr. (pre-cert req.)
Hospice	100% (pre-cert req.)	80%, up to 60 days (pre-cert req.)
ST Rehab and Physical Therapy	100%	80%, up to 60 inpt. days, 30 outpt. days per cond/yr.
Diagnostic X-Ray and lab	100%	80%
Pre-Admission Testing	100%	80%
Emergency Care	100% if emergency	100% if emergency
Durable Medical Equipment	100% (pre-cert req.)	80% (pre-cert req.)
Prosthetics	100% (pre-cert req.)	80% (pre-cert req.)
Routine Eye Exam	\$15, 1 exam per year	50%, 1 exam every 2 years
Audiological Screening	\$15, 1 exam per year	80%, 1 exam per year

Out-of-State for Medicare Retiree Plan: Refer to the plan summaries for details.

Dental Plans

Benefit Features	Indemnity	Dental HMO
Diagnostic & Preventative		
<i>Exam</i>	80%	100%
<i>X-Ray</i>	80%	100%
Restorative		
<i>Fillings</i>	80% ⁱ	100%
<i>Oral Surgery</i>	67%	100%
Orthodontia		
Children Under 19	Not Covered	\$1,440 coinsurance for 24 months of coverage ⁱⁱ
Adults 19 and older	Not Covered	\$2,070 coinsurance for 24 months of coverage ⁱⁱ

Indemnity Rider B (Dental – Prosthodontics) – Applies to Judges Only

Prosthetic services consisting of the following will be covered at 50% coinsurance

- Dentures, full and partial
- Bridges, fixed (including bridge abutments and pontics) and removable
- Addition of teeth to partial dentures to replace extracted teeth

Additional Covered Services

- Additional covered services for the Indemnity plan are outlined in the plan summary document, which can be found in the appendices.
- Additional covered services for the HMO are outlined in the fee schedule, which can be found in the appendices.

ⁱ For fillings and crowns on molars, the least expensive equally effective procedure will be reimbursed

ⁱⁱ Additional charges may apply for other orthodontic services such as evaluation, treatment plan, records, etc.

SECTION VI

HISTORICAL FINANCIAL DATA

The file attachments contain the following additional information.

Medical

- Monthly enrollment
- Monthly paid claims experience
- Monthly premiums
- Historical premium rates
- Current contribution rates

Dental

- Monthly enrollment
- Monthly paid claims experience
- Monthly premiums
- Historical premium rates
- Current contribution rates

Medical Utilization Statistics

Medical Large Claims Experience

Pharmacy Utilization Statistics

SECTION VII

NETWORK ACCESSIBILITY, PROFILE, AND DISRUPTION ANALYSIS EXHIBITS

NETWORK ACCESSIBILITY

Medical

Active Employees and Retirees – POS, POE Non-Gated, and POE Gated

Exhibits A1 through A10 request GeoAccess summary results by county, out-of-state, and in the aggregate for your POS, POE-NG and POE-G networks. When completing the Exhibits, please note the following:

1. It is assumed that your POS, POE-NG, and POE-G networks are identical. If this is not the case, a separate set of Exhibits must be completed for each network offered.
2. The mapping is to be based on all employees and retirees who are currently participating in the State's health plan. **Do not exclude employees not in a network service area.**
3. The access standards are as follows:

Provider Group	Access Standards
Primary Care Physicians*	1 in 10 miles
OB/Gyn	1 in 15 miles
Pediatricians	1 in 15 miles
All Other Specialists	1 in 15 miles
Hospitals	1 in 15 miles

***Primary care physicians include internists, family practitioners, OB/Gyns, pediatricians, and generalists.**

Prescription Drug

Active Employees and Retirees

Exhibits B1 and B2 request GeoAccess summary results by county, Out-of-State, and in the aggregate for your retail pharmacy networks. When completing the Exhibits, please note the following:

1. The mapping is based on all employees and retirees currently participating in the State’s health plan.
2. Provide mapping for your Broad (Exhibit B1) and Select (Exhibit B2) networks (if applicable). **Do not exclude employees not in a network service area.**
3. The access standard for both networks is 1 pharmacy within 10 miles.

Dental

Active Employees and Retirees

Exhibits C1 through C10 request GeoAccess summary results by county, Out-of-State, and in the aggregate for your HMO and PPO based dental networks. When completing the Exhibits, please note the following:

1. The mapping is to be based on all employees and retirees currently participating in the State’s dental plan. **Do not exclude employees not in a network service area.**
2. The access standards are as follows:

Provider Group	Access Standards
Generalists	1 in 10 miles
Endodontists	1 in 15 miles
Periodontists	1 in 15 miles
Orthodontists	1 in 15 miles
All Other Specialists	1 in 15 miles

NETWORK PROFILE**Medical**

Exhibit D is a request for provider and service area information with respect to your managed medical networks.

Retail Pharmacy

Exhibit E is a request for pharmacy and service area information with respect to your retail pharmacy networks.

Dental

Exhibit F is a request for provider and service area information with respect to your managed dental care networks.

DISRUPTION ANALYSIS**Medical**

Please note that Deloitte & Touche will be performing the disruption analysis for the current plans. In order to perform this analysis, Deloitte and Touche will require each Health Plan to provide a file containing all network providers, including provider tax ID number and provider name.

Dental

Please note that Deloitte & Touche will be performing the disruption analysis for the current plans. In order to perform this analysis, Deloitte and Touche will require each Health Plan to provide a file containing all network providers, including provider tax ID number and provider name.

Exhibit A1: POS/POE-NG/POE-G Medical Network

**Actives and Retirees
Fairfield County**

	Employees Within Access Standard				Employees Outside of Access Standard				Employees Without Network Access		
	Average Distance in Miles to:				Average Distance in Miles to:						
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
PCPs *											
• Internists/FP/Generalists											
• OB/Gyns Only											
• Pediatricians Only											
All Other Spec. (non-PCP)											
Hospitals											

*Primary care physicians include internists, family practitioners, OB/Gyns, pediatricians, and generalists.

Exhibit A2: POS/POE-NG/POE-G Medical Network

**Actives and Retirees
Hartford County**

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
PCPs *											
• Internists/FP/Generalists											
• OB/Gyns Only											
• Pediatricians Only											
All Other Spec. (non-PCP)											
Hospitals											

*Primary care physicians include internists, family practitioners, OB/Gyns, pediatricians, and generalists.

Exhibit A3: POS/POE-NG/POE-G Medical Network

**Actives and Retirees
Litchfield County**

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
PCPs *											
• Internists/FP/Generalists											
• OB/Gyns Only											
• Pediatricians Only											
All Other Spec. (non-PCP)											
Hospitals											

*Primary care physicians include internists, family practitioners, OB/Gyns, pediatricians, and generalists.

Exhibit A4: POS/POE-NG/POE-G Medical Network

**Actives and Retirees
Middlesex County**

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
PCPs *											
• Internists/FP/Generalists											
• OB/Gyns Only											
• Pediatricians Only											
All Other Spec. (non-PCP)											
Hospitals											

*Primary care physicians include internists, family practitioners, OB/Gyns, pediatricians, and generalists.

Exhibit A5: POS/POE-NG/POE-G Medical Network

**Actives and Retirees
New Haven County**

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
PCPs *											
• Internists/FP/Generalists											
• OB/Gyns Only											
• Pediatricians Only											
All Other Spec. (non-PCP)											
Hospitals											

*Primary care physicians include internists, family practitioners, OB/Gyns, pediatricians, and generalists.

Exhibit A6: POS/POE-NG/POE-G Medical Network

**Actives and Retirees
New London County**

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
PCPs *											
• Internists/FP/Generalists											
• OB/Gyns Only											
• Pediatricians Only											
All Other Spec. (non-PCP)											
Hospitals											

*Primary care physicians include internists, family practitioners, OB/Gyns, pediatricians, and generalists.

Exhibit A7: POS/POE-NG/POE-G Medical Network

**Actives and Retirees
Tolland County**

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
PCPs *											
• Internists/FP/Generalists											
• OB/Gyns Only											
• Pediatricians Only											
All Other Spec. (non-PCP)											
Hospitals											

*Primary care physicians include internists, family practitioners, OB/Gyns, pediatricians, and generalists.

Exhibit A8: POS/POE-NG/POE-G Network

**Actives and Retirees
Windham County**

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
PCPs *											
• Internists/FP/Generalists											
• OB/Gyns Only											
• Pediatricians Only											
All Other Spec. (non-PCP)											
Hospitals											

*Primary care physicians include internists, family practitioners, OB/Gyns, pediatricians, and generalists.

Exhibit A9: POS/POE-NG/POE-G Medical Network

Actives and Retirees

All Employees and Retirees Combined Exhibit

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
PCPs *											
• Internists/FP/Generalists											
• OB/Gyns Only											
• Pediatricians Only											
All Other Spec. (non-PCP)											
Hospitals											

*Primary care physicians include internists, family practitioners, OB/Gyns, pediatricians, and generalists.

**Exhibit A10: PPO Network
Actives and Retirees
Out-of-State**

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
PCPs *											
• Internists/FP/Generalists											
• OB/Gyns Only											
• Pediatricians Only											
All Other Spec. (non-PCP)											
Hospitals											

*Primary care physicians include internists, family practitioners, OB/Gyns, pediatricians, and generalists.

Exhibit B1: Retail Pharmacy Network

**All Employees and Retirees
Broad Network**

County	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access # of Employees without Network Access
	# of Employees within Access Standard	Average Distance in Miles to:				# of Employees outside Access Standard	Average Distance in Miles to:				
		1 Pharmacy	2 Pharmacies	3 Pharmacies	4 Pharmacies		1 Pharmacy	2 Pharmacies	3 Pharmacies	4 Pharmacies	
Fairfield											
Hartford											
Litchfield											
Middlesex											
New Haven											
New London											
Tolland											
Windham											
Out-of-State											
TOTAL											

Exhibit B2: Retail Pharmacy Network

**All Employees and Retirees
Select Network**

County	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	# of Employees within Access Standard	Average Distance in Miles to:				# of Employees outside Access Standard	Average Distance in Miles to:				
		1 Pharmacy	2 Pharmacies	3 Pharmacies	4 Pharmacies		1 Pharmacy	2 Pharmacies	3 Pharmacies	4 Pharmacies	# of Employees without Network Access
Fairfield											
Hartford											
Litchfield											
Middlesex											
New Haven											
New London											
Tolland											
Windham											
Out-of-State											
TOTAL											

**Exhibit C1: Dental Networks
Actives and Retirees
Fairfield County**

HMO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

PPO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

**Exhibit C2: Dental Networks
Actives and Retirees
Hartford County**

HMO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

PPO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

**Exhibit C3: Dental Networks
Actives and Retirees
Litchfield County**

HMO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

PPO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

**Exhibit C4: Dental Networks
Actives and Retirees
Middlesex County**

HMO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

PPO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

**Exhibit C5: Dental Networks
Actives and Retirees
New Haven County**

HMO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

PPO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

**Exhibit C6: Dental Networks
Actives and Retirees
New London County**

HMO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

PPO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

**Exhibit C7: Dental Networks
Actives and Retirees
Tolland County**

HMO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

PPO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

**Exhibit C8: Dental Networks
Actives and Retirees
Windham County**

HMO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

PPO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

**Exhibit C9: Dental Networks
Actives and Retirees
All Employees and Retirees Combined Exhibit**

HMO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

PPO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

**Exhibit C10: Dental Networks
Actives and Retirees
Out-of-State**

HMO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

PPO Network

	Employees Within Access Standard					Employees Outside of Access Standard					Employees Without Network Access
	Average Distance in Miles to:					Average Distance in Miles to:					
	# of Employees within Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees outside Access Standard	1 Provider	2 Providers	3 Providers	4 Providers	# of Employees without Network Access
Generalists											
Endodontists											
Periodontists											
Orthodontists											
All Other Specialists											

Exhibit D: Medical Network Profiles

Please complete a medical network profile for your Connecticut Network by identifying the number of providers by category. If your POS, POE-NG, and POE-G networks are not identical, case, a separate set of Exhibits must be completed for each network offered.

	Fairfield	Hartford	Litchfield	Middlesex	New Haven	New London	Tolland	Windham	Connecticut Total
PCPs *									
• Internists/FP/Generalists									
• OB/Gyns Only									
• Pediatricians Only									
All Other Spec. (non-PCP)									
Lab and X-ray Facilities									
Hospitals									

*Primary care physicians include internists, family practitioners, OB/Gyns, pediatricians, and generalists.

Exhibit E: Retail Pharmacy Network Profile

Please complete a network profile for your Connecticut Networks and National Networks by identifying the number of pharmacies.

Broad Network

Fairfield	Hartford	Litchfield	Middlesex	New Haven	New London	Tolland	Windham	Connecticut Total	National Total

Select Network

Fairfield	Hartford	Litchfield	Middlesex	New Haven	New London	Tolland	Windham	Connecticut Total	National Total

Exhibit F: Dental Network Profile

Please complete a HMO and a PPO dental network profile for your Connecticut Networks.

HMO Network

	Fairfield	Hartford	Litchfield	Middlesex	New Haven	New London	Tolland	Windham	Connecticut Total
Generalists									
Endodontists									
Periodontists									
Orthodontists									
All Other Specialists									

PPO Network

	Fairfield	Hartford	Litchfield	Middlesex	New Haven	New London	Tolland	Windham	Connecticut Total
Generalists									
Endodontists									
Periodontists									
Orthodontists									
All Other Specialists									

SECTION VIII

FINANCIAL BID RESPONSE EXHIBITS

Complete the attached exhibits based on the coverages (medical, prescription drug and/or dental) you are proposing. *Note: All fully insured rates should be based on the rate tier relationships outlined in Section II (page 7).*

GENERAL

Exhibit 1 - Deviations from Specifications

All deviations from the specifications and other standards included in this RFP must be clearly defined. This Exhibit must be signed by an Officer of your organization. In the absence of any identified deviations, your organization will be bound to all of the terms and conditions outlined in the RFP.

MEDICAL

Exhibit 2– Medical Rate Summary: Fully Insured and Non-Dividend Eligible

This exhibit requests your monthly fully insured rates for active and retired employees. Insured rates must be provided for each plan type quoted. Rates should be quoted both with and without prescription drug coverage.

Exhibit 3 - Medical Rate Change Values

This exhibit requests the impact on premium rates of various rating alternatives.

Exhibit 4 – Medical Retention Summary: Fully Insured and Dividend Eligible

This exhibit requests an illustration of your fully insured retention development.

Exhibit 5 – Medical Rating Practices

This exhibit requests additional information with respect to your retention and other experience rating practices.

Exhibit 6 – Medical R&C and Network Charges

This exhibit requests R&C and network charges for several medical procedures and zip codes, as well as overall state physician discount levels.

Exhibit 7 – Hospital Per Diem Charges and R&C Discounts

This exhibit requests per diem charges and R&C discounts for the State’s most utilized hospitals, as well as overall State hospital discount levels.

PRESCRIPTION DRUG**Exhibit 8– Prescription Drug Rate Summary: Fully Insured and Non-Dividend Eligible**

The exhibit requests your monthly fully insured rates for active and retired employees. Insured rates must be provided for your Broad and Select networks, if applicable.

Exhibit 9– Prescription Drug Retention Summary: Fully Insured and Dividend Eligible

This exhibit requests an illustration of your fully insured retention development.

Exhibit 10– Prescription Drug Rating Practices

This exhibit requests additional information with respect to your retention and other experience rating practices.

Exhibit 11 – Prescription Drug Ingredient Discounts, Administration and Dispensing Fees

This exhibit requests your negotiated ingredient discounts, administration and dispensing fees.

Exhibit 12 – Prescription Drug Average Retail Pricing Summary

This exhibit requests your average retail price before discount, average wholesale price and average price after discount.

Exhibit 13 – Prescription Drug Average Retail Pricing Summary

This exhibit requests your average mail order price before discount, average wholesale price and average price after discount.

DENTAL**Exhibit 14 – Dental Rate Summary: Fully Insured and Non-Dividend Eligible**

This exhibit requests your monthly fully insured rates for active and retired employees. Insured rates must be provided for each plan type quoted.

Exhibit 15 - Dental Rates: Plan Change Values

This exhibit requests the impact of various plan design and rating alternatives.

Exhibit 16 – Dental Retention Summary: Fully Insured and Dividend Eligible

This exhibit requests an illustration of your fully insured retention development.

Exhibit 17 – Dental Rating Practices

This exhibit requests additional information with respect to your retention and other experience rating practices.

Exhibit 18 – Dental R&C and PPO Network Charges

This exhibit requests R&C and PPO network charges for several dental procedures and zip codes, as well as overall state provider discount levels.

Exhibit 1 - Deviations from Specifications

I hereby certify that _____ has reviewed the terms of the
(Health Plan)

Request for Proposal for the State of Connecticut and agrees to honor those terms as described in the Bid Specifications.

Name (signature of Corporate Officer)

Date

Title

Exhibit 2 – Medical Rate Summary: Fully Insured and Non-Dividend Eligible

Active Employees

	July 1, 2003 through June 30, 2004		July 1, 2004 through June 30, 2005	
	With Prescription Drugs	Without Prescription Drugs	With Prescription Drugs	Without Prescription Drugs
POS				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
✓ FLES	\$ _____	\$ _____	\$ _____	\$ _____
POE Non-Gated				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
✓ FLES	\$ _____	\$ _____	\$ _____	\$ _____
POE Gated				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
✓ FLES	\$ _____	\$ _____	\$ _____	\$ _____
Out-of-State				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
✓ FLES	\$ _____	\$ _____	\$ _____	\$ _____

The above rates are to be guaranteed for a minimum of two years (i.e., July 1, 2003 through June 30, 2005) and only include claim service dates incurred on or after the effective date.

Exhibit 2 – Medical Rate Summary: Fully Insured and Non-Dividend Eligible

Non-Medicare Retirees

	July 1, 2003 through June 30, 2004		July 1, 2004 through June 30, 2005	
	With Prescription Drugs	Without Prescription Drugs	With Prescription Drugs	Without Prescription Drugs
POS - \$5 Office Visit (Retired Prior to 6/1/99)				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
POS - \$10 Office Visit (Retired After 6/1/99)				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
POE Non-Gated				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
POE Gated				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
Out-of-State				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____

The above rates are to be guaranteed for a minimum of two years (i.e., July 1, 2003 through June 30, 2005) and only include claim service dates incurred on or after the effective date.

Exhibit 2 – Medical Rate Summary: Fully Insured and Non-Dividend Eligible

Medicare Retirees

	July 1, 2003 through June 30, 2004		July 1, 2004 through June 30, 2005	
	With Prescription Drugs	Without Prescription Drugs	With Prescription Drugs	Without Prescription Drugs
POS - \$5 Office Visit (Retired Prior to 6/1/99)				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
POS - \$10 Office Visit (Retired After 6/1/99)				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
POE Non-Gated				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
POE Gated				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
Out-of-State				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____

The above rates are to be guaranteed for a minimum of two years (i.e., July 1, 2003 through June 30, 2005) and only include claim service dates incurred on or after the effective date.

Exhibit 3 – Medical Rate Change Values

1. Will you provide a three year rate guarantee or third year rate cap? If so, please provide details.
2. What would be the percentage change to your quoted premium rates under each of the following scenarios?

A. The program were insured on a fully insured and dividend eligible basis (if you are contractually licensed to offer).

_____ %

B. You were awarded all medical plans on an exclusive, sole health plan basis.

_____ %

C. You were awarded both the medical (not on an exclusive basis) and dental coverages.

_____ %

D. You were awarded both the medical (on an exclusive basis) and dental coverages.

_____ %

Exhibit 4 – Medical Retention Summary: Fully Insured and Dividend Eligible

	With Prescription Drugs	Without Prescription Drugs
Premium		
A. Total Annual Premium	100%	100%
Incurred Claims		
Total Paid Claims	_____ %	_____ %
IBNR Reserves Change	_____ %	_____ %
Accumulated IBNR Reserves	_____ %	_____ %
B. Total Incurred Claims	_____ %	_____ %
Retention		
Premium Tax ⁽¹⁾	0%	0%
Administration	_____ %	_____ %
Risk and Profit	_____ %	_____ %
Interest Credit	_____ %	_____ %
C. Total Retention	_____ %	_____ %
D. Balance (A-B-C)	_____ %	_____ %

Please provide the percentage of total premium, which the above items represent.

⁽¹⁾ The State of Connecticut is exempt from state premium tax.

Exhibit 5 – Medical Rating Practices

Please respond to the following questions with respect to your experience rating practices.

1. Are your retention charges guaranteed?
2. What credibility factor will you assign to the State's experience in the first renewal?
3. How are IBNR reserves calculated initially and in subsequent policy years?
4. What are your current interest rates for the following?
 - IBNR reserves _____ %
 - Positive cash flow _____ %
 - Negative cash flow _____ %
5. What are your current POS, POE-NG, POE-G, and PPO trend rates for prospective rate setting purposes?
6. What is the claim fluctuation margin allocation included in your quoted premium rates? How much will be included in subsequent renewals?
7. Confirm that there is no specific allocation for deficit recovery in your renewal rating formula for your fully insured non-dividend eligible arrangement.
8. For your fully insured dividend eligible funding arrangement, how do you handle premium deficits in the renewal rating? For example: Is there a specific allocation for deficit recovery? Is it limited to a predetermined percentage? Please describe.
9. Do you anticipate renegotiating provider contract in the next 12 to 24 months? If so, please describe the planned changes and anticipated impact on your book-of-business premium rates.
10. Please provide a history of the average change in State Insurance Department filed premium rates for your Non-Medicare book-of-business for the last 3 calendar years for your POS, POE-NG, POE-G, and PPO.
11. Provide your Per Employee /Retiree administrative fees by product for an Administrative Services Only contract on a basis with and without prescription drugs.
12. Under a self-insured arrangement, would your projected paid claims differ than those illustrated in Exhibit 4? If yes, please indicate the reason(s) and the estimated impact. (Note: if you are not legally able to offer a dividend eligible funding arrangement, please answer this question based on your non-dividend eligible retention charges.)
13. What would be the reduction to quoted premium rates if they were guaranteed for one year (i.e., July 1, 2003 through June 30, 2004)?

Exhibit 6 – Medical R&C and Network Charges

PROCEDURE	CODE	Hartford: 06101-80		New Haven: 06501-25		Stamford: 06901-22	
		R&C 80th%	Network Fee	R&C 80th%	Network Fee	R&C 80th%	Network Fee
Normal Delivery	59400	\$	\$	\$	\$	\$	\$
Cesarean Section	59510	\$	\$	\$	\$	\$	\$
Hysterectomy	58150	\$	\$	\$	\$	\$	\$
Hospital Visit (intermed)	99231	\$	\$	\$	\$	\$	\$
Office Visit	99214	\$	\$	\$	\$	\$	\$
Sonogram	76805	\$	\$	\$	\$	\$	\$
Proctosigmoidoscopy	45300	\$	\$	\$	\$	\$	\$
Angioplasty	33502	\$	\$	\$	\$	\$	\$
Tonsillectomy	42826	\$	\$	\$	\$	\$	\$
Appendectomy	44950	\$	\$	\$	\$	\$	\$
Triple Coronary Bypass	33512	\$	\$	\$	\$	\$	\$
Blood Glucose	82947	\$	\$	\$	\$	\$	\$

Connecticut Network Average

Physicians	Discount Off R&C
• Primary Care	_____ %
• Specialists	_____ %
Ancillary Providers	_____ %

Exhibit 7 – Hospital Per Diem Charges and R&C Discounts

	Per Diem Charges			Composite Discount (Off R&C)	
	Medical or Surgical	OB/Gyn	Intensive Care	Inpatient Discount	Outpatient Discount
Hartford Hospital	\$ _____	\$ _____	\$ _____	_____ %	_____ %
Hospital of St. Raphael	\$ _____	\$ _____	\$ _____	_____ %	_____ %
Lawrence & Memorial Hospital	\$ _____	\$ _____	\$ _____	_____ %	_____ %
Middlesex Hospital	\$ _____	\$ _____	\$ _____	_____ %	_____ %
New Britain General Hospital	\$ _____	\$ _____	\$ _____	_____ %	_____ %
St. Francis Hospital	\$ _____	\$ _____	\$ _____	_____ %	_____ %
UCONN/John Dempsey Hospital	\$ _____	\$ _____	\$ _____	_____ %	_____ %
Waterbury Hospital	\$ _____	\$ _____	\$ _____	_____ %	_____ %
William Backus Hospital	\$ _____	\$ _____	\$ _____	_____ %	_____ %
Yale New Haven Hospital	\$ _____	\$ _____	\$ _____	_____ %	_____ %
Network Average – Connecticut	\$ _____	\$ _____	\$ _____	_____ %	_____ %

Exhibit 8 – Prescription Drug Rate Summary: Fully Insured and Non-Dividend Eligible

Active Employees

	July 1, 2003 through June 30, 2004		July 1, 2003 through June 30, 2004	
	Broad Network	Select Network	Broad Network	Select Network
POS				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
✓ FLES	\$ _____	\$ _____	\$ _____	\$ _____
POE Non-Gated				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
✓ FLES	\$ _____	\$ _____	\$ _____	\$ _____
POE Gated				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
✓ FLES	\$ _____	\$ _____	\$ _____	\$ _____
Out-of-State				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
✓ FLES	\$ _____	\$ _____	\$ _____	\$ _____

The above rates are to be guaranteed for a minimum of two years (i.e., July 1, 2003 through June 30, 2005) and only include claim service dates incurred on or after the effective date.

Exhibit 8 – Prescription Drug Rate Summary: Fully Insured and Non-Dividend Eligible

Non-Medicare Retirees

	July 1, 2003 through June 30, 2004		July 1, 2003 through June 30, 2004	
	Broad Network	Select Network	Broad Network	Select Network
POS				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
POE Non-Gated				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
POE Gated				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
Out-of-State				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____

The above rates are to be guaranteed for a minimum of two years (i.e., July 1, 2003 through June 30, 2005) and only include claim service dates incurred on or after the effective date.

Exhibit 8 – Prescription Drug Rate Summary: Fully Insured and Non-Dividend Eligible

Medicare Retirees

	July 1, 2003 through June 30, 2004		July 1, 2003 through June 30, 2004	
	Broad Network	Select Network	Broad Network	Select Network
POS				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
POE Non-Gated				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
POE Gated				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____
Out-of-State				
✓ Employee only	\$ _____	\$ _____	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____	\$ _____	\$ _____

The above rates are to be guaranteed for a minimum of two years (i.e., July 1, 2003 through June 30, 2005) and only include claim service dates incurred on or after the effective date.

Exhibit 9 – Prescription Drug Retention Summary: Fully Insured and Dividend Eligible

Premium

<i>A. Total Annual Premium</i>	100%
--------------------------------	------

Incurred Claims

Total Paid Claims	_____ %
IBNR Reserves Change	_____ %
Accumulated IBNR Reserves	_____ %
<i>B. Total Incurred Claims</i>	_____ %

Retention

Premium Tax ⁽¹⁾	0%
Administration	_____ %
Risk and Profit	_____ %
Interest Credit	_____ %
<i>C. Total Retention</i>	_____ %

<i>D. Balance (A-B-C)</i>	_____ %
---------------------------	---------

Please provide the percentage of total premium, which the above items represent.

⁽¹⁾ The State of Connecticut is exempt from state premium tax.

Exhibit 10 – Prescription Drug Rating Practices

Please respond to the following questions with respect to your experience rating practices.

1. Will you provide a three year rate guarantee or third year rate cap? If so, please provide details.
2. What would be the percentage change to your quoted premium rates if the program were insured on a fully insured and dividend eligible basis?
3. Are your retention charges guaranteed?
4. What credibility factor will you assign to the State's experience in the first renewal?
5. How are IBNR reserves calculated initially and in subsequent policy years?
6. What are your current interest rates for the following?
 - ✓ IBNR Reserves _____ %
 - ✓ Positive cash flow _____ %
 - ✓ Negative cash flow _____ %
7. What is your current trend factor for rating prospective rate setting purposes?
8. What is the claim fluctuation margin allocation included in your quoted premium rates? How much will be included in subsequent renewals?
9. Confirm that there is no specific allocation for deficit recovery in your renewal rating formula for your fully insured non-dividend eligible arrangement.
10. For your fully insured dividend eligible funding arrangement, how do you handle premium deficits in the renewal rating? For example: Is there a specific allocation for deficit recovery? Is it limited to a predetermined percentage? Please describe.
11. Do you anticipate renegotiating provider contracts in the next 12 to 24 months that will have an impact on insured arrangements? If so, please describe the planned changes and anticipated impact on book-of-business premium rates.

Exhibit 10 – Prescription Drug Rating Practices

12. Provide your Per Employee /Retiree administrative fees for an Administrative Services Only contract.
13. Under a self-insured arrangement, would your projected paid claims differ than those illustrated in Exhibit 9? If yes, please indicate the reason(s) and the estimated impact.
14. What would be the reduction to quoted premium rates if they were guaranteed for one year (i.e., July 1, 2003 through June 30, 2004)?
14. What is the average rebate per script (including formulary and non-formulary, retail/mail order scripts) that you will guarantee to the State? Under what circumstances can this figure be higher?
15. The ingredient discounts on Exhibit 11 are straight discounts that are not reflective of other cost savings programs (e.g., UCR, DUR, etc.). What are your “effective” retail/mail/brand/generic discounts that take these programs into consideration? Are you willing to guarantee these levels of savings to the State?
16. What percentage of you retail and mail order drugs (based on a dollar and script count basis) are reimbursed at MAC pricing?

Exhibit 11 – Prescription Drug Ingredient Discounts, Administration and Dispensing Fees

	<i>Select Network</i>	<i>Broad Network</i>
MAIL ORDER		
Ingredient Discounts		
• Name Brand	AWP - _____ %	AWP - _____ %
• Generic	AWP - _____ %	AWP - _____ %
• Generic	MAC - _____ %	MAC - _____ %
Dispensing Fees (per script)		
• Name Brand	\$ _____	\$ _____
• Generic	\$ _____	\$ _____
Administrative Fees (per script)		
• In Network	\$ _____	\$ _____
• Out-of-Network	\$ _____	\$ _____
RETAIL		
Ingredient Discounts		
• Name Brand	AWP - _____ %	AWP - _____ %
• Generic	AWP - _____ %	AWP - _____ %
• Generic	MAC - _____ %	MAC - _____ %
Dispensing Fees (per script)		
• Name Brand	\$ _____	\$ _____
• Generic	\$ _____	\$ _____
Administrative Fees (per script)		
• In Network	\$ _____	\$ _____
• Out-of-Network	\$ _____	\$ _____

***Ingredient discounts should be based on the AWP and MAC discounts only, and should NOT be reflective of UCR, DUR, etc., savings.**

Exhibit 12 – Prescription Drug Average Retail Price Summary

Based on prices as of November 1, 2002, please provide your average retail price before discount, average wholesale price and average price after discount for the following prescription drugs (do not include dispensing fee), based on the quantities specified:

Drug	Average Retail Charge (Before Discount)	Average Wholesale Price	Average Price After Discount* Select Network	Average Price After Discount* Broad Network
Liptor 10mg tablet	\$ _____	\$ _____	\$ _____	\$ _____
Prilosec 20mg cap dr	\$ _____	\$ _____	\$ _____	\$ _____
Lipitor 20mg tablet	\$ _____	\$ _____	\$ _____	\$ _____
Celebrex 200mg cap	\$ _____	\$ _____	\$ _____	\$ _____
Prevacid 30mg cp dr	\$ _____	\$ _____	\$ _____	\$ _____
Aciphex 20mg tb ec	\$ _____	\$ _____	\$ _____	\$ _____
Nexium 40mg cap	\$ _____	\$ _____	\$ _____	\$ _____
Zocor 20mg tablet	\$ _____	\$ _____	\$ _____	\$ _____
Lipitor 40mg tablet	\$ _____	\$ _____	\$ _____	\$ _____
Zoloft 50mg tablet	\$ _____	\$ _____	\$ _____	\$ _____
Vioxx 25mg tablet	\$ _____	\$ _____	\$ _____	\$ _____
Wellbutrin Sr 150mg tablet sa	\$ _____	\$ _____	\$ _____	\$ _____
Paxil 20mg tablet	\$ _____	\$ _____	\$ _____	\$ _____
Zoloft 100mg tablet	\$ _____	\$ _____	\$ _____	\$ _____
Protonix 40mg tab ec	\$ _____	\$ _____	\$ _____	\$ _____

***Based on your quoted discount off of AWP, exclusive of UCR, DUR, etc., savings.**

Exhibit 13 – Prescription Drug Average Mail Order Price Summary

Based on prices as of November 1, 2002, please provide your average mail order price before discount, average wholesale price and average price after discount for the following prescription drugs (do not include dispensing fee), based on the quantities specified:

Drug	Average Retail Charge (Before Discount)	Average Wholesale Price	Average Price After Discount*
Liptor 10mg tablet	\$ _____	\$ _____	\$ _____
Prilosec 20mg cap dr	\$ _____	\$ _____	\$ _____
Lipitor 20mg tablet	\$ _____	\$ _____	\$ _____
Celebrex 200mg cap	\$ _____	\$ _____	\$ _____
Prevacid 30mg cp dr	\$ _____	\$ _____	\$ _____
Aciphex 20mg tb ec	\$ _____	\$ _____	\$ _____
Lamictal 25mg tab	\$ _____	\$ _____	\$ _____
Zocor 20mg tablet	\$ _____	\$ _____	\$ _____
Lipitor 40mg tablet	\$ _____	\$ _____	\$ _____
Pravachol 40mg tab	\$ _____	\$ _____	\$ _____
Vioxx 25mg tablet	\$ _____	\$ _____	\$ _____
Trizivir tablet	\$ _____	\$ _____	\$ _____
Neurontin 300mg cap	\$ _____	\$ _____	\$ _____
Zocor 40mg tablet	\$ _____	\$ _____	\$ _____
Fosamax 70mg tablet	\$ _____	\$ _____	\$ _____

*Based on your quoted discount off of AWP, exclusive of UCR, DUR, etc., savings.

Exhibit 14 – Dental Rate Summary: Fully Insured and Non-Dividend Eligible

Active Employees

	July 1, 2003 through June 30, 2004	July 1, 2004 through June 30, 2005
Indemnity – A & B Riders		
✓ Employee only	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____
✓ FLES	\$ _____	\$ _____
Indemnity – A, B & C Riders		
✓ Employee only	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____
✓ FLES	\$ _____	\$ _____
HMO		
✓ Employee only	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____
✓ FLES	\$ _____	\$ _____

Retired Employees

	July 1, 2003 through June 30, 2004	July 1, 2004 through June 30, 2005
Indemnity		
✓ Employee only	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____
HMO		
✓ Employee only	\$ _____	\$ _____
✓ Employee + one	\$ _____	\$ _____
✓ Family	\$ _____	\$ _____

The above rates are to be guaranteed for a minimum of two years (i.e., July 1, 2003 through June 30, 2005) and only include claim service dates incurred on or after the effective date.

Exhibit 15 – Dental Rates: Plan Change Values

1. Will you provide a three year rate guarantee or third year rate cap? If so, please provide details.

2. What would be the percentage change to your quoted premium rates under each of the following scenarios?
 - A. The program were insured on a fully insured and dividend eligible basis.
_____ %
 - B. You were awarded both dental plans (i.e., HMO and indemnity) on an exclusive basis.
_____ %
 - C. You were awarded the dental HMO on an exclusive basis.
_____ %
 - D. You were awarded both the dental and medical (not on an exclusive basis) coverages.
_____ %
 - E. You were awarded both the dental and medical (on an exclusive basis) coverages.
_____ %
 - F. A “passive” Preferred Provider Organization (i.e., no change in plan coverage levels whether care is rendered in or out-of-network) was added to the indemnity plan.
_____ %
 - G. What would be the reduction to quoted premium rates if they were guaranteed for one year (i.e., July 1, 2003 though June 30, 2004)?

Exhibit 16 – Dental Retention Summary: Fully Insured and Dividend Eligible

Premium

<i>A. Total Annual Premium</i>	100%
--------------------------------	------

Incurred Claims

Total Paid Claims	_____ %
IBNR Reserves Change	_____ %
Accumulated IBNR Reserves	_____ %
<i>B. Total Incurred Claims</i>	_____ %

Retention

Premium Tax ⁽¹⁾	0%
Administration	_____ %
Risk and Profit	_____ %
Interest Credit	_____ %
<i>C. Total Retention</i>	_____ %

<i>D. Balance (A-B-C)</i>	_____ %
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Please provide the percentage of total premium, which the above items each represent.

⁽¹⁾ The State of Connecticut is exempt from state premium tax.

Exhibit 17 – Dental Rating Practices

Please respond to the following questions with respect to your experience rating practices.

1. Are your retention charges guaranteed?
2. What credibility factor will you assign to the State's experience in the first renewal?
3. How are IBNR reserves calculated initially and in subsequent policy years?
4. What are your current interest rates for the following?
 - ✓ IBNR Reserves _____ %
 - ✓ Positive cash flow _____ %
 - ✓ Negative cash flow _____ %
5. What are your current Indemnity, HMO, and PPO trend factors for prospective rate setting purposes?
6. What is the claim fluctuation margin allocation included in your quoted premium rates? How much will be included in subsequent renewals?
7. Confirm that there is no specific allocation for deficit recovery in your renewal rating formula for your fully insured non-dividend eligible arrangement.
8. For your fully insured dividend eligible funding arrangement, how do you handle premium deficits in the renewal rating? For example: Is there a specific allocation for deficit recovery? Is it limited to a predetermined percentage? Please describe.
9. What percentage do capitated arrangements comprise of the total insured HMO rate?
10. Do you anticipate renegotiating provider contracts in the next 12 to 24 months that will have an impact on insured arrangements? If so, please describe the planned changes and anticipated impact on book-of-business premium rates.
10. Under a self-insured arrangement, would your projected paid claims differ than those illustrated in Exhibit 16? If yes, please indicate the reason(s) and the estimated impact.
11. Provide your Per Employee /Retiree administrative fees for an Administrative Services Only contract.

Exhibit 18 – Dental R&C and PPO Network Charges

Procedure Code	Description	Hartford: 06101-80		New Haven: 06501-25		Stamford: 06901-22	
		R&C 80th%	Network Fee	R&C 80th%	Network Fee	R&C 80th%	Network Fee
00120	Periodic Oral Evaluation	\$	\$	\$	\$	\$	\$
00272	Bitewing – Two Films	\$	\$	\$	\$	\$	\$
00220	Intraoral – Periapical – First	\$	\$	\$	\$	\$	\$
00290	Posterior-Anterior or Lateral	\$	\$	\$	\$	\$	\$
00150	Comprehensive Oral Evaluation	\$	\$	\$	\$	\$	\$
00210	Intraoral – Complete Series	\$	\$	\$	\$	\$	\$
00230	Intraoral – Periapical – Each	\$	\$	\$	\$	\$	\$
00330	Panoramic Film	\$	\$	\$	\$	\$	\$
09110	Palliative (Emergency) Treatment	\$	\$	\$	\$	\$	\$
00240	Intraoral – Occlusal Film	\$	\$	\$	\$	\$	\$

Connecticut Network Average

	Discount Off R&C
• Generalists	_____ %
• Specialists	_____ %

QUESTIONNAIRE

*Health Plans are required to respond to all requests for information contained in this questionnaire. All responses must be provided on a diskette and, when possible, provide responses in a brief, bulleted format. This questionnaire will be scored; therefore, it is necessary that you provide **concise** answers. Should there be instances where certain questions are not applicable to your organization or its operations, please so indicate.*

Health Plans must complete the following sections of the questionnaire based on the programs being proposed. Please note that organizations proposing on more than one coverage must answer the general section for each, if they differ. Also, if the medical Health Plan responses differ based on the plan designs, please answer separately for each (e.g. POS, POE, etc.).

	<u>Medical</u>	<u>Prescription Drug</u>	<u>Dental</u>
Part A: General Information	Yes	Yes	Yes
Part B: Medical	Yes	No	No
Part C: Prescription Drug	No	Yes	No
Part D: Dental	No	No	Yes

Note: Where applicable, responses must be based on the specific network, claim office, member service center, etc. that is being proposed for the State.

PART A -- GENERAL INFORMATION

GENERAL

1. In 1,200 words or less, please provide a description of your organization including its managed care philosophy.
2. Include an organizational chart for your company, which illustrates relationships with any parent company, subsidiaries, sister companies and reporting lines.
 1. Attached
 2. Other, please specify
3. Attach your most recent annual report and/or audited financial statement.
 1. Attached
 2. Other, please specify
4. Attach your most recent Insurance Department Annual Statement (calendar year 2001 and first three quarters of 2002).
 1. Attached
 2. Other, please specify

5. Have there been any governmental investigations of your organization due to Medicare fraud? If so, please describe.
 1. Yes
 2. No

6. Has your organization ever been sued regarding your services and, if so, what were the results?
 1. Yes
 2. No

7. Was the employer named? If so, describe.
 1. Yes
 2. No

8. Have you applied for or received any other accreditations (e.g., JCAHO, URAC)? If so, please select all that apply:
 1. JCAHO - Accreditation with Commendation
 2. JCAHO - Accreditation without Type I Recommendations
 3. JCAHO - Accreditation with Type I Recommendations
 4. JCAHO - Provisional Accreditation
 5. JCAHO - Conditional
 6. JCAHO - Preliminary Denial of Accreditation
 7. JCAHO - Accreditation Denied
 8. URAC - Accredited
 9. URAC - Not Accredited
 10. Other, please specify
 11. Not Applicable

9. Please complete the attachment table that provides the address and telephone number for each office (if different) that will provide the following services to the State. This table is in the GENERAL tab.
 1. Completed
 2. Other, Please specify

10. Attach a sample of the master contracts and attendant agreements that would be issued to the State by your organization. Include samples for insured (dividend and non-dividend eligible) and self-insured arrangements.

1. Attached
 2. Other, Please specify
11. Within the past two years, have there been any significant developments in your organization (changes in ownership, merger/acquisition, personnel reorganization, change in business emphasis, etc.)? If so, please describe.
1. Yes
 2. No
12. Within the past two years, have there been any significant changes in your operations (consolidation of claims operations, new customer service center, etc.)? If so, please describe.
1. Yes
 2. No
13. Do you anticipate any changes in your organization's basic ownership structure or any other significant changes in your organization within the next 12 months? If so, please describe.
1. Yes
 2. No
14. Please complete the attachment table of three current and former clients in Connecticut (including contact name and number) that have (had) your quoted products. List the names, types of products (e.g., POS, POE, etc.), number of lives and length of relationship. This table is in the GENERAL tab.
1. Completed
 2. Other, please specify
15. From a premium or membership perspective, please complete the attachment table for your five largest clients in Connecticut. This table is in the GENERAL tab.
1. Completed
 2. Other, please specify

16. Attach an organizational chart showing the key staff member(s) who will handle account management for State's account, and indicate which staff members will be 100% dedicated to State. Include separate charts for each product if the staff varies. Include the following information for **each** of these staff members:
- Name, title, address, telephone number, role on the State account
 - A brief biography, including:
 - Managed care qualifications and experience
 - Length of service with your organization
 - Current account responsibilities
 - Relevant large client experience
1. Attached
 2. Other, Please Specify
17. Specify what percent of time the Senior Account Executive will dedicate to the State's account *after* implementation.
1. <50%
 2. 50% to 60%
 3. 60% to 70%
 4. 70% to 80%
 5. 80% to 90%
 6. 90% to 100%
18. Specify how many meetings per year will the Senior Account Executive meet with the State's benefit staff to discuss plan performance and strategic approaches related to plan management.
1. 12 or more
 2. 10 to 12
 3. 6 to 10
 4. 4 to 6
 5. Less than 4
19. Will the Senior Account Executive be available to meet with the State on an "as needed" basis?
1. Yes
 2. No

20. Describe the implementation process and provide a detailed timetable assuming notice by **March 1, 2003 for a July 1, 2003 implementation**. Also, assume that the State specific communications must be complete by May 1, 2003. Be specific with regards to the following:
- Timing of significant tasks
 - Names and titles of key implementation staff
 - Responsibilities of the State
 - Data requirements (indicate type and format of data required)
 - Transition with incumbent Health Plans
 - Staff assigned to attend open enrollment/educational sessions
21. Provide an attachment of names, titles and responsibilities of account manager and key implementation staff and indicate percentage of time each will dedicate to State during implementation.
1. Attached
 2. Other, please specify
22. How do you recommend the State handle transition of care issues (note: Current health plans will comply with State continuation requirements)? Be specific with respect to pregnancy, hospitalization, chronic/terminal illness, mental health, and prescription drugs.
23. For how long will you authorize non-network care for these conditions? How will you interface with current health plans to assure smooth implementation?
24. Please describe your current appeal process.
25. Would you be willing to establish an outside, independent appeals process for State members?
1. Yes
 2. No
26. Would there be an additional charge for this service? If so, please specify amount.
1. Yes
 2. No
 3. N/A
27. Describe how independence would be assured and how appeals would be expeditiously handled under this proposed independent appeals process.

28. Would you consent to being sued for decisions made by you or your contracted providers regarding medical management decisions?
1. Yes
 2. No
 3. N/A

GENERAL - HIPAA

29. What impact will HIPAA administrative simplification and privacy rules have on your organization's costs and ability to provide services to the State?
30. What services does your organization outsource, or delegate to vendors, that fall under HIPAA's definition of "business partners"?
31. How close is your organization to adopting the HIPAA health data transmission standards? Please include the implementation month, year, and any caveats or comments.
1. Not started
 2. 25% complete
 3. 50% complete
 4. 75% complete
 5. Complete
 6. Other
32. How close is your organization to adopting the HIPAA standardized data elements & medical code sets? Please include the implementation month, year, and any caveats or comments.
1. Not started
 2. 25% complete
 3. 50% complete
 4. 75% complete
 5. Complete
 6. Other

33. How close is your organization to having a designated "privacy official" responsible for the development & implementation of privacy regulations, as well as to answer questions and receive complaints? Please include the implementation month, year, and any caveats or comments.
1. Not started
 2. 25% complete
 3. 50% complete
 4. 75% complete
 5. Complete
 6. Other
34. How close is your organization to having "firewalls" in place between employees handling individually-identifiable health information and other employees? Please include the implementation month, year, and any caveats or comments.
1. Not started
 2. 25% complete
 3. 50% complete
 4. 75% complete
 5. Complete
 6. Other
35. How close is your organization to creating safeguards for information, develop procedures for tracking compliance, and sanctions for noncompliant employees? Please include the implementation month, year, and any caveats or comments.
1. Not started
 2. 25% complete
 3. 50% complete
 4. 75% complete
 5. Complete
 6. Other

36. How close is your organization to having established an "accounting" procedure to track releases of health information? Please include the implementation month, year, and any caveats or comments.
1. Not started
 2. 25% complete
 3. 50% complete
 4. 75% complete
 5. Complete
 6. Other
37. How close is your organization to fully complying with the HIPAA Nondiscrimination rules? Please include the implementation month, year, and any caveats or comments.
1. Not started
 2. 25% complete
 3. 50% complete
 4. 75% complete
 5. Complete
 6. Other

GENERAL – FINANCIAL HISTORY

38. Your organization is:
1. Publicly Traded
 2. Privately Held
 3. Other, please specify

39. If Publicly traded, enter the price per share: (if not publicly traded enter 0 for each option and write N/A in the detailed response box.)
1. End of 3rd Quarter 2002
 2. End of 2nd Quarter of 2002
 3. End of 1st Quarter of 2002
 4. End of 4th Quarter of 2001
 5. End of 3rd Quarter of 2001
 6. End of 2nd Quarter of 2001
 7. End of 1st Quarter of 2001
 8. End of 4th Quarter of 2000
40. If Publicly traded, enter the earnings per share: (if not publicly traded enter 0 for each option and write N/A in the detailed response box.)
1. End of 3rd Quarter 2002
 2. End of 2nd Quarter of 2002
 3. End of 1st Quarter of 2002
 4. End of 4th Quarter of 2001
 5. End of 3rd Quarter of 2001
 6. End of 2nd Quarter of 2001
 7. End of 1st Quarter of 2001
 8. End of 4th Quarter of 2000

41. If Publicly traded, enter the percentage of ownership: (if not publicly traded enter 0 for each option and write N/A in the detailed response box.)
1. End of 3rd Quarter 2002
 2. End of 2nd Quarter of 2002
 3. End of 1st Quarter of 2002
 4. End of 4th Quarter of 2001
 5. End of 3rd Quarter of 2001
 6. End of 2nd Quarter of 2001
 7. End of 1st Quarter of 2001
 8. End of 4th Quarter of 2000
42. If not publicly traded, your organization is:
1. For-Profit
 2. Not-for-Profit
 3. Not Applicable
43. If for-profit, what are the names of the top five shareholders? If not applicable, respond with N/A.
44. If not-for-profit, complete the table below. (If table does not apply enter 0s and write N/A in the detailed response box)
1. Net Profit / Loss through first nine months 2002
 2. Net Profit / Loss 2001
 3. Net Profit / Loss 2000
 4. Net Profit / Loss 1999
45. If not-for-profit, is your organization seeking to change to for-profit status in 2003 or 2004?
1. Yes
 2. No
 3. Not Applicable

46. Provide your CURRENT RATIO for fiscal year-end financials for the following years:
1. Fiscal Year ended 1999/2000 (or CY 2000)
 2. Fiscal Year ended 2000/2001 (or CY 2001)
 3. Fiscal Year ended 2001/2002 (or first nine months 2002)
47. Provide your SALES / WORKING CAPITAL RATIO for fiscal year-end financials for the following years:
1. Fiscal Year ended 1999/2000 (or CY 2000)
 2. Fiscal Year ended 2000/2001 (or CY 2001)
 3. Fiscal Year ended 2001/2002 (or first nine months 2002)
48. Provide your RETURN ON EQUITY for fiscal year-end financials for the following years:
1. Fiscal Year ended 1999/2000 (or CY 2000)
 2. Fiscal Year ended 2000/2001 (or CY 2001)
 3. Fiscal Year ended 2001/2002 (or first nine months 2002)
49. Provide your G&A EXPENSES AS A % OF TOTAL PREMIUM for fiscal year-end financials for the following years:
1. Fiscal Year ended 1999/2000 (or CY 2000)
 2. Fiscal Year ended 2000/2001 (or CY 2001)
 3. Fiscal Year ended 2001/2002 (or first nine months 2002)
50. Provide your NET WORTH for fiscal year-end financials for the following years:
1. Fiscal Year ended 1999/2000 (or CY 2000)
 2. Fiscal Year ended 2000/2001 (or CY 2001)
 3. Fiscal Year ended 2001/2002 (or first nine months 2002)

51. Provide your DEBT SERVICE RATIO for fiscal year-end financials for the following years:
1. Fiscal Year ended 1999/2000 (or CY 2000)
 2. Fiscal Year ended 2000/2001 (or CY 2001)
 3. Fiscal Year ended 2001/2002 (or first nine months 2002)
52. Provide your OVERALL LOSS RATIO for fiscal year-end financials for the following years:
1. Fiscal Year ended 1999/2000 (or CY 2000)
 2. Fiscal Year ended 2000/2001 (or CY 2001)
 3. Fiscal Year ended 2001/2002 (or first nine months 2002)
53. Provide your ADMINISTRATIVE LOSS RATIO for fiscal year-end financials for the following years:
1. Fiscal Year ended 1999/2000 (or CY 2000)
 2. Fiscal Year ended 2000/2001 (or CY 2001)
 3. Fiscal Year ended 2001/2002 (or first nine months 2002)
54. Provide your MEDICAL LOSS RATIO for fiscal year-end financials for the following years:
1. Fiscal Year ended 1999/2000 (or CY 2000)
 2. Fiscal Year ended 2000/2001 (or CY 2001)
 3. Fiscal Year ended 2001/2002 (or first nine months 2002)
55. Provide your OPERATING PROFIT MARGIN for fiscal year-end financials for the following years:
1. Fiscal Year ended 1999/2000 (or CY 2000)
 2. Fiscal Year ended 2000/2001 (or CY 2001)
 3. Fiscal Year ended 2001/2002 (or first nine months 2002)

56. Provide your DAYS CASH ON HAND for fiscal year-end financials for the following years:

1. Fiscal Year ended 1999/2000 (or CY 2000)
2. Fiscal Year ended 2000/2001 (or CY 2001)
3. Fiscal Year ended 2001/2002 (or first nine months 2002)

57. Provide your RATIO OF CASH TO CLAIMS PAYABLE for fiscal year-end financials for the following years:

1. Fiscal Year ended 1999/2000 (or CY 2000)
2. Fiscal Year ended 2000/2001 (or CY 2001)
3. Fiscal Year ended 2001/2002 (or first nine months 2002)

58. Provide your DAYS IN RECEIVABLE for fiscal year-end financials for the following years:

1. Fiscal Year ended 1999/2000 (or CY 2000)
2. Fiscal Year ended 2000/2001 (or CY 2001)
3. Fiscal Year ended 2001/2002 (or first nine months 2002)

59. Provide your DAYS IN UNPAID CLAIMS for fiscal year-end financials for the following years:

1. Fiscal Year ended 1999/2000 (or CY 2000)
2. Fiscal Year ended 2000/2001 (or CY 2001)
3. Fiscal Year ended 2001/2002 (or first nine months 2002)

60. Provide your ADMITTED RESERVES for fiscal year-end financials for the following years:

1. Fiscal Year ended 1999/2000 (or CY 2000)
2. Fiscal Year ended 2000/2001 (or CY 2001)
3. Fiscal Year ended 2001/2002 (or first nine months 2002)

61. Provide your RISK BASED CAPITAL (RBC) RATIO (1) for fiscal year-end financials for the following years:

(1) Develop your RBC based on your current financials or project it for 12/31/2002. Indicate which has been done by placing a "C" (current) or "P"(projected) in the detailed response box.

1. Fiscal Year ended 1999/2000 (or CY 2000)
2. Fiscal Year ended 2000/2001 (or CY 2001)
3. Fiscal Year ended 2001/2002 (or first nine months 2002)

62. Provide your RBC NUMERATOR for fiscal year-end financials for the following years:

1. Fiscal Year ended 1999/2000 (or CY 2000)
2. Fiscal Year ended 2000/2001 (or CY 2001)
3. Fiscal Year ended 2001/2002 (or first nine months 2002)

63. Provide your RBC DENOMINATOR for fiscal year-end financials for the following years:

1. Fiscal Year ended 1999/2000 (or CY 2000)
2. Fiscal Year ended 2000/2001 (or CY 2001)
3. Fiscal Year ended 2001/2002 (or first nine months 2002)

64. Do you have sufficient capital to meet Risk Based Capital requirements in Connecticut?

1. Yes
2. No

PART B -- MEDICAL

MEDICAL - GENERAL

1. Please complete the attachment table of your Connecticut book-of-business. This table is in the MEDICAL – GENERAL tab.
 1. Completed
 2. Other, please specify

2. Please complete the attachment table that identifies the funding arrangement availability table for your Connecticut book-of-business. This table is in the MEDICAL – GENERAL tab.
 1. Completed
 2. Other, please specify

MEDICAL - COMMUNICATION MATERIALS

3. Attach samples of the following communication materials in the Appendices of your proposal for your plans. Each set of your proposal should contain one copy of each of these materials.
 - Provider directories (note if available on the Web)
 - POS
 - POE Non-Gated
 - POE Gated
 - Out-of-Network Claim forms
 - ID cards
 - Sample EOBs
 - Sample wellness/health promotion newsletter and program description
 - Web site address (if applicable)
 - Sample enrollment kits
 1. Attached
 2. Other, please specify

4. Are you willing to customize the above materials annually, not just during implementation?
 1. Yes
 2. No

5. How often are the provider directories updated?
 1. Daily
 2. Weekly
 3. Bi-Weekly
 4. Monthly
 5. Quarterly
 6. Semi-Annually
 7. Annually

6. Through your website, can members (select all that apply):
 1. Access Directories
 2. Make PCP changes
 3. Inquire about plan design
 4. Inquire about referral status
 5. Claim Status
 6. Other, please specify

MEDICAL - MEMBER SERVICES

7. Describe your process for handling retroactive enrollment and cancellations.

8. What is your anticipated ratio of **dedicated** member service representatives per 5,000 State members?
 1. <1
 2. 1
 3. 2
 4. 3
 5. 4
 6. Other, please specify

9. Will one member service unit support all of the State plans?
 1. Yes
 2. No

10. What is the average length of service for member service representatives?
 1. < 1 year
 2. 2 – 5 years
 3. 6-10 years
 4. 11-15 years
 5. > 16 years

11. Provide your hiring criteria for your member service representatives (including formal training, qualifications and minimum experience required).
12. Do your member service representatives receive special training for dealing with seniors or Medicare participants? If yes, please describe.
 1. Yes
 2. No
13. Please complete the attached table illustrating your telephone capabilities for the member services unit that will handle the State. This table is in the MEDICAL - MEMBER SERVICES tab.
 1. Completed
 2. Other, please specify
14. Do member service representatives have on-line access to (select all that apply):
 1. Eligibility
 2. Actual claims (scanned claim form)
 3. Claims history/status
 4. Benefits descriptions
 5. Status of question/complaint
 6. Hospital and physician status/information
 7. Other, please specify
15. Are members able to leave after hour voicemails?
 1. Yes
 2. No
16. What is the time goal for a member service representative to call back a member on an issue?
 1. Within 24 hours
 2. 24 to 48 hours
 3. 48 to 72 hours
 4. > 72 hours

MEDICAL - UTILIZATION MANAGEMENT

17. Select the type(s) of UM that are included within your premium rates and administrative fees.

1. Preadmission review
2. Concurrent review
3. Ambulatory review
4. Large case management
5. Referral management
6. Chronic care management
7. Demand management
8. Nurse hotline
9. Out-of-state case management

18. Please indicate which of the type(s) of UM included within your premium rates and administrative fees are **subcontracted**.

1. Preadmission review
2. Concurrent review
3. Ambulatory review
4. Large case management
5. Referral management
6. Chronic care management
7. Demand management
8. Nurse hotline
9. Out-of-state case management

19. What medical necessity criteria are utilized by your organization for authorizing inpatient admissions? Provide specific examples.

20. Discuss the process for identification of patients for UM.

- What are the automatic and manual triggers to identify cases for UM?
- How do you ensure that cases are appropriately managed?
- How do you calculate UM savings?
- How do you interface with medical group and hospital staff in the UM function?

21. Discuss the process for identification of patients for large case management.
- What are the automatic and manual triggers to identify cases for large case management?
 - How do you ensure that large cases are appropriately managed?
 - How do you calculate case management savings?
 - How do you interface with medical group and hospital staff in the case management function?

22. What is the **percent** of new pre-certification reviews completed in one workday?

1. <50%
2. 50%-60%
3. 61%-70%
4. 71%-80%
5. 81%-90%
6. 91%-95%
7. >95%

23. What is the **percent** of pre-certification reviews referred to a physician?

1. <5%
2. 5%-10%
3. 11%-15%
4. 16%-20%
5. 21%-50%
6. 51%-75%
7. >75%

24. Please complete the attachment table of pre-certification and concurrent review information. This table is in the MEDICAL - UTILIZATION MANAGEMENT tab.

1. Completed
2. Other, please specify

MEDICAL - PROVIDER NETWORK

25. Is any part of your network leased? If yes, identify owner of the network and the geographic service area.

1. Yes
2. No

26. Describe the selection process used for your provider network. Include the following:
1. Procedures for verifying application information
 2. Physician profiling
 3. Hospital profiling
 4. System for maintaining information
 5. Approval process for credentialing and selection
27. Please provide the following samples:
- Current physician application
 - Current hospital application
1. Attached
 2. Other, please specify
28. Does your selection and credentialing process allow you to decline an individual physician of a medical group or an IPA?
1. Yes
 2. No
29. How long is the process to add an individual physician?
1. < 2 weeks
 2. 2-4 weeks
 3. 5-16 weeks
 4. > 16 weeks
30. How long is the process to add a medical group?
1. < 2 weeks
 2. 2-4 weeks
 3. 5-16 weeks
 4. > 16 weeks
31. Will you agree to have the State's approval prior to a change in applicable network composition?
1. Yes
 2. No

32. What will be your standard process and advance notification timeframe to notify the State and its members of network changes?

1. At least 30 days in advance
2. At least 45 days in advance
3. At least 60 days in advance
4. At least 90 days in advance
5. At least 120 days in advance

33. How often is each physician and hospital recredentialed?

1. Semi-annually
2. Annually
3. Every other year
4. Other, please specify

34. What information is verified during physician/hospital recredentiaing?

	Physician	Hospital
State license		
DEA		N/A
JCAHO	N/A	
Board status		
Hospital privileges		N/A
Malpractice		
Site visits		
Practice patterns		N/A
Morality	N/A	
Morbidity	N/A	
Readmission rates	N/A	
Other: list		

35. Please complete the attachment table that identifies provider turnover (**expressed in absolute numbers**) for the following calendar years. This table is in the MEDICAL - PROVIDER NETWORK tab.

1. Completed
2. Other, please specify

36. Describe your “Centers of Excellence” program, including a list of the “Centers of Excellence” facilities and the types of procedures that will be referred to these centers.

37. What methods are available to participants for selecting their PCP? Please select all that apply.

1. Phone
2. Web Sites
3. Other, please specify

38. How do you maintain the PCP selection in your system?

39. Can family members select different medical groups and PCPs?

1. Yes
2. No

40. What is the process for changing PCPs and how often is it allowed?

41. What is the current **percentage** of PCPs that are accepting new patients for POS?

1. <75%
2. 75%-80%
3. 81%-85%
4. 86%-90%
5. 91%-85%
6. >95%

42. What is the current **percentage** of PCPs that are accepting new patients for POE?

1. <75%
2. 75%-80%
3. 81%-85%
4. 86%-90%
5. 91%-85%
6. >95%

43. How is the level of PCP capacity monitored and updated? Please select all that apply.

1. Meetings with providers
2. Reporting
3. Survey (e.g., patient load and wait time)
4. Site visits
5. Membership growth
6. Other, please specify

44. If a PCP has a closed practice, will your enrollment system allow a new member to enroll if he/she is currently a patient of the PCP through a different health plan?

1. Yes
2. No

45. What is the current average number of **days** a member is required to wait to receive an appointment with a PCP for an **initial check-up**?

1. <10 days
2. 11-20 days
3. 21-30 days
4. 31-40 days
5. >40 days

46. What is the current average number of **days** a member is required to wait to receive an appointment with a PCP for a **non-urgent problem**?

1. <10 days
2. 11-20 days
3. 21-30 days
4. 31-40 days
5. >40 days

47. What is the current average number of **days** a member is required to wait to receive an appointment with a PCP for a routine **follow-up appointment**?

1. <10 days
2. 11-20 days
3. 21-30 days
4. 31-40 days
5. >40 days

48. How do you monitor the current appointment waiting times? Please select all that apply.

1. Provider surveys
 2. Patient complaints
 3. Site visits
 4. Membership growth
 5. Other, please specify
49. If a need for additional providers is identified, how are these needs filled and how long does this process take?
50. Under the current managed medical and workers' compensation programs, if a workers' compensation in-network claim were denied, the claim would then be considered under the medical program. However, there is a potential issue in that if an employee utilizes a physician who participates in the workers' compensation network but does not participate in the medical network and the claim is subsequently denied under workers' compensation, the employee's claim would be paid at the out-of-network level (in the case of the POS plans) or not at all (in the case of POE plans). **How would you propose handling this potential issue?**
51. Would you be willing to reimburse these claims at the in-network levels? If yes, please specify, if any, what impact this would have on the quoted premium rates.
1. Yes
 2. No
52. Describe how integration of the State's workers' compensation network would impact the State's health plan premium and claim costs.
53. Does your organization use a separate PPO network manager that provides nationwide access or reciprocity with other (affiliated) health plans outside Connecticut? If yes, list the states where you use a network manager or reciprocity, provide the name of the network manager, and explain your relationships.
1. Yes
 2. No

MEDICAL - PROVIDER CONTRACTING

54. Identify any changes to your provider contracting strategies that you anticipate over the next three years.

MEDICAL - PROVIDER REIMBURSEMENT

Provider Reimbursement - Physicians

55. Enter the **percentage** of physicians that are reimbursed by the following methods.

Primary Care Physicians	POS	POE
Salary		
Discounted fee for service w/withhold		
Fee for service w/bonus		
Fee schedule		
Capitation		
Capitation w/withhold		
Capitation w/bonus		
Percentage discount		
Other (specify)		
Total	100%	100%

Specialists	POS	POE
Salary		
Discounted fee for service w/withhold		
Fee for service w/bonus		
Fee schedule		
Capitation		
Capitation w/withhold		
Capitation w/bonus		
Percentage discount		
Other (specify)		
Total	100%	100%

56. Enter the **percentage** of inpatient hospitals that are reimbursed by the following methods:

	POS	POE
Discount		
Per Diem		
Capitation		
DRG Case Rates		
Global Fees		
Other		
Total	100%	100%

MEDICAL - WELLNESS PROGRAMS (CARE/DISEASE MANAGEMENT)

57. Identify the wellness or disease management initiatives for your health plan that are currently operational.

58. What are the costs of these programs and their expected resulting savings? Identify how the program costs and savings figures were derived.

59. List all of the disease management programs that are **included in your premium rates** and the corresponding PMPM cost for each program.

60. Are you willing to place premium/administrative fees at risk based on the performance of these programs? If so, please provide your guidelines.

1. Yes
2. No

61. For each currently operational initiative, explain the process used to measure outcomes.

62. What initiatives are currently being developed? Identify the programs and their expected effective date.

63. Does your care management program include pre-natal/pregnancy management?

(1) If yes, briefly describe your pregnancy management program.

1. Yes
2. No
3. N/A

(2) If yes, how do you identify high-risk pregnancies? If not applicable respond with N/A.

(3) If yes, how do you track and report on those accessing care through to delivery? If not applicable respond with N/A.

(4) If yes, is the clinical staff for prenatal management the same as the utilization management staff?

1. Yes
2. No
3. N/A

64. Does your care management program include chronic care or catastrophic case management programs? If so, briefly describe.

1. Yes
2. No

65. What are the diagnoses and/or dollar amount triggers for chronic care management and catastrophic case management?

66. Does your care management program include disease management? Please select all that apply. If so, briefly describe your capabilities for the programs offered:

1. Diabetes
2. Cardiac care management
3. Asthma
4. Cancer
5. Other, please specify

67. By disease, how are you identifying candidates for disease management?

68. Does intervention vary by status of disease? If so, describe by disease.
1. Yes
 2. No
69. How do you evaluate the results of your disease management programs? What types of reports are you producing for outcomes measurement?
70. What types of programs do you have that identify individuals at risk for injury and offer programs to reduce problems? How do you identify these individuals?
71. Please attach a sample process flow for the following scenarios, including how the case is identified, who is responsible for intervening/coordinating, member transition through the delivery system, and the ultimate outcome:
- Normal elective surgery
 - Emergency admission for asthma attack
 - High risk pregnancy
 - Parent requesting advice regarding sick child in the middle of the night
 - Inpatient stroke patient with no support system
 - Late stage AIDS patient
 - Heart transplant
 - High risk breast cancer
 - Diabetes
 - Chronic hypertension
1. Attached
 2. Other, please specify
72. How are the care management components integrated with the network physicians treatment program? Indicate the approach if using your own network versus a separate network.
73. Are physicians supplied with educational materials or training in these areas?
1. Yes
 2. No
74. Do you have a nurseline/demand management program?
1. Yes
 2. No

75. Is the nurseline/demand management program leased or owned?

1. Leased
2. Owned
3. N/A

76. How do you advise physicians and members for the appropriateness of hospice care and the role it will play in the treatment of the patient?

77. Identify what hospices are currently in your Connecticut network.

MEDICAL - CLAIM ADMINISTRATION

Note: All responses must be based on the claim office you are proposing for the State of Connecticut.

78. In 1,200 words or less, explain your experience and capabilities to administer the State's plans.

79. Is your system capable of administering the State's retiree medical plan split options (family with Medicare eligible and non-Medicare eligible members)?

1. Yes
2. No

80. Are there any benefits in the State's plan designs that would require manual intervention? If yes, please describe.

1. Yes
2. No

81. How long has your claims system been operational?

1. Less than 1 year
2. 1 – 3 years
3. 4 – 6 years
4. 7 – 10 years
5. Greater than 10 years
6. Other, please specify

82. Do you expect to make any major system changes (i.e., move locations, upgrades, etc.) in the next 24 months? If yes, what are they and how will this impact the State of Connecticut?

1. Yes
2. No

83. What are your claim system capabilities? Please select all that apply.

1. Capture \$ amount (i.e., total charges, covered charges, discount adjustments)
2. Identify providers by Tax ID #
3. Track deductibles, copayments and out-of-pocket maximums
4. Adjudicate claims based on per diems or DRGs
5. Record 5-digit ICD-9s for both primary and secondary diagnosis with full reporting access
6. Track comorbidity
7. Produce reports by DRGs or other acuity measures

84. Does your system identify claims that require the attention of utilization management or care management by (please select all the apply):

1. Diagnosis
2. Dollar Amount
3. Procedure Code

85. Do you have the capability to provide the State with on-line access to claims and utilization data? If yes, what is the charge for this service?

1. Yes
2. No

86. What database do you utilize to determine reasonable and customary (R&C)?

1. CRVS
2. HIAA
3. Book-of-business
4. Other, please specify

87. What **percentile** do you use to pay medical claims?

1. 80%
2. 85%
3. 90%
4. Other, please specify

88. How often is the database updated?

1. Weekly
2. Bi-Weekly
3. Monthly
4. Quarterly
5. Semi-annually
6. Annually
7. Every two years
8. Other, please specify

89. Are there any differences or special procedures for the State members living away from the service area? If yes, please describe.

1. Yes
2. No

90. How do you identify out-of-service area dependents?

91. Describe your "Disaster Recovery Plan".

IF YOUR ANSWERS TO THE FOLLOWING QUALITY QUESTIONS DIFFER BY PLAN (e.g., POS, POE-NG, POE-G, ETC.) COMPLETE THIS SECTION FOR EACH

MEDICAL - QUALITY

92. Describe your medical quality assurance (QA) committee functions. Include:

- The frequency of QA committee meetings
- A list of committee members
- Two important quality improvements recently identified by the QA committee and identified in QA committee minutes

93. Do you “profile” physicians for use patterns? If yes, please describe.
1. Yes
 2. No
94. Do you “profile” physicians for quality of care? If yes, please describe.
1. Yes
 2. No
95. Please attach a copy of a sample profile report to a physician.
1. Attached
 2. Other, please specify
96. What benchmarks do you use to compare physician performance?
97. Are these benchmarks developed internally or are they based on external data?
1. Developed Internally
 2. Based on External Data
 3. Other, please specify
98. How often are your benchmarks revised?
1. Monthly
 2. Semi-annually
 3. Annually
 4. Every other year
 5. Other, please specify.
99. Please complete the attachment table that describes your claims processing quality assurance program for your plans. This table is in the MEDICAL – QUALITY tab.
1. Completed
 2. Other, please specify
100. Please attach your most recent HEDIS 2002 report.
1. Attached
 2. Other, please specify
101. Please complete the attachment table identifying HEDIS 2002 quality information. This table is in the MEDICAL – QUALITY tab.
1. Attached
 2. Other, please specify

102. Is your current HEDIS 2002 report based on your POS?

1. Yes
2. No

103. Please state your definition of medical necessity.

104. Do your network physicians determine the course of treatment? If not, when and how does your organization supersede the network physician's recommendation?

1. Yes
2. No

105. Briefly describe the methods you use to monitor clinical or treatment outcomes. Examples could be:

- Retrospective review of all hospital re-admissions for selected diagnosis
- Hospital mortality (morbidity)
- Focused review of hospital adverse occurrences
- Patient survey regarding outcomes/function status/etc.
- Review of appropriateness of selected procedures

106. Do you conduct written participant satisfaction surveys?

1. Yes
2. No

107. What is the frequency of the written participant satisfaction surveys?

1. Monthly
2. Semi-annually
3. Annually
4. Every other year
5. Other, please specify
6. N/A

108. Attach survey methods and a recent copy along with your most recent results.

1. Attached
2. Other, please specify
3. N/A

109. Is your plan NCQA accredited? If yes, how long is the accreditation for? If not, when were you last reviewed and when are you scheduled for your next review?

1. Yes
2. No

MEDICAL - REPORTING

110. Provide a copy of **all** sample reports outlined in **Section III** for your 2002 book-of-business.

1. Attached
2. Other, please specify

MEDICAL - RETIREE PLANS

111. Under the current Medicare carve out plan, the Health Plan directly coordinates with Medicare on behalf of the retiree (i.e. the retiree pays whatever copayment required for the Health Plan who then coordinates payment with Medicare). Please confirm your ability to duplicate this arrangement.

1. Confirmed
2. Not Confirmed

PART C - PRESCRIPTION DRUG**PRESCRIPTION DRUG - GENERAL**

1. Describe the development of your pharmacy management card program. Include the date it became operational and its current membership.
2. How is eligibility integrated between the medical plans and the Pharmacy Benefit Manager (PBM)? How often is eligibility data transferred? Describe the process.

PRESCRIPTION DRUG - PROVIDER NETWORK

3. Does your organization have ownership interest in or management contracts with any pharmacy, dispensing outlet or drug manufacturer? If so, please describe.
 1. Yes
 2. No
4. Does your leasor have ownership interest in or management contracts with any pharmacy, dispensing outlet or drug manufacturer? If so, describe.
 1. Yes
 2. No
 3. N/A
5. How do you select participating pharmacies?
6. Do you conduct site visits to the pharmacy?
 1. Yes
 2. No
7. How do you monitor quality at the pharmacy level?

PRESCRIPTION DRUG - GENERICS

8. Describe your generic substitution policy and process for both mail order and retail. What special steps do you take to increase the use of generic drugs by enrollees?
9. Since generic drugs generally represent only a small percent of drugs dispensed for maintenance medications, what cost containment programs can you recommend that address source brand medications?

10. What are your criteria for drug manufacturer selection? How are suppliers initially evaluated and then monitored?
11. What was the generic substitution rate for your book of business during 2000, 2001, and 2002 YTD? **Include generic substitution rates for both mail order and retail. Provide percentages on both a script and dollars basis.**

PRESCRIPTION DRUG - UTILIZATION REVIEW

12. Describe your prospective, concurrent and retrospective Drug Utilization Review (DUR) programs. What is the source of your clinical database?
13. Please identify and briefly explain all concurrent DUR edits and the options that a pharmacist has to override the edit or not fill the prescription.
14. What procedures do you utilize for profiling the prescribing practices of providers?

PRESCRIPTION DRUG - MAIL ORDER

15. Name the primary pharmacy that would provide mail order prescription medication to participants. What is the dispensing capacity of this pharmacy and what capacity is currently utilized? How would you handle the additional utilization by State members?
16. Does your mail order system have the on-line capability to detect interactions and compare utilization information with retail pharmacy utilization? How do you manage this? How is this coordinated with retail?
17. If DUR edits differ for mail order, please identify and briefly explain all DUR edits and the options that a pharmacist has to override the edit or not fill the prescription. Under what conditions do you contact the physician?
18. Describe your systems backup capabilities. Describe your procedures in the event of a natural disaster that shuts down the mail service pharmacy.
19. Is there a toll-free number or website available for ordering refills? If so, what are the number's hours of operation?

1. Yes
2. No

20. Do you provide 24-hour emergency telephone assistance? If yes, are experienced pharmacists available to assist program enrollees?
1. Yes
 2. No
21. What is your turnaround time from the time a patient mails the prescriptions to receipt of medication by the patient (including mailing time)?
1. <3 days
 2. 4-6 days
 3. 7-9 days
 4. 10-12 days
 5. 13-15 days
 6. >15 days
22. What anti-tampering precautions are taken in your packaging process?
23. Describe any security measures taken at your pharmacy to guard against improper handling or adulteration of medications.
24. Upon final prescription check by a pharmacist, what **percentage** of prescriptions is reprocessed in any way? What types of errors are caught (give percentages if possible)?

PRESCRIPTION DRUG - FORMULARY

25. Do you offer an open formulary option?
1. Yes
 2. No
26. How do you determine what drugs go into the formulary?
27. How frequently is the formulary updated?
1. Daily
 2. Weekly
 3. Bi-Weekly
 4. Monthly
 5. Quarterly
 6. Semi-Annually
 7. Annually

28. In an open formulary arrangement, what percentage of the drugs dispensed is within the formulary?
1. <50%
 2. 50%-60%
 3. 61%-70%
 4. 71%-80%
 5. 81%-90%
 6. >90%
29. In an open formulary arrangement, what percentage is generic?
1. <15%
 2. 15%-20%
 3. 21%-25%
 4. 26%-30%
 5. 31%-35%
 6. 36%-40%
 7. >40%
30. How do you educate the providers to use the formulary?
31. How is the formulary communicated to physicians, pharmacists, and members?

PRESCRIPTION DRUG - FINANCIAL

32. What is your mechanism for including drugs on the MAC list?
33. How often is the MAC list updated?
1. Daily
 2. Weekly
 3. Bi-Weekly
 4. Monthly
 5. Quarterly
 6. Semi-Annually
 7. Annually
34. How is the MAC price calculated?
35. How many drugs are on your MAC list?

PART D -- DENTAL**DENTAL - CLAIMS ADMINISTRATION**

1. Provide the location of the office(s) that will process claims for the HMO and Indemnity/PPO plans.
 1. Attached
 2. Other, please specify
2. Explain your experience and capabilities to administer the State's proposed plans.
3. Please describe the claims processing system and its capabilities as they relate to dental indemnity/PPO, and HMO plans.
4. How is UCR established?
5. What **percentile** of UCR is used?
 1. 80%
 2. 85%
 3. 90%
 4. Other, please specify
6. How often is the UCR updated?
 1. Semi-Annually
 2. Annually
 3. Other, please specify
7. Are there any benefits in the State's plan designs that would require manual intervention?
8. Describe the configuration of the State's dedicated claims and customer service teams.
9. Describe your claims processing quality assurance program. Include:
 - Percent of and frequency of claim audits performed
 - Special procedures, if any, for processing high claims or those with complex diagnoses or unusual procedures.

DENTAL - NETWORK SELECTION AND STRUCTURE

10. Describe the selection criteria used for your provider network. Include:
- The standards for provider selection
 - The process for confirming the education, training and licensure status of provider applicants and any other standards used in the selection process (include a provider application form).
 - The ongoing efforts to monitor the performance of providers for decisions to continue or withdraw from the network
 - The recredentialing process and frequency
11. Do you maintain individual cost profiles on each provider? How are these profiles modified over time?

DENTAL - MEMBER SERVICES

12. Please describe the mechanisms and organization responsible for monitoring and responding to member inquiries/problems.
13. What is your target ratio of member services representatives to members?
14. Describe the customer service support available for the State.
15. Will one 800 number be available for all customer service, claim inquiry, and provider network information?
1. Yes
 2. No
16. Attach samples of the following communication materials:
- HMO and PPO Provider directories
 - Claim forms
 - ID cards
 - Enrollment forms
1. Attached
 2. Other, please specify

17. Describe your quality assurance program. Include:
- The structure of the department and the number of staff dedicated to the monitoring of quality of care
 - The type of information collected and monitored
 - Examples of any changes that have been implemented as a result of this process.
 - Provider profiling
18. Please describe your formal member grievance procedure.
19. To what extent, if any, do you survey members to determine their comprehension of and satisfaction with your program? Please provide results of any satisfaction surveys for networks proposed for the State.
20. Indicate the **days and hours of operation** when a member can reach a live member services representatives (Monday – Sunday).

DENTAL - PROVIDER NETWORK

21. Do you currently negotiate with providers:
1. Directly
 2. Using a third party
 3. Other, please specify
22. Are your networks:
1. Leased
 2. Subcontracted
 3. Other, please specify
23. How often are provider contract rates renegotiated?
1. Semi-Annually
 2. Annually
 3. Every other year
 4. Other, please specify
24. Do your contracts include a specific clause that limits the amount of increase?
1. Yes
 2. No
25. What are your network development and recontracting plans for the next two years?

26. Indicate the percentage of your providers that are reimbursed on:

- Discounted fee-for-service: _____%
- Fee schedule basis: _____%

DENTAL - REPORTING

27. Please provide samples (and frequency with which they are provided) of the types of management reports that are included within your quoted fees.

1. Attached
2. Other, please specify

28. What is your fee for customizing reports and also for on-going production of customized reports?