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AMENDED: DECEMBER 21, 2012

STATE OF VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS
Vermont Health Connect

REQUEST FOR PROPOSALS

TITLE: SELECTION OF QUALIFIED HEALTH PLANS

REQUISITION NUMBER: 03410-

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CHAPTER 1

INFORMATION FOR THE BIDDER

1. GENERAL PROVISIONS

1.1. INTRODUCTION

The Department of Vermont Health Access (DVHA) is seeking to establish agreements with health insurance issuers (“Issuer”) to offer certified qualified health plans and stand-alone dental plans for sale through the Vermont Health Benefit Exchange, Vermont Health Connect.

In March 2010, the Patient Protection and Affordable Care Act of 2010 (“PPACA”; Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (“HCERA”; Public Law 111-152), (together the ACA) were enacted by Congress and signed into law by the President of the United States. The ACA authorizes the creation of state-based and operated Health Benefit Exchanges that will allow consumers to access and evaluate health insurance options from private insurance issuers, determine eligibility for federal subsidies, and enroll in the health insurance coverage of their choice.

Vermont Act 48 established the Vermont Health Benefit Exchange (Vermont Health Connect) within DVHA, the agency responsible for the management of Vermont's publicly funded health insurance programs. Vermont Health Connect supports DVHA's mission to improve access to health care and increase coverage by offering the means for all Vermonters to compare information on available health insurance plans and public health coverage, determine eligibility for premium tax credits and cost sharing reductions, and enroll in plans or public coverage. The Commissioner of DVHA, through this proposal, will select the qualified health plans to be offered on Vermont Health Connect for qualified individuals and qualified employees of qualified employers.

This Request for Proposals is open to all health insurance organizations licensed in Vermont interested in providing coverage for health services to individuals and small businesses through Vermont Health Connect.

1.2. SCHEDULE OF EVENTS

The timetable, including the Proposal Due Date and other important dates are set forth below.

RFP Posted	11/1/2012
Intent to Bid	11/13/2012
Bidder's Questions Due	12/03/2012
Dept. Response to Questions	12/07/2012
Proposal Due/Closing Date	1/08/2013
Rate Filings Due	3/15/2013

Rates Filings Due (dental only)	4/15/2013
Selection Notification	7/15/2013

1.3. SINGLE POINT OF CONTACT

All communications concerning this Request For Proposal (RFP) are to be addressed in writing to the attention of: Greg Paradiso, Exchange Project Director, State of Vermont, Department of Vermont Health Access, 312 Hurricane Lane, Suite 201, Williston, VT 05495; Greg.Paradiso@state.vt.us will be the sole contact for this proposal. Attempts by bidders to contact any other party could result in the rejection of their proposal.

1.4. LETTER OF INTENT – PRE-REQUISITE

In order to ensure all necessary communication with the appropriate bidders and to prepare for the review of proposals, one letter of intent to bid must be submitted per bidder. The letter must identify whether the Issuer intends to offer for selection as a qualified health plan both standardized and non-standardized plan design(s), and whether the issuer intends to offer a stand-alone dental plan.

Letters of Intent must be submitted by November 13, 2012 by 4:30 p.m. to: Greg Paradiso, Exchange Project Director, State of Vermont, Department of Vermont Health Access, 312 Hurricane Lane, Suite 201, Williston, VT 05495.

1.5. QUESTION AND ANSWER PERIOD

An Issuer requiring clarification of any section of this proposal must submit specific questions in writing according to the Schedule listed in section 1.2. Questions must be e-mailed to the RFP Contact, Greg Paradiso, at Greg.Paradiso@state.vt.us. Any question not raised in writing on or before the last day of the initial question period is waived. Responses to the questions sent will be posted to the Electronic Bulletin Board (<http://www.vermontbidsystem.com>).

1.6. INSTRUCTIONS TO BIDDERS

An Issuer must file qualified health plan forms and supporting documents required under this RFP with the Department of Financial Regulation via SERFF. The work flow will proceed through the normal form review process pursuant to 8 V.S.A., Chapter 101 and other applicable Vermont insurance statutes. In order to be considered for offering on Vermont Health Connect, issuers must also submit rates to the Department of Financial Regulation by 3/15/2013, for medical plans, and 4/15/2013, for stand-alone dental plans, for review and recommendation, and receive approval of rates by the Green Mountain Care Board.

Issuers should submit plan designs using the summary of benefits and coverage template (Appendix E). This is an abbreviation of a standard template provided by the Centers for Medicare and Medicaid Services (CMS) (detailed information on this template is available here, <http://www.healthcare.gov/news/factsheets/2011/08/labels08172011a.html>). Additional materials that must be submitted include: attestations by the Issuer to meet the state and federal requirements for qualified

health plans (attached as Appendix C); and the Non-Standard Plan Questionnaire for each non-standardized plan design submitted (attached as Appendix F). The Department of Financial Regulation will review the submission and certify Qualified Health Plans which fulfill all requisite criteria offered by issuers with a license in good standing in the state. Vermont Health Connect will also evaluate each response for congruence with the goals of health reform in the state: 1) reduce health care costs and cost growth; 2) assure that all Vermonters have access to and coverage for high-quality health care (including mental and physical health and substance abuse treatment); 3) support improvements in the health of Vermont's population; and 4) assure greater fairness and equity in payment for health care.

This RFP shall not be construed as a contract between the State and the Bidder, and nothing in this RFP, nor in the State's acceptance of any response in whole or in part, shall obligate the State to complete negotiations with the related bidder. Acceptance by the State of any response shall be subject to this condition. The Commissioner of DVHA and chosen Bidder(s) shall later execute a contract. The Department reserves the right to end negotiations with a Bidder at any time up to the consummation of a contract arising from this RFP.

These requirements apply to an issuer and all of its subsidiaries. An issuer and its subsidiaries will be considered one bidder for plan submission purposes.

The Proposal Packet: Your proposal must include:

- 1.6.1. Certification and Assurances:** One copy of the signed Certifications and Assurances, found in Appendix A, signed by a person authorized to bind your Company to a contract.
- 1.6.2. Insurance certificate:** As part of the proposal packet the Bidder must provide a current certificate of insurance of which may or may not meet the minimum requirements laid out in the section 4 of this document. Any questions a bidder may have concerning the necessary insurance coverage must be raised during the question and answer period set out in section 1.5 of this document. In the absence of a question, and upon commencement of contract negotiations, the apparently successful bidder must provide a certificate of insurance that meets the minimum coverage specified in section 4 of this document.
- 1.6.3.** Any other attachments to the proposal labeled and attached.
- 1.6.4. Letter of Submittal:** One letter of submittal, signed by a person authorized to bind your organization to a contract. Your letter must include:
 - 1.6.4.1.** Identifying information about your organization and any sub-contractors or delegates. Include the name of the organization, names, addresses, telephone numbers, and address of principal officers and project/program leader, and a description of the type of organization you operate.
 - 1.6.4.2.** A detailed list of all materials and enclosures being sent in the proposal.

1.6.4.3. Any other statements you wish to convey to DVHA.

1.6.5. Your proposal should respond to the following four identified areas (see section 2-1_EVALUATION for more detail).

1.6.5.1. Technical Proposal/Program Specifications

1.6.5.1.1. Responsiveness to Specifications

1.6.5.1.2. Non-Standard Innovative Plan Features

1.6.5.2. Information From The Bidder

1.6.5.2.1. Quality of Bidder Experience

1.6.5.2.2. Bidder Capacity

1.6.6. Proposal Format:

Electronically submit all proposal documents via SERFF system. **Any Proposed Co-op as defined by the ACA shall not submit responses via SERFF. Any responses by a proposed Co-op to the Vermont Health Connect shall be submitted by email to greg.paradiso@state.st.us and also by CD sent to Greg Paradiso Exchange Project Director, State of Vermont, Department of Vermont Health Access, 312 Hurricane Lane, Suite 201, Williston, VT 05495 as described in 1.6.7.1.**

Attach supporting documents in PDF format to the form filing in SERFF, except for choice plan questionnaire(s) (Appendix F), which should be attached in Excel format. Also send proposals you are submitting as a computer file copy of the document on a CD using Microsoft Word and Excel for appropriate appendices to: Greg Paradiso, Exchange Project Director, State of Vermont, Department of Vermont Health Access, 312 Hurricane Lane, Suite 201, Williston, VT 05495.

1.6.6.1. State your organization's name on each page of your plan proposals and on any other information you are submitting.

1.6.6.2. Write the plan proposals in the order given in the evaluation criteria charts (bidder capacity, bidder experience, and program specifications).

1.6.7. Closing Date & Proposal Packet Delivery:

1.6.7.1. Send a CD of your proposals to:

Greg Paradiso, Exchange Project Director, State of Vermont, Department of Vermont Health Access, 312 Hurricane Lane, Suite 201, Williston, VT 05495.

1.6.7.2. Your proposal **whether electronically submitted on SERFF, emailed, mailed, or hand delivered** at the Division (DVHA), must arrive **no later than 3:00 PM**, January 8, 2013. Late responses shall not be accepted and shall automatically be disqualified from further consideration. The method of delivery shall be at your discretion, and shall be at your sole risk to assure delivery at the designated office. DVHA does not take responsibility for any problems in mail

or delivery, either within or outside DVHA. Receipt by any other office or mailroom is not equivalent to receipt by DVHA.

All responses must be valid for 180 days following the submission date. The terms of this RFP and all commitments stated in the bidder's response or its addenda, if that response is accepted by the Commissioner of DVHA, will become binding between the bidder and DVHA. The Commissioner of DVHA has the authority to request additional information from time to time from one or more Bidders, and the Commissioner reserves the right to do so.

DVHA, in its sole authority, anticipates that only Health Plans or Stand-alone Dental Plans (1) submitting responses which demonstrate the ability to satisfy the criteria set forth in this document and requirements detailed in the attached appendices subject to DVHA Commissioner approval; and (2) agreeing to execute, deliver and perform in accordance with Vermont Health Connect, will respond to this RFP.

1.7. GLOSSARY OF TERMS

“Actuarial value” – The percentage of total average costs for covered benefits that a plan will cover.

“Affordable Care Act” – The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

“Agent or broker” – A person or entity licensed by the State as an agent, broker, or insurance producer.

“CALT” – Collaborative Application Lifecycle Tool, a platform provided by CMS that supports the entire project life cycle, from requirements and release management, to code review and defect tracking, to build management, test and file releases (<https://calt.cms.gov/sf/sfmain/do/home>).

“Decertify” – A decertified plan will no longer be offered on the Vermont Health Connect and the Qualified Health Plan issuer must terminate coverage of the enrollees after providing notice in accordance with applicable Vermont law and after special enrollment has been offered to the plan's enrollees.

“Enroll” – The point at which an individual is covered for benefits under a group health plan (that is, when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to become covered under the plan.

“Health insurance issuer or issuer” – An insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates

insurance. For purposes of this RFP or any responses thereto, an issuer includes a proposed Co-op as defined by the ACA who has received Federal funding, or a multistate plan administered by OPM. NOTHING in the RFP or the responses thereto amends or preempts currently existing state insurance laws and or regulations. All issuers must fully comply with all Vermont insurance licensure requirements including but not limited to capital requirements, and form and rate filings.

“Initial enrollment period” – The period during which a qualified individual may enroll in coverage through Vermont Health Connect for coverage during the 2014 benefit year.

“Open Enrollment” – Annual period during which a qualified individual may enroll or change coverage in a Qualified Health Plan through Vermont Health Connect.

“Plan year” – The consecutive 12 month period during which a health plan provides coverage for health benefits.

“Premium Tax Credits” – When a person or family qualifies for a premium tax credit, the dollars from the credit go directly into the qualified health plan in which they are enrolled—offsetting the cost of the family's health premiums for that qualified health plan. The tax credits are also advanceable, meaning that families do not have to wait until their taxes have been filed and processed in order to receive the tax credit and enroll in coverage.

“Qualified health plan or QHP” – A health insurance plan that is certified by the Department of Financial Regulation and selected for offering through the Vermont Health Connect, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, coinsurance, and out-of-pocket maximum amounts), and meets other requirements.

“SERFF” – System for Electronic Rate and Form Filing.

“Special enrollment” – A period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through the Vermont Health Connect outside of the initial and annual open enrollment periods.

1.8. PUBLIC RECORD

All bid proposals and submitted information connected to this RFP may be subject to disclosure under the State of Vermont's access to public records law. The successful bidder's response will become part of the official contract file. Once the contract is finalized, material associated with its negotiation is a matter of public record except for those materials that are specifically exempted under the law. One such exemption is material that constitutes trade secret, proprietary, or confidential information. If the response includes material that is considered by the bidder to be proprietary and confidential under 1 V.S.A., Ch. 5 Sec. 317, the bidder shall clearly designate the material as such prior to bid submission. The bidder must identify each page or

section of the response that it believes is proprietary and confidential, and provide a written explanation relating to each marked portion to justify the denial of a public record request should the State receive such a request. The letter must address the proprietary or confidential nature of each marked section, provide the legal authority relied on, and explain the harm that would occur should the material be disclosed. Under no circumstances can the entire response or price information be marked confidential. Responses so marked may be denied consideration by DVHA for that reason alone, and if so DVHA will return the response to the bidder.

1.8.1. All proposals shall become the property of the State.

1.8.2. All public records of DVHA may be disclosed, except that submitted bid documents shall not be released until the Contractor and DVHA have executed the contract. At that time, the unsuccessful bidders may request a copy of their own score sheets as well as request to view the apparently successful bidder's proposal at DVHA Central Office. After contract execution the name of any Bidder submitting a response shall also be a matter of public record. Other persons or organizations may also make a request at that time or at a later date.

1.8.3. Consistent with state law, DVHA will not disclose submitted bid documents or RFP records until execution of the contract(s). At that time, upon receipt of a public records request, information about the competitive procurement may be subject to disclosure. DVHA will review the submitted bids and related materials and consider whether those portions specifically marked by a bidder as falling within one of the exceptions of 1 V.S.A., Ch. 5 Sec. 317 are legally exempt. If in DVHA's judgment, pages or sections marked as proprietary or confidential are not proprietary or confidential, DVHA will contact the bidder to provide the bidder with an opportunity to prevent the disclosure of those marked portions of its bid.

1.9. COSTS OF PROPOSAL PREPARATION

DVHA will not pay any bidder costs associated with preparing or presenting any proposal in response to this RFP, even if one or more of the bidder's plans are not selected for offer or the RFP is cancelled or withdrawn.

1.10. RECEIPT OF INSUFFICIENT COMPETITIVE PROPOSALS

If DVHA receives one or fewer responsive proposals as a result of this RFP, DVHA reserves the right to select the proposal which best meets DVHA's needs. Furthermore, DVHA reserves the right to reject all proposals. Such a decision may or may not result in reissuance of the RFP. Should a bidder be selected as a result of this RFP, that bidder need not be the sole bidder but will be required to document their ability to meet the requirements identified in this RFP. DVHA reserves the right to obtain clarification or additional information necessary to properly evaluate a proposal or any part thereof. Failure of a bidder to respond to a request for additional information or clarification could result in rejection of that bidder's proposal.

1.11. NON-RESPONSIVE PROPOSALS/WAIVER OF MINOR IRREGULARITIES

Read all instructions carefully. If you do not comply with any part of this RFP, DVHA may, at its sole option, reject your proposal as non-responsive. DVHA reserves the right to waive minor irregularities contained in any proposal.

DVHA is not required to accept all proposals that meet the criteria stated in the preceding sections. DVHA reserves the right to reject a proposal or portion thereof, or to accept any proposal or portion thereof, based on what the commissioner of DVHA deems to be in the best interest of the individuals and qualified employers in the state of Vermont. Issuance of this RFP is not an offer to enter into a contract. It is a request to receive proposals from organizations interested in providing the services listed herein. DVHA reserves the right to, at any time prior to the execution of a contract, for any reasons and without penalty, to amend this RFP upon notice to bidders. DVHA reserves the right, at any time prior to the execution of a contract, to cancel this request for proposals and reject all responses. Cancellation may result from, but may not be limited to, elimination of available funding, significant change in circumstances regarding this request for proposal, or lack of necessity for the request for proposals.

1.12. RFP AMENDMENTS

DVHA reserves the right to amend this RFP. DVHA will post any RFP amendments to the Electronic Bulletin Board (<http://www.vermontbidssystem.com>).

1.13. REJECTION RIGHTS

The Commissioner of DVHA reserves the right to reject any and all proposals, to waive any minor irregularities in the proposal, to request clarification of information from any Bidder and effectuate any agreement with one or more Bidders that the Commissioner deems to be in the best interest of individuals and qualified employers. The Commissioner reserves the right to amend or withdraw this RFP at any time prior to the award of a contract. Changes to the contract after its execution by the parties shall be made only by written amendment. The Commissioner reserves the right to amend any contract resulting from this RFP to implement new initiatives or modify initiatives related to (1) changes to Vermont state law, (2) changes in federal law, regulation or policy, and change in the federal Medicaid waivers for Vermont. Furthermore, a proposal may be rejected for one or more of the following reasons or for any other reason deemed to be in the best interest of the State:

- 1.13.1.** The failure of the bidder to adhere to one or more provisions established in this RFP.
- 1.13.2.** The failure of the bidder to submit required information in the format specified in this RFP.
- 1.13.3.** The failure of the bidder to adhere to generally accepted ethical and professional principles during the RFP process.

1.14. AUTHORITY TO BIND DVHA

The Commissioner and Deputy Commissioners of DVHA (in parent AHS Secretary or Deputy Secretary) are the only persons who may legally commit DVHA to any contract agreements.

2. **NON-STANDARD PLAN PROPOSAL REVIEW**

For each Non-Standard plan proposal, the four sub-sections outlined in this section must be responded to within your proposal (see Appendix F). Significant details are to be provided as they relate to Responsiveness to Specifications, Non-Standard Innovative Plan Features, Quality of Bidder's Experience, and Bidder's Readiness to Perform.

A review team of knowledgeable individuals will evaluate each proposal. The team members will consist of subject matter experts from both DVHA and the Department of Financial Regulation. The review team shall review all proposals for compliance with RFP procedural instructions. If the procedural instructions are not followed, the proposal may be considered non-responsive. Non-responsive proposals will be eliminated from further evaluation.

2.1.EVALUATION

Proposals will be evaluated by individual team members. This evaluation is intended to clarify strengths and weaknesses of proposals relative to one another and to provide guidance to the Commissioner of DVHA.

It is expected that proposed non-standardized plan designs will vary from the standardized plan designs to provide a meaningful difference in consumer choice. Meaningful difference in plan designs may include but are not limited to the following:

1. Deductible and Maximum Out of Pocket (MOOP) Changes. All Standardized plans have a Medical Deductible and a MOOP. Any significant differences in deductible and MOOP would also provide consumers with valuable choice. This assumes plans meet ACA requirements as appropriate for both coverage groups, individual and small employer.
2. Specific cost sharing for high utilized services could be adjusted by changing the applicability of the deductible, changing the amount of cost share, and/or changing whether the cost sharing is coinsurance or copay. While not all of these changes will have a difference in the actual out of pocket costs for a consumer, they will provide the consumer with meaningful choice.

It is expected that any non-standardized plan designs will encourage behavior to explore, consider and choose services based on consumer value. Specific examples of plan differences are indicated below. The combination of total differences and the overall effect will be considered to determine meaningful difference.

Examples of Plan Design Differences

Plan Design has a different structure (Copay vs. Deductible vs. HDHP)
Deductible and Maximum Out of Pocket (MOOP) differences
Medical deductible difference
Drug deductible difference of \$50 or more
Medical MOOP difference greater than \$1000
Changes in Cost Sharing for key service categories
Inpatient – at least a 10% difference or if the applicability of the deductible is changed
Outpatient – at least a 10% difference or if the applicability of the deductible is changed
Primary Care Provider Office Visits – at least a \$10 or 10% difference or if the applicability of the deductible is changed
Specialist Office Visits – at least a \$10 or 10% difference or if the applicability of the deductible is changed
Generic Drugs – at least a \$5 average difference or if the applicability of the deductible is changed
Brand Drugs – at least a \$10 or 10% average difference or if the applicability of the deductible is changed
Change from Coinsurance to Copay or vice versa
Inpatient
Outpatient
Primary Care Provider Office Visits
Specialist Office Visits
Additional Rating Tier Offerings

Evaluation Criteria for Non-Standard Plan Proposal
1 TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS
A. Responsiveness to Specifications
<ul style="list-style-type: none"> Bidder will demonstrate and explain how plan meets program goals and which research-based approaches will be employed to meet these goals and how will performance and quality be evaluated.
B. Non-Standard Innovative Plan Features
1. Meaningful Difference from Standard Plan <ul style="list-style-type: none"> Quantitative and qualitative information demonstrating significant differences.
1. Mental Health and Substance Abuse <ul style="list-style-type: none"> Integration and promotion within plan design.
3. Individual Engagement in Preventive Health Programs and Practices <ul style="list-style-type: none"> Use of innovative practices proved effective in engaging individuals in preventive health (could include Wellness, Advanced Primary Care, Patient-Centered Medical Home, Community Health Teams).
4. Payment Reform <ul style="list-style-type: none"> Programs that advance and tighten alignment of financial incentives with healthcare goals.
2 INFORMATION FROM THE BIDDER
A. Quality of Bidder's Experience
<ul style="list-style-type: none"> Specify past outcomes, the number of years and geographic areas served by the bidder with the proposed plan. Data on the number of individuals served, funds expended and sources of funds for same or similar services to those called for in this RFP.
B. Bidder's Readiness to Perform
<ul style="list-style-type: none"> Organizational structure of the bidder, especially as it pertains to any unique program offering. Provide a staff organizational chart that identifies the major operational components of the organization, the lines of authority and responsibility, how this program fits into the organization's structure. Organizational Quality - describe licensures or accreditations of the organization or other indicators of quality review that attest to the quality of bidder programs. As this RFP includes a wide range of services, DVHA recognizes that not all bidders may currently have the capacity to offer these services at the onset of the contract period. Include a detailed strategic plan as to how your company would build this capacity (including specific timelines and activities) in your narrative.

2.2.AWARD OF CERTIFICATION

The Department of Financial Regulation will certify health plans, stand-alone dental plans and issuers. An award of certification does not necessarily mean the plan or issuer will be offered on Vermont Health Connect.

Vermont Health Connect will select among qualified health plans and agree to offer selected health plans for a term of one year beginning January 1, 2014 and ending December 31, 2014. Only health plans certified and selected during this process may be offered through Vermont Health Connect during this period. Certification will be reviewed throughout the year for compliance, but the award of certification will remain so long as

no regulatory issues arise that force decertification. For Decertification standards, see Chapter 3.

2.3.SELECTION

The review team will evaluate the proposals based on responsiveness to this RFP and forward the completed evaluation tools as well as copies of the proposals to the Commissioner for final review and determination of the Apparently Successful Bidder(s).

2.4.NOTIFICATION OF AWARD

DVHA will notify all bidders in writing of selection of the Successful Bidder(s). DVHA will notify all bidders when the contract(s) resulting from this RFP are signed by posting to the Electronic Bulletin Board (<http://www.vermontbidsystem.com>).

3. CONTRACT DEVELOPMENT

3.1.CONTRACT TERM

All contracts entered into as a result of this RFP shall be valid from date of contract agreement to December 31, 2014.

3.2.CONTRACT STIPULATIONS

DVHA reserves the right to incorporate standard contract provisions which can be mutually agreed upon into any contract negotiated as a result of any proposal submitted in response to this RFP. These provisions may include such things as the normal day-to-day relationships with the bidder, but may not substantially alter the requirements of this RFP. Further, bidders must be aware that all material submitted in response to this RFP, as well as the RFP itself, may be incorporated as part of the final negotiated contracts. These contracts will be subject to review throughout their term.

4. STATE AND AGENCY CUSTOMARY CONTRACTING PROVISIONS

ATTACHMENT C CUSTOMARY PROVISIONS FOR CONTRACTS AND GRANTS

- 1. Entire Agreement.** This Agreement represents the entire agreement between the parties on the subject matter. All prior agreements, representations, statements, negotiations, and understandings shall have no effect.
- 2. Applicable Law.** This Agreement will be governed by the laws of the State of Vermont.
- 3. Definitions:** For purposes of this Attachment, "Party" shall mean the Contractor (Issuer) with whom the State of Vermont is executing this Agreement and consistent with the form of the Agreement.
- 4. No Employee Benefits For Party:** The Party understands that the State will not provide any individual retirement benefits, group life insurance, group health and dental insurance, vacation or sick leave, workers compensation or other benefits or services available to State employees, nor will the state withhold any state or federal taxes

except as required under applicable tax laws, which shall be determined in advance of execution of the Agreement. The Party understands that all tax returns required by the Internal Revenue Code and the State of Vermont, including but not limited to income, withholding, sales and use, and rooms and meals, must be filed by the Party, and information as to Agreement income will be provided by the State of Vermont to the Internal Revenue Service and the Vermont Department of Taxes.

5. **Independence, Liability:** The Party will act in an independent capacity and not as officers or employees of the State.

The Party shall defend the State and its officers and employees against all claims or suits arising in whole or in part from any act or omission of the Party or of any agent of the Party. The State shall notify the Party in the event of any such claim or suit, and the Party shall immediately retain counsel and otherwise provide a complete defense against the entire claim or suit. The Party shall notify its insurance company and the State within 10 days of receiving any claim for damages, notice of claims, pre-claims, or service of judgments or claims, for any act or omissions in the performance of this Agreement.

After a final judgment or settlement the Party may request recoupment of specific defense costs and may file suit in Washington Superior Court requesting recoupment. The Party shall be entitled to recoup costs only upon a showing that such costs were entirely unrelated to the defense of any claim arising from an act or omission of the Party.

The Party shall indemnify the State and its officers and employees in the event that the State, its officers or employees become legally obligated to pay any damages or losses arising from any act or omission of the Party.

6. **Insurance:** Before commencing work on this Agreement the Party must provide certificates of insurance to show that the following minimum coverage is in effect. It is the responsibility of the Party to maintain current certificates of insurance on file with the state through the term of the Agreement. No warranty is made that the coverage and limits listed herein are adequate to cover and protect the interests of the Party for the Party's operations. These are solely minimums that have been established to protect the interests of the State.

Workers Compensation: With respect to all operations performed, the Party shall carry workers' compensation insurance in accordance with the laws of the State of Vermont.

General Liability and Property Damage: With respect to all operations performed under the Agreement, the Party shall carry general liability insurance having all major divisions of coverage including, but not limited to:

Premises – Operations
 Products and Completed Operations
 Personal Injury Liability

Contractual Liability

The policy shall be on an occurrence form and limits shall not be less than:

\$1,000,000 Per Occurrence

\$1,000,000 General Aggregate

\$1,000,000 Products/Completed Operations Aggregate

\$ 50,000 Fire/ Legal/Liability

Party shall name the State of Vermont and its officers and employees as additional insureds for liability arising out of this Agreement.

Automotive Liability: The Party shall carry automotive liability insurance covering all motor vehicles, including hired and non-owned coverage, used in connection with the Agreement. Limits of coverage shall not be less than: \$1,000,000 combined single limit.

Party shall name the State of Vermont and its officers and employees as additional insureds for liability arising out of this Agreement.

Professional Liability: Before commencing work on this Agreement and throughout the term of this Agreement, the Party shall procure and maintain professional liability insurance for any and all services performed under this Agreement, with minimum coverage of \$ n/a per occurrence, and \$ n/a aggregate.

- 7. Reliance by the State on Representations:** All payments by the State under this Agreement will be made in reliance upon the accuracy of all prior representations by the Party, including but not limited to bills, invoices, progress reports and other proofs of work.
- 8. Fair Employment Practices and Americans with Disabilities Act:** Party agrees to comply with the requirement of Title 21V.S.A. Chapter 5, Subchapter 6, relating to fair employment practices, to the full extent applicable. Party shall also ensure, to the full extent required by the Americans with Disabilities Act of 1990, as amended, that qualified individuals with disabilities receive equitable access to the services, programs, and activities provided by the Party under this Agreement. Party further agrees to include this provision in all subcontracts.
- 9. Taxes Due to the State:**
- a. Party understands and acknowledges responsibility, if applicable, for compliance with State tax laws, including income tax withholding for employees performing services within the State, payment of use tax on property used within the State, corporate and/or personal income tax on income earned within the State.
 - b. Party certifies under the pains and penalties of perjury that, as of the date the Agreement is signed, the Party is in good standing with respect to, or in full compliance with, a plan to pay any and all taxes due the State of Vermont.

- c. Party understands that final payment under this Agreement may be withheld if the Commissioner of Taxes determines that the Party is not in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont.
- d. Party also understands the State may set off taxes (and related penalties, interest and fees) due to the State of Vermont, but only if the Party has failed to make an appeal within the time allowed by law, or an appeal has been taken and finally determined and the Party has no further legal recourse to contest the amounts due.

10. Sub-Agreements: Party shall not assign, subcontract or subgrant the performance of his Agreement or any portion thereof to any other Party without the prior written approval of the State. Party also agrees to include in subcontract or subgrant agreements a tax certification in accordance with paragraph 13 above.

Notwithstanding the foregoing, the State agrees that the Party may assign this agreement, including all of the Party's rights and obligations hereunder, to any successor in interest to the Party arising out of the sale of or reorganization of the Party.

- 11. No Gifts or Gratuities:** Party shall not give title or possession of anything of substantial value (including property, currency, travel and/or education programs) to any officer or employee of the State during the term of this Agreement.
- 12. Copies:** All written reports prepared under this Agreement will be printed using both sides of the paper.
- 13. Certification Regarding Debarment:** Party certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, neither Party nor Party's principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in federal programs or programs supported in whole or in part by federal funds.
- 14. Certification Regarding Use of State Funds:** In the case that Party is an employer and this Agreement is a State Funded Grant in excess of \$1,001, Party certifies that none of these State funds will be used to interfere with or restrain the exercise of Party's employee's rights with respect to unionization.

State of Vermont - Attachment C
Revised AHS - 7-1-2012

ATTACHMENT F AGENCY OF HUMAN SERVICES' CUSTOMARY CONTRACT PROVISIONS

- 1. Agency of Human Services - Field Services Directors** will share oversight with the department (or field office) that is a party to the contract for provider performance using outcomes, processes, terms and conditions agreed to under this contract.

2. **2-1-1 Data Base:** The contractor providing a health or human services within Vermont, or near the border that is readily accessible to residents of Vermont, will provide relevant descriptive information regarding its agency, programs and/or contact and will adhere to the "Inclusion/Exclusion" policy of Vermont's United Way/Vermont 211. If included, the contractor will provide accurate and up to date information to their data base as needed. The "Inclusion/Exclusion" policy can be found at www.vermont211.org
3. **Non-discrimination Based on National Origin as evidenced by Limited English Proficiency.** The Contractor agrees to comply with the non-discrimination requirements of Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, et seq., and with the federal guidelines promulgated pursuant to Executive Order 13166 of 2000, which require that contractors and subcontractors receiving federal funds must assure that persons with limited English proficiency can meaningfully access services. To the extent the contractor provides assistance to individuals with limited English proficiency through the use of oral or written translation or interpretive services in compliance with this requirement, such individuals cannot be required to pay for such services.
4. **Drug Free Workplace Act.** The Contractor will assure a drug-free workplace in accordance with 45 CFR Part 76.
5. **Privacy and Security Standards.**

Protected Health Information: The Contractor shall maintain the privacy and security of all individually identifiable health information acquired by or provided to it as a part of the performance of this contract. The Contractor shall follow federal and state law relating to privacy and security of individually identifiable health information as applicable, including the Health Insurance Portability and Accountability Act (HIPAA) and its federal regulations.

Substance Abuse Treatment Information: The confidentiality of any alcohol and drug abuse treatment information acquired by or provided to the Contractor or subcontractor shall be maintained in compliance with any applicable state or federal laws or regulations and specifically set out in 42 CFR Part 2.

Other Confidential Consumer Information: The Contractor agrees to comply with the requirements of AHS Rule No. 08-048 concerning access to information. The Contractor agrees to comply with any applicable Vermont State Statute, including but not limited to 12 VSA §1612 and any applicable Board of Health confidentiality regulations. The Contractor shall ensure that all of its employees and subcontractors performing services under this agreement understand the sensitive nature of the information that they may have access to and sign an affirmation of understanding regarding the information's confidential and non-public nature.

Social Security numbers: The Contractor agrees to comply with all applicable Vermont State Statutes to assure protection and security of personal information, including protection from identity theft as outlined in Title 9, Vermont Statutes Annotated, Ch. 62.
6. **Security and Data Transfers.** The State shall work with the Contractor to ensure

compliance with all applicable State and Agency of Human Services' policies and standards, especially those related to privacy and security. The State will advise the Contractor of any new policies, procedures, or protocols developed during the term of this agreement as they are issued and will work with the Contractor to implement any required.

The Contractor will ensure the physical and data security associated with computer equipment – including desktops, notebooks, and other portable devices – used in connection with this agreement. The Contractor will also assure that any media or mechanism used to store or transfer data to or from the State includes industry standard security mechanisms such as continually up-to-date malware protection and encryption. The Contractor will make every reasonable effort to ensure media or data files transferred to the State are virus and spyware free. At the conclusion of this agreement and after successful delivery of the data to the State, the Contractor shall securely delete data (including archival backups) from the Contractor's equipment that contains individually identifiable records, in accordance with standards adopted by the Agency of Human Services.

7. **Computing and Communication:** The Contractor shall select, in consultation with the Agency of Human Services' Information Technology unit, one of the approved methods for secure access to the State's systems and data, if required. Approved methods are based on the type of work performed by the Contractor as part of this agreement. Options include, but are not limited to:
1. Contractor's provision of certified computing equipment, peripherals and mobile devices, on a separate Contractor's network with separate internet access. The Agency of Human Services' accounts may or may not be provided.
 2. State supplied and managed equipment and accounts to access state applications and data, including State issued active directory accounts and application specific accounts, which follow the National Institutes of Standards and Technology (NIST) security and the Health Insurance Portability & Accountability Act (HIPAA) standards.

The State will not supply e-mail accounts to the Contractor.

8. **Non-discrimination.** The Contractor will prohibit discrimination on the basis of age under the Age Discrimination Act of 1975, on the basis of handicap under section 504 of the Rehabilitation Act of 1973, on the basis of sex under Title IX of the Education Amendments of 1972, or on the basis of race, color or national origin under Title VI of the Civil Rights Act of 1964. No person shall on the grounds of sex (including, in the case of a woman, on the grounds that the woman is pregnant) or on the grounds of religion, be excluded from participation in, be denied the benefits of, or be subjected to discrimination, to include sexual harassment, under any program or activity supported by state and/or federal funds.

The Contractor will also not refuse, withhold from or deny to any person the benefit of services, facilities, goods, privileges, advantages, or benefits of public accommodation on the basis of disability, race, creed, color, national origin, marital status, sex, sexual orientation or gender identity under Title 9 V.S.A. Chapter 139.

9. **Environmental Tobacco Smoke.** Public Law 103-227, also known as the Pro-children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, child care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds.

The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, & Children (WIC) coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

Contractors are prohibited from promoting the use of tobacco products for all clients. Facilities supported by state and federal funds are prohibited from making tobacco products available to minors.

Attachment F – Revised AHS –12/10/10

CHAPTER 2

TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

PROGRAM SUMMARY

Vermont Health Connect has worked in conjunction with the Department of Financial Regulation to identify the requirements to be certified as a Qualified Health Plan in Vermont Health Connect. Pursuant to these requirements, DVHA is issuing this RFP to:

- a) Articulate standards for QHP certification, decertification, and recertification applicable to issuers and health plans seeking to offer coverage through Vermont Health Connect;
- b) Specify the process by which issuers and health plans will be evaluated for certification; and
- c) Solicit responses from issuers seeking to offer coverage through Vermont Health Connect.

Issuers seeking to offer plans through Vermont Health Connect must respond to this RFP and meet the criteria and process requirements it contains in order to be evaluated for participation in Vermont Health Connect. Only health plans (1)

submitting responses which demonstrate the ability to satisfy the criteria set forth in this RFP; (2) agreeing to the minimum federal requirements of a QHP as outlined in 45 CFR Parts §155 and §156; (3) submitting all rates and forms through the SERFF system to the Department of Financial Regulation (hereinafter “DFR”); (4) executing Vermont Health Connect Issuer Agreements, and (5) agreeing to be operationally ready by October 1, 2013, will be accepted for participation in Vermont Health Connect. Qualified health plans selected will be displayed on the Vermont Health Connect website beginning in the summer of 2013 for sale on October 1, 2013 and will have an effective date of coverage beginning January 1, 2014.

This RFP invites health insurance issuers to formally express interest in providing qualified health plans to be offered on Vermont Health Connect. The Department of Vermont Health Access seeks only organizations firmly committed to the ideals of health care reform: providing affordable, high quality, accessible health coverage to all Vermonters.

RESPONSIBILITIES OF BIDDER

1. PROGRAM REQUIREMENTS

1.1 COMPLIANCE WITH FEDERAL QHP CERTIFICATION STANDARDS

Participating issuers will be subject to all applicable ACA provisions and related federal regulations. Including, but not limited to:

Requirement Category	Federal Certification Standard
Licensing	45 CFR §156.200(b)(4)
Accreditation	45 CFR §156.275
Health Care Quality	45 CFR §156.200(b)(5)
Risk Adjustment	45 CFR §156.200(b)(7)
Actuarial Value Designation	Forthcoming
Offering Requirements	45 CFR §156.200(c)
Rating Variations	45 CFR §156.255
Marketing	45 CFR §156.225
Abortion Services	45 CFR §156.280
Premium Rate and Benefit Information	45 CFR §156.210
Service Area	45 CFR §155.1050
Network Adequacy	45 CFR §156.230
Enrollment Processes and Periods	45 CFR §156.260 (small employer,; 45 CFR §155.725)
Transparency in Coverage	45 CFR §156.220
Non-discrimination	45 CFR §156.200(e)
Benefit Design Standards	45 CFR §456.200(b)(3)

1.2 COMPLIANCE WITH VERMONT INSURANCE REGULATIONS

Only plans selected by the Commissioner of DVHA may be offered through Vermont Health Connect. Products developed for Vermont Health Connect not currently approved for sale in Vermont must be submitted to the Department of Financial Regulation for its review and approval. All licensure and product filing requirements of the DFR shall apply to qualified health plans offered through Vermont Health Connect. Issuers must adhere to all Vermont state insurance laws and regulations, including, but not limited to:

Requirement Category	Current Vermont Regulations
Licensing	<ul style="list-style-type: none"> • 8 V.S.A §4080(a) • 8 V.S.A §4080(b) • 8 V.S.A §4813(b)
Accreditation	n/a
Health Care Quality	<ul style="list-style-type: none"> • Rule H-2009-03 • Rule H-2007-05
Rating Variations	<ul style="list-style-type: none"> • 8 V.S.A §4080a(h)(1) • 33 V.S.A §1811(f)
Marketing	<ul style="list-style-type: none"> • 8 V.S.A §4084 • 8 V.S.A. §3368(a)
Premium Rate and Benefit Information	<ul style="list-style-type: none"> • 8 V.S.A §4062 • 33 V.S.A §1811(i) • Rule H-2009-03
Service Area	<ul style="list-style-type: none"> • Rule H-2009-03
Network Adequacy	<ul style="list-style-type: none"> • Rule H-2009-03
Enrollment Processes and Periods	<ul style="list-style-type: none"> • 33 V.S.A §1805 • 8 V.S.A §4089 (h) • 18 V.S.A §9410 • 8 V.S.A. §4090 (c) • 8 V.S.A. §4091 • PPACA, specifically §1412, c(2)(B)(II)
Transparency in Coverage	<ul style="list-style-type: none"> • Rule H-2009-03 • 33 V.S.A §1806
Non-discrimination	<ul style="list-style-type: none"> • 8 V.S.A §4083
Wellness	<ul style="list-style-type: none"> • Rule H-2008-05

1.3 OFFERING REQUIREMENTS

An issuer must offer plans through Vermont Health Connect at each of the four coverage metal levels described at 42 U.S.C. 18022(d)(1), and in accordance with 42 U.S.C. 18021(a) (1), and 33 V.S.A. 1806(b)(2). To be eligible to offer plans on the Vermont Health Connect, an issuer must, at a minimum, submit each of the six specified standard plans approved by the Green Mountain Care Board (Appendix D). Issuers must also offer a child-only plan at each level of coverage, or offer a single QHP as long as the QHP includes rating for child-only coverage in accordance with applicable premium rating rules. Such a plan must only be offered to individuals who, at the start of the plan year, have not reached the age

of 21. If a catastrophic plan is proposed, the same requirements and review process will apply. Only one catastrophic plan per issuer may be submitted.

- a) Family Rating Tiers – An issuer shall offer a health benefit plan rate structure which at least differentiates between single person, two person, and family rates. Issuers are encouraged to offer a fourth tier for single head-of-household.
- b) Vermont Specified Plan Designs – Issuers must offer benefit designs that conform with Vermont-specified standard plan designs and the limitations on the number of plans that may be submitted as provided in section 2.1, below.

Allocation—Issuers must provide the allocation of the rate and expected claims costs for: (1) the plan for EHB coverage, excluding abortion services under 45 CFR §156.280 and (2) any other services or benefits. The allocation must comply with the standards set out in 45 CFR § 156.470(c). For stand-alone dental plans, the issuer must provide a dollar allocation of the expected premium for the plan for: (1) pediatric EHB and (2) any benefits that are not pediatric EHB.

1.4 DENTAL OFFERING GUIDELINES

Stand-alone Dental Plans – Vermont Health Connect must allow for the offer of a limited scope dental benefits plan if the plan meets the requirements of section 9832(c)(2)(A) of the Internal Revenue Code, and section 2791(c)(2)(A) of the Public Health Service Act and covers at least the pediatric dental essential health benefits, as provided at 42 U.S.C. 18031(d). A stand-alone dental plan may be offered either independently from a QHP or as a subcontractor of an issuer (45 CFR § 155.1065, 77 FR 18411). The plan and the issuer of such plan must meet the applicable QHP certification standards defined by the ACA except for any certification requirement that cannot be met because the plan only covers the pediatric dental essential health benefit, and as defined by the State of Vermont as set forth in Appendix H. Stand-alone dental plans may offer plans at any of the four rating tiers described in section 1.3. A stand-alone dental plan must offer a child only plan pursuant to 45 CFR § 155.1065(a)(3). **Vermont Health Connect will not approve bundled dental plans.**

Pediatric Dental Essential Health Benefit – Vermont Health Connect allows an issuer the choice whether to integrate the pediatric oral health benefit, or to separately offer and separately price the pediatric dental benefit. Cost-sharing limits and the restrictions on annual and lifetime limits apply to stand-alone dental plans for pediatric dental essential health benefit coverage. QHPs and limited scope dental plans offering pediatric oral health benefits must accumulate claims to an integrated deductible and an integrated out of pocket maximum. **Stand-alone dental plans accumulate claims separately.** Pediatric dental benefits will have no cost-sharing for Class I services, 30% cost-sharing for Class II services, and 50% for Class III services. **Vermont Health Connect will only approve PED plans at both the 75% and 85% AV level.** Pediatric dental benefits are available to individuals who as of the beginning of a plan year have not attained 21 years of age.

1.5 SMALL BUSINESS–SPECIFIC GUIDELINES

Qualified employers with 50 or fewer employees not offering a grandfathered health plan to their employees must use Vermont Health Connect to provide employees with a meaningful choice of qualified health plans. Small employers participating in Vermont Health Connect will select a “choice” model of plans and set a contribution level, and then their employees will use this contribution to select a qualified health plan. Vermont Health Connect will transmit enrollment information to issuers, notify employees of the effective date of coverage, administer payments, terminate non-compliant employers, receive and maintain enrollment and participation records, reconcile information at least monthly, and notify the employer and the issuer if an employee terminates coverage. Vermont Health Connect will administer enrollment periods, including the initial open enrollment period, and ensure that enrollment transactions are sent to issuers, who must adhere to all coverage effective dates.

Vermont Health Connect will provide the capability to easily report changes to issuers, and accept information from issuers on changes to employer/employee information.

Because employees can have a choice of plans, this means that a given employer’s employees may be enrolled with multiple issuers. Federal regulations require Vermont Health Connect to provide employers with a single bill on a monthly basis that identifies the employer contribution, the employee contribution, and the total amount that is due. Vermont Health Connect must collect payments from employers and distribute them to issuers. Upon selection, issuers must comply with the small employer program premium methodology.

Vermont Health Connect will work with the selected issuers to build and maintain the processes, file formats and technology deemed necessary for the transmission of enrollment, financial, and other essential data between Vermont Health Connect and the issuers. This includes any existing requirements at the time of the contracting process, and any state or federally mandated data collection and reporting changes. All issuers offering health benefit plans through Vermont Health Connect must be able to accept enrollment data and financial data in the required format.

1.6 COST–SHARING SUBSIDY SUBMISSION GUIDELINES

Section 1402(a)–(c) of the Affordable Care Act directs issuers to reduce cost sharing on essential health benefits (EHB) for an individual with a household income of 400 percent of the Federal Poverty Level (FPL) or below who enrolls in a silver-level qualified health plan (QHP) through an Exchange. Additionally, section 1402(d) of the Affordable Care Act directs an issuer to eliminate cost sharing for an Indian (as defined in Section 4(d) of the Indian Self-Determination and Education Assistance Act) with a household income of 300 percent of the FPL or below who is enrolled through the Exchange in a QHP at any level of coverage. CMS has issued the “Actuarial Value and Cost-Sharing Reductions Bulletin” in which CMS outlines its intended approach to implementing cost-sharing reductions for eligible individuals and to making payments to issuers for these reductions.

Issuers offering qualified health plan in Vermont Health Connect must participate in any and all applicable state and federal cost sharing subsidy guidelines. Recently released federal regulations state that the issuer must submit to the Exchange for certification and approval the cost-sharing silver variations. Cost-sharing and cost-sharing reductions apply only with respect to EHB services. The de minimis value for silver plan variation is 1%, as opposed to 2% for standard silver plans.

In designing the plan, the issuer should first reduce maximum annual limitation on cost-sharing. The maximum annual limitation for 2014 is estimated at \$6,400 for individual plans and \$12,800 for non-individual plans. For individuals within 100-250% FPL, issuers should reduce the maximum annual limitation to the following numbers:

Eligibility	Reduced maximum annual limitation for individual	Reduced maximum annual limitation for non-individual
100-150% FPL	\$2,250	\$4,500
150-200% FPL	\$2,250	\$4,500
200-250% FPL	\$5,200	\$10,400
250%+	\$6,400	\$12,800

The reduced maximum annual limitation has been modified for “potential inaccuracies.” As a result, the numbers provided under federal regulations do not align with the fractions of maximum annual limitations released under the Affordable Care Act.

Next, if reducing the maximum annual limitation results in an AV that is off by more than 1%, then adjust cost-sharing structure to achieve the applicable AV levels by decreasing copayments, deductibles or coinsurance (or further reduce the annual limitation on cost sharing). The cost sharing reductions at lower AV levels must be the same or more generous than those at higher AV levels to ensure standardization. Accordingly, the deductible at an 87% AV level must be the same or higher than a deductible at the 94% AV level.

When designing the silver plan variation for 200-250% FPL, the variation must differ by at least 2% from the standard silver plan. For instance, if the standard silver plan has a 72% AV due to the de minimis AV, then the 200-250% FPL AV plan must have a 74% AV.

The QHP issuer must ensure that the individual eligible for cost-sharing reductions pay only the cost sharing required for a service when the payment is collected. The issuer cannot require the individual to pay full cost and then apply for reimbursement or a refund.

Reduced Cost Sharing for Standardized Plans – Cost sharing reductions for the standardized plan designs will be defined by DHVA once the Federal AV calculator is released and HHS publishes the annual notice of benefits and payment parameters (the annual notice will define the reduced maximum out of pocket for each of the federal subsidization levels). The reduced cost sharing will only be defined for the service categories specified in the standardized plan designs. Cost sharing for other services can be proposed by the issuer in accordance with section 2.1.

Reduced Cost Sharing for Non-Standardized Plans – Cost sharing reductions for the non-standardized plan designs will be proposed by the issuer. DHVA will provide the issuers with requirements for which they must comply in the development of the reduced cost sharing. DHVA will release these requirements once the Federal AV calculator is released and HHS publishes the annual notice of benefits and payment parameters. DHVA may incorporate requirements such as reductions in the maximum out of pocket beyond the federal requirements, maximum deductible amounts, and a preference for which service categories receive reduced cost sharing (copays and co-insurance). Requirements will vary based on the level of cost sharing subsidization.

1.7 ENROLLMENT POLICIES AND PROCEDURES

Issuers must comply with the following enrollment policies and procedures.

Initial Open Enrollment for: Qualified individual subscribers and their qualified dependents will occur between October 1, 2013 and March 31, 2014.

Vermont Health Connect and issuers offering through Vermont Health Connect will enroll:

1. Qualified individual subscribers and their qualified dependents. For QHP selection received on or before December 15, 2013, coverage is effective on January 1, 2014. For QHP selection between the first and fifteenth of any subsequent month during the initial open enrollment period, coverage is effective the first day of the following month. For QHP selection between the sixteenth and the last day of any month during the initial open enrollment period, coverage is effective the first day of the second following month. Individual subscribers and their qualified dependents (if applicable) may change their QHP selection during the initial open enrollment period specified above.
2. Qualified small employer groups and their qualified employees (and their eligible dependents if applicable). For QHP selection received on or before December 15, 2013, coverage is effective on January 1, 2014. For QHP selection between the first and fifteenth of any subsequent month during the initial open enrollment period, coverage is effective the first day of the following month. For QHP selection between the sixteenth and the last day of any month during the initial enrollment period, coverage is effective the first day of the second following month.

Annual Open Enrollment for: Qualified individual subscribers and their qualified dependents for benefit years beginning on or after January 1, 2015, the annual open enrollment period begins October 15 and extends through December 7 of the preceding calendar year. Starting in 2014, Vermont Health Connect must provide a written open enrollment notification no earlier than September 1, and no later than September 30.

Vermont Health Connect and issuers offering through Vermont Health Connect will enroll:

1. Qualified individual subscribers and their qualified dependents. For QHP selection received during the annual open enrollment period, coverage is effective the first day of the following benefit year. Individual subscribers and their qualified dependents (if applicable) may change their QHP selection during the annual open enrollment period specified above.

Annual Open Enrollment for: Qualified small employer groups and their qualified employees (and their eligible dependents if applicable) for benefit years beginning on or after January 1, 2014.

Vermont Health Connect and issuers offering through Vermont Health Connect must:

1. Provide a period of no less than 30 days prior to the completion of the employer's plan year and before the annual employee open enrollment in which to change its participation in Vermont Health Connect.
2. Permit a qualified employer to purchase coverage at any point during the year. The employer's plan must consist of a 12-month period beginning with the qualified employer's effective date of coverage.
3. Allow for an annual open enrollment period of no less than 30 days for a qualified employee, prior to the completion of the employer's plan year.
4. Allow for an employee who becomes a qualified employee outside of the initial or annual open enrollment period to seek coverage in a QHP beginning the first day of becoming a qualified employee.
5. Allow for special open enrollments, not otherwise defined as a triggering event; including, but not limited to, errors with enrollment stemming from clerical, processing or other undefined exceptions to special enrollment periods. The state will provide further guidance prior to open enrollment on October 1, 2013 on how individuals will apply for a waiver to open enrollment in these to be defined special circumstances.

Special Enrollment Periods: Qualified individual subscribers and their qualified dependents must be allowed a period of sixty (60) days to enroll in or change their QHP selection as a result of a qualifying event as defined by Vermont Health Connect and Vermont law.

Vermont Health Connect and issuers offering through Vermont Health Connect will enroll:

1. Qualified individual subscribers and their qualified dependents. For a QHP selection received between the first and fifteenth day of any month, coverage is effective the first day of the following month. For a QHP selection received between the sixteenth and that last day of any month, coverage is effective the first day of the second following month.
2. Qualified individual subscribers and their qualified dependents. Coverage is not effective until the first day of the following month in the case of birth, adoption, or placement for adoption, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage or a loss of minimum essential coverage as defined by Vermont Health Connect, coverage is effective on the first day of the following month.

Enrollee Notification for: (1) Qualified individual subscribers and their qualified dependents, and (2) Qualified small employer groups and their qualified employees (and their eligible dependents if applicable) must be notified of their effective dates of coverage and be provided with an enrollment information package consistent with accessibility and readability standards as defined by Vermont Health Connect.

Enrollment Process for qualified individuals: for Qualified individual subscribers and their qualified dependents

Vermont Health Connect will accept a QHP selection from an applicant who is determined eligible for enrollment in a QHP in accordance with the process defined in Subpart D of Part 155 of Title 45 of the Code of Federal Regulations (CFR) and any applicable standards adopted by State Law. Vermont Health Connect and issuers offering through Vermont Health Connect will enroll qualified individuals using a process that is consistent with the enrollment requirements defined in 45 CFR § 156.265.

Termination of coverage: for Qualified individual subscribers and their qualified dependents. An issuer may only terminate coverage as permitted by the Vermont Health Connect policies outlined in 45 CFR §155.430. Vermont Health Connect must provide to the enrollee, and to the issuer a notice of termination, including reason for termination in accordance with Vermont law.

Non-payment of Premium: by Qualified individual subscribers. Vermont Health Connect must establish a policy that allows for the termination of coverage due to non-payment of premium by the enrollee. The policy must include a grace period of three consecutive months for enrollees receiving advanced payments of premium tax credits, as allowed for in 45 CFR § 156.270(d), and must be applied uniformly to all enrollees in similar

circumstances. If an enrollee is delinquent on premium payments, Vermont Health Connect must provide the enrollee with notice of such delinquency.

1.8 QUALITY INITIATIVES

Issuers shall comply with DFR Rule H-09-03, applicable Vermont law and applicable federal law. As CMS guidance becomes available, an issuer must implement and report on the required quality improvement strategy or strategies consistent with the standards of section 1311(g) of the ACA including quality reporting, effective case management, care coordination, chronic disease management, medication compliance and others; disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H) including information on clinical conditions; and (I) of the ACA, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the ACA in which the Secretary develops such a survey to evaluate the level of satisfaction with a plan offered through Vermont Health Connect.

1.9 REPORTING REQUIREMENTS

Issuers shall comply with all applicable State and Federal reporting requirements, including but not limited to those associated with:

- annual and quarterly financial statements
- form and rate filings, and
- Vermont Rules H-2007-05, H-2008-01, and H-2009-03

Reporting requirements pursuant to 45 CFR §156.220 must be submitted in an accurate and timely manner and utilize plain language, as defined by §1311(e)(3)(B) of the ACA. The manner and timeframe of the submissions will be determined by HHS. The information reported must be made available to Vermont Health Connect, HHS, the Commissioner of the Department of Financial Regulation, and the public.

Issuers will submit prescription drug distribution and cost reports to HHS as required by 45 CFR §156.295. The form and manner for the report shall be specified by HHS.

Vermont Health Connect will provide issuers with recurring enrollment reports. Issuers must identify and reconcile any discrepancies between the data transmitted from Vermont Health Connect and data maintained by the issuer. The enrollment report shall include subscriber data pertinent to enrollment status, eligibility, and demographic data. The system specifications and data dictionary will be jointly developed by issuers and Vermont Health Connect.

1.10 ACCREDITATION REQUIREMENTS

An issuer will be accredited on the basis of local performance of its QHPs by an accrediting entity recognized by HHS. The accrediting entity may release to Vermont Health Connect and HHS a copy of its accreditation survey and any other related information. The issuer

must be accredited within the timeframe established by the Vermont Health Connect, and must maintain accreditation so long as the issuer offers the QHP.

An issuer must present evidence that they are accredited by either URAC or NCQA, or that they will have applied for accreditation by open enrollment on October 1, 2013. Issuers not URAC or NCQA accredited by execution of the contract for offering on Vermont Health Connect shall comply with federal guidance, 45 CFR §156.275(b), regarding accreditation timelines and standards.

1.11 PROVIDER DIRECTORY

Issuers will make the provider directories for its QHP(s) available to Vermont Health Connect for publication online in accordance with any guidance from Vermont Health Connect. The provider directory must also be made available to potential enrollees in hard copy upon request. Within the provider directory, an issuer must identify providers that are not accepting new patients.

For each health benefit plan proposed, issuers should submit in electronic format a listing of in-network providers by practice specialty and location/zip code. A separate file should be included that lists the name and location/zip code of in-network hospitals. This data shall be sent in an electronic format, and all data requests from Vermont Health Connect shall be handled in a timely manner to ensure the public is being provided the most up to date plan information.

At a minimum, Vermont Health Connect will provide a link on the Vermont Health Connect website to the online provider directory of that QHP. In the future, this may be superseded by the development of a state Master Provider Directory intended to expand consumer search and comparison options by offering a tool that narrows a plan search by the consumer's personal physician or hospital preference. Issuers will be required to support this future state effort when it occurs.

All issuers must ensure that their provider directories are in compliance with H-09-03 and other applicable Vermont statutes.

1.12 CUSTOMER SERVICE AND MEMBER TRANSITION SUPPORT

Vermont Health Connect will contract with third-party entities to handle customer service, enrollment, premium billing and collection, and IT administrative functions. These entities will also provide individuals, employers, employees, and brokers with information about the qualified health plans available through the Vermont Health Connect.

Issuers will be expected to have customer service representatives available during normal business hours to assist enrolled consumers with Claims related inquires, to respond to inquiries from potential enrollees to direct them to the Vermont Health Connect, and to coordinate customer service between their own representatives, Vermont Health Connect, and the Customer Support Center vendor's representatives.

The state of Vermont is developing a set of operational processes and technical integration designs that will establish a standard of consistency for how external partners will interact with the state. It is the expectation of the state that issuers that would like to offer their benefit plans through Vermont Health Connect will comply with and use the standards defined by the state.

1.13 MARKETING INITIATIVES

All issuers will be expected to actively market products available through Vermont Health Connect and to participate in joint marketing efforts with Vermont Health Connect, which has established its own logo and will create a “bug” that designates the certification of a qualified health plan. The logo or bug cannot be modified, and no other logo can be used to represent Vermont Health Connect or certification of a qualified health plan. Vermont Health Connect will review and approve the use of the logo and bug on any issuer’s marketing materials. Issuers will be able to review any Vermont Health Connect marketing materials that use the issuer’s logo.

Issuers will be required to post one brochure and one benefit summary for each QHP offered on the Vermont Health Connect website. In these marketing materials issuers can, but are not required to, communicate that the plan was selected by Vermont Health Connect as a qualified health plan and was certified by the Department of Financial Regulation. The issuer cannot communicate that Vermont Health Connect’s selection of a qualified health plan implies any form of endorsement or support of the qualified health plan. An issuer and its officials, employees, agents and representatives must not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs (§156.225(b)). Marketing materials should be submitted in PDF form.

Selected issuers will be expected to create marketing and enrollment materials in advance of the October 1, 2013 open enrollment date. It is the expectation of the state that further guidance will be forthcoming and issuers will comply with and use this guidance as defined by the state. Issuers shall also submit advertisement to the Department of Financial Regulation, pursuant to DFR Regulation 91-4b.

1.14 PROVIDER NETWORK

An issuer must ensure that the network of each of its QHPs meets the following standards:

- i. Maintain a network that is sufficient in number and type of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay;
- ii. Includes essential community providers in accordance with 45 CFR §156.235;
- iii. Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act. (45 CFR §156.230(a)); and
- iv. Complies with network adequacy requirements of Rule H-2009-03.

1.15 OPERATIONAL REQUIREMENTS

The state of Vermont is developing a set of operational processes and technical integration designs based on Service Oriented Architecture that will establish a standard of consistency for how external partners will interact with the state. It is the expectation of the state that issuers that would like to offer their benefit plans through Vermont Health Connect will comply with and use the standards defined by the state. The State of Vermont is also in the process of developing a data exchange service level agreement with which the issuer will be expected to comply.

Vermont expects the effort of the issuer will reflect adherence and outcomes consistent with:

- Vermont's Service Oriented Architecture (SOA) platform - which is the Oracle Suite
- Building scalable solutions to meet the needs across the Agency
- Medicaid Information Technology Architecture (MITA) 3.0 framework and the CMS Seven Standards and Conditions; and
- Leveraging any guidance, information and solutions made available for reuse by CMS and/or exist in CALT

2. PLAN DESIGN PARAMETERS

Vermont Health Connect will offer to qualified individuals and qualified employees of qualified employers a combination of both standardized benefit designs that have been selected by the state, as well as discretionary non-standard benefit designs that may be developed by issuers and selected for offer by Vermont Health Connect. All benefit design offerings must comply with federal requirements related to QHPs, Actuarial Value (AV) standards, and must also meet Vermont regulatory and statutory requirements, as indicated above. All plans, standard or non-standard, must at a minimum, provide the full list of services in the benchmark Vermont Health Plan, Blue Care Certificate of Coverage, and any as approved by the Green Mountain Care Board.

2.1 STANDARDIZED PLAN DESIGNS

Issuers are required to submit plans for each of the standardized plan designs specified by Vermont Health Connect at required metal levels. The specific plan designs are outlined in Appendix D. These plan designs will be adjusted and/or modified if necessary once the federal actuarial value calculator is released, to the extent needed to comply with the actuarial value requirements. All Essential Health Benefits (EHB) and cost sharing will adhere to Green Mountain Care Board (GMCB) plan design decisions.

For all cost sharing not specifically indicated in the GMCB approved Standard Plans, issuers shall define these service related co-pays, or co-insurance, within an existing approved service category within the corresponding metal level approved by the GMCB. If issuers cannot apply the cost-sharing of an existing category issuers shall explain which are not

and why they are not, and propose cost sharing values for the services. These proposals must adhere to metal level AV calculation standards and other plan design criteria per federal regulation and Vermont law.

Issuers may substitute services that are determined to be “substantially” equal. To meet the EHB coverage standard, a health plan may offer benefits that are substantially equal to the benefits of the benchmark plan allowing for limited flexibility to adjust benefits, including specific services covered and any quantitative limits. Substitutions may occur only within each of the 10 categories specified by the Affordable Care Act, not across categories and must not be a prescription drug benefit. For prescription drug benefits, the EHB plan must cover the greater of: one drug in every United States Pharmacopeia (USP) category and class; or the same number of prescription drugs in each category and class as in the benchmark Vermont Health Plan, Blue Care Certificate of Coverage. To the extent the issuer substitutes services and quantitative limits based on Vermont’s Essential Health Benefits (EHB) package, the issuers will need to certify that the benefit substitutions are actuarially equivalent. The certification must be conducted by a member of the American Academy of Actuaries; be based on an analysis performed in accordance with generally accepted actuarial principles and methodologies; and use a standardized plan population.

The resulting benefit package will also need to be substantially equal to the EHB package such that the overall benefits covered should be the same as the EHB package with minimal exceptions. The issuer must explain any substitutions, including how they support issuer initiatives such as innovation and wellness. When an issuer elects to not provide a service and related quantitative limits the issuer shall include in form submission documentation to support the actuarial value equivalence of the substitution and a survey of clinical literature supporting the substitution of the service.

Issuers must submit standardized plan designs in accordance with the following:

1. Network Configuration. Issuers may choose to submit standardized plans incorporating either a broad or a narrow network configuration.
2. Product Type. Issuers may choose to submit the standardized plan design in any product type (e.g., PPO, HMO, EPO).

These requirements apply to an issuer and all of its subsidiaries. An issuer and its subsidiaries will be considered one entity for plan submission purposes. An issuer may only submit one network configuration and product type per standardized plan design.

Standard plans chosen shall be determined to be in the best interest of individuals and qualified employers in this state. In determining the best interest, the DVHA Commissioner shall consider affordability; promotion of high-quality care, prevention, and wellness; promotion of access to health care; participation in the state’s health care reform efforts; and such other criteria as the Commissioner, in his or her discretion, deems appropriate.

2.2 NON-STANDARDIZED PLANS: PREFERRED DESIGN FEATURES

In addition to the required, standardized plans, the Commissioner of the Department of Vermont Health Access may choose non-standardized “innovative” plan designs for sale on Vermont Health Connect. These non-standardized plans must provide the Essential Health Benefits (EHB) and must adhere to all federal and state regulations. Such plans shall be determined to be in the best interest of individuals and qualified employers in Vermont. In determining the best interest, the Commissioner shall consider affordability; promotion of high-quality care, prevention, and wellness; promotion of access to health care; participation in the state’s health care reform efforts; and such other criteria as the Commissioner, in his or her discretion, deems appropriate.

Submission of a non-standardized plan is optional to interested issuers; however, issuers are encouraged to offer one or more non-standardized plans. Accepted plans shall be innovative products that offer good value and can help achieve cost savings for consumers. Each non-standardized plan must comply with state and federal requirements. Non-standardized plans will not be offered at the Platinum level. Interested issuers may submit no more than two non-standardized plans at each of the remaining three actuarial value levels: gold, silver, and bronze.

Non-standardized plans will be evaluated against the criteria outlined in Chapter 1, including the advancement of the goals and vision in Vermont’s Blueprint for Health. These could include innovations in:

- **Wellness:** programs that promote individual health and demonstrate return-on-investment and success
- **Mental Health and Substance Abuse:** integration and promotion within the plan design
- **Engagement in Prevention:** strategies and programs proved effective in engaging individuals in preventive health
- **Preventive Health:** progressive services such as Advanced Primary Care Practices, Patient-Centered Medical Homes, and Community Health Teams.
- **Payment Reform:** advancing practices that tighten alignment of financial incentives with healthcare goals.

Vermont Health Connect is interested in issuers offering value-added benefits that promote primary care, wellness, and individual engagement. We encourage innovative plan design and the use of evidence based wellness programs, which may include incentives or rebates so long as these do not discriminate based on a health status factor. As stated, any submitted plan designs must provide the consumer with “meaningful” choice. Each innovative plan submission will be reviewed to ensure meaningful difference compared to the standardized plan design(s) at each metal level as described above. A meaningful

difference comparison will make sure that any additional plan designs offered in Vermont Health Connect will increase the diversity of options for consumers. Plan designs can have both quantitative and non-quantitative differences. **Any wellness programs proposed must meet the requirements set forth in recently proposed federal regulations, Incentives for Nondiscriminatory Wellness Programs in Group Health Plans.** The evaluation of meaningful difference is discussed in detail in Chapter 1, Section 2.1: Evaluation. Issuers are discouraged from offering High Deductible Health Plan designs for non-standardized plans.

To the extent the issuer substitutes benefits based on the EHB package, the issuers will need to certify that the benefit substitutions meet the guidelines as described in Chapter 2, section 2.1, above.

While providing benchmark benefit services and adhering to metal level actuarial calculations, issuers have flexibility to vary from standard plans on cost sharing, networks and adding components above the benchmark. For example, issuers might include plan design features that reward members for completing health risk assessments, participating in appropriate disease and case management programs, providing other programs to change their eating, exercise, smoking, and/or other life-style habits.

Issuers that submit non-standardized plan designs must complete the table included in Appendix E and Appendix F for each non-standardized plan design submitted for review and approval. For each of the products proposed, the issuer must submit detailed supporting documentation specified in the Program Requirements, including the Schedule of Benefits and Provider Directory.

3. CERTIFICATION, DE-CERTIFICATION, AND RE-CERTIFICATION

3.1 AWARD OF CERTIFICATION

Certification will be awarded by the Department of Financial Regulation. An award of certification does not necessarily mean the plan or issuer will be offered on Vermont Health Connect. Final selection of Qualified Health Plans will be done by the Department of Vermont Health Access within the timeframe described in Chapter 1.

3.2 REASONS FOR DE-CERTIFICATION

If, during the term of initial certification, it is determined that an issuer or health plan no longer meets the requirements for certification, the Department of Financial Regulation can de-certify either the issuer or the health plan and cease offering the plan or plans to new members in accordance with Vermont law. The Department of Financial Regulation must issue a notice of decertification to all affected parties: issuer, enrollees and HHS.

The Department of Financial Regulation may decertify a plan if, during the term of the agreement, DVHA determines or is informed that:

- I. The plan ceases to meet certification criteria as reflected in this document and/or contained in applicable state or federal laws and/or regulations;
- II. The issuer or plan enters a status with DFR that is other than in good standing; or
- III. The issuer intends to leave the market. Issuers intending to exit the market must inform DFR and Vermont Health Connect in accordance with Vermont Law. Issuers must inform Vermont Health Connect and the Department of Financial Regulation at least 60 days prior to informing enrollees that a QHP will be closed to enrollment. DFR must decertify the QHP. The Vermont Health Connect must remove the QHP from offering, thereby terminating coverage for all enrollees in the decertified plans, and make provision for a special enrollment period for affected enrollees.

The issuer will be notified by the Commissioner of the Department of Financial Regulation and given a thirty-day period by which to cure the compliance issue prior to decertification. The Department of Financial Regulation will notify the Vermont Health Connect that a compliance issue or reason for decertification has been identified with either the issuer or the QHP. This process will be governed by 8 V.S.A. §4062.

During the corrective period, the Vermont Health Connect may, at its sole discretion, apply one or both of the following penalties until compliance or demonstration of adequate progress is achieved:

- I. Freeze the issuer's QHP or QHPs to new enrollment
- II. Cease displaying the issuer's QHP or QHPs on the Vermont Health Connect website

Current enrollees can retain their coverage in a decertified QHP, until such time as the appeal process is completed and a final disposition regarding de-certification is rendered. The Department of Financial Regulation will notify Vermont Health Connect that the de-certification process is complete, so that Vermont Health Connect can notify enrollees as well as remove the plan for offering.

A special enrollment period must be offered to the enrollees in the decertified QHP to change from one QHP to another (45 CFR §155.420). When closed to new enrollment, a qualified health plan will not participate in the special enrollment events of subscribers from different qualified health plans. The closed qualified health plan, however, must continue to enroll individuals through special enrollments performed for its own subscribers.

3.3 PENALTIES

The penalty for non-compliance with the requirements listed in this document, as well as the to-be-executed contract will be de-certification, and removal of offering from Vermont Health Connect.

3.4 APPEAL PROCESS

When a potential performance issue is identified, the Department of Financial Regulation will work with the issuer to ensure all aspects of the issue are documented and a resolution is developed and executed. The Department of Financial Regulation will proceed with an appeal pursuant to 8 V.S.A §4062.

3.5 RE-CERTIFICATION AND RENEWALS

The Department of Financial Regulation will only recertify issuers that will actively offer enrollment through Vermont Health Connect. The Department of Financial Regulation will complete the recertification process on a tri-annual basis, on or before September 15 of the applicable calendar year. The recertification process will involve a review of the certification standards reflected in this document, as well as any State regulatory requirements. Issuers will be notified by the Department of Financial Regulation of their certification status at the completion of the renewal period. Upon notification recertification or failure, an issuer may:

- I. Appeal the determination of recertification.
- II. Apply for certification in the next year during the annual certification and renewal process.

APPENDIX A Required General Forms

CERTIFICATIONS AND ASSURANCES

I/we make the following certificates and assurances as a required element of the bid or proposal to which it is attached, understanding that the truthfulness of the facts affirmed here and the continuing compliance with these requirements are conditions precedent to the award or continuation of the related contract(s):

1. The prices and/or cost data have been determined independently, without consultation, communication or agreement with others for the purpose of restricting competition. However, I/we may freely join with other persons or organizations for the purpose of presenting a single proposal or bid.
2. The attached proposal or bid is a firm offer for a period of 180 days following receipt, and it may be accepted by DVHA without further negotiation (except where obviously required by lack of certainty in key terms) at any time within the 180 day period.
3. In preparing this proposal or bid, I/we have not been assisted by any current employee of the State of Vermont whose duties related (or did relate) to this proposal, bid or prospective contract, and who was assisting in other than his or her official, public capacity. Neither does such a person nor any member of his or her immediate family have any financial interest in the outcome of this proposal or bid. (Any exceptions to these assurances are described in full detail on a separate page and attached to this document).
4. I/we understand that the DVHA will not reimburse me/us for any costs incurred in the preparation of this proposal or bid. All proposals or bids become the property of DVHA.
5. I/we understand that any contract(s) awarded as a result of this RFP will incorporate terms and conditions substantially similar to those attached to the RFP. I/we certify that I/we will comply with these or substantially similar terms and conditions if selected as a Contractor.
6. I hereby certify that I have examined the accompanying RFP forms prepared by: [REDACTED] and that to the best of my knowledge and belief, the contents are true, and correct, and complete statements prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Signature: _____ Date: _____

Title: _____

APPENDIX B REQUIRED COVER SHEET

DEPARTMENT OF VERMONT HEALTH ACCESS

APPLICANT INFORMATION SHEET

(To be included in the proposal packet)

****NOTE:** This information sheet must be included as the cover sheet of the application being submitted. Be sure to complete this form in its entirety. Please fill out and attach a form W-9 to this form signed by the duly appointed signing official for your company.

Applicant Organization: _____

Contact Person: _____

Title: _____

Mailing Address: _____

Town, State, ZIP: _____

Telephone: _____ Fax #: _____

E-mail Address: _____

Fiscal Agent (Organization Name): _____

FY Starts: _____ FY Ends: _____

Financial Contact Person: _____

Mailing Address: _____

Town, State, ZIP: _____

Telephone: _____ Fax #: _____

E-mail Address: _____

Federal Tax ID Number: _____

Whom should we contact if we have questions about this application?

Name _____ Phone Number _____

APPENDIX C Acknowledgements and Attestations

A. Rules of Plan Participation

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

<u>Rules of Plan Participation</u>	<u>Confirmation or Explanation</u>
Please confirm that you meet the standards described in subpart C of part 156 of Title 45 of the CFR and are in compliance with any and all applicable state laws.	

B. Licensing

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

<u>Licensing</u>	<u>Confirmation or Explanation</u>
Please confirm your understanding that only health benefits plans that have been approved and reviewed by the Department of Financial Regulation and are in current good standing pursuant to 45 CFR §156.200(b)(4), may be offered through Vermont Health Connect	

C. Accreditation

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

<u>Accreditation</u>	<u>Confirmation or Explanation</u>
1. Please confirm that your company is accredited on the basis of QHP performance by a HHS recognized accrediting entity pursuant to 45 CFR §156.275.	
2. Please confirm that you are accredited or will become accredited within the timeframe established by Vermont Health Connect pursuant to 45 CFR §155.1045.	

D. Health Care Quality

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

<u>Health Care Quality</u>	<u>Confirmation or Explanation</u>
1. Please confirm that you have in place, a quality improvement strategy consistent with the standards of section 1311 (g) of the Affordable Care Act and Vermont rule H-2009-03.	
2. Please confirm your understanding that you are required to disclose and report information on health care quality and outcomes as described in section 399JJ of the Public Health Service Act.	
3. Please confirm your understanding that you are required to report to HHS at least annually, the pediatric quality reporting measures described in section 1139A of the Social Security Act.	
4. Please confirm that you plan to conduct enrollee satisfaction surveys consistent with the requirements of section 1311(c) of the Affordable Care Act.	

E. Risk Adjustment Program

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

<u>Risk Adjustment Program</u>	<u>Confirmation or Explanation</u>
1. Please confirm your participation in a risk adjustment program pursuant to the requirements described in 45 CFR Part 153	

F. Actuarial Value Designation

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

<u>Actuarial Value Designation</u>	<u>Confirmation or Explanation</u>
1. Please confirm your understanding that all submitted benefit plans must be within a 2% range of the set actuarial value amounts set forth in federal regulation.	

G. Offering Requirements

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

<u>Offering Requirements</u>	<u>Confirmation or Explanation</u>

1. Please confirm that your company will submit for consideration the requisite number of health benefit plans under each of the four plan benefit levels (Platinum, Gold, Silver, and Bronze).	
2. Please confirm that you will submit a child-only plan to be offered through Vermont Health Connect to individuals who have not yet attained the age of 21 in accordance with federal regulations described in 45 CFR §165.200 (c)(2).	

H. Rating Variations

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

<u>Rating Variations</u>	<u>Confirmation or Explanation</u>
1. Please confirm that you will utilize the rating methodology described in 8 V.S.A. 4080a(h)(1) , 33 V.S.A. §1811(f).	

I. Marketing

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

<u>Marketing</u>	<u>Confirmation or Explanation</u>
1. Please confirm that you will comply with marketing regulations described in 8 V.S.A. § 4084, 8 V.S.A. §3368, and any other applicable regulations.	
2. Please confirm your understanding that no health benefit plan may employ marketing practices of benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs.	

J. Abortion Services

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

<u>Abortion Services</u>	<u>Confirmation or Explanation</u>
1. Please confirm that your company will comply with all Federal and State laws regarding abortion coverage.	

K. Premium Rate and Benefit Information

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

<u>Premium Rate and Benefit Information</u>	<u>Confirmation or Explanation</u>
1. Please confirm that all submitted rates will be set for an entire benefit year, or for small business, plan year.	
2. Please confirm that you will submit rate and benefit data to the Department of Financial Regulation.	
3. Please confirm that you will submit a justification for any rate increase prior to the implementation of such increase and that such justification is posted prominently on your website.	
4. Please confirm that you will submit the information described in 45 CFR §155.1020(c) at least annually to Vermont Health Connect.	

L. Service Area

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

<u>Service Area</u>	<u>Confirmation or Explanation</u>
1. Please confirm that the Service area of each QHP submitted for review covers at a minimum the entire State of Vermont.	
2. Please confirm that the Service area of each QHP submitted for review was established without regard to racial, ethnic, language, health status related factors, or other factors that exclude specific high-utilizing, high cost, or medically-underserved populations.	

M. Network Adequacy

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

<u>Network Adequacy</u>	<u>Confirmation or Explanation</u>
1. Please confirm that the provider networks of each QHP submitted for review includes essential community providers as described in 45 CFR §156.235.	

<p>2. Please confirm that the provider networks of each QHP submitted for review maintains a network that is sufficient in number and type of providers including those that specialize in mental health and substance abuse services.</p>	
<p>3. Please confirm that the provider networks of each QHP submitted for review is consistent with the network adequacy provisions of section 2702 of the Public Health Service Act and Vermont Rule H-2009-03.</p>	
<p>4. Please confirm that you will make the provider directory for each QHP available to Vermont Health Connect for publication online, and to potential enrollees in hard copy upon request.</p>	
<p>5. Please confirm that the provider directory for each QHP identifies those providers who are not accepting new patients.</p>	

N. Enrollment Processes and Periods

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

<u>Enrollment Processes and Periods</u>	<u>Confirmation or Explanation</u>
<p>1. Please confirm that you will enroll a qualified individual during the initial and annual open enrollment periods and abide by the effective dates of coverage described in 45 CFR §155.410.</p>	
<p>2. Please confirm that you will offer special enrollment periods and abide by the effective dates described in 45 CFR §155.420.</p>	
<p>3. Please confirm your understanding that plans submitted for Vermont Health Connect must comply with the small business enrollment periods described in 45 CFR §155.725.</p>	
<p>4. Please confirm that your company will notify a qualified enrollee of his or her effective date of coverage.</p>	
<p>5. Please confirm that your company will provide a new enrollee with an enrollment information package consistent with the accessibility and readability standards described in 45 CFR §155.230(b).</p>	
<p>6. Please confirm that you will enroll a qualified individual if Vermont Health Connect has determined the eligibility of the individual and has provided enrollment information.</p>	

7. Please confirm that you will accept enrollment information consistent with the privacy and security requirements to be established by Vermont Health Connect in accordance with 45 CFR §155.260, and in an electronic format.	
8. Please confirm that you will follow the premium payment process to be established by Vermont Health Connect pursuant to 45 CFR §155.240.	
9. Please confirm that you will reconcile your enrollment files with Vermont Health Connect no less than once a month.	
10. Please confirm that you will acknowledge receipt of enrollment information transmitted from Vermont Health Connect in accordance with Vermont Health Connect standards pursuant to 45 CFR §155.400.	
11. Please confirm that you may only terminate coverage as permitted by Vermont Health Connect in accordance with 45 CFR §155.430(b).	
12. Please confirm that this notice will contain the termination effective date and reason for termination.	
13. Please confirm that you have established a standard policy for the termination of coverage of enrollees due to non-payment of premiums as permitted by Vermont Health Connect pursuant to 45 CFR §156.270 and Vermont law.	
14. Please confirm that you will provide an enrollee with a notice of payment delinquency if such enrollee is delinquent on premium payments.	
15. Please confirm that you will provide a grace period for tax credit recipients pursuant to 45 CFR §156.270 (d).	

O. Transparency in Coverage

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

<u>Transparency in Coverage</u>	<u>Confirmation or Explanation</u>
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<p>1. Please confirm that you will provide in plain language, to Vermont Health Connect, HHS, and the Commissioner of DFR, the following information:</p> <ul style="list-style-type: none"> ▪ Claims payment policies and practices ▪ Periodic financial disclosures ▪ Data on enrollment ▪ Data on disenrollment ▪ Data on number of claims that are denied ▪ Data on rating practices ▪ Information on cost-sharing and payments with respect to any out-of-network coverage ▪ Information on enrollee rights under title I of the ACA 	
<p>2. Please confirm that you will provide the information described above in an accurate and timely manner as determined by HHS, and that such information will be made available to the public</p>	
<p>3. Please confirm that you will make the amount of enrollee cost sharing under the individual’s plan or coverage with respect to the furnishing of a specific item or service, available upon request and in a timely manner. Such information must be made available through an internet website and through such other means for individuals without access to the internet.</p>	

P. Non-Discrimination

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

<u>Non-Discrimination</u>	<u>Confirmation or Explanation</u>
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<p>Confirm your understanding that no health benefit plan shall be offered through Vermont Health Connect that excludes an individual from coverage because of race, color, religion, national origin, sex, gender identity, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income, or age pursuant to the non-discrimination regulations within federal and state law.</p>	
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Q. Benefit Design Standards

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

<u>Benefit Design Standards</u>	<u>Confirmation or Explanation</u>
<p>1. Please confirm that each plan submitted for review complies with the benefit design standards defined in 45 CFR §156.20.</p>	
<p>2. Substantially Equal Substitutions. Please confirm the actuarial value equivalence for each service and/or related quantitative limits being substituted within any of the 10 categories specified by the ACA, and confirm that a survey of clinical literature supporting the substitution of the service is provided.</p>	

R. DENTAL PLAN SUBMISSIONS

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

<u>Benefit Design Standards</u>	<u>Confirmation or Explanation</u>
<p>1. Please confirm that each plan submitted for review complies with Appendix H & Section 1.4</p>	

APPENDIX D STANDARD PLAN DESIGNS Standard Platinum Plan

Deductible/OOP Max	
Type of Plan	Deductible
Medical Ded	\$250
Rx Ded	\$0
Integrated Ded	No
Medical OOPM	\$1,250
Rx OOPM	\$1,250
Integrated OOPM	No
Family Deductible / OOP	Stacked, 2x Individual
Medical Deductible waived for:	Prev, OV, UC, Amb, ER
Drug Deductible waived for:	N/A
Minimum E'er HSA Contribution	N/A
Service Category	Copay / Coinsurance
Inpatient ¹	10%
Outpatient ²	10%
ER ³	\$100
Radiology (MRI, CT, PET)	10%
Preventive	\$0
PCP Office Visit	\$10
MH/SA Office Visit	\$10
Specialist Office Visit ⁴	\$20
Urgent Care	\$40
Ambulance	\$50
Rx Generic	\$5
Rx Preferred Brand	\$40
Rx Non-Preferred Brand	50%
ACA Compliance	
Complies with Max OOP Limit	Yes
Complies with Group Ded Limit	Yes
Market	Both

¹ Inpatient includes surgery, ICU/NICU, maternity, SNF and MH/SA. This cost sharing will also include physician and anesthesia costs, as appropriate.

² Outpatient includes ASCs. This cost sharing will also include physician and anesthesia costs, as appropriate.

³ ER copay is waived if admitted.

⁴ Specialist copay also applies to PT/ST/OT, vision, and any alternative medicine benefits, as appropriate.

Standard Gold Plan

Deductible/OOP Max	
Type of Plan	Deductible
Medical Ded	\$750
Rx Ded	\$50
Integrated Ded	No
Medical OOPM	\$4,250
Rx OOPM	\$1,250
Integrated OOPM	No
Family Deductible / OOP	Stacked, 2x Individual
Medical Deductible waived for:	Prev, OV, UC, Amb, ER
Drug Deductible waived for:	Generic scripts
Minimum E'er HSA Contribution	N/A
Service Category	
Inpatient ¹	20%
Outpatient ²	20%
ER ³	\$150
Radiology (MRI, CT, PET)	20%
Preventive	\$0
PCP Office Visit	\$15
MH/SA Office Visit	\$15
Specialist Office Visit ⁴	\$25
Urgent Care	\$45
Ambulance	\$50
Rx Generic	\$5
Rx Preferred Brand	\$40
Rx Non-Preferred Brand	50%
ACA Compliance	
Complies with Max OOP Limit	Yes
Complies with Group Ded Limit	Yes
Market	Both

¹ Inpatient includes surgery, ICU/NICU, maternity, SNF and MH/SA. This cost sharing will also include physician and anesthesia costs, as appropriate.

² Outpatient includes ASCs. This cost sharing will also include physician and anesthesia costs, as appropriate.

³ ER copay is waived if admitted.

⁴ Specialist copay also applies to PT/ST/OT, vision, and any alternative medicine benefits, as appropriate.

Standard Silver Plan – Silver Plan 1

Deductible/OOP Max	
Type of Plan	Deductible
Medical Ded	\$1,900
Rx Ded	\$100
Integrated Ded	No
Medical OOPM	\$5,000
Rx OOPM	\$1,250
Integrated OOPM	No
Family Deductible / OOP	Stacked, 2x Individual
Medical Deductible waived for:	Prev, OV, UC, Amb, ER
Drug Deductible waived for:	Generic scripts
Minimum E'er HSA Contribution	N/A
Service Category	
Copay / Coinsurance	
Inpatient ¹	40%
Outpatient ²	40%
ER ³	\$250
Radiology (MRI, CT, PET)	40%
Preventive	\$0
PCP Office Visit	\$20
MH/SA Office Visit	\$20
Specialist Office Visit ⁴	\$30
Urgent Care	\$50
Ambulance	\$100
Rx Generic	\$10
Rx Preferred Brand	\$50
Rx Non-Preferred Brand	50%
ACA Compliance	
Complies with Max OOP Limit	Yes
Complies with Group Ded Limit	Yes
Market	Both

¹ Inpatient includes surgery, ICU/NICU, maternity, SNF and MH/SA. This cost sharing will also include physician and anesthesia costs, as appropriate.

² Outpatient includes ASCs. This cost sharing will also include physician and anesthesia costs, as appropriate.

³ ER copay is waived if admitted.

⁴ Specialist copay also applies to PT/ST/OT, vision, and any alternative medicine benefits, as appropriate.

Standard Silver Plan – Silver Plan 2

Deductible/OOP Max	
Type of Plan	HSA Q/HDHP
Medical Ded	\$1,750
Rx Ded	\$1,250
Integrated Ded	Yes
Medical OOPM	\$6,250
Rx OOPM	\$1,250
Integrated OOPM	Rx –No, Medical – Yes
Family Deductible / OOP	Aggregate, 2x Individual
Medical Deductible waived for:	Preventive
Drug Deductible waived for:	Wellness scripts
Minimum E'er HSA Contribution	N/A
Service Category	
Copay / Coinsurance	
Inpatient ¹	20%
Outpatient ²	20%
ER ³	20%
Radiology (MRI, CT, PET)	20%
Preventive	0%
PCP Office Visit	20%
MH/SA Office Visit	20%
Specialist Office Visit ⁴	20%
Urgent Care	20%
Ambulance	20%
Rx Generic	\$10
Rx Preferred Brand	\$50
Rx Non-Preferred Brand	50%
ACA Compliance	
Complies with Max OOP Limit	Yes
Complies with Group Ded Limit	Yes
Market	Both

¹ Inpatient includes surgery, ICU/NICU, maternity, SNF and MH/SA. This cost sharing will also include physician and anesthesia costs, as appropriate.

² Outpatient includes ASCs. This cost sharing will also include physician and anesthesia costs, as appropriate.

³ ER copay is waived if admitted.

⁴ Specialist copay also applies to PT/ST/OT, vision, and any alternative medicine benefits, as appropriate.

Standard Bronze Plan – Bronze Plan 1

Deductible/OOP Max	
Type of Plan	Deductible
Medical Ded	\$1,900
Rx Ded	\$100
Integrated Ded	No
Medical OOPM	\$6,250
Rx OOPM	\$1,250
Integrated OOPM	Rx –No, Medical – Yes
Family Deductible / OOP	Stacked, 2x Individual
Medical Deductible waived for:	Preventive
Drug Deductible waived for:	Applies to all scripts
Minimum E'er HSA Contribution	N/A
Service Category	
Copay / Coinsurance	
Inpatient ¹	50%
Outpatient ²	50%
ER ³	\$350
Radiology (MRI, CT, PET)	50%
Preventive	\$0
PCP Office Visit	\$35
MH/SA Office Visit	\$35
Specialist Office Visit ⁴	\$80
Urgent Care	\$100
Ambulance	\$100
Rx Generic	\$12
Rx Preferred Brand	40%
Rx Non-Preferred Brand	60%
ACA Compliance	
Complies with Max OOP Limit	Yes
Complies with Group Ded Limit	Yes
Market	Both

¹ Inpatient includes surgery, ICU/NICU, maternity, SNF and MH/SA. This cost sharing will also include physician and anesthesia costs, as appropriate.

² Outpatient includes ASCs. This cost sharing will also include physician and anesthesia costs, as appropriate.

³ ER copay is waived if admitted.

⁴ Specialist copay also applies to PT/ST/OT, vision, and any alternative medicine benefits, as appropriate.

Standard Bronze Plan – Bronze Plan 2

Deductible/OOP Max	
Type of Plan	HSA Q/HDHP
Medical Ded	\$2,000
Rx Ded	\$1,250
Integrated Ded	Yes
Medical OOPM	\$6,250
Rx OOPM	\$1,250
Integrated OOPM	Rx –No, Medical – Yes
Family Deductible / OOP	Aggregate, 2x Individual
Medical Deductible waived for:	Preventive
Drug Deductible waived for:	Wellness scripts
Minimum E'er HSA Contribution	N/A
Service Category	
Copay / Coinsurance	
Inpatient ¹	50%
Outpatient ²	50%
ER ³	50%
Radiology (MRI, CT, PET)	50%
Preventive	0%
PCP Office Visit	50%
MH/SA Office Visit	50%
Specialist Office Visit ⁴	50%
Urgent Care	50%
Ambulance	50%
Rx Generic	\$12
Rx Preferred Brand	40%
Rx Non-Preferred Brand	60%
ACA Compliance	
Complies with Max OOP Limit	Yes
Complies with Group Ded Limit	Yes
Market	Both

¹ Inpatient includes surgery, ICU/NICU, maternity, SNF and MH/SA. This cost sharing will also include physician and anesthesia costs, as appropriate.

² Outpatient includes ASCs. This cost sharing will also include physician and anesthesia costs, as appropriate.

³ ER copay is waived if admitted.

⁴ Specialist copay also applies to PT/ST/OT, vision, and any alternative medicine benefits, as appropriate.

APPENDIX E SUMMARY OF BENEFITS AND COVERAGE

Plan Name: _____
Metal Level: _____

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$	
Are there other deductibles for specific services?	\$	
Is there an out-of-pocket limit on my expenses?	\$	
What is not included in the out-of-pocket limit?		
Is there an overall annual limit on what the plan pays?		
Does this plan use a network of providers?		
Do I need a referral to see a specialist?		
Are there services this plan doesn't cover?		

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness			
	Specialist visit			
	Other practitioner office visit			
	Preventive care/ screening/immunization			

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition	Generic drugs			
	Preferred brand drugs			
	Non-preferred brand drugs			
More information about prescription drug coverage.	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)			
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services			
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)			
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services			
	Mental/Behavioral health inpatient services			
	Substance use disorder outpatient services			
	Substance use disorder inpatient services			
If you are pregnant	Prenatal and postnatal care			
	Delivery and all inpatient services			
If you need help recovering or have other special health needs	Home health care			
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice service			

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam			
	Glasses			
	Dental check-up			

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover

Other Covered Services

APPENDIX F NON-STANDARD PLAN QUESTIONNAIRE

<p>Vermont Health Connect Non-Standard Plan Questionnaire</p>	
Non-Standard Plan Name:	
Metal Level:	<input style="width: 80px; height: 20px;" type="text"/>
Question 1	Plans must reflect program goals. Which research based approaches will be employed to meet these goals and how will performance and quality be evaluated.
Please briefly describe	
Question 2	Does the plan include design features or innovations that are meaningfully different from Standard plans in significant quantitative or qualitative ways? (e.g., design structure, cost sharing)
Select Yes or No	If yes, please briefly describe the innovations and why they are meaningfully different.

Question 3		Does the plan include innovation(s) pertaining to mental health and substance abuse with improved integration within the plan design
Select Yes or No	If yes, please briefly describe the innovation(s).	
Question 4		Does the plan include innovation(s) pertaining to individual engagement in preventive health programs and practices?
Select Yes or No	If yes, please briefly describe the innovation(s).	
Question 5		Does the plan include innovation(s) pertaining to payment reform that tighten alignment between financial incentives and healthcare goals?
Select Yes or No	If yes, please briefly describe the innovation(s).	
Question 6		Does the plan include other innovation(s) not already mentioned?
Select Yes or No	If yes, please briefly describe the innovation(s).	
Question 7		Specify past outcomes, the number of years and geographic areas served by the bidder with the proposed plan.
Please briefly describe		
Question 8		Data on the number of individuals served, funds expended, and sources of funds for same or similar services to those called for in this RFP.
Please briefly describe		
Question 9		Provide a staff organizational chart that identifies the major operational components of the organization, the lines of authority and responsibility, how this program fits into the organization's structure.

Please briefly describe	
Question 10	Describe licensures or accreditations of the organization or other indicators of quality review that attest to the quality of bidder programs
Please briefly describe	
Question 11	As this RFP includes a wide range of services, DVHA recognizes that not all bidders may currently have the capacity to offer these services at the onset of the contract period. Include a detailed strategic plan as to how your company would build this capacity (including specific timelines and activities).
Please briefly describe	

APPENDIX G FEDERAL REQUIREMENTS

In order to clarify the expectations for qualified health plan issuers the following should serve as a guide but not an exhaustive list of requirements:

Req. Number	Requirement Category	Federal Requirement	Reference
1	Licensing	State Licensure	45 CFR §156.200(b)(4)
2	Accreditation	General requirement	45 CFR §156.275(a)
3	Accreditation	Timeframe for Accreditation:	45 CFR §156.275(b)
4	Health care quality requirements	Quality Improvement Initiative	45 CFR §156.200(b)(5), Section 1311(g) of the ACA
5	Health care quality requirements	Quality and Outcomes Reporting	45 CFR §156.200(b)(5), Section 1311(c)(1)(I) of the ACA
6	Health care quality requirements	Enrollee Satisfaction Surveys	45 CFR §156.200(b)(5), Section 1311(c)(4) of the ACA
7	Risk Adjustment	Participation in Risk Adjustment Programs	45 CFR §156.200(b)(7)
8	Actuarial Value Designation	Actuarial Value Standards	Federal guidance not yet final
9	Offering requirements	Actuarial Value Tiers	45 CFR §156.200(c)(1)
10	Offering requirements	Child-only plan.	45 CFR §156.200(c)(2)

Req. Number	Requirement Category	Federal Requirement	Reference
11	Rating variations	Product Pricing	45 CFR §156.255(b)
12	Rating variations	Allowable Variability	45 CFR §156.255(a)
13	Marketing	Marketing Rule Compliance	45 CFR §156.225(a)
14	Marketing	Non-discrimination	45 CFR §156.225(b)
15	Abortion Services	Compliance with State Abortion Laws	45 CFR §156.280(a)
16	Abortion Services	Abortion Funds Segregation	45 CFR §156.280
17	Premium Rate and Benefit Information	Rate Plan Year	45 CFR §156.210(a)
18	Premium Rate and Benefit Information	Rate submission	45 CFR §156.210 (b)
19	Premium Rate and Benefit Information	Rate Increase Justification	45 CFR §156.210(c), 45 CFR §155.1020(a)
20	Premium Rate and Benefit Information	Rate Increase Consideration	45 CFR §155.1020 (b)
21	Premium Rate and Benefit Information	Benefit and Rate Information	45 CFR §155.1020(c)
22	Service Area	Minimum Service Area	45 CFR §155.1050(a)
23	Service Area	Non-Discriminatory Service Area	45 CFR §155.1050(b)
24	Network Adequacy	Network Adequacy Standards	45 CFR §156.230
25	Network Adequacy	Provider Directory	45 CFR §156.230(b)
26	Enrollment Processes and Periods	Enrollment Periods and Processes	45 CFR §156.260, §156.265 (small employer: 45 CFR §155.725)
27	Enrollment Processes and Periods	Termination	45 CFR §156.270
28	Transparency in Coverage	Required Information Related to Coverage Transparency	45 CFR §156.220(a)
29	Transparency in Coverage	Reporting Requirement	45 CFR §156.220(b), 45 CFR §156.220(c)
30	Transparency in Coverage	Enrollee Cost Sharing	45 CFR §156.220(d)
31	Non-discrimination	Non-Discrimination	45 CFR §156.200(e)
32	Benefit Design Standards	Minimum Coverage	45 CFR §156.200(b)(3)

APPENDIX H Dental

The stand-alone dental plan and the issuer of such plan will meet the QHP certification standards defined by the ACA and the State of Vermont, except for any certification requirement that cannot be met because the plan only covers the pediatric dental essential health benefit. In order to clarify the expectations for dental plan offerings the following should serve as a guide but not an exhaustive list of requirements:

Chapter 1:

All submission provisions and requirements shall apply to the submission of dental plan offerings, including filing of forms, and timelines contained within the RFP.

Chapter 2:

Benefit Design:

Essential Health Benefits: The requirement to offer all essential health benefits does not apply to stand-alone dental plans, and dental plans should comply with ACA Section 1311 (d)(2)(B)(ii).

Cost Sharing: Dental plan offerings must comply with ACA Section 1302(c) and if integrated into a health benefit plan, comply with OOP maximum limitations. **Proposed federal regulations require stand-alone pediatric dental plans to limit OOP costs to a “reasonable” amount. Dental carriers should submit an OOP max at each PED AV level for stand-alone plans, along with a proposed justification for that standard. Carriers shall make any future necessary modifications to comply with any specific threshold CMS or DVHA chooses to adopt.**

Coverage Metal Tiers: Dental plan offerings do not need to comply with ACA Section 1302 (d), ACA Section 1302 (e), 45 CFR § 156.200(b) and 45 CFR § 155.20.

Licensing:

All dental plan offerings must comply with 45 CFR § 156.200(b)(4) and applicable Vermont state licensing law.

Quality Improvements:

Dental plan offerings currently must not comply with 45 CFR § 155.200(b)(5) or DFR Rule H-09-03. It is anticipated that specific quality measures for dental plan offerings will be developed and dental plan offerings shall comply with further federal guidance when available.

Risk Adjustment:

Vermont Health Connect does not expect dental plan offerings to participate in risk

adjustment or comply with 45 CFR § 156.200(b)(7).

Actuarial Value:

Vermont Health Connect does not expect dental plan offerings to comply with ACA Section 1302(d)(1) and 45 CFR § 156.200(c)(1).

Child-Only Plans:

The plan must cover at least the pediatric dental essential health benefits, as provided for by 42 U.S.C. 18031(d) and in accordance with 45 CFR § 156.200(c)(2).

Discrimination:

All dental plan offerings must comply with 45 CFR § 156.200(e).

Plan Rates:

All dental plan offerings must comply with 45 CFR § 156.210(a) and applicable Vermont state law. Dental plan rates must be reviewed and approved by the Department of Financial Regulation. Rates must be submitted to DFR for review by March 15, 2013.

Additional dental plan offerings must be in accordance with 45 CFR § 156.210(b), 45 CFR § 156.210(c).

Policy & Enrollee Information:

All dental plan offerings must comply with 45 CFR § 156.220(a), 45 CFR § 156.220 (b) and 45 CFR § 156.220(c).

Provider Costs:

All dental plan offerings must comply with 45 CFR § 156.220(d).

Marketing:

All dental plan offerings must comply with the provisions of Section 1.13 and 45 CFR § 156.225.

Network Adequacy:

All dental plan offerings must comply with 45 CFR § 156.230(a)(2), 45 CFR § 155.1050(a). Additionally, it is expected that further state guidance is forthcoming regarding the collective capacity of stand-alone dental plans to ensure sufficient access to pediatric dental coverage in terms of solvency and provider networks. It is anticipated that further state guidance will have requirement similar to DFR Rule H-09-03.

Community Providers:

All dental plan offerings must comply with 45 CFR § 156.230(a)(1), 45 CFR § 156.1050 and 45 CFR § 156.235.

Geographic Location:

All dental plan offerings must comply with 45 CFR § 156.230(a)(3).

Provider Information:

All dental plan offerings shall comply to the extent possible with 45 CFR § 156.230(b), 45 CFR § 155.206(b)(1)(viii), applicable Vermont state law requirements for provider networks, and Section 1.11 of this RFP.

Enrollee Notification:

All dental plan offerings must comply with 45 CFR § 156.250, 45 CFR § 156.230(d) and applicable portions of Section 1.7 of this RFP.

Premium Rates:

All stand-alone issuers must charge the same premium rate with respect to a plan that is offered through an Exchange as the issuer would charge with respect to a plan offered directly by issuer or through an agent or broker, 45 CFR §156.255(b).

Plan Offerings:

All dental plan offerings must comply with section 1.4 of this RFP, and 45 CFR § 156.265(b)(1)&(2).

Enrollment Periods:

All dental plan offerings shall comply with enrollment provisions contained in section 1.7 and section 1.9 of this RFP, and 45 CFR § 156.260(a), 45 CFR § 156.270, 45 CFR § 155.430(c)(3) and 45 CFR §430(b).

Accreditation:

All dental plans offering need not comply with section 1.10 of this RFP or 45 CFR §156.275(b).

Abortion Coverage:

45 CFR § 156.280 is not applicable to dental plan offerings.

Small Business Specific Guidelines:

All dental plan offerings shall comply with section 1.5 of this RFP, and applicable provisions of 45 CFR § 156.285.

Decertification, and Recertification:

All dental plan offerings shall comply with sections 3.1, 3.2, 3.3, 3.4 and 3.5 of this RFP. Additionally, dental plan offerings must comply with applicable provisions of 45 CFR § 156.290.

Prescription Coverage:

ACA Section 6005, and 45 CFR § 156.296 is not applicable to dental plan offerings.

Geographic Coverage:

All dental plan offerings must comply with 45 CFR § 155.1055(b).

APPENDIX I

Summary of Benefits & Coverage: Dental

Plan Name: _____

Outline of Benefits

Benefits Period: _____

Coverage Type	Benefit Percentages Paid
---------------	--------------------------

Diagnostic & Preventative	
Basic Restorative	
Major Restorative	
Orthodontics	

Diagnostic & Preventative Benefits

Diagnostic:

Preventive:

Exclusions & Limitations:

Basic Restorative

Restorative:

Radiographs:

Oral Surgery:

Periodontics:

Space Maintainers:

Palliative Treatment:

Anesthesia:

Exclusions & Limitations:

Major Restorative

Restorative Crowns:

Prosthodontics:

Oral Surgery:

Periodontal:

Endodontics:

Clinical Crown Lengthening:

Denture Repair:

Implant Services:

Implant Support Prostheses:

Exclusions & Limitations:

Orthodontics

Orthodontics:

Exclusions & Limitations: