State of Maine

Dirigo Health Agency

Response to Solicitation for State Proposals to Operate Qualified High Risk Pools

Dirigo Health Agency

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Section A - Proposal Certification

I, Trish Riley, attest to the following:

I have read the contents of the completed proposal and the information contained herein is true, correct, and complete. If I become aware of any information in this proposal that is not true, correct, or complete, I agree to notify the Department of Health and Human Services (HHS) immediately and in writing.

I authorize HHS to verify the information contained herein. I agree to notify HHS in writing of any changes that may jeopardize my State's ability to meet the qualifications stated in this proposal prior to such change or within 30 days of the effective date of such change.

I agree that if HHS approves this proposal and awards a contract to my State or State's designated high risk pool, that my State or State's designated high risk pool will abide by the requirements contained in the contract and provide the services as outlined in this proposal.

I agree that HHS may inspect any and all information necessary, including inspecting the premises of the high risk pool program's organization or contractors to ensure compliance with Stated Federal requirements. I further agree to immediately notify HHS if, despite these attestations, I become aware of circumstances which preclude full compliance with the requirements stated in this proposal.

I certify that I am authorized to certify this submission on behalf of my State or my State's designated entity.

_Trish Riley_____	__Director__
Authorized Representative Name (printed)	Title
_____	__06/01/2010_____
Authorized Representative Signature	Date (MM/DD/YYYY)

Section B - Technical Approach

C.4.1 Instruction / Question
Describe in detail the State proposal for establishing and providing for the ongoing administrative functions of operating a high risk pool program. The description should describe how the State proposes to make the high risk pool program operational, including all sub-contracting relationships that may be included in the implementation plan and a proposed timeline for the implementation of the high risk pool program that includes the first date on which the program will accept enrollments and the first date on which the program will provide coverage for enrollees. If the State operates another high risk pool, describe how the State will segregate funding and expenditures for the two programs and track enrollees separately across all benefits and services. **If the proposal is to delegate the operation to a nonprofit entity, the State should clearly indicate if it proposes that HHS contract with the State (that will subcontract with the nonprofit) or proposes that HHS contract directly with the nonprofit high risk pool. If the State proposes that HHS contract directly with the nonprofit high risk pool, provide copies of all governing authorities of the nonprofit entity, including statutes, regulations, governance, and plan of operation.** **As part of the technical approach, the State or its designated entity may subcontract with either a for-profit or nonprofit entity.**
C.4.1 Response
Maine proposes to create a High Risk Pool program within its subsidized health insurance plan, DirigoChoice, offered by Harvard Pilgrim Health Care (HPHC). The applicant, the Dirigo Health Agency (DHA), a state agency, is an eligible entity (Sec. 1101(b)(2)(A) of the Patient Protection and Affordable Care Act (PPACA)) and meets all the requirements for a Qualified High Risk Pool (Sec. 1101(c)(2)(A-D)). The program will serve eligible individuals (Sec. 1101(d)) who are citizens or nationals who have not had creditable coverage for 6 months and have a pre-existing condition. To meet the intent of the law to provide "immediate access to insurance for uninsured individuals with a pre-existing condition" (Sec. 1101), Maine will use its existing infrastructure to provide coverage,

thereby reducing administrative costs and ensuring immediate coverage for eligible individuals on August 1, 2010 or sooner. That coverage will meet all the requirements of Sec. 1101. To do so, DHA will subsidize premium costs to eligible enrollees, who pay premiums on an income based sliding scale, and support a modest risk sharing arrangement to ensure the adequacy of rates. Maine has already adopted guaranteed issue and rate reforms in advance of the requirement to do so in PPACA; it does not have "uninsurable" population. Maine can meet the requirements of a High Risk Pool and serve eligible individuals without establishing a traditional High Risk Pool and can do so more quickly and at less cost than by establishing a traditional High Risk Pool. Indeed, to create a traditional High Risk Pool that pays claims "in excess of the amount premiums collected" (Sec. 1101(g)(1) would revert Maine to a pre-reform environment, create significant avoidable administrative costs and delay coverage for eligible individuals, which clearly conflicts with the goal of the Subtitle B of the PPACA to take "immediate actions to preserve and expand coverage" and provide "immediate access to insurance for uninsured individuals with a pre-existing condition". (Sec. 1101)

In short, Maine is uniquely positioned to implement the provisions of the High Risk Pool program immediately if coverage is affordable to eligible enrollees.

According to the America's Health Insurance Plans' report, Individual Health Insurance, 2009, Maine had the 4th highest average annual premiums in the individual market in 2009 (exceeded only by MA, NY and RI).

However, Maine's median income of $48,600 is significantly lower than those states (MA $60,000; NY $51,000 and RI $55,600) making the high cost of individual coverage even more unaffordable and challenging our ability to meet the high risk pool program goal of access to coverage at a "standard rate for a standard population" (1101(c)(2)(C)(iii).

Maine already has enacted guaranteed issue, community rating and offers a program that can provide immediate access to insurance for uninsured individuals with pre-existing conditions that meet all the conditions of Section 1101 of the PPACA through a program that subsidizes enrollee premium costs to ensure accessible, standard rates for eligible enrollees.

C.4.2 Instruction / Question

In response to the questions below, describe how the State will design a high risk pool program that will meet the basic requirements to operate the program as described in A.4.2 of the

Statement of Work.

C.4.2 Response

The State proposes to build on our existing Dirigo Health program, which currently covers uninsured persons with pre-existing conditions through its subsidized insurance program DirigoChoice. Maine will ensure maintenance of effort in our current program and use federal funds to extend coverage to those uninsured for at least six months who also have pre-existing conditions.

DirigoChoice is a private health coverage plan administered by HPHC under contract to the State through DHA. The State provides DirigoChoice enrollees premium and cost sharing subsidies based on income.

The Dirigo Health program is the only plan in the individual market that has no waiting period for pre-existing conditions, assures mental health parity and covers preventive services with no cost sharing. Through guaranteed issue protection and subsidies for premiums and out-of-pocket costs, we have established a program that serves the same individuals targeted under the high-risk pool program. Maine has also achieved most of the rate reforms proposed in the PPACA. We believe our current Dirigo Health program meets the requirements in the Act because it:

a) Does not impose any pre-existing condition limitations on coverage for eligible individuals;

b) The issuer's share of cost is not less than 65% of the actuarial costs of benefits;

c) Out-of-pocket limits are no greater than those permitted under the rules for health savings accounts ($5,950 for individual coverage; $11,900 for family coverage);

d) Premiums will be the standard premiums for the Dirigo individual population;

e) Age rating is less than 4 to 1.

The State proposes to use the funds made available through this contract to both provide premium and cost sharing subsidies to uninsured, high risk members and to construct a limited risk sharing arrangement with HPHC (an "experience modification program" – EMP) to pay for claims costs beyond that of the current DirigoChoice population.

Because the State is leveraging an existing program, we are to accept applications for uninsured, high risk applicants starting in July 2010 (assuming funding is available) with an

effective date of coverage for August 1, 2010.

C.4.2 (1) Instruction / Question

Describe the eligibility criteria that the qualified high risk pool will use to determine if individuals are eligible to enroll in the proposed high risk pool program.

C.4.2 (1) Response

The eligibility criteria that the qualified high risk pool will use to determine if individuals are eligible to enroll in the high risk pool program are described in section 1101 of the Patient Protection and Affordable Care Act (Public Law 111-148). Eligible individuals must:

- Be a citizen or national of the United States or lawfully present in the United States;
- Not have been covered under creditable coverage (as defined in Section 2701(c)(1) of the Public Health Service Act) for the previous 6 months before applying for coverage; and
- Have a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary.

C.4.2 (2) Instruction / Question

Describe the coverage and benefits to be offered by the qualified high risk pool. At a minimum, the response to this question must address the benefits elements contained in A.4.2 of the Statement of Work and include all benefit plan variations that may be proposed by the State.

C.4.2 (2) Response

Please refer to Exhibit 1 – Summary of Benefits

C.4.2 (3) Instruction / Question

How will the qualified high risk pool comply with the requirements to cover pre-existing conditions described in A.4.2.3?

C.4.2 (3) Response

There are no pre-existing condition limitations or exclusions in the DirigoChoice program. Individuals are covered for all services listed in the Evidence of Coverage as of their effective date of coverage.

C.4.2 (4) Instruction / Question

Describe how the qualified high risk pool will derive its premiums, including a description of its

methodology in determining the standard risk rate.

C.4.2 (4) Response

Premium rates for the high risk pool will be the same as the rates that apply to DirigoChoice individuals and sole proprietors who are not enrolled in the high risk pool. HPHC develops DirigoChoice rates using its standard rate development methodology. Rates are based on the experience of the DirigoChoice population and target a 90% medical loss ratio. Rates are subject to negotiation with DHA and approval by the Maine Bureau of Insurance.

C.4.2 (5) Instruction / Question

Describe the cost sharing structure of the benefit package(s) proposed to be offered by the qualified high risk pool that complies with the requirements outlined in A.4.2.7.

C.4.2 (5) Response

The aggregate actuarial value of the DirigoChoice plans is 82%, as independently calculated by Gorman Actuarial, LLC. Please see attached Exhibit 2.

DHA offers two plans to enrolled individuals (1750 and 2500 deductibles for non-subsidized enrollees). While the core medical benefits are the same for all enrollees, the specific cost sharing structure depends upon an enrollee's financial status, and ranges from a 72% actuarial value for those members who receive no subsidy to 86% for those who receive the highest subsidy.

Members who are eligible for subsidies also receive premium assistance of up to 84% of the monthly premium cost.

Specific deductibles and out-of-pocket limits for one person policies range from $500 / $700 for those with the highest subsidy to $2,500 / $5,600 for those not eligible for subsidy.

Please refer to Exhibit 3 for a full schedule of premium, deductible, and out of pocket subsidies and cost sharing.

All DirigoChoice plans have a $25 office visit co-pay and 30% co-insurance for claims incurred beyond the deductible up to the out-of-pocket limit.

There is no co-pay for preventative services.

C.4.2 (6) Instruction / Question

If applicable, describe the provider network(s) proposed to be used by qualified high risk pool enrollees and demonstrate that the network(s) has a sufficient number and range of providers

to ensure that all covered services are reasonably available and accessible in those networks.

C.4.2 (6) Response

HPHC has a comprehensive, statewide provider network, which is comprised of contractual arrangements with physicians who practice in a variety of settings. In addition, HPHC contracts with health care facilities including integrated delivery systems, hospitals, skilled nursing facilities and ancillary providers. HPHC's network complies with Maine Bureau of Insurance Rule 850 which establishes provider access standards for managed care plans.

C.4.2 (7) Instruction / Question

Describe the appeals and reconsiderations process that the qualified high risk pool proposes to make available to enrollees in the high risk pool program as per the description of section A.4.2.10.

C.4.2 (7) Response

DHA and HPHC have established and maintain procedures for individuals to appeal program eligibility and coverage determinations. The appeals procedures provide enrollees and potential enrollees the right to a timely redetermination by DHA of a determination concerning program eligibility. Through HPHC members have the right to a timely reconsideration of a coverage redetermination.

Program Eligibility Appeals

An applicant has 30 calendar days from the date of the determination letter to request an independent review of the subsidy determination.

An independent review committee (IRC) must render a written decision within 10 calendar days of receipt of the request for review.

The chairperson is responsible for notifying the applicant in writing of the decision rendered by the IRC and the applicable timeframe for appeal.

An applicant has 15 calendar days from the date of the IRC decision to request an appeal.

The appeals committee must render a written decision within 10 calendar days of receipt of the request for appeal. Members of the appeals committee include the following DHA staff: Executive Director; Deputy Director; and the Operations Director.

The chairperson is responsible for notifying the applicant in writing of the decision rendered by the appeals committee.

HPHC Coverage Appeals

First level appeal: An assigned Appeals Coordinator investigates all initial appeals. The Appeals Coordinator will inform the member in writing whether the appeal has been approved or denied.

Second level appeal: If the member is dissatisfied with the decision of the first level appeal process, they may ask that their appeal be reviewed by an HPHC review committee. A review meeting is held within 45 working days of the member request. The decision of the review committee will be sent to the member in writing within five working days of the meeting. The decision of the review committee is the final decision of HPHC.

Independent external review of appeals: Appeal decisions involving an Adverse Utilization Determination by HPHC are eligible for review by an independent review organization designated by the Maine Bureau of Insurance. In most cases the member is required to complete HPHC's first and second level appeals process to be eligible for external review. However, this requirement does not apply if:

(1) HPHC has failed to make a decision on the first or second level appeal in the timeframes noted above

(2) the member and HPHC mutually agree to bypass the HPHC Member appeals process;

(3) the member's life or health is in jeopardy

(4) the Member for whom external review is requested has died

Requests for external review must be in writing to the Maine Bureau of Insurance and must be made within 12 months of HPHC's final denial of covered benefits prior to the initiation of the appeals process.

C.4.3 Instruction / Question

Describe the qualified high risk pool's proposed eligibility determination and enrollment standards as outlined in Section A.4.3.

C.4.3 (1) Instruction / Question

How will the qualified high risk pool develop and utilize an eligibility determination process that will ensure that only individuals eligible for coverage, as described in Section A.4.2 of the Statement of Work, receive benefits from the program?

C.4.3 (1) Response

DHA will screen all applicants to ensure that only those qualified and eligible for coverage are enrolled in the high risk pool program. Screening will be based upon a health risk questionnaire. Those individuals who self identify one of the conditions listed on the health risk questionnaire will be deemed eligible for the high risk pool program. The health questionnaire will include the following diagnoses:

Acquired immune deficiency syndrome (HIV/AIDS)

Angina pectoris

Cirrhosis of the liver

Coronary occlusion

Cystic fibrosis

Friedreich's ataxia

Hemophilia

Hodgkin's disease

Huntington's chorea

Juvenile diabetes

Leukemia

Metastatic cancer

Motor or sensory aphasia

Multiple sclerosis

Muscular dystrophy

Myasthenia gravis

Myotonia

Heart disease requiring open-heart surgery

Parkinson's disease

Polycystic kidney disease

Psychotic disorders

Quadriplegia

Stroke

Syringomyelia

Wilson's disease

Diabetes

Asthma

Coronary Artery Disease

Congestive Heart Failure

Hypertension

C.4.3 (2) Instruction / Question

How will the qualified high risk pool obtain all of the information described in Section A.4.2 of the Statement of Work as part of the proposal process in the high risk pool program?

C.4.3 (2) Response

There will be a specialized application form and accompanying materials for the high risk pool program. Questions will be tailored to meet the needs and requirements of the program. The applicants will call the DHA customer service center and receive guidance and screening for their entrance into the high risk pool program. DHA customer service staff will request application materials and rate information from HPHC. HPHC will mail or email the application materials and rate information to the applicant. The completed applications will be sent to DHA by the applicant and processed by staff trained in the specifics of the program.

C.4.3 (3) Instruction / Question

Describe the process that the qualified high risk pool will use to confirm that an enrollee is a citizen or national of the United States or an alien lawfully present in the United States.

C.4.3 (3) Response

DHA will screen all applicants to ensure only those citizens or nationals of the United States (US) or those lawfully present in the US are accepted into the high risk pool program. The screening will include but is not limited to:

- US birth certificate
- US passport
- Record of military service showing citizenship
- Adoption papers showing place of birth
- Verification of Supplemental Social Security Income Benefits (SSI)
- Verification of Social Security Disability Income (SSDI)
- Proof of previous Medicaid coverage which in the State of Maine is called MaineCare.
- Copy of a Green Card
- Verification via use of the applicant's social security number with the Social Security Administration
- Query to the Office of Vital Statistics

Note: Some of the documents above are already utilized for the DirigoChoice program.

C.4.3 (4) Instruction / Question

Describe the enrollment process that the qualified high risk pool proposes to use.

C.4.3 (4) Response

DHA and HPHC share responsibility for enrollment of members into the program in the manner described below.

DHA responsibilities include, but are not limited to:

- Ensuring completeness of application materials
- Determining eligibility for the subsidy program and other components of plan eligibility
- Communicating information regarding the subsidy level and amount to the applicant

HPHC responsibilities include, but are not limited to:

- Providing quotes to new and renewing accounts for the non-discounted cost of coverage

- Enrolling the applicant in the insurance product
- Performing the required compliance checks. Compliance checks include:
    - student verifications,
    - domestic partner verifications; and
    - disabled dependent eligibility.
- Sending the appropriate information to the Member.
- Making all appropriate changes to the account during the plan year
- Filing all required rates and enrollment/renewal materials with the State Bureau of Insurance.

Premium Quotes

New and renewing accounts first obtain a quote for the cost of their coverage from the HPHC.

Submission of Application to DHA

Accounts submit to DHA the completed application packet. The completed packet must be received no later than the fifteenth day of any month to ensure effective date of coverage as the 1st day of the following month (i.e. December 15th for January 1st coverage; March 15th for April 1st coverage).

Processing of new applications by DHA

DHA processes the subsidy application and notifies the applicant of the subsidy determination. Once the subsidy determination has been made, DHA forwards the subsidy level and relevant application information to HPHC via a secure electronic transmission for processing. DHA does not forward the financial subsidy application or any personal financial information to HPHC.

Effective Date of Coverage

Is the first day of the month following the 15th day of the month that follows receipt of a completed application packet. For example, a member whose application is received on May 6th will be effective on June 1st. A member whose application is received on May 22nd will be effective on July 1st.

Application Material

DHA and HPHC jointly develop all application and renewal material. HPHC will produce and distribute the application materials for the program to anyone requesting application materials. The

complete application packet is the packet of documents that must be signed and submitted to DHA to apply for participation in the program.

All applicants, regardless of whether or not they are applying for a subsidy, must complete the subsidy application. Applicants who are not applying for a subsidy do not need to supply financial information with the subsidy application, but do need to certify that they are not requesting a subsidy.

Changes

DHA notifies HPHC of subsidy changes through the secure electronic file transfer process. HPHC makes these changes effective the date DHA specifies.

Demographic and other non-subsidy changes originate at HPHC. HPHC reports these changes to DHA via the secure electronic file transfer process.

C.4.3 (5) Instruction / Question

Describe the disenrollment process that the high risk pool plan proposes to use.

C.4.3 (5) Instruction / Question

1. Termination by the subscriber:
    - Membership may end by submitting a completed Enrollment/Change form to HPHC within 60 days of the date membership is to end.
2. Termination for loss of eligibility:
    - Coverage may end for failing to meet any of the specified eligibility requirements. Member will be notified in writing if coverage ends for loss of eligibility.
3. HPHC may end coverage for any of the following reasons for cause including:
    - Providing false or misleading information on an application for membership
    - Committing or attempting to commit fraud to obtain benefits for which they are not eligible
    - Obtaining or attempting to obtain benefits for a person who is not a Member.

Misrepresentation or fraud may go back to the Applicants effective date or the date of the misrepresentation or fraud as determined by HPHC. Notice of termination of membership for the other causes will be effective fifteen (15) days after notice. Premiums paid for periods after the effective date of termination will be refunded.

4. Terminations for non payment:

- HPHC may end coverage for failure to make required premium payments in a timely manner.
- Termination for failure to make required premium payments will be effective at the end of the payment grace period. Premium payments must be received by HPHC within 15 days of the due date.

C.4.4 Instruction / Question

Describe the customer service functions and standards that will be employed by the qualified high risk pool program. The description should include the qualified high risk pool's proposal for the staffing, hours of operation and service levels that the qualified high risk pool will provide to enrollees in the qualified high risk pool.

C.4.4 Response

DHA and HPHC each operate customer service operations.

DHA's customer service unit provides specific guidance for eligibility criteria, subsidy information, and the enrollment and renewal process. HPHC's customer service unit provides specific guidance for benefit and claim information.

Each unit provides

- live operator assistance between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday (local time) and 24-hour, seven-day-per-week voice message service for after-hours coverage;
- bilingual and TTY services for Members with special needs and;
- Member Service staff with online access to eligibility, enrollment, and subsidy information to respond to Member inquiries, resolve problems, and make appropriate call referrals when necessary.

HPHC further ensures that after hours, on weekends, and on holidays the Member Service Call Center inbound telephone lines are answered by an automated system with the capability to provide callers with operating hours and instructions on what to do in cases of emergency. A voice mailbox is available after hours for callers to leave messages. Member calls received by the automated system

are returned by HPHC's Member Service representatives on the next working day.

The customer service operations of DHA and HPHC are integrated such that callers face "no wrong door." Service representatives from each organization can effect soft transfers of callers to the other while remaining on the line, so that callers do not have to call a different number to get service. This soft transfer process also ensures that representatives from both organizations can coordinate service for members in real time.

C.4.5 Instruction / Question

Describe the technical support center to respond to health care and pharmacy providers for information that will be employed by the qualified high risk pool. The description should include the qualified high risk pool's proposal for the staffing, hours of operation and service levels that the qualified high risk pool will provide.

C.4.5 Response

HPHC provides the same telephone service to providers as it does to members. The service unit responds to all requests for eligibility verification, claims status and benefits form providers. This service includes:

- "live" operator assistance between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday (local time) and 24-hour, seven-day-per-week voice message service for after-hours coverage;
- bilingual and TTY services for as needed;
- an automated logging system to track and report telephone service performance (e.g., volume, response time, abandonment rate, etc.), and
- Customer Service staff with online access to eligibility, enrollment and claim information to respond to all, resolve problems, and make appropriate call referrals when necessary.

After hours, weekends and holidays service is available through an automated system which gives providers the ability to leave messages. Provider calls received in the automated system are returned by the appropriate representative on the next working day.

HPHC also supports the on-line submission of health claims and verification of eligibility and benefits through HIPAA compliant EDI transactions.

HPHC utilizes a service agreement with MedImpact Healthcare Systems to adjudicate pharmacy claims and related tasks. MedImpact has call centers located in San Diego, California, and Tempe, Arizona. In all locations, Customer Service Representatives access the same database to respond to calls received from pharmacies, plan sponsors and members, ensuring consistency. Call centers operate 24 hours a day, 7 days a week, 365 days a year and include more than 100 team members. The MedImpact Customer Service Team also has access to Benefits Specialists and IT support if needed, during normal business hours, as well as after-hours via on call staff. To ensure that high levels of service are maintained, performance guarantees are in place to make certain that callers are able to access a live Customer Service Representative within 30 seconds and that all calls are answered within 30 seconds, resulting in a call abandonment rate of 3% or less. MedImpact consistently meets these guarantees.

C.4.6 Instruction / Question

Describe the qualified high risk pool's system for billing, collecting, and accounting for premiums.

C.4.6 Response

HPHC bills the individual the net amount of their premium after the application of the subsidy on a monthly basis. The individual makes payment to the DHA. HPHC bills DHA for each account, indicating the account charge and the DHA charge. DHA then remits the entire payment (account and DHA shares) to HPHC.

For example, if an individual has a rate of $450, and the subsidy for the individual is $100, HPHC would bill the individual $350. The individual would remit $350 to DHA. DHA remits $450 to HPHC.

Membership Fees

There is an annual membership fee of $150 for participation in the program which covers a portion of DHA's administrative costs. HPHC incorporates the fee in its monthly billing and forward fees received from accounts to DHA.

Delinquency and Termination

HPHC is responsible for managing the delinquency and termination process for accounts, including

mailing dunning notices and notifying DHA when accounts have terminated for non-payment.

Any collection activity HPHC pursues in relation to delinquent accounts is taken with notice to DHA

C.4.7 Instruction / Question

If the qualified high risk pool intends to develop and implement utilization and care management as part of the qualified high risk pool coverage, describe the utilization and care management processes that the qualified high risk pool proposes to use.

C.4.7 Response

HPHC provides case management services and utilization support for members at all levels of care including outpatient services such as diagnostic testing and ambulatory surgeries. Members are identified based upon diagnosis and utilization history. The oversight and coordination of the members care is holistic, addressing educational deficits and providing guidance for imminent testing and procedures. Coaching and support is made available to assist the member with preparation for potential services.

For diagnostic services, HPHC contracts with National Imaging Associates (NIA) for completion of prior authorization review for specific diagnostic services including:

- CT Scans
- PET Scans
- MRI/MRA
- Nuclear Cardiology

HPHC retains oversight of all activities delegated to NIA.

HPHC's Utilization Management and Clinical Policy Committee (UMCPC) meets every two weeks to propose, evaluate and discuss the implementation of new policies relevant to innovative and changing technologies & procedures. As part of the evaluation phase, an analysis of evidence based guidelines and industry benchmarks are completed; draft policies are then vetted by subject matter experts. UMCPC makes recommendations to organizational operations committees, as well as relevant other share holders to implement and communicate changes or updates to services and treatment protocols.

C.4.8 Instruction / Question

Describe the system for processing and paying for health and prescription drug claims that will be implemented by the qualified high risk pool. The description should include the basis for payment rates and the timeliness of payments to providers. The description should also include the point of sale claim system that will be utilized for prescription drug claims.

C.4.8 Response

Payment of the health claims for the members of the qualified high risk pool is based on the negotiated rates in place between HPHC and contracted providers in the State of Maine.

Medical claims are processed on the Healthpac system supported by Eldoroado Computing, Inc. This system supports all aspects of health insurance claims processing, including fully integrated determination of eligibility, negotiated rates for contracted providers and usual and customary for non-contracted providers, and the appropriate application of benefits.

All medical claims are processed and paid no more than 30 days from the receipt of the claims in the processing center for the qualified high risk pool. Currently, the DirigoChoice medical claims turnaround time is 95.1% within 14 calendar days and 100% within 30 calendar days.

With respect to pharmacy claims, MedImpact processes claims through a powerful, proprietary claims adjudication engine with sub-second adjudication performance. The claims adjudication engine is a real-time on-line claims adjudication system. All pharmacies participating in the MedImpact Pharmacy Network are required to have on-line billing capabilities in the current NCPDP 5.1 format. To ensure that high levels of service are maintained, performance guarantees are in place to make certain that claims adjudicate at an accuracy rate of 99% or better and that system response time on submitted claims is 4 seconds or less on a minimum of 98% of claims submitted. MedImpact performs a standard check cycle every two weeks, which includes invoicing to health plans for claims processed and claims payment to pharmacies. From the time that the health plan is invoiced, remittance to pharmacies normally occurs within 15 business days. Pharmacies are reimbursed based on rates specified in the contract executed between the pharmacy and MedImpact.

C.4.9 Instruction / Question

Describe the qualified high risk pool's proposed efforts to conduct outreach and marketing for the high risk pool program.

C.4.9 Response

DHA and HPHC are in the process of developing an outreach plan for the DirigoChoice program. If DHA is awarded a contract for the high risk pool program the outreach for this targeted population will be an extension of the strategies we employ for the DirigoChoice program at large. To achieve our growth objectives DHA and HPHC may employ the following strategies:

- Develop and maintain an actionable DirigoChoice eligible prospect database
- Utilize database for strategic planning and targeted marketing to DirigoChoice eligible prospects
- Employee promotional program to create awareness and favorability for HPHC brand, products and related services
- Create clear and easily accessible printed and web communications for DirigoChoice prospects and their dependents
- Provide ongoing training, tools and education to Broker distribution channel
- Continue to measure and evaluate effectiveness of sales and marketing plan and adjust for improved performance
- Partner with consumer advocacy groups
- Work with the press to promote the program
- Inform the Legislature
- Conduct educational sessions with a preferred network of brokers

C.4.10 Instruction / Question

Describe the process the qualified high risk pool proposes to use to identify and report to HHS instances in which health insurance issuers or group health plans are discouraging high-risk

individuals from remaining enrolled in their current coverage in compliance with A.4.10.

C.4.10 Response

The application for coverage in the high risk pool program will include questions as to current and previous health care coverage for the applicant, their spouse/domestic partner and dependents. This is the current process for the DirigoChoice program. DHA will review Certificates of Credible Coverage to check for previous medical insurance coverage.

Consistent with current process in the DirigoChoice program, DHA will work closely with the following entities to review any instances of impropriety which come to their attention:

- State of Maine Bureau of Insurance
- Consumer advocacy groups
- Maine Equal Justice
- State Department of Health and Human Services

DHA letters of determination on the acceptance into the high risk pool program and notification of any subsidy off their monthly payment will include:

- language indicating notification to us of change in status of applicant is mandatory
- language indicating ramifications of lack of notification to us
- responsibility in notifying us of changes in the status of their dependents if covered under the high risk pool program

C.4.11 Instruction / Question

Describe the procedures that qualified high risk pool proposes to implement to prevent, detect, and report incidences of waste, fraud, and abuse.

C.4.11 Response

DHA currently uses the following procedures to prevent, detect, and report incidences of waste, fraud and abuse:

Program eligibility and subsidy determinations are handled by DHA staff. Supervisors directly oversee the work performed. Supervisors perform a 100% quality check of the application files prior to staff being allowed to handle eligibility and discount determinations independently.

DHA staff eligibility and subsidy determinations use, but are not limited to:

- IRS Tax Form 1040
- Quarterly Estimates of Earnings
- Pay check stubs
- Social Security Statements
- Unemployment Statements
- Bank and other Financial Institution Statements
- Pension Statements

Further monthly samplings (25%) of program eligibility and subsidy determinations are reviewed.

Once members are enrolled, DHA engages in active monitoring of accounts to ensure that subsidies and benefits are accurate. This monitoring includes, but is not limited to:

Aggregate analysis of payments against budget. DHA monitors total payments against projected amounts to ensure that the total program cost falls within expected forecasts.

Specific account verification: each month DHA validates the amount charged to each account based on rate, covered lives, and subsidy levels. DHA reviews those accounts that demonstrate discrepancies and coordinates system changes, if required, between HPHC and DHA.

When DHA determines that an account has received subsidy or benefit improperly, it engages in collection activities. For those accounts DHA is unable to collect from, DHA refers the account to Maine Revenue. Maine Revenue is able to offset future tax refunds to the account to recoup any amounts due.

When DHA becomes aware of fraudulent or illegal activity pertaining to enrollment in the program, it refers the accounts to the Maine Attorney General. The Attorney General has a dedicated office for the investigation and, if necessary, prosecution of individuals who engage in fraudulent or illegal activities in their participation in State benefit programs.

When DHA becomes aware of fraud pertaining to a member's attestation of uninsured status and/or

pre-existing condition(s), DHA will terminate the member's coverage.

C.4.12 Instruction / Question

Describe the system for routine monitoring and identification of compliance risks.

C.4.12 Instruction / Question

The system DHA has established to monitor and identify compliance risks includes:

As described in the response to C.4.3 (4), DHA maintains a daily secure electronic file transfer with HPHC. This daily exchange allows for:

- dependents are removed from coverage during the plan year - the coverage tier and discount for the member is adjusted as needed.
- coverage is terminated immediately upon the death of a member to protect against fraudulent use of the member benefits by others.

Additionally, DHA reviews member income and assets prior to a monetary subsidy being provided during each annual renewal cycle.

As described in the response to C.4.11, DHA has in place regular, routine validations of account billing and balances.

In addition, annual rate negotiations with HPHC will ensure that financial stipulations set forth in the Solicitation for State Proposals to Operate Qualified High Risk Pools continue and are adhered to.

DHA may require specific documentation to prove the existence of a pre-existing condition. In addition, DHA will routinely screen annual claims from high risk enrollees and compare them to the condition (or conditions) claimed in the application process. DHA will audit those members who do not demonstrate claims consistent with the condition reported.

C.4.13 Instruction / Question

Describe the system the qualified high risk pool proposes to implement to coordinate benefits as described in A.4.13.

C.4.13 Response

Benefits will be coordinated to the extent permitted by law with other plans covering health benefits, including: motor vehicle insurance, medical payment policies, workers' compensation insurance; home owners insurance, governmental benefits (including Medicare), and all health benefit plans.

Coordination of benefits will be based upon the usual, customary and reasonable charges for any service that is a covered service under the high risk pool benefit plans. If benefits are provided in the form of services, or if a provider of services is paid under a capitation arrangement, the reasonable value of such services will be used as the basis for coordination. No duplication in coverage of services shall occur among plans. When a Member is covered by two or more health benefit plans, one plan will be primary and the other plan will be secondary. The benefits of the primary plan are determined before those of secondary plan and without considering the benefits of secondary plan. The benefits of secondary plan are determined after those of the primary plan and may be reduced because of the primary plan's benefits.

To determine coordination of benefits HPHC sends a periodic letter asking for other insurance coverage. There are triggers via the data in the eligibility file and the data submitted on the UB-04 and the CMS-1500 claims forms that the claims processing computer system uses to flag and detect potentials for other insurance coverage.

Exhibit 1 – DirigoChoice Summary of Benefits

The DirigoChoice PPO Plan

This is a Summary of Benefits to your DirigoChoice PPO Plan. It is attached to and becomes part of your DirigoChoice Benefit Handbook.

Group Name: **Group Number:** **Effective Date:**

1.1. Cost Sharing	
Calendar Year Deductibles: General Deductible Mental Health (Non-Biologically Based Mental Illnesses)	 $2,500 Individual Deductible $5,000 Family Deductible $150
Deductible Rollover Your Plan has a Deductible Rollover. This allows you to apply any Deductible amount incurred for Covered Benefits during the last three (3) months of a calendar year toward the Deductible for the next year. In order for the Deductible Rollover to apply, you, or your covered family, must have had continuous coverage under DirigoChoice at the time the charges for the prior year were incurred.	
Calendar Year Out-of-Pocket Limit	$3,500 Individual Limit $7,000 Family Limit
Lifetime Benefit Maximum	No Limit

	In-Network Benefit	1.2. Out-of-Network Benefit
Coinsurance	The Plan pays 70% The Member pays 30% Unless otherwise indicated	The Plan pays 50% The Member pays 50% Unless otherwise indicated
Copayment	$25 Copayment where indicated	$35 Copayment where indicated
Service	**In-Network Benefit** **The Plan Pays:**	Out-of-Network Benefit **The Plan Pays:**
Hospital Services Inpatient[1] Outpatient	70% after Deductible	50% after Deductible
Emergency Room Services	70% after Deductible	70% after Deductible
Screening Mammograms	100%, no Copayment or Deductible	100%, no Copayment or Deductible
Professional Services Inpatient **Outpatient** Diagnostic tests, x-rays, and surgery	70% after Deductible	50% after Deductible
Endoscopic Procedures (including Colonoscopies)	70% after Deductible	50% after Deductible
Maternity Pre- & Post-natal Delivery	$25 Copayment first prenatal visit, then 100% 70% after Deductible	$35 Copayment first prenatal visit, then 70% 50% after Deductible

[1] Failure to obtain Prior Approval for non-emergency inpatient hospital services may result in services not being covered or a penalty of $150. Please see your Benefit Handbook Section C.4 for further information.

Service	**In-Network Benefit** **The Plan Pays:**	Out-of-Network Benefit **The Plan Pays:**
Physician Office Visits		
Sick Care Specialists	100% after $25 Copayment, Deductible does not apply	70% after $35 Copayment, Deductible does not apply
Routine/Preventive (including any associated diagnostic tests and x-rays)	100%, no Copayment or Deductible	50% after $35 Copayment, Deductible does not apply
Hearing aids For Members through the age limit required by Maine law[2]. Limited to one (1) hearing aid every 36 months, per hearing impaired ear, up to a limit of $1,400	70% after Deductible	50% after Deductible
Other Services Occupational, Speech, and Physical Therapies – Combined limit of $3,000 per calendar year	70% after Deductible	50% after Deductible
Chiropractic Care / Manipulative Therapy Combined limit of 40 visits per calendar year	70% after Deductible	50% after Deductible
lled Nursing Facility – Up to 100 days per Member per calendar year	70% after Deductible	50% after Deductible
Hospice		

[2] Effective January 1, 2008, for Members from birth through age 5. Effective January 1, 2009, for Members from birth through age 13. Effective January 1, 2010 and thereafter, for Members from birth through age 18. No coverage for Members over 18 years of age.

	100% after $25 Copayment, Deductible does not apply	50% after $35 Copayment, Deductible does not apply
Home Health Care	70% after Deductible	50% after Deductible
Ambulance	70% after Deductible	70% after Deductible
Cardiac Rehabilitation – Up to 24 visits per Member per calendar year	70% after Deductible	50% after Deductible
Durable Medical Equipment – Up to $3,500 per Member per calendar year	70% after Deductible	50% after Deductible
Prostheses (excluding limbs)	70% after Deductible	50% after Deductible
Prostheses for limb replacement	70%, Deductible does not apply	70%, Deductible does not apply
Smoking Cessation:		
Smoking Cessation Program – up to $35 per program /$70 per lifetime	100%, no Copayment or Deductible	100%, no Copayment or Deductible
Physician Office Visits – up to 2 per Member per calendar year	100% after $25 Copayment, Deductible does not apply	70% after $35 Copayment, Deductible does not apply
Smoking Cessation Medications	See the Prescription Drug section for additional information	See the Prescription Drug section for additional information

Mental Health and Substance Abuse Services		
Mental Health and Substance Abuse services are managed and all Inpatient and Day Treatment services require preauthorization. Failure to comply with the requirements outlined in your Benefit Handbook may result in a penalty up to $150. Coinsurance for Non-Biologically Based Mental Illness services does not count toward meeting the annual Coinsurance limit. Coinsurance continues to apply to these services after the Coinsurance limit is met.		
Service	**In-Network Benefit** **The Plan Pays:**	Out-of-Network Benefit **The Plan Pays:**
***Biologically Based Mental Illnesses including Substance Abuse services:**		
Inpatient, Day treatment, Outpatient	70% after Deductible	50% after Deductible
Office Visits	100% after $25 Copayment, Deductible does not apply	70% after $35 Copayment, Deductible does not apply
Home Health Care Services	70% after Deductible	50% after Deductible
Non-Biologically Based Mental Illnesses:		
Deductible – combined in and out of network	$150	$150
Inpatient – Combined limit of 30 days per calendar year. Two days of Day Treatment equal one day of Inpatient Treatment.	70% after mental health Deductible	50% after mental health Deductible
Outpatient – Combined limit of 40 visits per Member per calendar year		
Home Health Care Services	70% after mental health Deductible	50% after mental health Deductible

	70% after Deductible	50% after Deductible

Prescription Drug Coverage	
The Plan provides prescription drug coverage with Copayments. The Plan places all covered drugs into one of three levels or "tiers." Each tier has its own Copayment amount. The specific Copayments for prescription drugs that apply to your Plan are listed below. Your Copayments are also listed on your Member ID card. Prescription drugs are not subject to the Deductible. Please see your Benefit Handbook Section O for further information.	
Prescription Drug Tier	**Participating & Non-Participating Pharmacies**
Tier 1	$10 Copayment, up to a 30-day supply
Tier 2	$30 Copayment, up to a 30-day supply
Tier 3	$50 Copayment, up to a 30-day supply

Exhibit 2 – Gorman Actuarial, LLC DirigoChoice Summary Actuarial Value Calculation

		Non Group HPHC					
Plan	Income Category	Office Visit Copay	Deductible	In Network Coinsurance	Out Network Coinsurance	OOP Max	Actuarial Value
1750	B	25	500	30%	50%	1600	0.824
1750	C	25	800	30%	50%	2600	0.787
1750	D	25	1125	30%	50%	3600	0.758
1750	E	25	1450	30%	50%	4600	0.735
1750	F	25	1750	30%	50%	5600	0.716
2500	B	25	500	30%	50%	700	0.862
2500	C	25	1000	30%	50%	1400	0.814
2500	D	25	1500	30%	50%	2100	0.779
2500	E	25	2000	30%	50%	2800	0.751
2500	F	25	2500	30%	50%	3500	0.727
Total							0.818

Exhibit 3 – Subsidy and Cost Sharing Schedule

Federal Poverty Level	150%	200%	250%	300%	300%+
Less than:					
Subsidy Level	B	C	D	E	F
% off Premium	80%	60%	40%	20%	0%

Subsidy Level B			
1750 Plan	Single	$ 500	$1,600
	Family	$1,000	$3,200
2500 Plan	Single	$ 500	$ 700
	Family	$1,000	$1,400
Subsidy Level C			
1750 Plan	Single	$ 800	$2,600
	Family	$1,600	$5,200
2500 Plan	Single	$1,000	$1,400
	Family	$2,000	$2,800
Subsidy Level D			
1750 Plan	Single	$1,125	$3,600
	Family	$2,250	$7,200
2500 Plan	Single	$1,500	$2,100
	Family	$3,000	$4,200
Subsidy Level E			
1750 Plan	Single	$1,450	$4,600
	Family	$2,900	$9,200
2500 Plan	Single	$2,000	$2,800
	Family	$4,000	$5,600
Subsidy Level F			
1750 Plan	Single	$1,750	$5,600
	Family	$3,500	$11,200
2500 Plan	Single	$2,500	$3,500
	Family	$5,000	$7,000

Section C – Cost Proposal

Budget Narrative

The State proposes to use its allocation of high risk pool dollars in two ways to assist eligible individuals. The first is by providing these individuals with income-based premium subsidies through the DirigoChoice program. The second is to provide risk-sharing payments to HPHC to promote premium rate stability for both high risk pool eligible individuals and other DirigoChoice members.

Premium rates charged to high risk pool eligible individuals will be the same as the premium rates charged to other individuals enrolled in the DirigoChoice program. Currently, premium rates for DirigoChoice are developed to target a 90% medical loss ratio. Under the risk sharing program, high risk pool funds will be used to make additional payments to HPHC if the medical loss ratio for high risk pool members exceeds 90%.

To develop the budget for the high risk pool program, HPHC developed premium, claim and administrative cost and enrollment estimates. The premium and claim cost estimates are based on reasonable actuarial assumptions regarding health care trends and the anticipated morbidity of high risk pool enrollees. Actual experience may vary from these estimates. Factors that may impact the actual experience include changes in general unit cost and utilization trends in the State of Maine, finalization of eligibility requirements for the high risk pool and the actual morbidity of the enrolled population.

Enrollment estimates were developed using the premium and claim cost estimates, the assumption that a $17 million is available for the program and the assumption that funding may be used for income-based premium subsidies available through the DirigoChoice program and risk sharing payments to HPHC.

We project that the high risk pool program will be able to serve an average of 515 members each month. Based on the claims projections for this population, $9,541,727.61 will be used for risk sharing payments and $7,458,272.39 will be used for subsidies. DHA and HPHC will review and revise membership projections annually and, if necessary, will suspend new enrollment into the program in order to ensure that program spending does not exceed available funding.

Administrative cost estimates are based on HPHC's administrative cost allocation methodology for each of the categories of services listed in Table 1. The overhead category of services includes governance, real estate, compliance/audit, human resources and certain information technology expenses. The other administrative costs category includes premium taxes and care management expenses. With respect to administrative services provided by DHA, such as eligibility determinations, no additional administrative costs have been assumed as DHA will absorb these expenses within its existing administrative budget.

Maintenance of Effort

As noted in the technical proposal, the State proposes to build on the existing Dirigo Health program, which currently covers uninsured persons with pre-existing conditions through its subsidized insurance program DirigoChoice. Dirigo Health is currently statutorily funded through an annual assessment on health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers of 2.14% of paid claims (MRSA 24-A §6917 (1)). DHA estimates that this assessment will result in approximately $42.1 million in revenue in State Fiscal Year 2011 (July 2010 – June 2011) and enable the State to provide coverage to approximately 20,000 Maine residents. In addition, DHA currently receives $8.5 million annually from a State Health Access Grant Program (SHAP) from the Health Resources and Services Administration (HRSA).

This program allows DHA to extend benefits to an additional 3,000 low-income, part-time, uninsured workers in the State[1]

These funds will allow DHA to meet the maintenance of effort requirement set forth in section 1101(b)(3) of the Affordable Care Act. DirigoChoice is not a traditional high risk pool, but as the State is proposing using the program to insure a high risk population and to meet the requirements set forth in 1101(c)(2)(A-D) of the Affordable Care Act it will apply the maintenance of effort requirements to the program. Existing funding, therefore, will ensure that the existing DirigoChoice population will continue to receive benefits and that the State is agreeing to not reduce the annual amount expended for the operation of DirigoChoice during the year proceeding the year of the contract.

[1] This grant requires annual renewals and may be extended through 2014.

Section C - Cost Proposal

Table 1
Administrative Costs

The administrative costs projected in Table 1 should include all administrative costs that the State anticipates during e
calendar year from 2010-2013.

Administrative Costs					
Cost Category	**Annual Administrative Costs**				
	2010	**2011**	**2012**	**2013**	**2014**
Marketing and Outreach	$4,668.55	$9,792.12	$10,426.78	$11,106.46	
Member Materials					
Customer Service	$6,816.66	$14,297.69	$15,224.38	$16,216.80	
Provider Relations					
Information Technology	$6,788.02	$14,237.62	$15,160.41	$16,148.66	
Eligibility/Enrollment	$4,668.55	$9,792.12	$10,426.78	$11,106.46	
Premium Administration	$7,790.47	$16,340.22	$17,399.29	$18,533.49	
Claims Processing**	$8,563.79	$17,962.23	$19,126.43	$20,373.21	
Appeals/Reconsiderations					
Legal Services	$1,661.20	$3,484.31	$3,710.14	$3,951.99	
Accounting Services	$11,914.84	$24,990.92	$26,610.68	$28,345.33	
Actuarial Services					
Procurement	$85.92	$180.22	$191.90	$204.41	
Personnel Expenses					
Overhead*	$54,246.89	$113,780.79	$121,155.35	$129,053.02	
Other Administrative Costs*	$49,950.67	$104,769.64	$111,560.15	$118,832.35	
TOTAL	$157,155.58	$329,627.89	$350,992.30	$373,872.19	

*Provide a detailed description of costs included in this category of administration costs
Other Administrative tax is Premium Tax and Care Management
Overhead expenses include governance, real estate, compliance/audit, HR, as well as HPHC IT expenses

**Including prescription drug point of sale claims

Table 2
Administrative and Claims Costs

Year	Average Enrollment	Premium Revenue	Total Claims	Administrative Costs	Total Claims Against Federal Fund Allotment
2010					
Plan Option 2B	146	$380,712.99	$642,453.17		
Plan Option 2C	55	$182,081.29	$307,262.17		
Plan Option 2D	23	$68,069.91	$114,867.97		
Plan Option 2E	12	$38,324.88	$64,673.23		
Plan Option 2F	24	$59,062.01	$99,667.15		
Plan Option 3B	148	$452,212.06	$763,107.84		
Plan Option 3C	57	$234,765.12	$396,166.14		
Plan Option 3D	19	$64,550.70	$108,929.30		
Plan Option 3E	11	$35,334.48	$59,626.94		
Plan Option 3F	21	$56,442.35	$95,246.46		
2010 TOTAL	515	$1,571,555.79	$2,652,000.39	$157,155.58	$1,237,600.18
2011					
Plan Option 2B	146	$798,531.11	$1,347,521.25		
Plan Option 2C	55	$381,908.62	$644,470.80		
Plan Option 2D	23	$142,774.06	$240,931.23		
Plan Option 2E	12	$80,384.98	$135,649.66		
Plan Option 2F	24	$123,880.34	$209,048.08		
Plan Option 3B	148	$948,497.69	$1,600,589.86		
Plan Option 3C	57	$492,410.97	$830,943.51		
Plan Option 3D	19	$135,392.65	$228,475.10		
Plan Option 3E	11	$74,112.74	$125,065.26		
Plan Option 3F	21	$118,385.69	$199,775.85		
2011 TOTAL	515	$3,296,278.87	$5,562,470.59	$329,627.89	$2,595,819.61

2012					
Plan Option 2B	146	$850,286.88	$1,434,859.11		
Plan Option 2C	55	$406,661.54	$686,241.34		
Plan Option 2D	23	$152,027.78	$256,546.88		
Plan Option 2E	12	$85,595.03	$144,441.62		
Plan Option 2F	24	$131,909.49	$222,597.26		
Plan Option 3B	148	$1,009,973.35	$1,704,330.04		
Plan Option 3C	57	$524,325.96	$884,800.05		
Plan Option 3D	19	$144,167.95	$243,283.42		
Plan Option 3E	11	$78,916.27	$133,171.20		
Plan Option 3F	21	$126,058.70	$212,724.06		
2012 TOTAL	515	$3,509,922.95	$5,922,994.98	$350,992.30	$2,764,064.32
2013					
Plan Option 2B	146	$905,713.95	$1,528,392.29		
Plan Option 2C	55	$433,170.31	$730,974.89		
Plan Option 2D	23	$161,937.91	$273,270.23		
Plan Option 2E	12	$91,174.66	$153,857.24		
Plan Option 2F	24	$140,508.18	$237,107.56		
Plan Option 3B	148	$1,075,809.80	$1,815,429.03		
Plan Option 3C	57	$558,504.83	$942,476.91		
Plan Option 3D	19	$153,565.73	$259,142.17		
Plan Option 3E	11	$84,060.53	$141,852.14		
Plan Option 3F	21	$134,276.01	$226,590.76		
2013 TOTAL	515	$3,738,721.90	$6,309,093.21	$373,872.19	$2,944,243.50
2014					
TOTAL		$12,116,479.51	$20,446,559.17	$1,211,647.95	$9,541,727.61

Notes:

· State should list total administrative costs for each calendar year. Administrative costs do not need to be broken down for each plan option if multiple plan options are offered.

· States may offer one or more plan option. State may add additional plan options following the format in template Table 2.

· Claims against Federal Fund Allotment for each year and for the total contract equal the total administrative and claims expenses, minus the premium revenue.

· The projected total for the term of the contract should not exceed the provided Federal fund allotment.

· States must attest to the actuarial soundness of the projects contained in this table in the budget narrative section of the Cost Proposal.

· Based on estimates above, approximately $7.5 million of the federal allotment will be used for coverage subsidies available through the DirigoChoice program. DHA and HPHC will review and revise membership assumptions annually based on actual experience.