

## MEMORANDUM

**TO:** Board of Directors  
**FROM:** Jon Kingsdale & Bob Carey  
**RE:** Request for Responses from Commercial Health Plans  
**DATE:** November 28, 2006

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### **Background**

The Connector will soon issue a request for responses (RFR) for health benefit plans to receive the Connector's Seal of Approval. Plans that receive the Seal will be offered for purchase through the Connector to individuals and small-groups (<51 employees). The Connector's target markets are individuals, small employers who are not currently offering health insurance to their employees, and those small employers that currently provide their employees with employer-sponsored insurance but who may prefer to offer their employees a broader choice of benefit plans and/or insurance carriers. With the exception of the Young Adults Plan, approved health benefit plans will also be available outside the Connector, i.e. directly from the carriers and their brokers and intermediaries. In addition, many other plans may be available to small-group and non-group purchasers outside the Connector.

It is important to note that the awarding of the Seal to particular plan designs (other than the Young Adults Plan) does **not** distinguish Connector offerings from the rest of the market; even a new plan design approved by the Connector **must** be offered by the same carrier outside the Connector to the newly-merged small-group/non-group market on a guaranteed issue and renewal basis. Nor does the withholding of the Seal for any particular plan design eliminate that plan from the market. In particular, there are many options in the market now that will remain in the market, regardless of whether they receive the Connector's Seal of Approval.

Rather, the Connector is a new distribution channel that represents an alternative to existing channels for buying health insurance plans. Therefore, the Policy Committee has concluded that the criteria for the Seal should stress, among other elements, the selection of high value and quality health plans which represent: (a) popular plan designs, i.e., those for which demand is demonstrable; and/or (b) plan designs that are likely to be attractive to the target market to be served by the Connector; and (c) a broad range of coverage options, from higher premium, comprehensive benefits to lower premium, Minimum Creditable Coverage.

In addition to offering “popular” plan designs, the Board is also charged with defining, and making available for purchase, Minimum Creditable Coverage, which is the minimum benefits plan that individuals must have to satisfy the mandate that they have health insurance. This is also the plan from which tax penalties will be calculated in 2008 (and beyond) for those individuals failing to have health insurance coverage. (The penalty applicable for 2008 is half the premium of the lowest cost plan that satisfies Minimum Creditable Coverage.) It is anticipated that many of those who are currently uninsured or who currently purchase less comprehensive insurance than Minimum Creditable Coverage will “buy-up” to this standard, if only to avoid tax penalties. Therefore, it is also anticipated that demand for less comprehensive products than Minimum Creditable Coverage will shrink.

(The Policy Committee anticipates using a two-step process for defining Minimum Creditable Coverage. First, a general set of guidelines for proposals that meet the Board’s intent for Minimum Creditable Coverage will be developed as part of the RFR for the Connector’s Seal of Approval. This RFR will be issued shortly after the anticipated Board vote on November 30<sup>th</sup>. Second, based on review of what carriers propose for Minimum Creditable Coverage, further discussion by the Board and public input, the Connector will promulgate regulations in early spring specifying Minimum Creditable Coverage and the criteria for granting waivers to the individual mandate.)

Finally, the Connector alone is authorized to sell to individuals (non-group buyers) a Young Adults Plan, to be defined in regulations promulgated by the Commissioner of Insurance, in consultation with the Executive Director of the Connector. Purchase of the Young Adults Plan by individuals 19-26 years old will satisfy the requirement to have health insurance, even if its benefits are less comprehensive than Minimum Creditable Coverage. Therefore, it is anticipated that many of the uninsured aged 19-26 will purchase a Young Adults Plan, if it is inexpensive enough relative to Minimum Creditable Coverage, rather than pay half the premium for Minimum Creditable Coverage as a tax penalty and still not have any health insurance coverage.

The principal issue before the Policy Committee is to develop recommendations or options for the Board regarding the number and design of health insurance plans to be requested of proposing carriers (in an RFR to be issued by the Connector in early December 2006) and to be offered by the Connector, including plan designs that should meet the definition of Minimum Creditable Coverage. (As noted above, Minimum Creditable Coverage will need to be defined in regulations to be promulgated by the Connector.)

## **Objectives**

In approaching these decisions, the Board set the following programmatic objectives:

1. Cover a large share of the uninsured above 300% of the federal poverty level
2. Stimulate development of affordable, quality health plans, including select networks
3. Educate consumers generally on “shopping“ for a health plan, and facilitate informed choice of those health plans offered via the Connector
4. Minimize unintended disruption to the existing small-group insurance market
5. Achieve financial stability and low administrative costs for the Connector’s commercial functions, by:
  - a. becoming the distribution system of choice for buyers and sellers of non-group and multi-carrier small-group insurance
  - b. creating a unique buying experience for the target market
  - c. attracting a balanced spread of risk
  - d. achieving economies of scale

Most of these objectives are self-explanatory, but one aspect at least merits further discussion. The Connector has consciously set as a goal to minimize unintended disruption to the small group market and to be a popular distribution channel for participating carriers and for buyers. Doing so requires carefully crafting solutions to several technical challenges posed by the merger of small-group and non-group markets and by the offering of a choice of carriers through the Connector.

For example, small employers generally (although not always) offer their employees a single carrier and have difficulty enough administering group payroll deduction and premium remittance for one carrier, with monthly reconciliation for drops, adds, births, deaths, retirement, COBRA, etc. To attract and serve small employers, the Connector should try to simplify relations between small employers and carriers, so that the Connector looks to the employer as much as possible like a single carrier would in administering premium collections, responding to customer service issues, etc.

To take a somewhat more technical example, the Connector should avoid skewing risk selection so as to significantly disadvantage those carriers that participate in it. These carriers and the Connector are “partnering” to sell insurance under a uniform set of rates that will be applied the same inside and outside the Connector. Should the Connector inadvertently set up a dynamic whereby claims experience is significantly worse in the Connector for a given set of products and purchasers than outside the Connector, carriers will not seek sales through the Connector. There is a well-documented history of such dynamics leading to the demise of similarly conceived health insurance purchasing cooperatives in other states. (As explained below, offering small groups only one level or

tier of plans is an important way to minimize the adverse financial consequences of skewed risk selection.)

### **Key Design Features of the Connector**

The Policy Committee has examined information from the Massachusetts small-group and non-group markets, as well as national non-group information, in order to provide guidance to the Board on appropriate benefits and price targets for the Commercial plans that will be considered for the Connector's Seal of Approval. (Because design of non-group products in Massachusetts has been limited by regulation, the experience of less regulated states may actually be a better guide to non-group demand than Massachusetts' own constrained experience.) In doing so, staff and the Policy Committee have used the following construct:

1. The Connector would offer to potential enrollees a sample of the most popular small-group plans currently in the market, organized into comparable actuarial levels of premium/benefits, plus two additional "levels" (3 & 4 below). There are several reasons to specify benefit/premium levels and organize specific plan design options into these levels.
  - a. To facilitate comparison shopping, by allowing the consumer to hone in on one level of coverage, and then compare options across carriers; this is simpler than trying to compare multiple plan design options of vastly different costs and benefits across carriers.
  - b. To allow an employer to select a benefit/premium level and one benchmark plan at that level, to which the employer can peg his/her premium contribution, as small employers commonly do now. (To minimize skewed risk selection inside versus outside the Connector, the Connector's participation rules for group insurance will mirror current market practice in Massachusetts, to the extent practicable: carriers require employers to contribute at least 50% of premium toward the least expensive option offered to his/her employees.)
  - c. To minimize risk selection within each level of coverage, by allowing employers to constrain group beneficiaries' choice to one level of benefits/premiums. If unconstrained, risk selection would lead to reduced premium revenue versus claims costs for group insurance sold within the Connector, relative to those same policies sold outside the Connector.
  
2. The most popular plans currently in the market would be offered at two levels, reflecting the current distribution of plan enrollment in the small-group market:
  - a. Two "Premier" plans, representing an HMO or a PPO, broad or select networks, tiered or non-tiered networks, with minimal cost-sharing in-network
  - b. Three "Value" plans, representing an HMO or a PPO, broad or select networks, tiered or non-tiered networks, with greater cost-sharing than at the Premier level

3. Two Minimum Creditable Coverage plans will also be requested.
4. One “Young Adults Plan,” valued at less than the Minimum Creditable Coverage benefits will be requested from those carriers statutorily eligible to offer a Young Adults Plan, i.e., carriers with at least 5,000 covered lives in the small group or non-group markets as of December 31, 2005. The Division of Insurance and the Executive Director of the Connector are conferring about the design of the Young Adults Plan, for reference in the Connector’s RFR and for the promulgation of regulations by the Division.
5. Carriers will be requested to propose plan designs at the first three levels (Premier, Value and Minimum Creditable Coverage), and the totality of their plan design proposals -- again, at each of these three levels -- will be assessed in awarding the Seal, such that carriers will **not** be approved for less than all three levels.
6. Carriers with at least 5,000 covered lives in the small-group and non-group market will also be allowed to offer a Young Adults Plan, which will be made available to individuals age 19 – 26 and sold exclusively through the Connector.
7. Small employers who meet the Connector’s group participation requirements will be required to select one premium/benefits level for their employees -- Premier, Value or Minimum -- and the employees may in turn select from any of the offerings (2-3 per carrier) available at that level.

This construct was felt to be administratively feasible, providing plenty of choice without unnecessarily confusing consumers. The Committee reserved judgment as to how many plans from each carrier should be awarded its Seal. The Committee expressed an interest in reviewing the carriers’ proposals before committing to offer the number of plan options requested at each of these three levels. Under this framework, the Policy Committee wrestled with the following questions:

1. How to describe the Premier level plans and how prescriptive to be?
2. How to describe the Value level plans and how prescriptive to be?
3. How to describe Minimum Creditable Coverage and how prescriptive to be?
4. How many options should be requested for each of these three premium/benefits levels?

### **Premier & Value Plans**

One benchmark of market demand for Connector products and what is considered a reasonable health plan design is the current enrollment in the small-group market. Of the roughly 750,000 enrollees through Massachusetts’ small employer groups (<51 employees), the vast majority (87%) falls into two “natural” levels of premium/benefits:

1. Comprehensive coverage with virtually no cost-sharing for most services; relatively modest cost-sharing for physicians' office visits (e.g., \$10 co-payment) and emergency room visits not resulting in admission (e.g., \$50 co-payment), and a three-tier drug co-payment structure (e.g., \$10/\$25/\$45); approximately 27% of the small-group beneficiaries are buying at this level or above. (Historically, this type of benefit package, allowing for modest inflation in co-payments, is quite similar to what HMOs started out selling 30 years ago.) We refer to this as "Premier" plans (see Appendix A for more details on covered services and co-payments).
2. Of growing popularity over the past 15 years are plans that require members to bear more cost of care at the point of service, including inpatient and day-surgery, and are typically priced between 71% to 90% of the Premier plans. Such plans, which we refer to as "Value," now account for 60% of the small-group market.

(See spreadsheet, "Policy Committee Data," Tab 1, for detailed information on the Massachusetts small group market, membership by plan type and relative premium.)

By definition, this small-group distribution leaves out demand from small employers who currently do not participate but who are expected to enter the insurance market in the future under health reform. This is precisely one of two primary market targets for the Connector.

Nevertheless, the distribution of enrollment in the current small-group market makes a compelling case for offering at least a Premier level of plans and a Value level. The Committee had relatively little difficulty in agreeing on the specifications for the Premier plans. Because the range of benefits and relative value for these plans is quite tight, and the plan design in the market is generally standardized, the Committee readily agreed that it could actually specify these elements of benefits design for Premier plans. (See spreadsheet, "Policy Committee Data, Tab 2, for a fuller summary of coverage and cost-sharing for Premier and Value plans, and see Appendix A for a fuller list of covered services and cost sharing for the Premier plan.)

Carriers would be required to submit the benefit design detailed in Appendix A. (For purposes of prescribing the value of other levels and plan designs, the Premier plan's benefits will have an index value of 1 or 100%.) In order to encourage innovation, carriers will be asked to submit a second plan design for the Premier level. The second plan design at the Premier level must also cover the same medical services but need not replicate the benefits (cost-sharing), so long as the estimated value of claims covered under this design is within 5% of that projected for the Premier plan. For example, a second plan design might increase E.R. and/or specialists visit co-payments, decrease primary care and/or generic drug co-payments, offer a more limited provider network, and/or enhance wellness/fitness benefits.

Since the Value level is more popular (60% of small-group enrollees) than Premier (27%), and more diverse in terms of benefit design, the Committee decided to request three different plan designs at this level. If possible, at least one design should be an HMO, at least one design should be a PPO, and at least one design should offer a limited or select provider network. (Not every carrier currently offers all three types of plans, so we will not require carriers to submit an HMO and PPO design.) Because of the very tight time schedule for developing a limited network, carriers would not necessarily be denied a Seal if they do not have a limited network commercial product or a licensed HMO to propose.

The Committee debated where to index the Value level relative to Premier, and how much variation around that mid-point to allow. The Connector's actuarial consultants considered a 15% range (i.e., +/- 7.5%) the maximum allowable within a comparable level of benefit plans. An actuarial range of 10% (i.e., +/- 5%) is "safer" from the perspective of discouraging self-selection that might lead sicker enrollees to gravitate toward the upper end of this range and healthier enrollees to gravitate toward the lower end. By reducing cross-subsidization, this selection factor will tend to increase costs relative to premiums. However, constraining the range to 10% would mean cutting out some of the most popular plan designs, regardless of where the mid-point is set. Therefore, the Committee recommends using the broader range of 15%.

Because the two most popular plan designs in the small group market have relative values of 86% - 90% and of 76% - 80% of the Premier plans, it is advisable to establish a mid-point that encompasses at least part of these two ranges. It is also desirable to clearly differentiate this middle level from the Premier plans and from Minimum Creditable Coverage, in order to provide broad choice at three distinct levels. Having established the Premier level of plans, the Committee decided to establish Minimum Creditable Coverage before fixing the level for Value plans to be offered through the Connector.

### **Minimum Creditable Coverage ("MCC")**

Several distinct and legitimate perspectives have been articulated within the Policy Committee for fixing the benefits "floor." First, although the minimum does not affect the licensure status of available plans (outside the Connector), it will affect the individual mandate to obtain coverage, effective July 1, 2007 ("individual mandate"). By definition, health insurance that is less generous than Minimum Creditable Coverage will not satisfy the statutory requirement regarding the individual mandate (except for 19-26 year olds). Therefore, it is reasonable to assume that most people who have less generous coverage will buy-up to the MCC, and that many individuals who are currently uninsured will purchase the MCC. Moreover, the tax penalty in 2008 and beyond for not having MCC is 50% of the premium of the lowest cost MCC available.

Therefore, the richer these benefits and the higher the premium, the more that individuals will have to pay, either to satisfy the individual mandate or as a tax penalty for not satisfying it. The political and financial implications of raising this minimum premium

too high could be ominous. (The exception is for college students, who can already satisfy the mandate with student health insurance and for other 19-26 year-olds who buy a “Young Adults Plan.”) On the other hand, should the cost-sharing under MCC be too great, those consumers who purchase MCC and experience unexpectedly high medical expenses will be disappointed that despite paying thousands of dollars in premiums, they still have to pay thousands of dollars for medical services.

One way to balance these conflicting considerations is to insist that the MCC plans limit deductibles and out-of-pocket spending, and to insist that MCC cover some common, highly cost-effective services, outside of the annual deductible. Initially, the Committee seemed to favor building all three of these features into MCC plans, but the Committee did not reach consensus on what those specific constraints should be or whether in fact they should be required.

The Committee did agree, however, that the benefits covered -- regardless of the trade off between premium payments and out-of-pocket costs -- should be comparable to coverage available at the Value and Premier plan levels. That is, an individual covered by an MCC plan will likely pay more at the point of service (i.e., higher co-payments and/or upfront deductible), but health care services (e.g., inpatient, outpatient, office visit, etc.) should be comparable across all of the plan levels.

A second perspective relates to the purpose of health insurance. Insurance, in general, is traditionally purchased to protect policyholders from the cost of large, unbudgeted and unforeseeable adverse events, such as the loss of property, premature death, and/or (in the case of whole life insurance) as a form of savings. Such insurance is commonly purchased by the subscriber for his/her own benefit and is intended to cover catastrophic loss, not to prepay routine expenses. However, health insurance is commonly subsidized by employers or government, as a benefit for the insured. As such, the deeper the coverage, the greater the benefit. Indeed, many people consider “good” insurance synonymous with comprehensive first-dollar coverage, in which the premium covers almost all of the costs and there is minimal cost-sharing at the point of service.

Under health reform predicated mainly on employer mandates and the expansion of government (tax-payer) funded insurance, the benefits perspective on more or less comprehensive benefits revolve around how *good* are the benefits and how *much* should government compel employers and taxpayers to spend on behalf of others (the beneficiaries). In the context of a mandate on individuals to buy a minimum level of self-protection and self-financing, the same arguments do not apply. Rather, the question is how much prepayment and protection should government compel each (non-poor) citizen to buy for him or herself? To simplify the point, one dollar more of prepaid premium equals one dollar less of spending at the point of medical care and vice versa. To what extent should government mandate that citizens pay for their own health care monthly rather than as they use it?

Again, the Policy Committee addressed this question by considering setting a maximum annual deductible and total out-of-pocket spending—to ensure that level of financial protection—and prescribed a minimum relative premium value for MCC that would correspond with such protections. As benchmarks for specifying these caps on deductibles and total out-of-pocket spending, the Policy Committee asked: what do people currently purchase for coverage on their own? The available information is less readily applicable than one would like.

Looking at the small-group market, it is clear that 90% of the employer-subsidized market in Massachusetts represents what we will call a Value level or higher. However, this tells us little about what individuals want to buy if someone else is not paying for it.

Unfortunately, distribution of enrollment in Massachusetts' non-group market provides even less guidance, because the options available are so constrained by regulation. In the newly merged market for small- and non-group, these product constraints will disappear, allowing individuals access to a much broader choice of products. (See spreadsheet, "Policy Committee Data," Tabs 3 and 4, for more information on the Massachusetts non-group market.)

However, distribution of the non-group enrollment nationally, in which product choice is often much less constrained by state regulation, provides some useful insights into what residents of other states choose to purchase, if they have the option. Based on a 2004 survey by America's Health Insurance Plans (AHIP), people tend to buy policies with annual deductibles of \$1,500 to \$2,000 and with coinsurance of 20% to 40%. (See spreadsheet, "Policy Committee Data," Tabs 5-9, for more survey data from the AHIP 2004 national survey of the non-group market.)

Another data point of some relevance is what the Health Reform Act (chapter 58 of the Acts of 2006) says about maximum allowable deductibles. The legislation addresses this issue by explicitly excluding deductibles for Commonwealth Care (for the uninsured below 300% of fpl) and by implicitly authorizing a level of HMO deductibles for the private market.

Annual deductibles in the private market are not constrained by Massachusetts regulation of indemnity and PPO plans. However, deductibles in HMO plans have been constrained by policy bulletins of the Mass. Division of Insurance, interpreting the language in M.G.L., c.176(g) that characterizes HMO benefits as "reasonably comprehensive." To date, the Division of Insurance has interpreted this to mean that annual deductibles should not exceed \$2,000 for an individual and \$4,000 for a family. C. 58 explicitly authorizes HMOs to set deductibles up to half the level of deductibles allowed under the Medicare Modernization Act of 2003 (which authorizes Health Savings Accounts and corresponding High Deductible Health Plans). Currently, the maximum deductible allowed by c. 58 for HMOs is \$2,700 for individuals and \$5,450 for families, indexed annually for inflation.<sup>1</sup>

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<sup>1</sup> In calendar year 2007, the deductible must be at least \$1,100 for individual or \$2,200 for family coverage, and out-of-pocket expenses cannot exceed \$5,500 for individual or \$11,000 for family coverage.

A third perspective relates to how insurance coverage influences utilization of medical care. On the one hand, coverage of primary and preventive care with little cost-sharing is often considered a positive way to encourage desirable utilization of services, that can lead to early detection and thereby save lives and reduce more costly medical interventions in the future. On the other hand, making individuals--other than the poor--pay substantially toward the cost of non-catastrophic care is often considered a positive way to discourage unnecessary medical care.

One inference the Policy Committee drew from these generally accepted principles of health insurance design is to require that MCC policies with annual deductibles cover selected services prior to an up-front annual deductible. However, the Committee has not definitively debated staff's proposal that MCC plans cover four primary care visits per year and emergency room visits outside the deductible, and drugs with a small Rx-deductible. The four primary care visits are to encourage preventive care and some level of diagnosis and referral; and coverage of drugs is intended to allow for cost-effective prevention and care of chronic conditions. There may be other preventive services and/or screenings that the health insurance carriers may wish to offer prior to the deductible, and the Committee believes that allowing the carriers greater latitude with regard to coverage of pre-deductible services.

Finally, philosophies differ as to how proscriptive the Connector should be in establishing benefits. Should a minimum mandated level of coverage try to assure that someone's concept of "decent, adequate" coverage apply to everyone? Or should any such mandate be tempered by an appreciation for the preferences of some individuals to purchase other than what the directors of the Connector might consider "decent and adequate." Logically, these questions should have very different answers in the context of picking and paying for group health insurance or Medicaid on behalf of others, versus ruling out some options by putting a floor on what individuals can choose and buy for themselves.

Nevertheless, even in the context of setting a minimum on how much insurance one has to buy for oneself, there are considerations of how much bad debt providers who must treat residents can tolerate, how much financial and health risk one should be allowed to accept for oneself, how well consumers will understand varying plan features, and what does it mean to require insurance without putting some "reasonable" floor on the definition of insurance coverage? As distinct from health services research findings, market benchmarks, and textbook definitions of insurance, these are issues of community values and practical political feasibility. The element of judgment is inescapable.

Based on the information and considerations reviewed above, the Policy Committee recommends unanimously that MCC be set at a relative value that is equal to 60% (+/- 2%) of the Premier plan level. Four of the five Committee members did not yet wish to be very prescriptive as to maximum deductibles, out-of-pocket spending and the like. The Committee reviewed a plan design mock-up that would likely meet the 60% threshold but felt strongly that the Board should allow some latitude for the health

insurance carriers to develop their own 60% plan design and not establish the particular plan design features. (See spreadsheet, “Policy Committee Data,” Tab 10, for a draft product design that would likely have a relative value of 60%.)

### **Value Plans**

Having established the value for MCC at 60% of the Premier level, the Policy Committee decided to fix the relative value of the Value plans mid-way between the two book-ends, at 80% of the Premier level.

### **Options for Premier, Value and MCC**

The Connector could ask each carrier to submit just one plan design for each level. The logic for doing so is to manage the number of options so as to minimize consumer confusion—to avoid the potential “overload” such as some seniors experienced a year ago with the availability of 40, 50 or 100 different Part D plans under Medicare. The arguments in favor of requesting more than one option from each carrier are: (1) to maximize consumer choice and options, (2) to encourage carriers to take the risk of proposing innovative plan designs, knowing they are not putting “all their eggs” in one plan design, and (3) to encourage plans that are customized to differing consumer preferences.

In order to manage choice, the Policy Committee endorsed these precepts:

1. Organize proposals and consumer options by actuarial levels of plans, to facilitate comparison shopping
2. Standardize plan designs for all but a handful of variables—network, formulary, benefits, cost-sharing, and premium--to minimize “hidden” differences among the plans
3. Ask for the minimum number of plan design proposals at each level necessary to accommodate very different types of plan designs from a carrier and appropriate to the volume of demand anticipated at that level.

Specifically, the Committee recognizes six highly differentiated products designs: a broad-network HMO, a broad-network PPO, a select-network HMO, a select-network PPO, a tiered-network HMO and a tiered-network PPO. At the Premier level, the Committee recommends asking each carrier for two of these six designs. At the Value level, the Committee recommends asking for three of these plan designs. At the MCC level, the Committee recommends asking for two of these plan designs.

## **Preferred Features**

In order to encourage certain “progressive” features of health plan design, the Committee also recommends that plans include, or explain why they are not including, each of the following features in their proposals.

- Select, High-Performance Networks of Physicians and Hospitals
- Designation of Centers of Excellence for Complex Procedures
- Innovative Pharmacy Management Programs
- Consumer Engagement, Including Transparency of Health Care Cost and Quality Data, and Web-Based Decision Support Tools
- HSA Option with High Deductible Health Plan
- Wellness Incentives and Medical Management Programs
- Preventive and Flex Benefits for Chronic Conditions

## **Exclusions**

The Policy Committee recommends that the Connector not solicit or offer for sale any products that have the following features:

Any benefits limits, per sickness or per year or over the insured’s lifetime.

An indemnity fee schedule benefit that provides enrollees with a predetermined level of benefits, commonly set as a specified dollar amount of coverage, for medical services (i.e., physician office visits, outpatient procedures, inpatient confinements).

Any products that do not offer prescription drug coverage.

## **Conclusion**

The table below summarizes the recommendations of the Policy Committee:

Plan Level	Actuarial Value	# of Products/Carrier
Premier	100% based on Connector-provided schedule of benefits and cost sharing	Two
Value	73% - 87% of the Premier Plan	Three
Minimum Creditable Coverage	60% the Premier Plan (+/- 2%)	Two

**APPENDIX A**

**COVERED SERVICES  
PREMIER PLAN**

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

**All services are subject to a determination of medical necessity.**

**All Massachusetts mandated benefits must be covered.**

\* Co-pay only applies to the use of emergency room services in acute care hospitals for non-emergency conditions that do not result in an inpatient confinement.