



State of New Hampshire  
DEPARTMENT OF ADMINISTRATIVE SERVICES  
OFFICE OF THE COMMISSIONER  
25 Capitol Street – Room 120  
Concord, New Hampshire 03301

CHARLES M. ARLINGHAUS  
Commissioner  
(603)-271-3201

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Assistant Commissioner  
(603)-271-3204

May 23, 2018

His Excellency, Governor Christopher T. Sununu  
and the Honorable Council  
State House  
Concord, New Hampshire 03301

**REQUESTED ACTION**

1. Authorize the Department of Administrative Services (DAS), Risk Management Unit (RMU) to amend an existing contract with Anthem Health Plans of New Hampshire, Inc., d/b/a Anthem Blue Cross and Blue Shield (Anthem) (VC# 177335), Manchester, NH 03101-2000, in the approximate amount of \$5,764,000, decreasing the total amount of the contract from \$20,900,000 for the administration of the medical benefit provided to state employees, non-Medicare and Medicare retirees to an amount not to exceed \$15,136,000. This reduction removes the self-funded Medicare Retiree Health Benefit (RHB) Plan administration fee for calendar years 2019 and 2020 in order to replace it with a fully-insured Medicare Advantage Plan covering the State's Medicare retirees. The original contract was approved by Governor and Council on November 8, 2017, item #84, copy attached. **Approximately 36% General Funds, 15% Federal Funds, 4% Enterprise Funds, 11% Highway Funds, 2% Turnpike Funds and 32% Other Funds.**

2. To further amend the contract as noted in Action #1 above, to authorize DAS, Risk Management Unit, to enter into a fully-insured Medicare Advantage Plan with Anthem (VC#177335), in an amount not to exceed \$29,460,000 for the Medicare Advantage Plan premium for Medicare eligible participants for calendar years 2019 and 2020, increasing the total contract amount from \$15,136,000 to \$44,596,000 including a contingency fund in the amount of \$250,000 to be available to address plan administration costs that may arise. The original contract was approved by Governor and Council on November 8, 2017, item #84, copy attached. **Approximately 39% General Funds, 9% Federal Funds, 3% Enterprise Funds, 14% Highway Funds, 1% Turnpike Funds and 35% Other Funds.**

Funding is available in the Employee Benefit Risk Management Fund contingent upon availability and continued appropriations for all fiscal years with the authority to adjust encumbrances in each of the State fiscal years through the Budget Office if needed and justified:

**Administration Costs**

**01-14-14-140560-66000000**

**102-500634 Medical Administrative Fee – Actives** (No change to existing contract)

State Fiscal Year	Current Contract	Increase (Decrease) Amount	Amended Contract
2018	\$1,686,000	\$0	\$1,686,000
2019	\$3,372,000	\$0	\$3,372,000
2020	\$3,372,000	\$0	\$3,372,000
2021	\$1,686,000	\$0	\$1,686,000
Total - Actives	\$10,116,000	\$0	\$10,116,000

**01-14-14-140560-66600000**

**102-500634 Medical Administrative Fee – Troopers** (No change to existing contract)

State Fiscal Year	Current Contract	Increase (Decrease) Amount	Amended Contract
2018	\$50,000	\$0	\$50,000
2019	\$100,000	\$0	\$100,000
2020	\$100,000	\$0	\$100,000
2021	\$50,000	\$0	\$50,000
Total - Troopers	\$300,000	\$0	\$300,000

**01-14-14-140560-66500000**

**102-500634 Medical Administrative Fee – Non-Medicare** (No change to existing contract)

State Fiscal Year	Current Contract	Increase (Decrease) Amount	Amended Contract
2018	\$325,000	\$0	\$325,000
2019	\$650,000	\$0	\$650,000
2020	\$650,000	\$0	\$650,000
2021	\$325,000	\$0	\$325,000
Total – Non-Medicare Retirees	\$1,950,000	\$0	\$1,950,000

**01-14-14-140560-66500000**

**102-500653 Medical Administrative Fee – Medicare** (Reduction in Medicare admin fee per Requested Action #1)

State Fiscal Year	Current Contract	Increase (Decrease) Amount	Amended Contract
2018	\$1,385,000	\$0	\$1,385,000
2019	\$2,770,000	(\$1,385,000)	\$1,385,000
2020	\$2,881,000	(\$2,881,000)	\$0
2021	\$1,498,000	(\$1,498,000)	\$0
<b>Total – Medicare Retirees</b>	<b>\$8,534,000</b>	<b>(\$5,764,000)</b>	<b>\$2,770,000</b>

<b>Total Administrative Expense</b>	<b>\$20,900,000</b>	<b>(\$5,764,000)</b>	<b>\$15,136,000</b>
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**Medicare Advantage – Fully Insured Premium**

**01-14-14-140560-66500000**

**102-504104 Medicare Advantage Premium** (New expenditure per Requested Action #2)

State Fiscal Year	Current Contract	Increase (Decrease) Amount	Amended Contract
2018	\$0	\$0	\$0
2019	\$0	7,622,500	7,622,500
2020	\$0	\$14,735,000	\$14,735,000
2021	\$0	\$7,102,500	\$7,102,500
<b>Total Medicare Advantage Premium Expense</b>	<b>\$0</b>	<b>\$29,460,000</b>	<b>\$29,460,000</b>

<b>Total Amended Contract Expense</b>	<b>\$20,900,000</b>	<b>\$23,696,000</b>	<b>\$44,596,000</b>
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**EXPLANATION**

The purpose of this item is to obtain authority to change the funding arrangement for providing Retiree Health Benefits (RHB) to the State’s 9,600 Medicare retirees. Today, the State self-funds a RHB Plan that includes Medicare supplemental coverage, commonly referred to as Medcomp. The State pays Anthem an administrative fee to act as the Medcomp third-party administrator and process medical claims. The State then reimburses Anthem for the medical claims that Anthem pays on behalf of the State and its Medicare retirees. Over the two-year period from January 1, 2019 through December 31, 2020, the State projects medical claims and third-party administrator fees to total approximately \$41 million.

This contract, if approved, would replace the self-funded, third-party administrator funding arrangement with a fully-insured, federally funded Medicare Advantage (Medicare Part C) benefit. Over the two-year period from January 1, 2019 through December 31, 2020, the State projects the total Medicare Advantage premium expense to total approximately \$29.2 million. Therefore, this change in funding arrangement for Medicare retirees projects savings for the State to be approximately \$11.8 million while continuing to maintain the same level of health benefits for its Medicare retirees.

	<b>CY2019</b>	<b>CY2020</b>	<b>TOTAL</b>
<b><u>Current Plan</u></b>			
Projected Medical Claims	\$138.79	\$142.27	
ASO Fee per contract	\$23.00	\$23.00	
Total projected PEPM	\$161.79	\$165.27	
Projected Medicare eligible enrollment	10,239	10,648	
Total projected Medical Claims & Admin	\$19,879,000	\$21,118,000	\$40,997,000
<b><u>Medicare Advantage</u></b>			
Medicare Advantage Rates	\$124.26	\$109.11	
Projected Medicare eligible enrollment	10,239	10,648	
Total projected Medicare Advantage	\$15,268,000	\$13,942,000	\$29,210,000
<b>TOTAL PROJECTED SAVINGS</b>	<b>\$4,611,000</b>	<b>\$7,176,000</b>	<b>\$11,787,000</b>

**Background: Medicare Retiree Health Benefits and Funding Challenges**

The State of New Hampshire (State) provides and funds a RHB Plan for eligible State retirees and their dependents. The RHB Plan provides medical and prescription drug benefits for approximately 2,800 non-Medicare and 9,600 Medicare-eligible State retiree participants. The current medical Plan for Medicare-eligible retirees provides supplemental coverage, also known as Anthem’s Medcomp Plan, which coordinates with Medicare Parts A and B. Prescription drug

benefits are separate from the medical benefits and managed under a contract with Express Scripts.

Under State law, DAS must manage the RHB Plan within the limits of the funds appropriated at each biennial session. As the retiree population continues to grow and healthcare costs continue to rise, the State has faced and will continue to face significant financial challenges to maintain current benefit coverage for retirees. In fact, in 2015 the Joint Legislative Fiscal Committee worked extensively to close a \$10.6 million funding gap between budget appropriations and projected RHB expenses for the FY 16/17 biennium. In addition, the FY 18/19 budget included an additional \$25.4 million in funding to meet projected RHB expenses. While most of this budget increase was funded by the State, non-Medicare retirees experienced an increase in the percentage of premium contribution they pay from 17.5% to 20% and Medicare retirees born on or after January 1, 1949 began paying a first-ever 10% premium contribution.

At the request of the Fiscal Committee, in February 2017, DAS submitted a draft report prepared by The Segal Company (Segal), the State's health benefits consultant, titled the Retiree Health Benefits Long-Term Study. The Study provided an overview of potential Retiree Health Benefit Plan long-term options; one of the options was a Group Medicare Advantage Plan. The Study is available on the DAS Risk Management Unit webpage under the Resources section.

### **Medicare Advantage: Medicare Part C**

Medicare Advantage plans (Medicare Part C) were created as part of the Medicare Modernization Act enacted in 2003 and replace coverage offered through Medicare Parts A and B. Under a Medicare Advantage plan, Insurance companies receive a per-person payment from the Centers for Medicare and Medicaid Services (CMS) to subsidize the cost of coverage. This capitated payment varies by county, the health of the members covered by the insurance company within that county, and the overall quality of care provided by the insurance company. While being at risk for all claims costs, the insurance company is incentivized to manage that risk, maximize CMS funding through risk adjustment strategies and minimize claim cost through medical management strategies. The insurance company is also incentivized to maintain a high level of member satisfaction. The insurance company's success with all of these factors helps contain premium costs.

In the group insurance marketplace, if 51% of a group's membership lives in the Medicare Advantage plan's network service area, the product may be offered on a "Passive" Preferred Provider Organization (PPO) basis which, from the members' perspective, treats out-of-network providers as in-network, as long as the provider accepts Medicare. Unfortunately, at the time the State reviewed the feasibility of Group Medicare Advantage plans in 2016, Anthem was not able to provide a quote that provided savings to the State, largely due to their "star rating" with CMS. In early 2017, Anthem's network improved, but their "star-rating" with CMS was not high enough to deliver savings to the State's Retiree Health Benefit Plan.

In December 2017, Anthem informed the State that its Medicare Advantage Plan not only succeeded in growing their network presence within the State of New Hampshire, but that Anthem had also achieved a higher "star-rating" score from CMS, increasing their federal subsidy dollars, resulting in more savings and competitive Medicare Advantage premium rates for the State. In working with Segal, the overall savings to the State's Health Benefit Plan equate to approximately \$11.8 million over the remaining twenty-four (24) months of the State's contract with Anthem.

### **Explanation of Requested Actions**

Pursuant to RSA 21-I:30, XII the DAS Commissioner is authorized "to utilize managed care and/or cost containment techniques for the State of New Hampshire retiree health care program through the underlying insurer and any additional specialized managed care or cost containment vendors as necessary." Based on the above savings projections, DAS determined that the State should proceed in amending its contract with Anthem, the underlying insurer, to replace the current self-insured Medcomp plan with a fully-insured Group Medicare Advantage Plan for CY 2019 and CY 2020. Therefore, DAS is bringing forward this request to amend the Anthem contract.

The first action in this amendment will decrease the original contract with Anthem by approximately \$5.8 million. This amount represents the administrative expense the State projects to pay Anthem for Medicare eligible retirees for calendar years 2019 and 2020 if the State were to remain a self-funded Medcomp Plan. The administrative fee per subscriber per month (PSPM) is \$23. By removing the Medicare administrative expenses, the amended contract amount for total remaining administrative expenses for the State's Active and Non-Medicare retirees will be reduced to approximately \$15.1 million.

The second action in the amendment will increase the contract by approximately \$29.2 million or \$29.5 million accounting for the contingency fund. This amount represents the conversion from a self-funded Medcomp Plan to a fully-insured Medicare Advantage Plan. Even though the Medicare Advantage Plan is a fully-insured product, transitioning to a Medicare Advantage Plan will ultimately decrease Retiree Health Benefit Plan total projected expenses. Savings are primarily derived from shifting the projected claims liability from the State to Anthem who is able to bring enhanced federal funding to help contain medical claims costs. In the current contract, estimated administrative expenses and claims expenses for Medicare eligible retirees are projected to be \$41 million for calendar years 2019 and 2020 combined. By approving this amendment and converting to a Medicare Advantage Plan, the total projected expense is projected to be \$29.2 million, which equals a projected savings to the State of approximately \$11.8 million over two years, as depicted in the above chart.

The fully insured rates for CY2019 and CY2020 are \$124.26 and \$109.11, respectively, that covers both the State's medical administrative and claims expenses. The 2020 rate is lower than the 2019 rate because Anthem, after one year of working with the State's retirees, will be more familiar with their clinical status and have the ability to more accurately reflect their risk scores that drives federal funding levels, resulting in a lower fully-insured rate in the second year. Under this contract the CY2020 rate could be adjusted downward or upward based on certain factors.

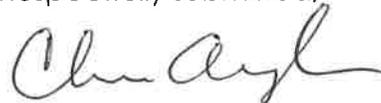
The CY2020 rate could be reduced by \$23.92 if Congress eliminates the premium tax on fully-insured plans, as it did for CY2019. In addition, the rates could change based on federal funding levels.

Maximizing federal subsidy dollars has been a successful cost containment strategy for DAS. In 2015 DAS, working with its Pharmacy Benefits Manager contractor Express Scripts, transitioned the Medicare-eligible Retiree Health Benefit Plan's prescription drug benefit from a Retiree Drug Subsidy (RDS) plan to an Employer Group Waiver Program (EGWP) with a wrap for Medicare Part D resulting in increased federal subsidy dollars while maintaining a consistent level of prescription drug coverage.

In addition to the estimated \$11.8 million in projected Health Benefit Plan savings, the transition to a Medicare Advantage Plan will enhance the focus on our Medicare eligible retirees' health and well-being. Anthem will work with retirees and their healthcare providers to coordinate care among a retiree's various health care providers to ensure the appropriate care is received. CMS incentivizes care coordination and care management to be monitored to optimize outcomes. Other than the increased attention to the care retirees are receiving, members should experience minimal disruption while continuing with the same level of medical coverage with the flexibility to see the same Medicare participating providers they see today.

Based on the foregoing, I am respectfully recommending approval of the contract amendment with Anthem Health Plans of New Hampshire, Inc. because the changes in the funding arrangement for Medicare retiree medical services delivers \$11.8 million in savings and maintains the same level of benefits for retirees.

Respectfully submitted,



Charles M. Arlinghaus  
Commissioner

FIRST AMENDMENT TO  
ADMINISTRATION OF MEDICAL BENEFITS  
AGREEMENT BETWEEN THE STATE OF NEW HAMPSHIRE AND  
ANTHEM BLUE CROSS AND BLUE SHIELD OF NH

This Amendment ("Amendment") to the Administration of Medical Benefits Agreement approved by the Governor and Executive Council on November 8, 2017 ("Agreement"), is by and between Anthem Health Plans of NH, Inc. doing business as Anthem Blue Cross and Blue Shield of New Hampshire ("Anthem" or "Contractor"), and the State of New Hampshire ("State"), each a "Party" and together the "Parties" hereto. This Amendment shall become effective on the date of Governor and Executive Council approval ("Effective Date"). The Agreement Period for this Amendment shall commence at 12:00 a.m. on January 1, 2019. The Agreement Period shall be comprised of two one year terms (each a "Term"). Each Term shall commence at 12:00 a.m. on January 1<sup>st</sup> and end at 11:59 p.m. on December 31<sup>st</sup> of the applicable calendar year. The parties agree that the Medicare Advantage Plan Services will commence at the start of the Agreement Period, even though the implementation services will commence upon the Effective Date. The Agreement Period shall also include the possibility of extension as described in Exhibit A, Article 1, D of the Agreement. Capitalized terms used but not defined in this Amendment shall have the meanings set forth in the Agreement.

**RECITALS**

WHEREAS, the Parties previously entered into the Agreement setting forth the terms and conditions under which Contractor would provide the administrative services to the State set forth in Exhibit A to the Agreement ("Administrative Services"), and the method of payment and terms of payment set forth in Exhibit B to the Agreement; and

WHEREAS, the State has requested Contractor to provide Medicare Advantage health insurance coverage (such health insurance, the "Medicare Advantage Plan Services") to the State's eligible retirees or other individuals as further described in Exhibit A-1, attached hereto and incorporated herein by reference; and

WHEREAS, pursuant to Section 18 of the P-37 of the Agreement, the Agreement may be amended only by an instrument in writing signed by the parties hereto and only after approval of such amendment by the Governor and Executive Council of the State of New Hampshire;

NOW THEREFORE, in consideration of the mutual promises and obligations set forth herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties, intending to be legally bound, agree as follows:

1. **SCOPE OF AMENDMENT**

The purpose of this Amendment is to modify certain provisions of the Agreement as follows:

- (a) To add the Medicare Advantage Plan Services to the Services being performed by Contractor for the State;
- (b) To make other modifications to the Agreement necessary to reflect the addition of the Medicare Advantage Plan to the Services; and

- (c) To make certain modifications to the Agreement with regard to the Administrative Services.
- (d) Inapplicability of Certain Exhibits. Contractor and State acknowledge and agree that the following Exhibits and Appendices to the Agreement shall remain in full force and effect but shall not be applicable to the Medicare Advantage Plan Services: Exhibit A (SERVICES TO BE PERFORMED), Exhibit B (CONTRACT PRICE/LIMITATION ON PRICE/PAYMENT), Exhibit D (INCORPORATION OF RFP RESPONSE), Exhibit E (WELLNESS PROGRAM), Exhibit F (VALUE-BASED PURCHASING), and Appendix A (VALUE-BASED PURCHASING (VBP) SPECIFICATIONS).

This Amendment (including the Exhibits and Addenda hereto) is an integral part of the Agreement. If there are any conflicts or inconsistencies between a specific term or condition of this Amendment and a specific term or condition of the Agreement, the specific term or condition of this Amendment shall control.

2. **AMENDMENT**

- (a) Section 1.8 of the P-37 is hereby amended by changing the Price Limitation to \$44,596,000.
- (b) Section 1.9 of the P-37 is hereby amended by changing Contracting Officer's title to Director of Risk and Benefits.
- (c) Addition of Exhibit A-1. The Agreement is hereby amended to add a new Exhibit A-1 in the form of Exhibit A-1 (Medicare Advantage Group Agreement) attached hereto and incorporated herein by reference.
- (d) Exhibit A, Article 2, Section B.3. Exhibit A, Article 2, Section B.3 is deleted in its entirety.
- (e) Exhibit B, Section 3.B.1. The sub-table titled "Administrative & Program Fees: Medicare Retiree Plan" under the heading "**ADMINISTRATIVE & PROGRAM FEES – MEDICAL**" set forth in Exhibit B, Section 3.B.1 is hereby amended to delete in their entirety the columns captioned "CY 2019 PEPM" and the column captioned "CY 2020 PEPM."
- (f) Exhibit C of the Agreement is hereby amended as follows:
  1. Delete "There are no Special Provisions to this Agreement"
  2. Section 2. Section 2 of the P-37 is hereby amended to read in its entirety as follows:

**"2. EMPLOYMENT OF CONTRACTOR/SERVICES TO BE PERFORMED.** The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT A (with respect to Administrative Services) and

EXHIBIT A-1 (with respect to Medicare Advantage Plan Services), each of which is incorporated herein by reference (collectively, "Services").

3. Section 5.1. Section 5.1 of the P-37 is hereby amended to read in its entirety as follows:

"5.1 The contract price, method of payment, and terms of payment with respect to Administrative Services are identified and more particularly described in EXHIBIT B which is incorporated herein by reference. However, with respect to Medicare Advantage Plan Services, contract price, method of payment, and terms of payment are identified in Exhibit A-1."

4. Section 5.4. Section 5.4 of the P-37 is hereby amended to read in its entirety as follows:

"5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder with respect to the Administrative Services described in Exhibit A hereto, exceed the Price Limitation set forth in block 1.8; provided, however, that such Price Limitation shall not apply to or include in its calculation the Medicare Advantage Plan Services described in Exhibit A-1."

5. Section 9.2. Section 9.2 of the P-37 is hereby amended to read in its entirety as follows:

"9.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason, subject to applicable state and federal privacy laws, including, without limitation, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and subject, with respect to the Medicare Advantage Plan Services, to CMS record retention requirements."

6. Section 10. Section 10 of the P-37 is hereby amended to read in its entirety as follows:

**"10. TERMINATION.** In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report with respect to Administrative Services shall be identical to those of any Final Report described in the attached EXHIBIT A."

7. Section 12. Section 12 of the P-37 is hereby amended to read in its entirety as follows:

**“12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.** The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice and consent of the State. None of the Services shall be subcontracted by the Contractor without the prior written notice and consent of the State, except as otherwise provided in the Exhibits hereto.”

(h) Exhibit F. Exhibit F of the Agreement is hereby amended to delete the first and second paragraphs following B. 2.

3. **GENERAL PROVISIONS.**

- (a) Except as expressly set forth herein, nothing contained in this Amendment shall, or shall be construed to, modify, alter or amend the Agreement. By execution hereof, the parties expressly reaffirm the Agreement, as modified by this Amendment.
- (b) To the extent any provision contained in this Amendment conflicts with the terms and conditions of the Agreement, this Amendment shall control only with regard to Medicare Advantage Plan Services.
- (c) This Amendment shall be effective as of the Amendment Effective Date.

**IN WITNESS WHEREOF**, the parties have caused this Amendment to be duly executed as of the Amendment Effective Date.

**The State of New Hampshire Employee and Retiree Health Benefit Program  
Department of Administrative Services**

  
\_\_\_\_\_  
State Agency Signature

Charlie M. Aelinghaus, Commissioner  
Name and Title of State Agency Signatory

5/24/18  
\_\_\_\_\_  
Date

**Anthem Health Plans of NH, Inc., d/b/a Anthem Blue Cross and Blue Shield of New Hampshire**

  
\_\_\_\_\_  
Contractor Signature

Lisa M. Guertin President  
Name and Title of Contractor Signatory

5/24/18  
\_\_\_\_\_  
Date

**Acknowledgement:**

STATE OF NEW HAMPSHIRE  
COUNTY OF Hillsborough

On this 24<sup>th</sup> day of May, 2018 before, Michael K. Brown, the undersigned officer, personally appeared Lisa Guertin who acknowledged herself to be the President of Anthem Health Plans of New Hampshire, Inc., a licensed health insurance corporation, and that she executed this document in her capacity as President.

In witness whereof I hereunto set my hand and official seal.

Michael K. Brown  
Signature of Notary or Justice of the Peace

Michael K. Brown  
Name

May 24<sup>th</sup> 2018  
Date

My Commission Expires: June 21, 2022

**Approval by the Attorney General (Form, Substance and Execution)**

Christen Lavers  
Department of Justice

Christen Lavers Assistant AG.  
Name and Title of DOJ Signatory

5/25/18  
Date

I hereby certify that the foregoing contract was approved by the Governor and Executive Council of the State of New Hampshire at the meeting on the JUN 20 2018 day of JUN 20 2018, 2018.

DM Seaman  
Office of the Secretary of State

**DEPUTY SECRETARY OF STATE**  
Name and Title of SOS Signatory

**EXHIBIT A-1**

**MEDICARE ADVANTAGE GROUP AGREEMENT**

- 1. Medicare Advantage Group Agreement**
- 2. Addendum A – Summary of Rates, State of New Hampshire**
- 3. Addendum B – Performance Guarantee Agreement**
  - a. Attachment to Performance Guarantee Addendum**

## Medicare Advantage Group Agreement

This Anthem Medicare Preferred (PPO) Medicare Advantage Group Agreement (hereinafter "MA Agreement") is entered into upon Governor and Executive Council approval (hereinafter "Effective Date"), with an Agreement Period commencing on January 1, 2019, by and between the State of New Hampshire (hereinafter "Group"), located at 25 Capitol Street, Concord, New Hampshire and Anthem Health Plans of New Hampshire, Inc. dba Anthem Blue Cross and Blue Shield of New Hampshire, sponsor of the Anthem Medicare Preferred (PPO) Medicare Advantage Program (hereinafter "MA Plan"), located at 145 South Pioneer Road; Fond du Lac, WI 54935 upon the following terms and conditions:

### ARTICLE 1 - PURPOSE

Group has requested MA Plan provide health insurance coverage to its eligible retirees or other individuals as described in this MA Agreement. This MA Agreement supersedes any prior agreements between the Parties regarding the subject matter of this MA Agreement. MA Plan's standard policies and procedures, as they may be amended from time to time, will be used in the performance of services specified in this MA Agreement and the provision of benefits contained in the Evidence of Coverage.

MA Plan shall administer this Medicare Advantage Plan consistent with State law and eligibility guidelines, subject to the provisions of Article 21, paragraph H below and with no benefit or plan design deviations from the current supplemental Medicare Retiree (Medicomp) plan. The MA Plan will be administered as a "Medicare Passive PPO", as defined below.

### ARTICLE 2 - DEFINITIONS

In this MA Agreement, the following terms will have the meanings shown below. Capitalized terms used in this MA Agreement that are not defined below are defined in the Evidence of Coverage. MA Plan and Group each are sometimes referred to herein as a "Party" and collectively as the "Parties."

**MA AGREEMENT.** The following documents will constitute the entire agreement between the parties regarding this Medicare Advantage Plan: this MA Agreement, the Schedule of Benefits, and any addenda, endorsements, and schedules which are hereby incorporated by reference; the Evidence of Coverage and endorsements or riders, if any, thereto; the Group application; the individual applications and any reclassifications thereof submitted by Members of the Group; applicable MA Plan underwriting assumptions, MA Plan administrative practices and procedures of MA Plan as adopted and revised from time to time (hereinafter referred to collectively as "Policies"). Although Subscribers are not parties to this MA Agreement, the information provided in their applications is used to determine eligibility for coverage and benefits.

**AGREEMENT PERIOD.** The period beginning at 12:00 a.m. on January 1, 2019 and ending at 11:59 p.m. on December 31, 2020 (local time at the Group's address) unless otherwise terminated pursuant to the termination provisions in the Agreement or in this MA Agreement. The Agreement Period shall also include the possibility of extension as described in Exhibit A, Article 1, paragraph D of the Agreement.

**CMS.** Centers for Medicare & Medicaid Services.

**COVERED SERVICE.** Any hospital, medical, prescription or other health care service rendered to Members for which benefits are provided pursuant to the Evidence of Coverage.

**EFFECTIVE DATE.** This MA Agreement shall be effective upon Governor and Executive Council approval.

**EVIDENCE OF COVERAGE.** The Evidence of Coverage and any endorsements or riders to the Evidence of Coverage shall define those services and benefits covered for Members as a consequence of this MA Agreement. The Evidence of Coverage also defines the rights and responsibilities of the Member and the MA Plan.

**MEDICARE PASSIVE PPO.** A Medicare Passive PPO Plan is a type of Medicare Advantage Plan (Part C) offered by a private insurance company in which the plan design is the same for both in and out-of-network providers. As long as the provider accepts Medicare, a member will receive the same level of coverage regardless of whether the provider participates in the Plan's network.

**MEMBER.** A Medicare eligible retiree or eligible dependent who has applied for coverage and who has satisfied the eligibility conditions specified in state law and eligibility guidelines (subject to the provisions of Article 21, paragraph H below), this MA Agreement, and the Evidence of Coverage. Although Members are not parties to this MA Agreement, the information provided in their applications is used to determine eligibility for coverage and benefits.

**SUBSCRIBER.** A Medicare eligible retiree of the Group who is enrolled under this MA Agreement and is eligible to receive benefits under the terms and conditions of the Evidence of Coverage.

### ARTICLE 3 – IMPLEMENTATION

- A. Implementation services will commence upon the Effective Date of this MA Agreement. However, payment under this MA Agreement shall not commence until the start of the Agreement Period. Parties agree to collaborate and establish protocols and processes for managing Medicare Advantage Plan Services.
- B. MA Plan will develop a detailed implementation plan that will contain tasks to be completed by MA Plan and/or Group and a timeframe for completion of each task. The implementation plan will also contain Measurement Periods specific to each task. The implementation plan will be modified as necessary, as mutually agreed by the Parties.
- C. The implementation plan shall include a process for the parties to mutually agree to all administrative forms including those related to enrollment, changes and terminations to the extent allowed under CMS regulations.

### ARTICLE 4 - ELIGIBILITY AND ENROLLMENT

- A. Eligibility. Members eligible to be covered under this MA Agreement shall be as specified in State law and eligibility guidelines, subject to the provisions of Article 21, paragraph H below, this MA Agreement, the Evidence of Coverage and MA Plan Policies. This MA Plan shall cover all those eligible current and future individuals, including disabled members under age 65 and members with ESRD, that would be covered under the current Medicare Supplement Plan in the same manner in which Anthem does today, subject to CMS guidelines.
- B. Initial Enrollment of Members. Those individuals initially enrolled shall be eligible Members who shall have timely filed an application for enrollment for such Members and their eligible dependents and who have satisfied MA Plan's Policies. Upon acceptance of such application by MA Plan and CMS, or modification thereof, and payment of the applicable premiums, such Members and dependents shall become enrolled under this MA Agreement for the type of coverage elected in such application on the Effective Date.
- C. Addition of New, Transferred and Newly Eligible Members. The Group shall have the opportunity to submit applications to add new, transferred and newly eligible Members to the group of Members initially enrolled under this MA Agreement. However, before qualifying for enrollment, the new, transferred or newly eligible Member must meet all of the applicable eligibility requirements as set forth in this MA Agreement, and any subsequent modifications thereto. Addition of the Members and their eligible dependents shall be made in accordance with the following procedures:  
  
The effective date of coverage for any such additional Member whose application is accepted by MA Plan shall be in accordance with State law (subject to the provisions of Article 21, paragraph H below), MA Plan's Policies and the Evidence of Coverage, and the Centers for Medicare & Medicaid Services (hereinafter CMS) regulations in effect at the time the Member's application is approved.
- D. Commencement of Coverage. Coverage hereunder for Subscribers and their eligible dependents that are enrolled on or before the commencement of the Agreement Period of this MA Agreement shall commence as of the start of the Agreement Period, subject to the provisions of the Evidence of Coverage. Thereafter, coverage for any eligible Member and dependent who makes a timely application for enrollment shall begin on the date determined in accordance with State law and eligibility guidelines, (subject to the provisions of Article 21, paragraph H below), MA Plan Policies and Medicare Advantage regulations.

- E. Monthly Eligibility Notice and Other Reports. The Group shall furnish to MA Plan initial information regarding Members and shall thereafter furnish, at least monthly, a notice of additions, deletions, and changes to this listing on or prior to the billing date. The Group shall keep such records and furnish to MA Plan such notification and other information as may be required by MA Plan for the purpose of enrolling Members, processing terminations, effecting changes in MA Agreement status, effecting changes due to a Member becoming eligible for Medicare, effecting changes due to a Member becoming disabled, determining the amount payable by the Group under this MA Agreement, or for any other purpose reasonably related to the administration of this MA Agreement.

MA Plan reserves the right to limit retroactive changes to enrollment to those set forth in CMS guidelines related to retroactive enrollment activity. Acceptance of payments from the Group or the payment of benefits to persons no longer eligible will not obligate MA Plan to provide benefits.

- F. Termination of Coverage. A Member who is determined by the Group to be ineligible for benefits shall be reported on the routine listing as a deletion from the listing of Members. Upon the Group's direction to MA Plan, the coverage of such Member shall terminate after providing notice to such Member in accordance with the MA Plan Policies, the Evidence of Coverage and the Medicare Advantage regulations.

The Group shall give MA Plan reasonable advance notice of any Member terminations in order to enable MA Plan to remove the Member from MA Plan's list of Members.

Retroactive disenrollment must be submitted to the MA Plan, so that the MA Plan can submit the retroactive disenrollment request to CMS. The Group shall be responsible for providing MA Plan with applicable data or information required to substantiate MA Plan's request for retroactive disenrollment.

#### **ARTICLE 5 - OBLIGATIONS OF MA PLAN**

- A. MA Plan will file all the necessary documents with governmental agencies as appropriate in order to file as an Employer Group Waiver Plan matching the current level of benefits provided by the Group.
- B. MA Plan shall provide health care benefits to Members who receive Covered Services under the terms of this MA Agreement and the Evidence of Coverage. However, in no event will MA Plan provide benefits for services rendered prior to the Effective Date or after the termination of this MA Agreement or for any period for which full premium payment has not been paid to MA Plan, except as provided in the Evidence of Coverage and applicable Medicare Advantage regulations.
- C. MA Plan shall furnish to Members and dependents an identification card and Evidence of Coverage and all other CMS required documents for each Member enrolled in the applicable plans covered by this MA Agreement.
- D. MA Plan shall furnish appropriate application forms and related material necessary and appropriate for the enrollment of Members and shall provide such assistance as may reasonably be necessary to the Group for enrollment purposes. MA Plan shall maintain current eligibility status records on all Members as submitted by the Group for the adjudication of claims.
- E. MA Plan is responsible for pursuing recoveries of claim payments as appropriate and as required by law. MA Plan shall determine which recoveries it will pursue. However, MA Plan may not pursue a recovery if the cost of collection is likely to exceed the recovery amount, or if the recovery is prohibited by law or an agreement with a Provider or other vendor.
- F. MA Plan will process claims, including investigating and reviewing the claims to determine what amount, if any, is due and payable according to the terms and conditions of this MA Agreement and the Evidence of Coverage. MA Plan has the right to make benefit payments to either Providers or Members as described in the Evidence of Coverage. MA Plan will coordinate benefits with other payors as required by law. MA Plan will give notice in writing to the Member when a claim for benefits has been denied. The notice will provide the reasons for the denial and the right to an appeal of the denial in accordance with the procedures set forth in the Evidence of Coverage.

- G. MA Plan will provide Group and other third parties as directed by the Group with claim line detail for all claims including, but not limited to, financial and diagnoses information upon request at no additional cost, subject to the requirements and limitations of applicable privacy laws, including, without limitation, HIPAA.
- H. The MA Plan shall accept the data files and coordinate as necessary with the State's Pharmacy Benefit Manager/EGWP administrator.
- I. Notwithstanding the Section 1(d) of the First Amendment, the Contractor shall designate an MA Plan Account Manager who shall participate in the Dedicated Support Account Management Model.
- J. MA Plan shall provide data and information necessary so the Group may audit any charges over and above the premium amount, including unrecovered claims at no additional cost. The audit will be subject to the requirements and limitations of applicable privacy laws, including, without limitation, HIPAA.
- K. Either Party may subcontract any of its duties under this MA Agreement subject to Section 12 of the P-37 and except as otherwise provided herein. Each Party is accountable for the subcontractor's performance. Such performance is held to the same performance standards and subcontractor failure to perform places the accountable party at risk. MA Plan shall be responsible for all performance guarantee penalties that may result from underperformance of the subcontractor.

**ARTICLE 6 - OBLIGATIONS OF GROUP**

- A. If more than one Medicare Advantage plan is offered to Members, then Group shall offer MA Plan coverage to all eligible Members at terms and contribution levels that are no less favorable than those applicable to any other health coverage available through the Group.
- B. The Group will timely provide MA Plan with any information as may reasonably be required by MA Plan for the purposes of determining eligibility for coverage, enrolling and disenrolling Members, determining the amount of premium payable by the Group or any other purpose reasonably related to the administration of this MA Agreement. The Group will give notification of eligibility to each Member who is or will become eligible for enrollment.
- C. The Group will timely distribute to Members any notices of premium changes. Group shall comply with all applicable laws and regulations relating to the distribution of notices and information to Members, including, if applicable, the Department of Health and Human Services regulations under Section 1557 of the Affordable Care Act.
- D. Group hereby acknowledges, agrees and certifies its compliance with the following requirements as they relate Group's MA Plan(s).

Premium – Group hereby agrees and certifies, as to waiver premium, that:

Different amounts can be subsidized for different classes of Members in an MA Plan pursuant to State (subject to Article 21, Section H below) and federal law provided such classes are reasonable and based upon objective business criteria (i.e., years of service, business location, job category, nature of compensation). Accordingly, Group hereby certifies that such classes (if any) are reasonable and based upon objective business criteria.

The premium within a given class does not vary by Member.

Group must maintain contribution levels required by Anthem's underwriting stipulations.

Members are not charged more than the premium an individual would pay if they purchased the applicable MA Plan individually including prescription drug coverage comparable to that provided by the State (i.e., Members are not charged more than 100% of the premium for the standard coverage plus

any supplemental coverage added by the group; thereby, passing along to the Member the CMS subsidy payment).

The foregoing certifications shall be based upon Group's best knowledge, information, and belief at the time such information is submitted or provided. To the extent any material information is discovered or changes occur after such certification that impact the accuracy, completeness and/or truthfulness of such certifications or data, Group agrees to make MA Plan immediately aware of such change or discovery.

#### **ARTICLE 7 – PREMIUM AND GRACE PERIOD**

- A. The premium rates for coverage under this MA Agreement are provided in Addendum A. Premium rates are based on the data provided by Group, consistent with applicable laws. MA Plan may retroactively modify the premium rates, subject to Group approval, if the data provided is inaccurate or new data is submitted that varies from the data previously provided to MA Plan
- B. MA Plan shall provide an invoice in a mutually agreed to format, which includes membership detail.
- C. The full invoice amount, including premium, taxes, fees or assessments, must be paid in advance by Group on or before the invoice due date. MA Plan does not have an obligation to accept a partial payment. Group must make payments regardless of any contributions to those payments by Subscribers.
- D. Premium payment is due and payable on the 1st of the month. However, there is a thirty (30) day Grace Period. The payment amount must equal the "TOTAL DUE" amount shown on the billing cover sheet, less any payment previously remitted but not reflected on the current billing statement. Once the Group exceeds their Grace Period and enters into a delinquency process they must pay 100% of the "TOTAL DUE" to avoid termination.

#### **ARTICLE 8 - NOTICES**

- A. Any required notice under this MA Agreement will be deemed sufficient when made in writing and delivered by first class mail; personal delivery; electronic mail, as permitted by law; or overnight delivery with confirmation capability. Such notice will be deemed to have been given as of the date of the mailing. MA Plan will provide notice to Group's principal place of business as shown on MA Plan's records. Group will provide notice to its designated MA Representative and to the Director of Medicare Advantage Group Operations at Senior Services, P.O. Box 110, Fond du Lac, WI 54936.
- B. The Group shall notify all Members of the termination of the MA Agreement. In the case of changes to the MA Agreement or the Evidence of Coverage, MA Plan shall provide notice to all Members, as required by CMS. Any such notice shall be subject to review and approval by the Group.

#### **ARTICLE 9 - CHANGES IN THE AGREEMENT**

- A. MA Plan may modify the benefit provisions and the terms and conditions thereof, by giving at least (forty-five) 45 days advanced written notice prior to the Anniversary Date of this Agreement however, such notice requirement shall not apply to changes in benefit provisions that are required by law. Group can also propose changes to the benefit provisions at any time by giving 45 days advance written notice of any such requested change to MA Plan. The effective date of such requested changes shall be agreed to by the Parties. In addition, MA Plan may modify the terms of this Agreement by giving (thirty) 30 days advanced written notice to Group of such changes, subject to Section 18 of the P-37.
- B. MA Plan may change the premium rates or other amounts due under the MA Agreement by providing written notice to the Group at least thirty (30) days before the effective date of such change; however, such notice requirement shall not apply to changes in premium rates which are the results of changes in benefits provisions that are required by CMS or federal law, nor to changes in premium rates that are the result of changes in benefit provisions requested by Group.

- C. For the 2019 and 2020 period of the agreement, premium rates may only change subject to the Terms and Conditions outlined in Addendum A to this contract.

An amendment to this Agreement will not be effective unless signed by an authorized representative of MA Plan and the Governor and Executive Council.

#### **ARTICLE 10 - TERMINATION AND/OR SUSPENSION OF PERFORMANCE**

- A. Except for termination due to Event of Default (the terms of which are set forth in Section 8 of the P-37), Group may terminate this MA Agreement at any time by giving MA Plan at least sixty (60) days advance written notice of termination. Group must pay the amounts due for each Member covered through the effective date of termination of this MA Agreement.
- B. Subject to Section 4 of the P-37 and notwithstanding any other provision of this Article, if the Group fails to make in full any payment when due under this MA Agreement within the ninety (90) day allowable time frame, MA Plan shall have the right to terminate this MA Agreement, with one hundred twenty (120) days written notice. Notwithstanding such termination or suspension, MA Plan may accept late payment of delinquent amounts. Upon termination of the MA Agreement as provided in this paragraph, MA Plan shall only have liability to make payment for Covered Services through the last date for which full premium payment has been paid by the Group.
- C. Notwithstanding any other provision of this MA Agreement, if MA Plan believes the Group has engaged in fraudulent conduct, misrepresentation, or non-compliance with contribution or participation requirements, MA Plan shall notify Group and shall have the right to rescind, cancel, or terminate this MA Agreement. In the event MA Plan believes the Group has failed to comply with MA Plan's contribution or participation requirements, MA Plan shall notify Group and shall have the right to terminate this MA Agreement. Any termination referenced in this subsection shall occur only after the Parties have met in good faith to resolve the dispute and only after the exhaustion of a mutually agreed to grace period to allow the Group to obtain a new provider, subject to CMS guidelines.
- D. In the event MA Plan decides, in its sole discretion to discontinue offering a particular Medicare Advantage product, MA Plan has the right to terminate such product as permitted by federal and state law, by giving written notice of termination to Group at least ninety (90) days before the effective date of termination of the discontinued product.
- E. In addition to the provisions of paragraphs (A) through (D) of this Article, upon termination of this MA Agreement, MA Plan shall cease to have any liability for benefits incurred after the effective date of termination (except as otherwise provided in the Evidence of Coverage) and shall have no liability to offer continuation or conversion coverage to Members under the terminated MA Agreement.

#### **ARTICLE 11 - CLAIMS PAID AFTER EFFECTIVE DATE OF TERMINATION**

In the event that the (1) Group terminates this MA Agreement without giving appropriate notice to MA Plan as provided herein or (2) the Agreement is terminated pursuant to Article 10(B) or (C) herein.

#### **ARTICLE 12 - TERMINATION OF COVERED PERSONS**

MA Plan reserves the right to cancel or rescind any health care benefits provided hereunder to any Member who engages in misrepresentation and/or fraudulent conduct, as determined by MA Plan, in relation to any claims made for coverage or any application for coverage under this MA Agreement. In addition, MA Plan reserves the right to cancel or terminate coverage provided hereunder to any Member in accordance with cancellation and termination provisions in their Evidence of Coverage.

### ARTICLE 13 - DATA REPORTS

- A. MA Plan will provide Group the Part C Medicare Membership Reports (MMR) twice a year after the risk score updates in January and July (or as needed upon request), including all fields as received from CMS
- B. MA Plan will provide Group the Part C Model Output Reports (MOR) upon request, no more often than annually and within thirty days of request, including all fields as received from CMS.
- C. MA Plan agrees to provide such additional reports as mutually agreed to by MA Plan and the Group. Standard reports are existing reports that MA Plan can run by changing report parameters. Ad-hoc requests include non-standard reports, or reports entailing actuarial or underwriting analysis. Such reports shall be provided by MA Plan within seven (7) business days unless otherwise mutually agreed and may be subject to an additional charge depending on complexity, and within a mutually agreeable timeframe.
- D. Notwithstanding the foregoing, the provisions of reports by MA Plan to the Group shall be subject at all times to the requirements and limitations of applicable privacy laws, including, without limitation, HIPAA.

### ARTICLE 14 - NO WAIVER

No failure or delay by either Party to exercise any right or to enforce any obligation under this MA Agreement in whole or in part, will operate as a waiver to enforce compliance with such right or obligation in the future. No course of dealing between Group and MA Plan will operate as a waiver of any right or obligation under this MA Agreement.

### ARTICLE 15 - ASSIGNMENT

Assignment of all or part of this MA Agreement may occur subject to Section 12 of the P-37.

### ARTICLE 16 - SERVICE MARKS

This MA Agreement constitutes a contract solely between Group and MA Plan. MA Plan is an independent corporation operating under a license with the Blue Cross and Blue Shield Association ("Association"), an association of independent Blue Cross and Blue Shield Plans, permitting MA Plan to use the Blue Cross and/or Blue Shield Service Marks in the State of New Hampshire. MA Plan is not contracting as the agent of the Association. Group has not entered into this Agreement based upon representations by any person other than MA Plan. No person, entity, or organization other than MA Plan will be held accountable or liable to Group for any of MA Plan's obligations provided under this MA Agreement. This paragraph will not create any additional obligations on the part of MA Plan, other than those obligations contained in this MA Agreement.

### ARTICLE 17 – INTERPLAN/MEDICARE ADVANTAGE PROGRAM

#### A. **Passive PPO**

The MA Plan is a passive PPO in which the plan design is the same for both in and out-of-network providers. As long as the provider accepts Medicare, a member will receive the same level of coverage regardless of whether the provider participates in the Plan's network

A Medicare Passive PPO Plan is a type of Medicare Advantage Plan (Part C) offered by a private insurance company.

#### B. **Out-of-Area Services – Medicare Advantage**

MA Plan has relationships with other Blue Cross and/or Blue Shield Licensees ("Host Blues") referred to generally as the "Inter-Plan Medicare Advantage Program." This Program operates under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). When Members access healthcare services outside the geographic area MA Plan serves, the claim for those services will be processed through the Inter-Plan Medicare Advantage Program. The Inter-Plan Medicare Advantage Program available to Members under this MA Agreement is described generally below.

**C. Member Liability Calculation**

When a Member receives Covered Services outside of the MA Plan service area from a Medicare Advantage PPO network provider, the cost of the service, on which Member liability (copayment/coinsurance) is based will be either:

- The Medicare allowable amount for covered services; or
- The amount either MA Plan negotiates with the provider or the Host Blue negotiates with its provider on behalf of MA Plan Members, if applicable. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

**D. Nonparticipating Healthcare Providers Outside of MA Plan Service Area**

When Covered Services are provided outside of the MA Plan service area by nonparticipating healthcare providers, the amount(s) a Member pays for such services will be based on either the payment arrangements described above, for Medicare Advantage PPO network providers, Medicare's limiting charge where applicable or the provider's billed charge. Payments for out-of-network emergency services will be governed by applicable federal and state law.

**E. Out-of-Country Travel**

Emergency or urgently needed care is covered while traveling outside the United States during a temporary absence of less than six months. Emergency and urgently needed outpatient care and inpatient care (60 days per lifetime) is covered. This coverage is worldwide and limited to what is allowed under the Medicare fee schedule for the services received in the United States.

Members may also access online and telephonic services Anthem offers.

**ARTICLE 18 - MA AGREEMENT ADMINISTRATION**

- A. MA Plan has the discretionary authority to determine eligibility for benefits under the Agreement in accordance with CMS requirements MA Plan also has the discretionary authority to resolve all questions arising under the Evidence of Coverage and to establish and amend the policies and procedures with regard to the administration of benefits under the Evidence of Coverage. In addition, MA Plan has all powers necessary or appropriate to carry out its duties in connection with the performance of services under this MA Agreement. MA Plan's authority to determine eligibility for benefits shall be exercised consistently with the provisions of the MA Agreement, the Evidence of Coverage, Provider agreements and applicable law.
- B. MA Plan shall furnish a draft Evidence of Coverage to the Group. The Parties shall agree upon any changes to the Evidence of coverage that may be necessary and/or in the best interest of Members and their dependents. In the event changes to the provisions of the Evidence of Coverage are mandated as a result of a change to any State or federal law, the Parties shall meet and determine the best manner to change the terms of the Evidence of Coverage to conform to such law. In the event of material changes to the Evidence of Coverage, the MA Plan will provide timely notice of such changes to Members. No change to the Evidence of Coverage shall be effective unless and until approved in writing by an authorized representative of each Party. Notwithstanding the foregoing, the Parties acknowledge and agree that only those portions of the Evidence of Coverage to which CMS allows modifications may be modified by the foregoing procedures, and then only in accordance with CMS requirements.
- C. MA Plan may waive or modify any referral, authorization, or certification requirements, benefit limits, or other processes contained in the Evidence of Coverage if such waiver is in the best interest of the Member or will facilitate effective and efficient claims administration.
- D. MA Plan may institute, from time to time, pilot or test programs regarding disease management, utilization management, case management or wellness initiatives. A pilot or test program may impact some, but not all Members. MA Plan reserves the right to discontinue a pilot or test program at any time without notice.

- E. MA Plan will have sole responsibility for resolving appeals from claim decisions, consistent with state and federal law. If Group receives a question or complaint regarding benefits under this MA Agreement, Group will advise the Member to contact MA Plan.
- F. All statements made by Group and any Member will be considered representations and not warranties.

**ARTICLE 19 - RELATIONSHIP OF THE PARTIES**

Group and MA Plan are separate legal entities. Nothing in this MA Agreement will cause either Party to be deemed a partner, agent or representatives of the other Party. Neither Party will have the expressed or implied right or authority to assume or create any obligation on behalf of the other Party.

**ARTICLE 20 – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT**The Parties hereby adopt the Business Associate Agreement in Appendix B of the Agreement. The Parties agree to comply with applicable law, including the Health Insurance Portability and Accountability Act of 1996 and its relevant regulations (“HIPAA”) when receiving or disclosing Protected Health Information.

**ARTICLE 21 - MISCELLANEOUS**

- A. MA Plan hereby informs the Group that MA Plan or its vendors may have reimbursement contracts with certain providers for the provision of and payment for health care services and supplies provided to, among others, Members under this MA Agreement. Under some of these contracts, there may be settlements which require MA Plan to pay the providers or vendor’s additional money (which may or may not be solely funded by MA Plan) or which require the providers or vendors to return a portion of volume discounts, rebates, or excess money paid. Such providers or vendors may include entities affiliated with MA Plan. Under many provider or vendor contracts, the negotiated reimbursement does not contemplate any type of settlement between MA Plan and the provider or vendor. Group has neither responsibility for additional payment to vendors nor any right to discounts, rebates, or excess money received from vendors.
- B. All Members enrolled under this MA Agreement shall be subject to the terms and conditions set forth herein to the rights and benefits granted by State and federal law, and subject further to the provisions of Article 21, paragraph H below.
- C. MA Plan makes no representations or warranties, express or implied, concerning whether the Group’s health benefit plan, as administered and implemented by the Group, complies with state and federal laws regulating employee insurance plans and benefits.
- D. MA Plan agrees to treat all proprietary information about Group’s operations and its Plan in a confidential manner. Group agrees to treat all information about MA Plan’s business operations, discount information, and other proprietary data in a confidential manner. Neither Party will disclose any such information to any other person without the prior written consent of the Party to whom the information pertains. However, Parties may disclose such information to its regulators, legal advisors, lenders, business advisors, and other third parties for commercial or research purposes. MA Plan may also make such disclosures as required or appropriate under applicable securities laws. If a Party is required by law to make a disclosure of any proprietary information, the disclosing Party will immediately provide written notice to the other Party detailing the circumstances of and extent of the disclosure. MA Plan agrees that all provisions of this subsection D are subject to the Group’s requirement to comply with RSA Chapter 91-A, the State’s right-to-know law.
- E. The parties acknowledge that MA Plan is not engaged in the practice of medicine; it merely makes decisions regarding the coverage of services. Providers participating in MA Plan’s networks are not restricted from exercising independent medical judgment regarding the treatment of their patients, regardless of MA Plan’s coverage determinations.

- F. Force Majeure: Neither party shall be deemed to be in violation of this MA Agreement if such party is prevented from performing any of its obligations hereunder for any reason beyond its reasonable control, including without limitation, acts of God, acts of any public enemy, acts of terrorists, acts of war, floods, statutory or other laws, regulations, rules, or orders of the federal, state, or local government or any agency thereof.
- G. Group agrees and understands that the MA Agreement is the controlling documents for all legal purposes regarding Medicare Advantage. The terms of the MA Agreement may not be altered or changed without the advance written agreement of both Parties and subject to Section 18 of the P-37.
- H. Reference is made to the provisions of 42 C.F.R. §422.402, as supplemented by Chapter 10 of the Medicare Managed Care Manual, regarding federal preemption of state laws with respect to Medicare Advantage plans, including Employer Group Waiver Plans, offered by Medicare Advantage organizations. Such plans are required to abide by all applicable federal laws, regulations and CMS or other federal agency rules, guidance or other requirements promulgated with respect to such plans (collectively, "Medicare Laws"). Any obligations of MA Plan in this MA Agreement or any agreement to which this Medicare Advantage Group Agreement is attached or made a part of to comply with or based upon the requirements of state or local law, regulations or guidance, including, without limitation, regulations or guidance issued by state or local governmental agencies, shall not be binding on the MA Plan, which shall comply with applicable Medicare Laws in all aspects of MA Plan governance and operations.
- I. This MA Agreement supersedes any and all prior agreements between the Parties, whether written or oral, and other documents, if any, addressing the subject matter contained in this MA Agreement.
- J. If any provision of this MA Agreement is found to be invalid, illegal or unenforceable under applicable law, order, judgment or settlement, such provision will be excluded from the MA Agreement and the remainder of this MA Agreement will be enforceable and interpreted as if such provision is excluded.

## **Addenda**

**RATE SHEET INCLUDING UNDERWRITING STIPULATIONS (Addendum A)**

**PERFORMANCE GUARANTEE AGREEMENT (Addendum B)**

- **Attachment to Performance Guarantee Addendum**

## Addendum A

<b>Summary of Rates State of New Hampshire Effective 01/01/2019</b>		
<u>Medical Plan</u>	2019 PMPM Premium	2020 PMPM Premium
Custom LPPO – A & B Members (Nationwide Passive PPO Plan)	\$124.26	\$109.11
<p><b>Medical Rates shown above are guaranteed for each year subject to the following:</b></p> <p><b>Additional Details and Terms &amp; Conditions for 2019 and 2020 rate guarantees:</b></p> <ul style="list-style-type: none"> <li>A. Combined CMS actions for 2020 and EGWP benchmarks and risk score actions - including normalization, model changes, and coding difference adjustments - not to be worse than a 0% reduction for 2020 in terms of overall impact on State of New Hampshire.</li> <li>B. The 2020 premium is a rate cap and would be adjusted down to:                             <ul style="list-style-type: none"> <li>○ remove premium tax in the event the tax is suspended for 2020</li> <li>○ account for an increase in the risk score</li> </ul> </li> <li>C. Renewal caps do not include additional products, or services being added to the offering.</li> <li>D. Renewal caps also exclude additional government imposed taxes or fees, and do not apply if regulatory or legislative changes materially modify the product offering.</li> </ul>		
<p><b>Underwriting Stipulations:</b></p> <ul style="list-style-type: none"> <li>• Rates and benefits may be revised based on legislative, regulatory or other changes including, but not limited to, CMS guidance effective for the 2019 and 2020 product years.</li> <li>• ACA Insurer Fees are included in the quoted premium. The fee included is calculated on a prorated basis across the full coverage period. The ACA Insurer Fee is excluded for months in 2019 within the rating period.</li> <li>• Eligibility for coverage for subscribers or their dependents is based on the subscriber meeting their plan sponsor's requirements for coverage of retiree medical benefits.</li> <li>• Contracted rates are on a Per-Member-Per-Month (PMPM) basis. Each individual will receive the same equal rate; a two member contract would receive twice the rate; a three member contract would receive triple the rate.</li> <li>• Broker commissions are excluded.</li> <li>• This quote assumes Anthem will be the exclusive post-65 retiree offering. Furthermore, the quote assumes that Anthem will offer a single plan design. Any additional plan selections will be subject to underwriting consideration.</li> <li>• The plan sponsor will contribute 100% towards the premium. Retiree contributions are paid to the State of New Hampshire and could change. State of New Hampshire agrees to notify Anthem of any changes in premium contributions.</li> </ul>		

## Addendum A

- CMS guidance does not allow a network based Medicare Advantage plan (LPPO, HMO) to be offered with an individual Part D waiver plan. If the Medicare Advantage plan is being offered with another carrier's Part D group waiver plan, the Part D carrier must coordinate care with Anthem.
- This quote is contingent upon the majority of the enrolled membership residing in an adequate network service area, as defined by CMS. The network service area and plan design are subject to CMS approval.

## Addendum B

### Performance Guarantee Agreement

#### Addendum to Fully Insured Medicare Advantage Group Agreement

This Addendum to the Medicare Advantage Group Agreement ("MA Agreement") provides certain guarantees ("Performance Guarantees") pertaining to Anthem Blue Cross and Blue Shield's (Anthem) performance under the MA Agreement between Anthem and the State of New Hampshire ("Employer") and shall be effective for the period from the Effective Date through December 31, 2020 (the "Performance Period"). Descriptions of the terms of each Performance Guarantee applicable to the Parties are set forth in the "Attachment to Performance Guarantee Addendum to Fully Insured Agreement" (the "Attachment") to this Addendum and made a part of this Addendum. This Addendum shall supplement and amend the MA Agreement between the Parties. If there are any inconsistencies between the terms of the MA Agreement including any prior Addendums and this Addendum, the terms of this Addendum shall control.

#### Section 1. General Conditions

- A. The Performance Guarantees described in the Attachment to this Addendum shall be in effect only for the Performance Period indicated above, unless specifically indicated otherwise in the Attachment. Each Performance Guarantee shall specify:
- (1) Performance Category. The term Performance Category describes the general type of Performance Guarantee.
  - (2) Reporting Period. The term Reporting Period refers to how often Anthem will report on its performance under a Performance Guarantee.
  - (3) Measurement Period. The term Measurement Period is the period of time over which Anthem's performance is measured, which may be the same as or differ from the period of time equal to the Performance Period.
  - (4) Penalty Calculation. The term Penalty Calculation generally refers to how Anthem's payment will be calculated, in the event Anthem does not meet the target(s) specified under the Performance Guarantee.
  - (5) Amount at Risk. The term Amount at Risk means the amount Anthem may pay if it fails to meet the target(s) specified under the Performance Guarantee.
- B. Anthem shall conduct an analysis of the data necessary to calculate any one of the Performance Guarantees within the timeframes provided in the Attachments to this Addendum. In addition, any calculation of Performance Guarantees, reports provided, or analysis performed by Anthem shall be based on Anthem's then current measurement and calculation methodology, which shall be available to Employer upon request.
- C. Any audits performed by Anthem to test compliance with any of the Performance Guarantees shall be based on a statistically valid sample size with a 95% confidence level.
- D. In the event the MA Agreement expires, Anthem is obligated to make payment for any Performance Guarantees that apply to the final term of the Agreement Period.
- E. Unless otherwise specified in the Attachment to this Addendum, the measurement of the Performance Guarantee shall be based on: (1) the performance of any service team, business unit, or measurement group assigned by Anthem to the activity to which the specific Performance Guarantee being measured relates; and (2) data that is maintained and stored by Anthem or its Vendors.
- F. If the MA Agreement is terminated prior to the completion date outlined in Section 1.7 of the P-37 for any reason, liability for any Performance Guarantees shall be calculated and paid based on the most recent completed Measurement Period.

- G. In accordance with Article 18 of the P-37, the Parties shall meet and agree to make changes to or eliminate any of the Performance Guarantees provided in the Attachment to this Addendum upon the occurrence of any of the following:
- (1) a change to the plan benefits or the administration of the plan initiated by Employer that results in a substantial change in the services to be performed by Anthem or the measurement of a Performance Guarantee; or
  - (2) an increase or decrease of 15% or more of the number of Members that were enrolled for coverage on the latter of the effective date or renewal date of this Addendum; or
  - (3) Enrollment in Employer's Medicare Advantage plans administered by Anthem is less than 500 Members.
- H. For the purposes of calculating compliance with the Performance Guarantees contained in the Attachment to this Addendum, if a delay in performance of, or inability to perform, a service underlying any of the Performance Guarantees is due to circumstances which are beyond the control of Anthem or its Vendors, including, but not limited to, any act of God, civil riot, floods, fire, acts of terrorists, acts of war, terrorism, or power outage, such delayed or non-performed service will not count towards the measurement of the applicable Performance Guarantee.
- I. Some Performance Guarantees measure and compare year to year performance. The term Baseline Period refers to the equivalent time period preceding the Measurement Period.
- J. As determined by Anthem, Performance Guarantees may be measured using either aggregated data or Employer-specific Data. The term Employer-specific Data means the data associated with Employer's Plan that has not been aggregated with other employer data. Performance Guarantees will specify if Employer-specific Data shall be used for purposes of measuring performance under the Performance Guarantee.
- K. If any Performance Guarantees are tied to a particular program and its components, such Performance Guarantees are only valid if the Employer participates in the program and its components for the entirety of the Measurement Period associated with the Performance Guarantee.

**Section 2. Payment:**

- A. If Anthem fails to meet any of the obligations specifically described in a Performance Guarantee, Anthem shall pay Employer the applicable amount set forth in the Attachment describing the Performance Guarantee. Payment shall be in the form of a check to Employer which will occur annually unless otherwise stated in the Performance Guarantee.
- B. Notwithstanding the foregoing, Anthem's obligation to make payment under the Performance Guarantees is conditioned upon Employer's timely performance of its obligations provided in the MA Agreement, in this Addendum and the Attachment, including providing Anthem with the information or data required by Anthem in the Attachment. Anthem shall not be obligated to make payment under a Performance Guarantee if Employer or Employer's vendor's action or inaction adversely impacts Anthem's ability to meet any of its obligations provided in the Attachments related to such Performance Guarantee, which expressly includes but is not limited to Employer or its vendor's failure to timely provide Anthem with accurate and complete data or information in the form and format expressly required by Anthem. Where there is a dispute regarding timely performance, adverse impact, timely provision of accurate and complete data and the form and format thereof, or any other issue contemplated by this subsection B, the Parties shall meet in good faith to resolve such dispute and shall mutually agree to the impact on the particular Performance Guarantee.
- C. Where the Amount at Risk for a Performance Guarantee is on a percentage of a Per Member Per Month (PMPM) fee basis, the Guarantee will be calculated by multiplying the PMPM amount by the actual annual enrollment during the Measurement Period.

D. Member: A member is defined as the individuals, including the retiree and his/her dependents, as defined in the Evidence of Coverage, who have satisfied the plan eligibility requirements of Employer, applied for coverage, and been enrolled for plan benefits.

**ATTACHMENT TO**  
**PERFORMANCE GUARANTEE AGREEMENT (ADDENDUM B)**  
**TO**  
**FULLY INSURED MEDICARE ADVANTAGE GROUP AGREEMENT**

**Implementation and Operations Performance Guarantees**

This Attachment is made part of Addendum B and will be effective for the Performance Period from the Effective Date through 12/31/2020. This Attachment is intended to supplement the Fully Insured Medicare Advantage Group Agreement (“MA Agreement”) between the Parties.

**Operations Performance Guarantees**

<b>Performance Category</b>	<b>Amount at Risk</b>	<b>Guarantee</b>	<b>Penalty Calculation</b>		<b>Measurement and Reporting Period</b>
<b>Implementation Guarantees</b>					
Implementation Timeliness	\$25,000	A minimum of 95% of all tasks will be completed by the dates specified in the implementation plan agreed to by the Parties. The implementation plan will be developed by Anthem and will contain tasks to be completed by the State and/or Anthem and a timeframe for completion of each task. The implementation plan will also contain Measurement Periods specific to each task. Anthem’s payment under this Guarantee is conditioned upon the State’s completion of all designated tasks by the dates specified in the implementation plan.	95.0% or Greater 91.0% to 94.9% 89.0% to 90.9% 85.0% to 88.9% Less than 85.0%	None 25% 50% 75% 100%	<u>Measurement Period</u> Effective Date of Contract <u>Reporting Period</u> 60 calendar days following the end of the implementation period
Open Enrollment ID Card Issuance	\$25,000	100% of ID cards will be mailed to Open Enrollment participants no later than December 15, 2018 provided that Anthem receives an accurate eligibility file by December 7, 2018.	100% of Amount at Risk		<u>Measurement Period</u> Effective Date of Contract <u>Reporting Period</u> 60 days following the State’s effective date.

**Operations Performance Guarantees**

Claim Timeliness (30 Calendar Days)	\$0.75 PMPM	<p>A minimum of 95% of Non-investigated medical Claims will be processed timely provided that Anthem receives accurate and timely eligibility information to allow timely Claims processing.</p> <p>Non-investigated medical Claims are defined as Claims that process through the system without the need to obtain additional information from the Provider, Subscriber, or other external sources. Processed Timely is defined as Non-investigated medical Claims that have been finalized within 30 calendar days of receipt.</p> <p>This Guarantee will be calculated based on the number of Non-investigated Claims that Processed Timely divided by the total number of Non-investigated Claims. The calculation of this Guarantee does not include Claim adjustments and does not include Claims for Members enrolled under COBRA. The calculation of this Guarantee also excludes in any quarter, Claims for the State when the State requests changes to Plan benefits, until all such changes have been implemented.</p> <p>This will be measured on Anthem's Medicare book of business.</p>	<p>95.0% or Greater 94.5% to 94.9% 94.0% to 94.9% Less than 94.0%</p>	<p>None 25% 50% 100%</p>	<p><b>Measurement Period</b> Annual, beginning with the start of the fourth month of the Initial Agreement Period or beginning with the start of the fourth month following an implementation</p>	<p><b>Reporting Period</b> Quarterly</p>
Claims Financial Accuracy	\$0.75 PMPM	<p>A minimum of 98% of medical Claim dollars will be processed accurately.</p> <p>This Guarantee will be calculated based on the total dollar amount of audited medical Claims paid correctly divided by the total dollar amount of audited medical Paid Claims. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter Claims for the State when the State requests changes to Plan benefits, until all such changes have been implemented.</p> <p>This will be measured on Anthem's Medicare book of business.</p>	<p>98.0% or Greater 97.5% to 97.9% 97.0% to 97.4% Less than 97.0%</p>	<p>None 25% 50% 100%</p>	<p><b>Measurement Period</b> Annual</p>	<p><b>Reporting Period</b> Quarterly</p>
Average Speed of Answer	\$0.75 PMPM	<p>The average speed to answer (ASA) will be 80% within 30 seconds or less provided that Anthem receives accurate and timely eligibility and benefit information.</p> <p>ASA is defined as the average number of whole seconds Members wait and/or are in the telephone system before receiving a response from a customer service representative (CSR) or an interactive voice response unit (IVR). This Guarantee will be calculated based on the total number of calls received in the customer service telephone system.</p> <p>This will be measured on the Medicare Advantage population enrolled through Group contracts only.</p>	<p>100% of Amount at Risk</p>	<p><b>Measurement Period</b> Annual beginning with the start of the fourth month of the Initial Agreement Period or beginning with the start of the fourth month following an implementation</p>	<p><b>Reporting Period</b> Quarterly</p>	

Call Abandonment Rate	\$0.75 PMPM	A maximum of 3% of member calls will be abandoned. Abandoned Calls are defined as member calls that are waiting for a customer service representative (CSR), but are abandoned before connecting with a CSR. This Guarantee will be calculated based on the number of calls abandoned divided by the total number of calls received in the customer service telephone system. Calls abandoned in less than 5 seconds will not be included in this calculation.  This will be measured on the Medicare Advantage population enrolled through Group contracts only.	100% of Amount at Risk		<b><u>Measurement Period</u></b> Annual beginning with the start of the fourth month of the Initial Agreement Period or beginning with the start of the fourth month following an implementation  <b><u>Reporting Period</u></b> Quarterly
MMR Reports	\$2,500 per occurrence	Anthem will provide accurate MMR reports as requested (no more frequent than monthly) within 30 days of the request, consistent with CMS guidelines for distribution, latter of date of request or CMS provides updated reports.	\$2,500 per occurrence		<b><u>Reported and assessed, as requested</u></b>
MOR Reports	\$2,500 per occurrence	Anthem will provide accurate MOR reports upon request, no more than annually, including all fields as received from CMS. The latest MOR will be submitted within 30 days of the request.	\$2,500 per occurrence		<b><u>Reported and assessed annually</u></b>
Claim Detail	\$2,500 per occurrence	Anthem will provide claim line detail for ALL claims including, but not limited to financial and diagnosis information, as requested, within 10 days of the request unless otherwise mutually agreed upon.	\$2,500 per occurrence		<b><u>Reported and assessed, as requested</u></b>
Reporting	\$5,000 per year	90% of Ad hoc reports within 7 business days unless otherwise mutually agreed upon	\$5,000 per year		<b><u>Annually</u></b>
Network Changes		Notification of significant hospital network changes must be communicated at least 60 calendar days in advance or within 3 calendar days of notification by the provider to Anthem, whichever is less. A significant change is defined as a reduction in network hospitals/facilities that would impact more than 10% of the State's retirees.	\$2,000 per occurrence		<b><u>Ongoing / per occurrence</u></b>
Website Availability	\$0.75 PMPM	Anthem guarantees 98% availability of all participant accessed anthem.com Web-based services; excluding regularly scheduled and emergency maintenance periods, Force Majeure events (e.g. power failure) network attacks, outages from Internet Service Providers (ISP) and system dependencies. Maintenance includes server backups, file backups, full database backups and database re-orgs, among other health checks.	98.0% or Greater 97.5% to 97.9% 97.0% to 97.4% Less than 97.0%	None 25% 50% 100%	<b><u>Measurement Period</u></b> <b><u>Annual</u></b>  <b><u>Reporting Period</u></b> <b><u>Quarterly</u></b>

Operations	\$0.75 PMPM	99% of eligibility updates received from the State processed within forty-eight (48) hours of receipts of a clean and complete eligibility file in an agreed upon format  This guarantee metric applies to systematic records and excludes records that fall out for manual review.	99% or greater 97.9% - 98.9% 95.0% - 96.9% 93.0% - 94.9% Less than 93%	0% 25% 50% 75% 100%	<b><u>Annually</u></b>
Operations	\$5,000 per audit	Contractor will respond to all independent auditor requests for clarification, following claims audits within 30 calendar days	\$5,000 at risk per audit		<b><u>Per Audit</u></b>
Operations	\$2,500 per occurrence	Timely and accurate implementation of all programs and program changes required by the State after year one.	\$2,500 per occurrence		<b><u>Ongoing/per occurrence</u></b>
Operations	\$2,500 per occurrence	Documentation provided, in a mutually agreed upon format, to the State of quality control testing prior to implementation of any programs and program changes	\$2,500 per occurrence		<b><u>Ongoing/per occurrence</u></b>
Operations	\$6,000 annually	Failure to issue any administrative invoice, with any agreed upon supporting documentation within a mutually agreed upon billed date range	\$500 per invoice per month		<b><u>Monthly</u></b>

# *The State of New Hampshire*



## *Office of the Insurance Commissioner*

IT IS HEREBY CERTIFIED THAT

**ANTHEM HEALTH PLANS OF NH, INC. (DBA ANTHEM  
BLUE CROSS AND BLUE SHIELD)**

Is organized under the laws of the State of New Hampshire, has complied with all requirements thereof, and is authorized to transact the business of Accident & Health insurance per RSA 401:1 IV in this State.

*IN WITNESS WHEREOF*, I have hereunto set my hand and affixed the official seal of the Insurance Department at the City of Concord, this 24<sup>th</sup> day of **April 2018**.



A handwritten signature in black ink, appearing to read "R. Sevigny".

Roger A. Sevigny  
Insurance Commissioner



# State of New Hampshire

## Department of State



5/22/2018 2:37:48 PM

Andrew Deselle  
1155 Elm Street Ste 200  
Manchester, NH, 03101, USA

Enclosed is the acknowledgment copy of your filing. It acknowledges this office's receipt and successful filing of your documents.

Should you have any questions, you may contact the Corporation Division at the phone number or email address below. Please reference your Business ID Number when contacting our office.

Please visit our website for helpful information regarding all your business needs.

Sincerely,  
Corporation Division

Business ID: **320378**  
Filing No: **4100454**

# State of New Hampshire

## Department of State

### CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify ANTHEM HEALTH PLANS OF NEW HAMPSHIRE, INC. is a New Hampshire corporation registered on June 30, 1999. I further certify that articles of dissolution have not been filed with this office.

INFORMATION REGARDING ANNUAL REPORTS AND/OR FEES MUST BE OBTAINED FROM THE NEW HAMPSHIRE INSURANCE DEPARTMENT.

Business ID: **320378**

Certificate Number : **0004100454**



IN TESTIMONY WHEREOF,

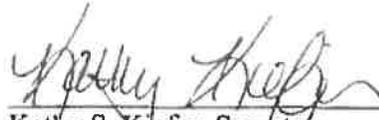
I hereto set my hand and cause to be affixed  
the Seal of the State of New Hampshire,  
this 22nd day of May A.D. 2018.

A handwritten signature in cursive script, reading "William M. Gardner".

William M. Gardner  
Secretary of State

**CERTIFICATION  
OF  
KATHY KIEFER, SECRETARY  
ANTHEM HEALTH PLANS OF NEW HAMPSHIRE, INC.**

I, Kathy S. Kiefer, Corporate Secretary of Anthem Health Plans of New Hampshire, Inc. certify that Lisa M. Guertin is the President and General Manager of Anthem Health Plans of New Hampshire, Inc. d/b/a Anthem Blue Cross and Blue Shield ("Anthem"), and as such President and General Manager, and consistent with Anthem policies, has the signatory authority to bind Anthem in contracts with the State of New Hampshire.

  
Kathy S. Kiefer, Secretary

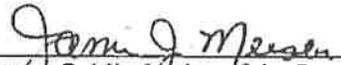
STATE OF INDIANA

COUNTY OF MARION

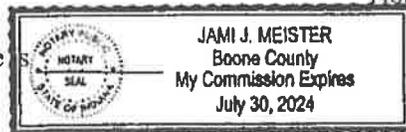
On this the 22<sup>nd</sup> day of May, 2018, before me, \_\_\_\_\_, the undersigned officer, personally appeared Kathy S. Kiefer who acknowledged herself to be the Corporate Secretary of Anthem Health Plans of New Hampshire, Inc., d/b/a Anthem Blue Cross and Blue Shield, a corporation, and that she, as such Corporate Secretary being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by herself as Corporate Secretary.

IN WITNESS WHEREOF I hereunto set my hand and official seal.

My commission expires: \_\_\_\_\_

  
Notary Public/Justice of the Peace

My county of Residence \_\_\_\_\_



**CERTIFICATE**

(Corporation With Seal)

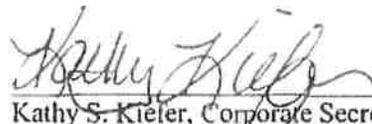
I, Kathy S. Kiefer, Corporate Secretary of Anthem Health Plans of New Hampshire, Inc., do hereby certify that: (1) I am the duly elected and acting Corporate Secretary of Anthem Health Plans of New Hampshire, Inc., doing business as Anthem Blue Cross and Blue Shield, a New Hampshire corporation (the "Corporation"); (2) I maintain and have custody of and am familiar with the Seal and Minute Books of the Corporation; (3) I am duly authorized to issue certificates with respect to the contents of such books and to affix such seal to such certificates; (4) the following is a true and complete copy of Bylaws adopted at a meeting on June 30, 1999; (5) the foregoing Bylaws are in full force and effect, unamended, as of the date hereof; and (6) the following person(s) lawfully occupy the office(s) indicated below:

Lisa M. Guertin President

Vincent E. Scher Treasurer

IN WITNESS WHEREOF, I have hereunto set my hand as the Secretary of the Corporation this 22<sup>nd</sup> day of May, 2018.

(Corporate Seal)

  
Kathy S. Kiefer, Corporate Secretary

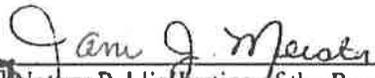
STATE OF INDIANA

COUNTY OF MARION

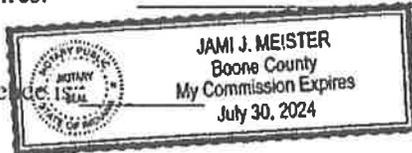
On this the 22<sup>nd</sup> day of May, 2018, before me, \_\_\_\_\_, the undersigned officer, personally appeared Kathy S. Kiefer who acknowledged herself to be the Corporate Secretary of Anthem Health Plans of New Hampshire, Inc., d/b/a Anthem Blue Cross and Blue Shield, a corporation, and that she, as such Corporate Secretary being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by herself as Corporate Secretary.

IN WITNESS WHEREOF I hereunto set my hand and official seal.

My commission expires:

  
Notary Public/Justice of the Peace

My county of Residence:





# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
5/3/2018

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

**IMPORTANT:** If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

<b>PRODUCER</b> Arthur J. Gallagher & Co. Insurance Brokers of California, Inc. License #0726293 505 N. Brand Boulevard, Suite 600 Glendale CA 91203	<b>CONTACT NAME:</b> Robin Johnston <b>PHONE (A/C, No., Ext):</b> 818-539-1354 <b>E-MAIL ADDRESS:</b> robin_johnston@ajg.com		<b>FAX (A/C, No):</b> 818-539-1654
	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
<b>INSURED</b> ANTHINC-02 Anthem, Inc. And Its Subsidiaries 2015 Staples Mill Road Mail Drop VA2001-N350 Richmond VA 23230	<b>INSURER A :</b> ACE American Insurance Company		22667
	<b>INSURER B :</b> Great American Insurance Company of NY		22136
	<b>INSURER C :</b> American Zurich Insurance Company		40142
	<b>INSURER D :</b> Zurich American Insurance Company		16535
	<b>INSURER E :</b> <b>INSURER F :</b>		

**COVERAGES**                      **CERTIFICATE NUMBER:** 1907678591                      **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			HDO G71094893	5/1/2018	5/1/2019	EACH OCCURRENCE \$1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$1,000,000 MED EXP (Any one person) \$25,000 PERSONAL & ADV INJURY \$1,000,000 GENERAL AGGREGATE \$25,000,000 PRODUCTS - COMP/OP AGG \$2,000,000 \$
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY			ISA H25157485	5/1/2018	5/1/2019	COMBINED SINGLE LIMIT (Ea accident) \$1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
B	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$ \$10,000			UMB 9999727	5/1/2018	5/1/2019	EACH OCCURRENCE \$25,000,000 AGGREGATE \$25,000,000 \$
C	<input checked="" type="checkbox"/> WORKERS COMPENSATION AND EMPLOYERS' LIABILITY <input type="checkbox"/> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below			WC9299269-17 EWS5347154-13 WC9376766-16	1/1/2018 1/1/2018 1/1/2018	1/1/2019 1/1/2019 1/1/2019	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$2,000,000 E.L. DISEASE - EA EMPLOYEE \$2,000,000 E.L. DISEASE - POLICY LIMIT \$2,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)  
Subject to policy terms, conditions and exclusions.  
Subject to policy terms, conditions & exclusions  
Named Insured includes Anthem Health Plans of New Hampshire, Inc. Evidence of Insurance Only.

<b>CERTIFICATE HOLDER</b>  State of New Hampshire Risk Management Unit 25 Capitol Street Concord NH 3301 USA	<b>CANCELLATION</b>  SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.  AUTHORIZED REPRESENTATIVE 
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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/30/2018

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

**IMPORTANT:** If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

<b>PRODUCER</b> Willis of Virginia, Inc. c/o 26 Century Blvd P.O. Box 305191 Nashville, TN 372305191 USA	<b>CONTACT NAME:</b> PHONE (A/C, No, Ext): 1-877-945-7378		<b>FAX (A/C, No):</b> 1-888-467-2378
	<b>E-MAIL ADDRESS:</b> certificates@willis.com		
<b>INSURED</b> Anthem, Inc. and Its Subsidiaries 120 Monument Circle Indianapolis, IN 46204	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	<b>INSURER A:</b> Illinois National Insurance Company		23817
	<b>INSURER B:</b>		
	<b>INSURER C:</b>		
	<b>INSURER D:</b>		
	<b>INSURER E:</b>		

**COVERAGES**

CERTIFICATE NUMBER: W5749718

REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	<b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:						EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR <b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A				<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A	<b>Security &amp; Privacy Liability</b>			01-310-43-66	03/31/2018	03/31/2019	Limits: \$10,000,000 X SIR

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Named Insured includes: Anthem Health Plans of New Hampshire, Inc.

**CERTIFICATE HOLDER****CANCELLATION**

State of New Hampshire Risk Management Unit 25 Capitol Street Concord, NH 03301	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.  AUTHORIZED REPRESENTATIVE 
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STATE OF NEW HAMPSHIRE

Department of Administrative Services

RISK MANAGEMENT UNIT

State House Annex

25 Capitol St., Concord NH 03301

Charles M. Arlinghaus

Commissioner

(603) 271-3201

Catherine A. Keane

Director, Risk & Benefits

(603) 271-3180

August 25, 2017

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Administrative Services (DAS), Risk Management Unit (RMU) to enter into an Agreement with Anthem Health Plans of New Hampshire, Inc., d/b/a Anthem Blue Cross and Blue Shield (Anthem) (VC# 177335), Manchester, NH 03101-2000. The term of the Agreement is for a period of three years, from January 1, 2018 through December 31, 2020, with an option to extend for up to an additional two years with approval from the Governor and Executive Council. Administrative charges are estimated to be \$20,900,000 during the initial term of the Agreement. Approximately 36% General Funds, 15% Federal Funds, 4% Enterprise Funds, 11% Highway Funds, 2% Turnpike Funds and 32% Other Funds.

Funding is available in the Employee Benefit Risk Management Fund contingent upon availability and continued appropriations for all fiscal years with the authority to adjust encumbrances in each of the State fiscal years through the Budget Office if needed and justified:

Table with 5 columns: Administration Costs, SFY2018 (1/1/2018 - 6/30/2018), SFY2019 (7/1/2018 - 6/30/2019), SFY2020 (7/1/2019 - 6/30/2020), SFY2021 (7/1/2020 - 12/31/2020). Rows include Med Admin Fee - Actives, Troopers, Non-Medicare, Medicare, FISCAL YEAR TOTALS, and GRAND TOTAL (\$20,900,000).

## EXPLANATION

The DAS Commissioner is authorized, pursuant to RSA 21-1:28, to enter into contracts with "any organization necessary to administer and provide a health plan." DAS contracts with a third party administrator (TPA) to administer the Employee and Retiree Health Benefit Plan's (HBP) medical claims. This contract provides medical benefits coverage for state employees, retirees, spouses and eligible dependents in accordance with the provisions of RSA 21-1:30 and the state collective bargaining agreements. The State's current medical TPA contract is with Anthem and expires on December 31, 2017.

DAS with the assistance of its health benefits consultant, the Segal Company (Segal), issued a Request for Proposal (RFP) for the administration of medical benefits on March 9, 2017. Ninety-nine firms received direct notification of this solicitation. In addition, DAS published notice of this RFP in the Union Leader and on the DAS Bureau of Purchase and Property website. On April 19, 2017, DAS received proposals from Anthem and Harvard Pilgrim Health Care (Harvard Pilgrim). DAS evaluated and scored both proposals.

The scoring of the proposals was based upon the areas of: Total Projected Costs (40%), Alternative Payment Models (10%), Value Based Purchasing (10%), Administrative Services, Member Services, Claims Paying Services and Reporting Services (10%), Health Management Programs (10%), Wellness Services (10%), Tiered Networks/Type of Service (5%) and references (5%). Based on the foregoing, Anthem's proposal received the highest ranking score and was unanimously recommended by evaluation team. The evaluation team members included: Catherine A. Keane (Director of Risk and Benefits), Joyce Pitman (Deputy Director, Health Benefit Plan, RMU), Robin Berube (Financial Reporting Administrator I, RMU), Michael Loomis (Wellness Program Administrator, RMU), Margaret Blacker (Benefits Manager, RMU), Gary Lunetta (Administrator IV, DAS Bureau of Purchase and Property), Matthew Newland (Manager of Employee Relations, DAS Division of Personnel), Linda Huard (Health Benefits Committee Chair, State Employees Association of New Hampshire), Tyler Brannen, Health Care Policy Analyst, Department of Insurance), Patricia Tilley (Chief, Bureau of Population Health and Community Services, Department of Health and Human Services (DHHS), Division of Public Health (DPH) and Marisa Lara (Manager, Diabetes, Heart Disease, Obesity and School Health, DHHS, DPH). Carolyn Russell, DAS Project Management Administrator, facilitated the bid scoring process. The scoring sheet is attached.

Anthem's lead score was driven by the strength of its financial proposal. Anthem's administrative fixed fees were 10% lower than Harvard Pilgrim's bid. As compared to the Calendar Year (CY) 2017 Anthem administrative fixed fee, Anthem's administrative fixed fee in its proposal represents an approximate \$1 million in savings to the State over the three-year contract period. After negotiation, Anthem agreed to decrease the administrative fixed fee by an additional \$385,000 over the three-year contract. The total cost of this contract represents the negotiated fixed fee of \$23.00 per employee per month (PEPM) for administration, \$2.25 PEPM for Vitals SmartShopper, and an average of \$1.50 PEPM for wellness programs, plus fees for usage-based wellness and other services that represent projected costs based on prior utilization under the HBP. Estimated Anthem network discounts are approximately 3.4% higher on average than those of Harvard Pilgrim. The State projects an annual \$11 million cost differential between medical claims paid with Anthem as compared to medical claims paid with Harvard Pilgrim. Anthem guarantees a medical trend of 5% or lower and agrees to place up to 10% of its fixed administrative fee at risk if the medical trend exceeds the 5% threshold.

This contract implements the State's goal to work in a new level of partnership with its medical TPA to enhance the quality of healthcare services received by plan members and the cost-effectiveness of the health care purchased by the State through a comprehensive valued based health care purchasing strategy. Value based purchasing incentivizes quality care and outcomes for individuals. Under this contract, Anthem will be required to collaborate with the State and develop broad-ranging strategies to improve clinical quality measures. The contract with Anthem includes additional performance guarantees of up to 5% of the fixed administrative fee focused on meeting defined clinical quality measures.

In summary, this contract renews Anthem's commitment to work with the State to achieve mutually beneficial financial and quality goals. Included in these goals is Anthem's commitment to meet performance guarantees with respect to its service of the State's account. I recommend the approval of this contract.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Charles M. Arlinghaus". The signature is fluid and cursive, with a large initial "C" and "A".

Charles M. Arlinghaus  
Commissioner

**Risk Management Unit**Scoring Summary

Category	Avail. Points	State Score	
		Anthem	Harvard
Technical Questionnaire & References	50		
Value-Based Purchasing	10	6.0	6.0
Administrative, Member, Claims Paying Services & Reporting Services	10	5.0	7.0
Health Management Programs	10	5.0	7.0
Wellness Services	10	6.0	7.0
Tiered-Networks / Site-of-Service	5	4.0	3.0
References	5	5.0	5.0
<b>Sub-Total</b>		<b>31</b>	<b>35</b>
<b>Financial</b>	<b>50</b>		
Financial – Total Projected Costs	40	40.0	34.0
Financial – Alternative Payment Models	10	8.0	8.0
<b>Sub-Total</b>		<b>48.0</b>	<b>42.0</b>
<b>Total Score</b>	<b>100</b>	<b>79.0</b>	<b>77.0</b>
Rank		1	2

## RFP 2017-192 –ADMINISTRATION OF MEDICAL BENEFITS

### Evaluation Committee Members

#### **CATHERINE KEANE**

Current Position: Director of Risk and Benefits, Risk Management Unit, Department of Administrative Services

Background: Catherine (Cassie) is an attorney and serves as the Director of the Risk Management Unit. Cassie worked in the NH Department of Justice as Counsel to the Health Benefit Program. Before that she worked at the NH Department of Health and Human Services for 14 years. She served as Director of the Division of Elderly and Adult Services for 5 years where she managed a \$300 million budget and worked to promote long term care system change. She also served as Assistant Director of the Office of Family Services, and Assistant to the Director for the Division of Human Services and in other roles within state government.

#### **JOYCE PITMAN**

Current Position: Deputy Director Health Benefit Program (HBP), Risk Management Unit, Department of Administrative Services

Background: As Deputy Director, Joyce leads implementation of all HBP plan initiatives, including procurements and contract management. Joyce is the Project Manager of the SONH's VBP Medical TPA procurement. Joyce has a BS in Health Management and Policy from the University of New Hampshire and an MBA in Business Administration/HR Management from Southern NH University. Previously, Joyce worked for 12 years in a Health Benefits leadership position at Concord Hospital where she lead a full-replacement benefits transition into a Consumer Driven Healthcare Plan model. She has a wealth of knowledge in vendor relations and the contract management process as well as with employee communications concerning benefits.

#### **GARY LUNETTA**

Current Position: Administrator IV, Bureau of Purchase & Property, Department of Administrative Services

Background: Gary has worked for the State of New Hampshire for 6 months as the Administrator of the Bureau of Purchase and Property. Gary has over 30 years of procurement and contract experience in the private sector working for companies like AlliedBarton Security Services as the District Area Manager and Client Value Manager and Raytheon Engineers & Constructors, Inc. as a Regional Manager. Gary has a Bachelor's Degree in Business Management and Associate's Degree in Procurement from Northeastern University.

#### **MATTHEW NEWLAND**

Current Position: Manager of Employee Relations, Division of Personnel, Department of Administrative Services

Background: Matt has been in his current position for 4.5 years. He has an additional 14 years of Full/Part-Time State Service. In his current position as Manager of Employee

Relations, he conducts negotiations with the unions, administers all collective bargaining agreements and represents the State in all grievance actions including the public employee labor relations board. Prior to working in this position, Matt was employed by BAE Systems (defense contractor) as a Principal Contract Negotiator for 13 years.

#### **LINDA HUARD**

Current Position: State Employees' Association of New Hampshire Chair and Health Benefits Committee (HBC) and Adjudicator, New Hampshire Employment Security

Background: Linda has been employed with the New Hampshire Employment Security for 15 years as an Adjudicator. Linda was formerly employed as a Human Resources Generalist on the Department of Defense (DoD) environment for 17+ years responsible for benefits, employee relations, compensation, training and development, recruitment and retention.

Linda has been a member of the State Employees' Association of NH (SEA) Health Benefits Committee (HBC) since 2007 when the HBC was formed. Linda has been serving as the SEA Chair of the HBC since 2011 and a member of the SEA Master Bargaining Team since 2007, working on her fourth State of NH contract. Linda has also been a SEA member of State Labor Management Committee since 2011.

#### **ROBIN BERUBE**

Current Position: Financial Reporting Administrator I, Risk Management Unit, Department of Administrative Services

Background: Robin has been employed with the State for the past twelve years, most recently in the Risk Management Unit. In her role, Robin assists with the financial and accounting management of the health and dental program. Previously, Robin worked as a Program Assistant for the Department of Safety at the Division of Motor Vehicles before receiving a promotion to the Division of Administration and Grants Management Unit within the Department of Safety. Robin assisted with the day-to-day accounting of the Division of Administration, primarily focusing on Homeland Security Grants awarded to Department of Safety. Robin holds a Master's of Science in Accounting and Finance from Southern New Hampshire University.

#### **TYLER BRANNEN**

Current Position: Health Care Policy Analyst, NH Insurance Department

Background: Tyler has been with the Insurance Department since 2006 and represents the department on issues related to health insurance policy, transparency, health care costs, health care data, and projects impacting the health care delivery system in NH. Tyler works closely with the New Hampshire legislature and on various health care commissions and boards in the state. Prior to coming to the Department, Tyler worked in strategic planning for Johns Hopkins Medicine, as a medical economics manager with a large pharmacy benefit manager, and in provider contracting at Blue Cross Blue Shield of New Hampshire. He has his master's degree from the Johns Hopkins School of Public Health and his undergraduate degree from the University of New Hampshire.

**MARGARET BLACKER**

Current Position: Benefits Manager, Risk Management Unit, Department of Administrative Services

Background: Margaret has been employed by the State since February 2016 as the Benefits Manager. Margaret oversees the active employee and retiree benefit program third party administrators to ensure benefits are administered in accordance with state contracts and processes and in compliance with current collective bargaining agreements, state and federal laws, rules and guidelines as well as evolving best practices in the industry. Prior to becoming employed by the State of New Hampshire, Margaret was employed by Elliot Health System in Manchester, NH, most recently as the Director of Employee Benefits. Margaret earned a Bachelor's degree in Business Administration from the University of Southern New Hampshire.

**MICHAEL LOOMIS, MPH**

Current Position: Wellness Program Administrator, Risk Management Unit, Department of Administrative Services

Background: As the Wellness Administrator, Michael analyzes demographics, health benefit utilization, and risk analysis to create innovative solutions to health improvement objectives in collaboration with State Agencies, Employee Union Groups, and Health Benefit Program Administrators. Michael holds a Master of Public Health Degree from A.T. Still University of Health Sciences, School of Health Management and a Bachelor of Science Degree from the University of New England.

**MARISA LARA, MPH, RD**

Current Position: Manager, Diabetes, Heart Disease, Obesity, and School Health, NH Division of Public Health, DHHS

Background: Marisa Lara, MPH, RD, has been with the NH Department of Health and Human Services, Division of Public Health Services, for over eight years. She currently manages the cooperative agreement with the Centers for Disease Control and Prevention for diabetes, heart disease, obesity and school health strategies. She has 10 years of experience leading state and community-based public health interventions in diabetes prevention and management and nutrition. Marisa holds a Master's degree in public health and is a registered dietitian.

**PATRICIA TILLEY, MS Ed**

Current Position: Chief, Bureau of Population Health and Community Services, NH Division of Public Health Services

Background: As the Chief of the Bureau of Population Health and Community Services, Patricia's role is to foster systemic approaches to promote health and wellbeing, prevent chronic conditions through population-level strategies and interventions, and to reduce health inequities. Patricia earned a bachelor's in Developmental Psychology from Hampshire College, Amherst, MA and a Master's of Science in Education from the University of Pennsylvania, Philadelphia, Pennsylvania.

**PATRICIA MANNING, MPH**

Current Position: Health Benefits Program Manager in the Risk Management Unit, for the State of NH, Department of Administrative Services

Background: As the Health Benefits Program Manager, Patricia is responsible for leading projects related to employee and retiree health benefits. She holds a Bachelor's Degree in Behavioral Science and a Master's in Public Health from the University of NH. She has over 25 years of experience in the Health and Human Services field, including health education, physical and developmental disabilities, emergency services, infectious disease, and housing services.

ADMINISTRATION OF MEDICAL BENEFITS  
 AGREEMENT BETWEEN THE STATE OF NEW HAMPSHIRE AND  
 ANTHEM BLUE CROSS AND BLUE SHIELD OF NH

**Table of Contents**

<b>AGREEMENT</b> .....	2
GENERAL PROVISIONS (Form P-37).....	2
EXHIBIT A – SERVICES TO BE PERFORMED.....	6
ARTICLE 1 - DEFINITIONS.....	6
ARTICLE 2 - ADMINISTRATIVE SERVICES PROVIDED BY THE CONTRACTOR.....	11
ARTICLE 3 - OBLIGATIONS OF STATE.....	18
ARTICLE 4 - CLAIMS PAYMENT METHOD.....	20
ARTICLE 5 - ADMINISTRATIVE SERVICES FEE.....	20
ARTICLE 6 - CLAIMS RUNOUT.....	20
ARTICLE 7 - INTEREST CHARGES.....	21
ARTICLE 8 - RENEWAL SCHEDULES.....	21
ARTICLE 9 - NOTICES.....	21
ARTICLE 10 - CHANGES IN THE BENEFIT BOOKLET AND AGREEMENT.....	21
ARTICLE 11 - TERMINATION AND/OR SUSPENSION OF PERFORMANCE.....	22
ARTICLE 12 – INTER-PLAN ARRANGEMENTS.....	22
ARTICLE 13 – LIABILITY AND INDEMNITY.....	25
ARTICLE 14 – REPORTING, IT and DATA REPORTS.....	25
ARTICLE 15 - CLAIMS AUDIT.....	27
ARTICLE 16 – USE OF SUBCONTRACTORS.....	27
ARTICLE 17 - CONTRACT ADMINISTRATION.....	28
ARTICLE 18 - THE CONTRACTOR AS RECOVERY AGENT.....	28
ARTICLE 19 – ACCOUNT MANAGEMENT.....	29
ARTICLE 20 – PERFORMANCE GUARANTEES.....	31
ARTICLE 21 – ORDER OF PRECEDENCE / AGREEMENT DOCUMENTS.....	37
EXHIBIT B: CONTRACT PRICE/LIMITATION ON PRICE/PAYMENT.....	38
EXHIBIT C: SPECIAL PROVISIONS.....	43
EXHIBIT D: INCORPORATION OF RFP RESPONSE.....	44
EXHIBIT E: WELLNESS PROGRAM.....	45
EXHIBIT F: VALUE-BASED PURCHASING.....	50
EXHIBIT G: REQUIRED PROTECTION OF CONFIDENTIAL INFORMATION.....	54
APPENDICES.....	57
APPENDIX A: VALUE-BASED PURCHASING (VBP) SPECIFICATIONS.....	58
APPENDIX B: BUSINESS ASSOCIATE AGREEMENT.....	67

Subject: ADMINISTRATION OF MEDICAL BENEFITS

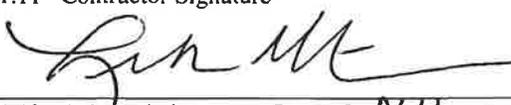
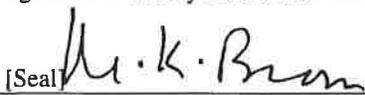
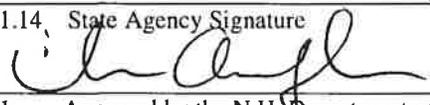
**Notice:** This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

**AGREEMENT**

The State of New Hampshire and the Contractor hereby mutually agree as follows:

**GENERAL PROVISIONS (Form P-37)**

**1. IDENTIFICATION.**

1.1 State Agency Name Department of Administrative Services - Risk Management Unit		1.2 State Agency Address 25 Capitol Street, Room 412 Concord, NH 03301	
1.3 Contractor Name Anthem Health Plans of NH, Inc. d/b/a Anthem Blue Cross and Blue Shield of NH		1.4 Contractor Address 1155 Elm Street, Suite 200 Manchester, NH 03101-2000	
1.5 Contractor Phone Number 603-541-2000	1.6 Account Number 01-14-14-140560-66000000 01-14-14-140560-66600000 01-14-14-140560-66500000	1.7 Completion Date December 31, 2020	1.8 Price Limitation \$20,900,000.00
1.9 Contracting Officer for State Agency Joyce Pitman, Deputy Director of Risk and Benefits		1.10 State Agency Telephone Number 603-271-3180	
1.11 Contractor Signature 		1.12 Name and Title of Contractor Signatory Lisa M. Guertin, President	
1.13 Acknowledgement: State of <u>NH</u> , County of <u>Hillsborough</u>  On <u>8/17/17</u> , before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.			
1.13.1 Signature of <del>Notary Public or</del> Justice of the Peace   [Seal]			
1.13.2 Name and Title of Notary or Justice of the Peace <u>Michael K. Brown, J.P. Exp. 6/21/22</u>			
1.14 State Agency Signature 		1.15 Name and Title of State Agency Signatory <u>Charles M. Arlinghaus, Commissioner</u>	
1. Approval by the N.H. Department of Administration, Division of Personnel (if applicable)  By: _____ Director, On: _____			
2. Approval by the Attorney General (Form, Substance and Execution) (if applicable)  By:  On: <u>8/28/17</u>			
3. Approval by the Governor and Executive Council (if applicable)  By:  <b>DEPUTY SECRETARY OF STATE</b>			

NOV 08 2017

**2. EMPLOYMENT OF CONTRACTOR/SERVICES TO BE PERFORMED.** The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT A which is incorporated herein by reference ("Services").

**3. EFFECTIVE DATE/COMPLETION OF SERVICES.**

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.18, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.14 ("Effective Date").

3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

**4. CONDITIONAL NATURE OF AGREEMENT.**

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds, and in no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to terminate this Agreement immediately upon giving the Contractor notice of such termination. The State shall not be required to transfer funds from any other account to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

**5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.**

5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT B which is incorporated herein by reference.

5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.

5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement

those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

**6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.**

6.1 In connection with the performance of the Services, the Contractor shall comply with all statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal opportunity laws. This may include the requirement to utilize auxiliary aids and services to ensure that persons with communication disabilities, including vision, hearing and speech, can communicate with, receive information from, and convey information to the Contractor. In addition, the Contractor shall comply with all applicable copyright laws.

6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.

6.3 If this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all the provisions of Executive Order No. 11246 ("Equal Employment Opportunity"), as supplemented by the regulations of the United States Department of Labor (41 C.F.R. Part 60), and with any rules, regulations and guidelines as the State of New Hampshire or the United States issue to implement these regulations. The Contractor further agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

**7. PERSONNEL.**

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

## **8. EVENT OF DEFAULT/REMEDIES.**

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely remedied, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 treat the Agreement as breached and pursue any of its remedies at law or in equity, or both.

## **9. DATA/ACCESS/CONFIDENTIALITY/PRESERVATION.**

9.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses; graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

9.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

9.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

**10. TERMINATION.** In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT A.

**11. CONTRACTOR'S RELATION TO THE STATE.** In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

## **12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.**

The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice and consent of the State. None of the Services shall be subcontracted by the Contractor without the prior written notice and consent of the State.

**13. INDEMNIFICATION.** The Contractor shall defend, indemnify and hold harmless the State, its officers and employees, from and against any and all losses suffered by the State, its officers and employees, and any and all claims, liabilities or penalties asserted against the State, its officers and employees, by or on behalf of any person, on account of, based or resulting from, arising out of (or which may be claimed to arise out of) the acts or omissions of the Contractor. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

## **14. INSURANCE.**

14.1 The Contractor shall, at its sole expense, obtain and maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than \$1,000,000 per occurrence and \$2,000,000 aggregate; and

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 9.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than thirty (30) days prior to the expiration date of each of the insurance policies. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference. Each certificate(s) of insurance shall contain a clause requiring the insurer to provide the Contracting Officer identified in block 1.9, or his or her successor, no less than thirty (30) days prior written notice of cancellation or modification of the policy.

**15. WORKERS' COMPENSATION.**

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A (*"Workers' Compensation"*).

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

**16. WAIVER OF BREACH.** No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

**17. NOTICE.** Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

**18. AMENDMENT.** This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

**19. CONSTRUCTION OF AGREEMENT AND TERMS.** This Agreement shall be construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party.

**20. THIRD PARTIES.** The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

**21. HEADINGS.** The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

**22. SPECIAL PROVISIONS.** Additional provisions set forth in the attached EXHIBIT C are incorporated herein by reference.

**23. SEVERABILITY.** In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

**24. ENTIRE AGREEMENT.** This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire Agreement and understanding between the parties, and supersedes all prior Agreements and understandings relating hereto.

## EXHIBIT A – SERVICES TO BE PERFORMED

This EXHIBIT A is made a part of the Agreement between the State of New Hampshire ("State") and Anthem Health Plans of New Hampshire, Inc. dba Anthem Blue Cross and Blue Shield of NH (hereinafter referred to as "Anthem" or "Contractor") and sets forth the services and obligations to be performed by Anthem.

### ARTICLE 1 - DEFINITIONS

For purposes of this EXHIBIT A and any addenda, attachments, appendices or schedules to the Agreement, the following words and terms have the following meanings unless the context or use clearly indicates another meaning or intent.

- A. **ADMINISTRATIVE SERVICES FEE.** The amount payable to the Contractor in consideration of its administrative services and operating expenses as specified in EXHIBIT B to this Agreement, excluding any cost for administration of external review, if applicable. Administrative Services Fee does not include any expenses associated with subrogation or any other recovery activities by the Contractor referred to under this Agreement. Administrative Services Fee may include network access charges, if applicable. All additional charges not included in the Administrative Services Fee are specified elsewhere in this Agreement.
- B. **ANTHEM AFFILIATE.** An entity controlling, under common control with, or controlled by Anthem.
- C. **AGREEMENT or CONTRACT.** The Agreement or Contract constitutes the following documents: State of New Hampshire Terms and Conditions, General Provisions, Form P-37, including Exhibit A, B, C, D, E, F, G and Appendices A and B.
- D. **AGREEMENT PERIOD.** The period commencing at 12:00 a.m. on January 1, 2018 and ending at 11:59 p.m. on December 31, 2020, unless otherwise terminated in accordance with the terms of the Agreement. The Agreement Period shall be comprised of three one year terms (each a "Term"). Each Term shall commence at 12:00 a.m. on January 1<sup>st</sup> and end at 11:59 p.m. on December 31<sup>st</sup> of the applicable calendar year. Agreement Period shall also include any extension of the Agreement for a period of up to two (2) additional years upon terms and conditions as the parties may mutually agree and upon the approval of the Governor and Executive Council.
- E. **BEHAVIORAL HEALTH.** Services related to both mental health and substance use disorder.
- F. **BENEFIT BOOKLET or BOOKLET.** A description of the portion of the health care benefits provided under the Program that is administered by the Contractor. A copy of said Benefit Booklet is available on the State's Human Resources website.
- G. **BILLED CHARGES.** The amount which appears on an Enrollee's Claim form (or other written notification acceptable to the Contractor that Covered Services have been provided) as the Provider's charge for the services rendered to a Enrollee, without any

adjustment or reduction and irrespective of any separate reimbursement contract between the Provider and the Contractor.

- H. **INTER-PLAN PROGRAMS.** Blue Cross and Blue Shield Association programs, including the BlueCard Program, where Anthem can process certain Claims for Covered Services received by Members, which may include accessing the reimbursement arrangement of a Provider that has contracted with another Blue Cross and/or Blue Shield plan.
- I. **CLAIM.** Written or electronic notice of a request for reimbursement of any hospital, medical, pharmacy, dental, vision or other health related service in a format acceptable to the Contractor.
- J. **CLAIM INCURRED DATE.** The date of hospital admission if the Claim is for in-patient hospital services or the date that the service is provided to an Enrollee if the Claim is for any other services.
- K. **CLAIMS RUNOUT SERVICES.** Processing and payment of Claims which are incurred but unreported and/or unpaid as of the effective date of termination of the Agreement.
- L. **CLINICAL PATHWAYS.** Standardized tools designed for a particular chronic condition or procedure provides clear care guidelines based on scientific evidence and organizational consensus regarding the best way to manage the condition or procedure.
- M. **COLLABORATIVE CARE MODEL.** The treatment of common mental health conditions such as depression and anxiety by trained primary care providers and embedded mental health professionals. See <https://aims.uw.edu/collaborative-care>.
- N. **COMPARATIVE EFFECTIVENESS RESEARCH (CER).** Direct comparison of existing health care interventions to determine which work best for which patients and which pose the greatest benefits and harms.
- O. **CONTRACTOR.** The entity responsible for providing third-party Plan administration services on behalf of the State and contracting with a provider organization(s) representing a defined network for purposes of providing benefits to Plan Participants. For the purposes of this Agreement the Contractor is Anthem.
- P. **COVERED SERVICE.** Any hospital, medical, pharmacy, dental, vision or other health related service rendered to Enrollees for which benefits are eligible for reimbursement pursuant to the terms of the Benefit Booklet.
- Q. **EFFECTIVE DATE.** The date as set forth in Section 3 of the Agreement (P37).
- R. **ENROLLEE.** The individuals, including the State of New Hampshire employees and retirees and their dependents, as defined in the Benefit Booklet, who have satisfied the eligibility requirements of the employee and retiree health benefit program of the State, applied for coverage, and been enrolled for benefits. Enrollee may also be referred to herein as Member or Program Member.
- S. **EPISODE-BASED PAYMENT.** Setting a single price for all services to providers and/or health care facilities for all services related to a specific procedure (e.g., hip replacement) or condition (maternity care). The payment is designed to improve value and outcomes by

using quality metrics for provider accountability. Providers may assume financial risk for the cost of services for a particular procedure/condition and related services for a specified time period, as well as costs associated with preventable complications.

- T. This provision left intentionally blank.
- U. **GROUP HEALTH PROGRAM.** See the definition of Program and Group Health Program.
- V. **GROUP IDENTIFICATION NUMBER (GID).** The identifying number assigned to the State or subgroups of the State.
- W. **HOSPITAL.** A facility which provides medical or surgical care to patients for a continuous period longer than twenty-four (24) hours and which is not primarily providing psychiatric, rehabilitative, drug or alcoholism treatment.
- X. **IMPROVEMENT GOALS.** The Contractor's annually defined objectives to improve the value generated to the State and Enrollees, including to satisfy the requirements of the Contract. Such Improvement Goals are based on the State's and the Contractor's identification of opportunities for improvement in the Contractor's management of health services to successfully meet the Value-Based Purchasing Specifications (contained in **Appendix A**).
- Y. **LINES OF COVERAGE.** The benefit plans, such as HMO, POS, or PPO, available to Enrollees under this Agreement, as determined by the Benefit Booklet.
- Z. **MEASURE.** The means by which the State determines the Contractor's compliance with the Purchasing Specifications and achievement of the Contractor's annual Improvement Goals. A Measure should be defined in quantitative terms whenever possible, with both 6-month and 12-month targets.
- AA. **MEDICAL TREND.** Medical Trend is the increase in average cost from one measurement period to the next and the full definition is outlined in the calculation methodology herein.
- BB. **PAID CLAIM.** The amount charged to the State for Covered Services or services provided during the term of this Agreement. Paid Claims shall also include any applicable interest, Claim surcharges or other surcharges assessed by a state or government agency and any Claims paid pursuant to pilot or test programs as described more fully in Article 2(g). Paid Claims shall be determined as follows:
  - 1. **Hospital, Provider and Subcontractor Claims.** Except as otherwise provided in this Agreement, Paid Claims shall mean the amount the Contractor actually pays the Hospital, Provider or Subcontractor (whether the Contractor reimburses a Hospital on a percentage of charges basis, a fixed payment basis, or a global fee basis, etc. or whether such amount is more or less than the Hospital's, Provider's or Subcontractor's actual Billed Charges for a particular service or supply). In the event that the Hospital, Provider, or Subcontractor participates in any the Contractor program where performance incentives or bonuses are paid (the "Performance Payments"), Paid Claims shall also mean an amount the Contractor adds to the Hospital, Provider, or Subcontractor payment for services or supplies under the terms of that program designed to reward for effectively managing the care of Enrollees. Such Performance Payments may be added on a per claim, lump sum, per Enrollee, or per

Member basis or on a pro-rata apportionment. The amount charged to the State may be greater than the amount actually paid to any one particular Provider or Subcontractor pursuant to the terms of the contract with such Provider or Subcontractor. In no event shall the amount charged to the State be greater than its proportionate share of total Performance Payments. Paid Claims may also include a portion of the Contractor's negotiated discounts with Hospitals, Providers or Subcontractors. Paid Claims may also include fees paid to Providers or Subcontractors for managing the care or cost of care for Enrollees. In addition, Paid Claims may also include an amount the Contractor charges to oversee programs. The parties shall meet to negotiate in good faith if the State's participation in these the Contractor programs described herein will result in an additional administrative charge.

2. Providers or Subcontractors Reimbursed on a Capitated Basis. Paid Claims shall mean the amount per Member per month which the Contractor actually pays the Provider or Subcontractor, Irrespective of whether services are actually rendered to Enrollees, plus any portion of the capitation or percent of premium equivalent that is retained by the Contractor to fund Performance Payments designed to support effective quality and utilization or reward Providers or Subcontractors for effective management under the terms of the contracts with such Providers and Subcontractors. Paid Claims shall also include any sums paid to a Provider as administrative fees charged by and retained by the Contractor to manage the Providers or Subcontractors. The State acknowledges and agrees that a portion of the amounts discussed in this paragraph may be retained or withheld by the Contractor and that, as a result, the capitation fee or percent of the premium equivalent charged to the State may be greater than the fees actually paid to the Providers or Subcontractors pursuant to the terms of the contracts with such Providers or Subcontractors. The parties shall meet to negotiate in good faith if the State's participation in these Contractor programs described herein will result in an additional administrative charge.
3. Claims Payment Pursuant to any Judgment, Settlement, Legal or Administrative Proceeding. Paid Claims shall include any amount paid as the result of a settlement, judgment, or legal, regulatory or administrative proceeding brought against the Program and/or the Contractor with respect to the decisions made by the Contractor, which are authorized by the Agreement or otherwise approved by the State, regarding the coverage of services under the terms of the Program, as well as any legal fees and costs awarded to any adverse party or incurred by the Contractor in such litigation, regulatory or administrative proceeding. Paid Claims also includes any amount paid as a result of the Contractor's billing dispute resolution procedures.
4. Claims Payment Pursuant to Inter-Plan Programs and other BCBSA Programs. Paid Claims shall include any amount paid for Covered Services that are processed through Inter-Plan Programs or for any amounts paid for Covered Services provided through another BCBSA program (e.g., BCBSA Blue Distinction Centers for Transplant). More information about the Inter-Plan Program is found in Article 12 of this EXHIBIT A.

CC. **PARTICIPATING PROVIDER.** A physician, health professional, hospital, pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with the Contractor to provide Covered Services to Enrollees at negotiated fees.

- DD. **PATIENT-CENTERED MEDICAL HOME.** The patient-centered medical home (PCMH) is a model of care that aims to transform the delivery of comprehensive primary care to children, adolescents, and adults. Through the medical home model, practices seek to improve the quality, effectiveness, and efficiency of the care they deliver while responding to each patient's unique needs and preferences. (source: AAFP)
- EE. **POPULATION-BASED PAYMENT.** A comprehensive payment to a group of providers to account for all or most of the care that will be received by a group of patients for a defined period of time.
- FF. **PRIMARY CARE CLINICIAN.** A Provider who focuses his or her practice on the provision of primary care; a Primary Care Clinician may include pediatricians, family physicians, nurse practitioners, internists, and based on a Plan Participant's diagnoses, may also include a specialty physician upon agreement by that physician and approval by the Contractor.
- GG. **PROGRAM and GROUP HEALTH PROGRAM.** The employee and retiree health benefit program established by the State, in effect during the Agreement Period, as it may be amended from time to time.
- HH. **PROGRAM ADMINISTRATOR.** The Program Administrator is the State.
- II. **PROGRAM DOCUMENTS.** The documents that set forth the terms of the Program, which documents include the Benefit Booklet.
- JJ. **PROVIDER.** A duly licensed person, organization or facility that provides health services or supplies within the scope of an applicable license and meets any other requirements set forth in the Benefit Booklet.
- KK. **SHARED RISK.** A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending, but also puts them at financial risk for any overspending. Shared risk provides both an upside and downside financial incentive for providers or provider entities to meet quality targets and to reduce unnecessary spending for a defined population of patients or an episode of care.
- LL. **STATISTICALLY SIGNIFICANT.** The likelihood that a desired change in performance results from chance is no more than 10%. For the purpose of assessing whether Anthem's performance improvement on selected quality measures was statistically significant, the State and Anthem shall apply a one-tailed significance test to assess whether performance improved. A t-test should be applied to determine whether improvement occurred at a level of  $p \leq .10$ .
- MM. **SUBCONTRACTOR.** A person or entity other than a Provider or an affiliate of the Contractor that provides services pursuant to a written contract with the Contractor.
- NN. **SUBSCRIBER or PROGRAM SUBSCRIBER.** An employee or retiree of the State or other eligible person (other than a dependent) who is enrolled in the Program.
- OO. **VALUE-BASED PURCHASING SPECIFICATIONS.** A detailed description of performance requirements and Measures. The Purchasing Specifications are contained in Appendix A.

## ARTICLE 2 - ADMINISTRATIVE SERVICES PROVIDED BY THE CONTRACTOR

- A. The Contractor shall administer the enrollment of eligible persons and termination of Enrollees as directed by the State, subject to the provisions of this EXHIBIT A. The Contractor shall, with the assistance of the State, respond to all direct routine inquiries made to it by employees and other persons concerning eligibility in the Program. Unless otherwise specifically provided in the Benefit Booklet or under this Agreement, the Contractor shall apply its standard administrative practices and procedures and enrollment policies, which may be revised or modified from time to time, in connection with the performance of its responsibilities hereunder.
- B. Due to the existence of collective bargaining agreements and required legislative authorization, The Contractor shall modify the active and retiree benefits or plan designs as directed by the State at any time during the term of this agreement.
1. The Contractor shall administer the current Active Employee Point of Service (POS) plan and the current Active Employee Health Maintenance Organization (HMO) plan with no benefit or plan design deviations.
  2. The Contractor shall administer the non-Medicare Retiree POS plan and non-Medicare PPO plan with no benefit or plan design deviations. Anthem agrees to offer two plans available to non-Medicare Retirees; BlueChoice New England POS plan, intended for retirees who maintain full or part-time residence in New England, and Preferred Blue PPO plan, intended for retirees residing full-time outside of New England. Benefits, cost-sharing and premium contributions will be equal under these plans.
  3. The Contractor shall administer the supplemental Medicare Retiree (MediComp) plan with no benefit or plan design deviations.
  4. The Contractor will process enrollment files received from the State as mutually agreed to.
- C. At no additional cost to the State, the Contractor shall agree to work with the State and/or the State's designated data management team for EDI 834 data interface file production and/or other data transfer matters. Any changes to the standard file format will be as specified by the State.

The Contractor agrees to accept and process an Interface file from the State twice per week, on dates agreed upon by the State and Contractor, to ensure timely subscriber eligibility and enrollments. Upon acceptance of the file by the Contractor, the Contractor agrees to process each file within 24 business hours of receipt of file.

The Contractor agrees to comply with State's requests for implementing subscriber division reporting and grouping under each Plan policy number assigned by the Contractor for billing and tracking purposes. The Contractor agrees to work with the State to add, subtract or make other changes to division or agency groups under each Plan, at any time as identified as necessary by the State during the Agreement period. The successful Contractor shall collaborate with the State when reviewing current systems and processes and make recommendations for improvement.

The State's standard is to exchange data with its contractors using the State of New Hampshire's Secure File Exchange Server. This Secure File Exchange Server is password protected and accessible by designated, State-approved Contractor staff via Internet access. All data files on this server are encrypted while at rest. The data stays protected until downloaded by the receiver. Unless otherwise mutually agreed upon, contractors are required to retrieve eligibility and enrollment data, from this server. In addition, contractors and/or subcontractors will be required to use this method for sending/receiving any other agreed upon data files to the State.

D. Site of Service Provision

The Contractor shall offer the option for eligible members to avoid paying the deductible for covered services if the member chooses to use an approved Site-of-Service (SOS) lab or Ambulatory Surgery Center, or other service provider as directed by the State. The Contractor agrees to offer SOS locations in all geographic regions of the State. The Contractor shall work with the State to promote the SOS program to increase utilization and cost savings. The Contractor shall provide the State with semi-annual reports on SOS provider utilization and cost comparison to non-SOS providers on a year over year basis or as otherwise directed by the State.

E. "Vitals SmartShopper" Program

The Contractor shall provide a voluntary employee incentive program that offers taxable cash payments to employees and non-Medicare retirees who utilize cost-effective health care providers. The Contractor shall provide the State with reports on utilization and cost savings on a year over year basis or as otherwise directed by the State.

F. The Contractor shall perform the following Claims administration services:

1. Process Claims with a Claim Incurred Date during the Agreement Period, including investigating and reviewing such Claims to determine what amount, if any, is due and payable with respect thereto in accordance with the terms and conditions of the Benefit Booklet, and this Agreement. In processing Claims, the Contractor shall perform coordination of benefits ("COB") services, and the State hereby authorizes the Contractor to perform such services in accordance with the Contractor's standard policies, procedures and practices which may be revised or modified from time to time, unless alternative provisions for COB are indicated in the Benefit Booklet.
2. In connection with its Claims processing function, disburse to the person or entities entitled thereto (including any Provider and Subcontractor entitled to payment under an appropriate contract with the Contractor or otherwise under the terms of the Benefit Booklet) payments that it determines to be due in accordance with the provisions of the Benefit Booklet. If applicable to the Program benefits as indicated in EXHIBIT B to this Agreement, the Contractor may utilize its standard medical policy, utilization management and quality improvement policies, case management and administrative practices and procedures (including any Claims bundling procedures) which may be revised or modified from time to time to determine benefit payments.

- G. The State designates the Contractor to serve as a fiduciary solely to determine claims for benefits under the Plan and authority to determine appeals of any adverse benefit determinations under the Plan. The Contractor shall have all the powers necessary and appropriate to enable it to carry out its Claims appeal processing duties. This includes, without limitation, the right and discretion to interpret and construe the terms and

conditions of the Program benefits described in the Benefit Booklet, subject to the Claims review provisions as described in this Agreement. The Contractor's interpretation and construction of this Agreement and Benefit Booklet in the course of its processing of any appeal of an adverse benefit determination shall be binding upon the Program, the State, and Enrollees. The Contractor shall be deemed to have properly exercised such authority unless an Enrollee proves that the Contractor has abused its discretion or that its decision is arbitrary and capricious. The State designates the Contractor to undertake fiduciary responsibilities exclusively in connection with the processing of appeals of adverse benefit determinations. The Contractor and the State agree that the Contractor shall not act as the administrator of the Plan and shall have no fiduciary responsibility in connection with any other element of the administration of the Program.

- H. The Contractor shall administer complaints, appeals and requests for independent review according to any applicable law and regulations and the Contractor's complaint and appeals policy, unless the Benefit Booklet provides otherwise. Enrollees shall be provided with a mandatory first level internal appeal, a voluntary second level internal appeal, and provided a mandatory first level appeal has been completed, an independent External Review of eligible adverse benefit determinations pursuant to federal law. The Contractor shall provide External Review services which are comparable to those offered to residents of New Hampshire according to RSA 420-J:5-a *et seq* and in compliance with federal law applicable to *governmental* group health plans. In addition, the Contractor reserves the right to exclude any such extra-contractual payments from performance guarantee calculations
- I. The Contractor shall have the authority to build and maintain its Provider network. The Contractor shall administer referral, authorization or certification requirements. The Contractor shall also have the authority to waive any such referral, authorization or certification requirement if such waiver will not adversely impact the effective and efficient Claims administration. In addition, the Contractor shall have the authority to change its administrative practices and procedures which it deems are necessary or appropriate for the effective utilization and administration of Covered Services. The Contractor shall provide the State with advance notice as practicable of any material change to any of its practices and/or procedures contemplated in this paragraph G. In addition, the Contractor shall provide notice to the State of the number and identity of the Enrollees impacted by such change (See Exhibit F - Value-Based Purchasing).
- J. If applicable to the Program benefits and as indicated in EXHIBIT B of this Agreement, and after consultation with and approval from the State, the Contractor shall have the authority, in its discretion, to institute from time to time, pilot or test programs regarding case management, disease management or health improvement and wellness services which may result in the payment of benefits not otherwise specified in the Benefit Booklet. The Contractor reserves the right to discontinue a pilot or test program at any time with advance notice.
- K. In the event that the Contractor determines that it has paid a Claim in an amount less than the amount due under the Benefit Booklet, the Contractor will promptly adjust the underpayment. If it is determined by the Contractor or the State that any benefit payment has been made for an ineligible person, that an overpayment has been made, or that a sum is due to the State under the coordination of benefits or subrogation provisions, the Contractor will make reasonable efforts to collect such amounts but shall not be required to initiate or maintain any judicial proceeding to make the recovery as described in Article 18 of this EXHIBIT A. The Contractor shall, during the term of this

Agreement, refund to the State any overpaid amounts only if the Contractor successfully recovers such amounts.

In the event the Contractor discovers a systemic claims processing error that results in the payment of claims that does not conform to the State's benefit design, the Contractor, upon discovering such error, shall notify the State about the claims processing error including type of claims, total number of claims paid, and total amount of claims paid. If applicable, the Contractor shall readjudicate such systemic claims processing errors to reimburse the State for the erroneous paid claims.

In the event the Contractor makes a systemic change in coverage levels that results in payment of claims prior to notification being provided to the State of the change, the Contractor, upon discovering such change in coverage level, shall notify the State about the change in coverage and how the claims will be paid including type of claim, total number of claims paid, and total amount of claims paid prior to notification.

- L. Upon request the Contractor shall provide the State with information about the Contractor's recovery programs and the success of those programs.
- M. The Contractor shall respond to inquiries by Enrollees regarding Claims for benefits under the Program.
- N. The Contractor shall provide a designated customer service representatives that are knowledgeable of the State's plan via a toll-free phone number to be answered by a live person in the United States from, at a minimum, weekday hours from 8AM to 8PM ET Monday to Thursday and 8AM to 5PM ET on Fridays, year round and shall provide customer service on all dates that are recognized as work days for state employees. In addition, the State's members can email the Customer Service team at any time.

The Contractor shall provide 24 hour a day access to an Interactive Voice Response system (IVR). Members shall be able to request a facsimile be sent to them with the information requested via the IVR by entering their fax number when prompted. Faxes should be sent immediately after the call. Through the IVR, members shall be able to:

- Obtain medical eligibility and benefit information
- Request member ID cards
- Request EOB forms
- Order claim forms
- Request a provider directory

For non-emergent health-related questions, the State's members shall have access to a 24/7 NurseLine or access to a healthcare provider via an online telemedicine application or website (like LiveHealth Online) for guidance on caring for acute conditions and behavioral health services.

The Contractor must have a timely and organized system(s) for resolving Members' complaints and formal grievances. The Contractor must inform members through the Benefit Booklet about services provided, access to services, charges, and scheduling, and must be in compliance with all State and Federal laws that are required of self-insured plans. The Booklet describes the translation services available to non-English

speaking Members. Member information must be comprehensible and well-designed as determined by the State.

- O. In processing Claims in accordance with the Benefit Booklet, the Contractor shall provide notice in writing when a Claim for benefits has been denied, setting forth the reasons for the denial, the right to a full and fair review of the denial under the terms of the Program, and otherwise satisfying applicable regulatory requirements governing notice of a denied Claim.
- P. This provision left intentionally blank.
- Q. The Contractor shall issue identification cards to each Enrollee, unless otherwise agreed upon by the Contractor and the State. Web Online Enrollment and Employer Access tools are available for the State to request ID Cards as well as print temporary ID Cards as needed in "real time". Such identification cards shall be for the administration of Enrollees' health care benefits under the Program only.
- R. The Contractor shall provide certificates of creditable coverage as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") with respect to Enrollees' participation in the Program for which the Contractor provides services, unless otherwise instructed by the State. The State agrees to provide the Contractor, within a reasonable timeframe, with any information relating to a Subscriber's employment history as may be necessary for the Contractor to provide the certificates of creditable coverage.
- S. The Contractor shall provide the State access to an online directory of providers contracted with the Contractor ("Provider Directories"). Such Provider Directories shall also be available and distributed in booklet format upon the State's request.  
  
The Provider Directories shall contain information such as medical specialty, office addresses and telephone number(s).
- T. The Contractor shall provide the State with information necessary to enable Enrollees to effectively access Program benefits described in the Benefit Booklet, including, but not limited to, Claim forms and Claim filing instructions.
- U. The Contractor reserves the right to make benefit payments to either Providers or Subscribers. The State agrees that during the Agreement Period, the terms of the Program will provide for such discretion in determining the direction of payment (including, but not limited to, the inclusion of a provision in the Program that an Enrollee may not assign rights to receive payment under the Program).
- V. The Contractor is the responsible reporting entity ("RRE") for the Plan as that term is defined pursuant to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. In order to fulfill its RRE obligation, the Contractor requires information from the State, including, but not limited to, Member Social Security Numbers. State shall cooperate with the Contractor and timely respond to any request for information made by the Contractor.
- W. The Contractor will provide the State with Summary of Benefits and Coverage ("SBC") accurately reflecting plan information related to the elements of the Plan that The Contractor administers. The Contractor will provide assistance in the preparation of the

SBC. The State is responsible for ensuring the accuracy of the SBC and for finalizing and distributing SBCs to subscribers. Notwithstanding the provisions in Article 20, if the State's open enrollment period is at a time other than 30 days prior to the end of an Agreement Period, the State agrees to provide the Contractor with any changes to the benefits the Contractor administers as soon as administratively possible prior to the start of the open enrollment period.

- X. If applicable to the Program benefits and as Indicated in EXHIBIT B to this Agreement, the Contractor will provide or arrange for the following managed care services. The Contractor may subcontract managed care services to another entity without the prior approval of the State. Managed care services shall include, but are not limited to:
1. Conduct utilization review. Such review may include preadmission review to evaluate and certify the medical necessity of an admission or procedure and appropriate level of care, and to authorize an initial length of stay for inpatient admissions, with concurrent review throughout the admission for certification of additional days of care as warranted by the patient's medical condition.
  2. Provide access to a specialty network of Providers if the Program includes a specialty network. The Contractor reserves the right to establish specialty networks for certain specialty or referral care.
  3. Provide any other managed care services incidental or necessary to perform the services set forth in Article 2 or other managed care services, including the right to make benefit exceptions from time to time on a case by case basis.
- Y. If a catastrophic event (whether weather-related, caused by a natural disaster, or caused by war, terrorism, or similar event) occurs that affects Members in one or more locations, and such catastrophic event prevents or interferes with the Contractor's ability to conduct its normal business with respect to such Members or prevents or interferes with Members' ability to access their benefits, the Contractor shall have the right, without first seeking consent from the State, to take reasonable and necessary steps to process Claims and provide managed care services in a manner that may be inconsistent with the Benefits Booklet in order to minimize the effect such catastrophic event has on Members. As soon as practicable after a catastrophic event, the Contractor shall report its actions to the State. The State shall reimburse the Contractor for amounts paid in good faith under the circumstances and such amounts shall constitute Paid Claims, even if the charges incurred were not for services otherwise covered under the Benefits Booklet.
- Z. Upon request of the State, the Contractor will produce and maintain a master copy of the Benefit Booklet. The Contractor shall make changes and amendments to the master copy of the Benefit Booklet and within 30-days of notice of the change shall incorporate the approved changes or amendments pursuant to Article 10 of this EXHIBIT A.
- AA. Upon written request, the Contractor will provide the State with Program data and assistance necessary for preparation of the State's information returns and forms required by federal or state laws. The Contractor shall prepare and mail all IRS Form 1099's and any other similar form that is given to Providers or brokers.
- BB. The Contractor shall have the authority to build and maintain its Provider network. Nothing in this Agreement shall be interpreted to require the Contractor to maintain

negotiated fees or reimbursement arrangements or other relationships with certain Providers or Subcontractors. The Contractor shall notify the State as soon as practicable in advance of or following termination of a facility and related physician(s) affecting State membership so that the State can proactively provide notice to the State's stakeholders. The Contractor shall provide the State with an impact analysis.

Subject to Exhibit F and Appendix A, the Contractor will be solely responsible for acting as a liaison with Providers including, but not limited to, responding to Provider Inquiries, negotiating rates with Providers or auditing Providers. The Contractor has oversight responsibility for compliance with Provider and Subcontractor contracts, including discount and multi-year compliance audits. The Contractor shall have authority to enter into a settlement or compromise regarding enforcement of these contracts. The State acknowledges and agrees that the Contractor shall retain any recoveries made from a Provider or Subcontractor resulting from these audits if the total recovery from one Provider or Subcontractor with respect to all of the Contractor's group-sponsored health benefit plans is \$1,000 or less.

- CC. If the Contractor retains outside Subcontractors, auditors, or counsel to conduct audits or reviews of or to enforce Provider or Subcontractor contracts or activities, and recoveries or cost avoidance is a result of such audits, reviews or enforcement activities, then the Contractor shall provide the State a credit, after a reduction in such recovery or cost avoidance amount of its expenses and a five percent (5%) fee. The Contractor shall credit the State a proportionate share of the net recovery equal to the ratio of (1) Enrollees' Paid Claims to such Provider or Subcontractor for the audit/review period, to (2) all Paid Claims to such Provider or Subcontractor for the audit/review period. The State acknowledges and agrees to the Contractor's retention of such 5% fee, and agrees that the fee will be charged on all recoveries or cost avoidance resulting from such audits, reviews or enforcement activities, including audits or reviews of Claims incurred prior to the Agreement Period.

The Contractor shall provide the State with a summary report of all audits of NH providers/Subcontractors. The report shall include information about recoveries and any fees charged to the State.

- DD. The Contractor agrees to provide a dedicated resource to assist the State with member eligibility and enrollment, claim system and data issues that may arise during the term of this Agreement.
- EE. The obligations, responsibilities, promises and statements as to scope of services to be provided contained in the Contractor's Response to the State's Request for Proposal (RFP), is incorporated as if fully set forth herein (see EXHIBIT D). In the event of a conflict between the RFP responses (EXHIBIT D) and this Agreement, this Agreement shall control.
- FF. The Contractor shall be responsible for any initial notice, open enrollment communication, election form, collection of fees, or communication regarding Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), or any other applicable law governing continuation of health care coverage. The Contractor shall provide the State with monthly COBRA premium reports by division.

Select state laws require employers to finance health related initiatives through residency-based assessments and/or surcharges added to certain Paid Claims. After the State completes the applicable forms, the Contractor shall make all assessment and/or

surcharge payments on behalf of the State to the appropriate pools administered by the respective states, based primarily upon the Contractor's Paid Claims information and Member information provided to the Contractor by the State. Examples of such assessments and surcharges include but are not limited to, the Massachusetts Health Safety Net Trust Fund, the New York Health Care Reform Act and the Michigan Health Insurance Claims Assessment Act.

- GG. Healthcare Reform Initiatives: the Contractor shall actively support such payment reform and other initiatives undertaken by the State of New Hampshire Employee and Retiree Health Benefit Program to control costs and improve the quality of health care in New Hampshire as may be reasonably requested by the State.

### ARTICLE 3 - OBLIGATIONS OF STATE

- A. The State, or its subcontractor, shall furnish to the Contractor initial information regarding Enrollees. The State is responsible for determining eligibility of persons and advising the Contractor in a timely manner, through a method agreed upon by the Contractor, including eligibility reports, electronic transmissions and individual applications, as to which employees, dependents, and other persons are to be enrolled Enrollees. The State shall keep such records and furnish to the Contractor such notification and other information as may be required by the Contractor for the purpose of enrolling Enrollees, processing terminations, effecting COBRA coverage elections, effecting changes in single or family contract status, effecting changes due to an Enrollee becoming eligible for Medicare, effecting changes due to an Enrollee becoming disabled or being eligible for short-term or long-term disability, determining the amount payable under this Agreement, or for any other purpose reasonably related to the administration of this Agreement.

The Contractor will have no obligation to pay Claims for persons no longer eligible for coverage. Further, if the Contractor has paid Claims for persons no longer eligible because the Contractor was provided inaccurate eligibility information, the Contractor did not receive timely notification of termination, or the Contractor received notice of a retroactive change to enrollment, then State shall reimburse the Contractor for all unrecovered amounts it has paid on Claims. In the event that the State has already reimbursed the Contractor for such unrecovered amounts paid on Claims, no further sums are owed under this Article 3(A).

The Contractor reserves the right to limit retroactive changes to enrollment to a maximum of sixty (60) days from the date notice is received unless otherwise requested by the State. Acceptance of payment of fees from the State or the payment of benefits to persons no longer eligible will not obligate the Contractor to continue to administer benefits.

- B. In determining any individual's right to benefits under the Benefit Booklet, and in performing its other obligations as set forth in Article 2, the Contractor shall rely on eligibility information furnished by the State. It is mutually understood that the effective performance of this Agreement by the Contractor will require that it be advised on a timely basis by the State during the term of this Agreement of the identity of employees, dependents, and other persons eligible for benefits under the Program. Such information shall identify the effective date of eligibility and the termination date of eligibility and

shall be provided in accordance with the terms of this Agreement with such other information as may reasonably be required by the Contractor for the proper administration of Program benefits described in the Benefit Booklet. The State acknowledges that prompt and complete furnishing of the required eligibility information is essential to the timely and efficient administration by the Contractor of Claims.

- C. The State acknowledges that it serves as Program Administrator, and shall have all discretionary authority and control over the management of the Program, and all discretionary authority and responsibility for the administration of the Program except as provided in Article 2 (D) of this Agreement. The Contractor does not serve either as Program Administrator or as a Named Fiduciary of the Program other than as a fiduciary for processing appeals of Claims. All functions, duties and responsibilities of the Contractor are governed exclusively by this Agreement and the Benefit Booklet.
- D. This provision left intentionally blank.
- E. The State acknowledges that it is the State's sole responsibility, and not the Contractor's, to comply with the Family and Medical Leave Act ("FMLA") in connection with certain Subscribers on leave.
- F. The State agrees to and shall notify Subscribers of their right to apply for health benefits and make available to them Claim forms and Claim filing instructions. Claim forms and Claim filing instructions shall also be supplied to the Enrollees by the Contractor upon request.
- G. The State agrees to and shall notify all Subscribers in the event of termination of this Agreement.
- H. This provision left intentionally blank.
- I. The Parties shall agree upon the terms of the Benefit Booklet to be provided to Enrollees. Material changes and/or modifications to the Benefit Booklet shall be made according to Article 10. The State shall be responsible for making Benefit Booklets available to Subscribers and Enrollees.
- J. The State shall prepare and is responsible to make all governmental filings.
- K. The State shall reimburse the Contractor for all payments made on behalf of the State pursuant to demand letters forwarded by the Centers for Medicare and Medicaid Services (CMS) or other government agency to recover a refund when Medicare has erroneously paid as the primary coverage.
- L. This provision left intentionally blank.
- M. The Parties agree during the implementation period to collaborate and establish protocols and processes for managing dependent eligibility, including such things as "qualified" medical child support orders, as more fully set forth in paragraph N below, and the age when dependents "age-off" the State's Program.
- N. The State shall have the responsibility to develop procedures and determine if a medical child support order is a "qualified" medical child support order, and shall perform all

administration relating to such determinations, including providing all appropriate notifications to the Contractor.

- O. The State is responsible for complying with all unclaimed property or escheat laws, and for making any required payment or filing any required reports under such laws.
- P. The State shall provide or designate others to provide all other services required to operate and administer the Program that is not expressly the responsibility of the Contractor under this Agreement.

#### **ARTICLE 4 - CLAIMS PAYMENT METHOD**

- A. The State shall pay the Contractor for Paid Claims according to the Claims Payment Method described in Section 3 of EXHIBIT B. In addition, from time to time, the Parties acknowledge that the appropriateness of a Claim payment may be reviewed. During the course of the period of time for review, the Contractor shall not hold the Claim payment and the State shall reimburse the Contractor for such Claim payment.
- B. The Parties acknowledge that, from time to time, a Claims adjustment is necessary as a result of coordination of benefits, subrogation, workers' compensation, payment errors and the like, and that the adjustment takes the form of a debit (for an additional amount paid by the Contractor) or a credit (for an amount refunded to the Contractor). The Parties agree that such Claims adjustments shall be treated as an adjustment to the Claims payment made in the billing period in which the adjustment occurs, rather than as a retroactive adjustment to the Claim as initially paid. No Claims adjustment shall be made beyond the Claims Runout period following termination of this Agreement or conclusion of the claims audit process, whichever is later.

#### **ARTICLE 5 - ADMINISTRATIVE SERVICES FEE**

- A. The State shall pay the Contractor the Administrative Services Fee, as described in EXHIBIT B, during the term of this Agreement.

#### **ARTICLE 6 - CLAIMS RUNOUT**

- A. The Contractor shall pay the Claims Runout for the period of time described in Section 5 of EXHIBIT B. Following termination of this Agreement, the terms of this Agreement shall continue to apply with respect to the processing and payment of such Claims Runout and Administrative Services Fee. The State acknowledges and agrees that the Contractor shall have no obligation to process or pay any Claims Runout or return Claims filed with the Contractor to the State beyond the Claims Runout period designated in Section 5 of EXHIBIT B, including any Claims incurred by a Enrollee under a continuation of coverage provision of the Benefit Booklet, and the State acknowledges and agrees that any amounts recovered beyond the Claims Runout period shall be retained by the Contractor.
- B. This provision intentionally left blank.

- C. This provision intentionally left blank.

#### **ARTICLE 7 - INTEREST CHARGES**

- A. This Article intentionally left blank.

#### **ARTICLE 8 - RENEWAL SCHEDULES**

- A. The State reserves the right, during the second and third Terms of the Agreement Period, to implement other retiree coverages and/or programs for its eligible retirees which may be administered in whole or in part by administrators other than the Contractor.

#### **ARTICLE 9 - NOTICES**

- A. This Article left intentionally blank.

#### **ARTICLE 10 - CHANGES IN THE BENEFIT BOOKLET AND AGREEMENT**

- A. The Contractor and the State shall agree upon any changes to the Benefit Booklets that may be necessary and/or in the best interest of Enrollees. In the event changes to the provisions of the Benefit Booklet are mandated as a result of a change to any state and/or federal law, the Parties shall meet and determine the best manner to change the terms of the Benefit Booklets to conform to such law. In the event of material changes to a Benefit Booklet, the State will provide timely notice of such changes to Enrollees.
- B. Upon the occurrence of one or more of the following events: (1) a change to the Plan benefits initiated by the State that results in a substantial change in the services to be provided by the Contractor; (2) a change in the total number of Members resulting in either an increase or decrease of 10% or more of the number of Members enrolled for coverage on the date the Administrative Services Fee was last modified; (3) a change in the State contribution (4) a change in applicable law that results in a material increase in the cost of administrative services from those currently being provided by the Contractor under this Agreement, the Parties shall meet to negotiate in good faith a corresponding adjustment in the Administrative Services Fee and such adjustment shall be made in accordance with Article 18 of the P-37. To the extent that the parties are unable to come to a mutually agreeable adjustment to the Administrative Services Fee, either Party shall have the right to terminate this Agreement by giving written notice of one hundred and twenty (120) days.
- C. No change to a Benefit Booklet shall be effective unless and until approved in writing by an authorized representative of the Contractor and the State.

## ARTICLE 11 - TERMINATION AND/OR SUSPENSION OF PERFORMANCE

- A. This Article left intentionally blank.

## ARTICLE 12 – INTER-PLAN ARRANGEMENTS

- A. **Out of Area Services.** Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Claims for certain services may be processed through one of these Inter-Plan Programs and presented to Anthem for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this Agreement are described generally below. Typically, Members' Claims are processed through an Inter-Plan Program when Members obtain care from health care Providers that have a contractual agreement (i.e., are "Network Providers") with a local Blue Cross and/or Blue Shield Licensee ("Host Blue"). In some instances, Members may obtain care from non-Network Providers. Anthem's payment practices in both instances are described below.
- B. **BlueCard® Program.** Under the BlueCard® Program, when Members access Covered Services within the geographic area served by a Host Blue, Anthem will remain responsible to the State for fulfilling Anthem's contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its Network Providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, Anthem's action will be consistent with the spirit of this description.
1. **Liability Calculation Method Per Claim.** The calculation of the Member liability on Claims for Covered Services processed through the BlueCard Program will be based on the lower of the Network Provider's Billed Charges or the negotiated price made available to Anthem by the Host Blue.

The calculation of the State liability on Claims for Covered Services processed through the BlueCard Program will be based on the negotiated price made available to Anthem by the Host Blue. Sometimes, this negotiated price may be greater than Billed Charges if the Host Blue has negotiated with its Network Provider(s) an inclusive allowance (e.g., per case or per day amount) for specific health care services. Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's health care Provider contracts. The negotiated price made available to Anthem by the Host Blue may represent a payment negotiated by a Host Blue with a health care Provider that is one of the following:

- a. **An actual price.** An actual price is a negotiated payment without any other increases or decreases, or
- b. **An estimated price.** An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries,

Provider refunds not applied on a Claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or

- c. **An average price.** An average price is a percentage of Billed Charges representing the aggregate payments negotiated by the Host Blue with all of its health care Providers or a similar classification of its Providers and other Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for Claims already paid to Providers or anticipated to be paid to or received from Providers). However, the amount paid by the Member and the State is a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims. The BlueCard Program requires that the price submitted by a Host Blue to Anthem is a final price irrespective of any future adjustments based on the use of estimated or average pricing. If a Host Blue uses either an estimated price or an average price on a Claim, it may also hold some portion of the amount that the State pays in a variance account, pending settlement with its Network Providers. Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from the State. Such payable or receivable would be eventually exhausted by health care Provider settlements and/or through prospective adjustment to the negotiated prices. Some Host Blues may retain interest earned, if any, on funds held in variance accounts.

A small number of states require Host Blues either (i) to use a basis for determining Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular Claim, or (ii) to add a surcharge. Should the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Anthem would then calculate Member liability and the State liability in accordance with applicable law.

2. **Return of Overpayments.** Under the BlueCard Program, recoveries from a Host Blue or its Network Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care Provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a Claim-by-Claim or prospective basis.

- C. **Negotiated National Account Arrangements.** As an alternative to the BlueCard Program, Member Claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue. For purposes of this Article, a "National Account" is the State that has membership in more than one state.

If Anthem and the State have agreed that (a) Host Blue(s) shall make available (a) custom health care Provider network(s) in connection with this Agreement, then the

terms and conditions set forth in Anthem's negotiated National Account arrangement(s) with such Host Blue(s) shall apply. In negotiating such arrangement(s), Anthem is not acting on behalf of or as an agent for the State, the Plan or Members.

The State agrees that Anthem will not have any responsibility in connection with the processing and payment of Claims when Members access such network(s), except as may be set forth in the relevant participation agreement.

**Member Liability Calculation.** Member liability calculation will be based on the lower of either Billed Charges or negotiated price made available to Anthem by the Host Blue that allows Members access to negotiated participation agreement networks of specified Network Providers outside of Anthem's service area.

**D. Non-Network Providers Outside Anthem's Service Area.**

1. **Member Liability Calculation.** When Covered Services are provided outside of Anthem's service area by non-Network Providers, the amount a Member pays for such services will generally be based on either the Host Blue's non-Network Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the Non-Network Provider bills and the payment Anthem will make for the Covered Services as set forth in this paragraph.

2. **Exceptions.** In some exception cases, Anthem may pay Claims from non-Network Providers outside of Anthem's service area based on the Provider's Billed Charges, such as in situations where a Member did not have reasonable access to a Network Provider, as determined by Anthem in Anthem's sole and absolute discretion or by applicable state law. In other exception cases, Anthem may pay such a Claim based on the payment it would make if Anthem were paying a non-Network Provider inside of Anthem's service area, as described elsewhere in this Agreement, where the Host Blue's corresponding payment would be more than Anthem's in-service area non-Network Provider payment, or in its sole and absolute discretion, Anthem may negotiate a payment with such a Provider on an exception basis. In any of these exception situations, the Member may be responsible for the difference between the amount that the non-Network Provider bills and the payment Anthem will make for the Covered Services as set forth in this paragraph.)

**E. Inter-Plan Program Fees and Compensation.** The State understands and agrees to reimburse Anthem for certain fees and compensation which it is obligated under BlueCard or any other Inter-Plan Program, to pay to the Host Blues, to the BCBSA, and/or to BlueCard or Inter-Plan Program subcontractors, as described below. Fees and compensation under BlueCard and other Inter-Plan Programs may be revised in accordance with the specific Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by any groups. Such revisions typically are made annually as a result of Program policy changes and/or subcontractor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with the Agreement Period. With respect to Negotiated National Account Arrangements, the participation with the Host Blue may provide that Anthem must pay an administrative and/or network access fee to the Host Blue. For this type of negotiated participation arrangement, any such administrative and/or network access fee will not be greater than the comparable fees that would be charged under the BlueCard Program.

### ARTICLE 13 – LIABILITY AND INDEMNITY

- A. This Article left intentionally blank.

### ARTICLE 14 – REPORTING, IT and DATA REPORTS

- A. **Data Reports.** Upon the State's request and as permitted by the Business Associate Agreement entered into between the Parties, the Contractor will provide data reports pursuant to the Contractor's standard reporting package. The Contractor's standard utilization reporting package is available online via Client Information Insights. In addition, the State will have access to reports such as:
1. A monthly accounting of Paid Claims paid by the Contractor in accordance with this Agreement and this EXHIBIT A and of payments to the Contractor for Administrative Services Fee and other costs, if any;
  2. A summary annual accounting of Paid Claims during the Agreement Period (Annual Claims Utilization Report) which were paid by the Contractor in accordance with this Agreement and EXHIBIT B and of payments to the Contractor of Administrative Services Fee and other costs during the Agreement Period and assistance in interpretation of such report will be provided within 90 days of the end of the contract year;
  3. A summary annual statement of Post-Settlement Amounts allocated to the State, if any, including the methodology used to determine the such allocation; and
  4. Additional reports mutually agreed to by the State and the Contractor. The Contractor shall also provide clinical and analytical reports and support in interpretation of same.
- B. **Call Center Reporting.** Call Center reporting will identify incoming calls that originated from the State's Program Staff and Agency HR Staff, and the associated metrics, including "issue type". These calls are considered escalated and should be included in general reporting by category, and should be segregated and reported as requested by the State.

Call Center reporting shall be delivered to the State quarterly and shall contain detailed reporting broken out by call type, allowing for meaningful analysis of the types of issues received as they relate to plan administration.

- C. **Ad-Hoc Requests.** The Contractor agrees to provide data to the State within three (3) business days for a standard request, and within seven (7) business days for the majority of ad-hoc requests (certain ad-hoc requests that require additional programming in order to access appropriate data may extend beyond this seven day period). Standard reports are existing reports that the Contractor can run by changing report parameters, of which such parameters are limited to incurred date, paid date and maximum dollar amount. Ad-hoc requests include non-standard reports, or reports entailing actuarial or

underwriting analysis. Such reports shall be provided by the Contractor at no additional cost to the State.

D. **Data Sharing.** The Contractor will also:

1. Receive pharmacy claims data feed from the State's Pharmacy Benefits Manager to be used as mutually agreed to by the State and Contractor.
2. Agrees to share member and claim information to designated third-parties as mutually agreed to by the State and the Contractor.

If the State requests the Contractor to provide a data extract or report to any third party engaged by the State (a "Plan Contractor") for use on the State's behalf, the Contractor agrees to do so:

- a) to the extent such extract or report includes protected health information ("PHI") as defined in HIPAA, the Contractor's disclosure of the PHI and Plan Contractor's subsequent obligations with respect to the protection, use, and disclosure of the PHI will be governed by the State's applicable business associate agreements with the Contractor and the Plan Contractor; and
- b) to the extent such data or report includes the Contractor's Proprietary Information and/or the Contractor's Confidential Information, the State acknowledges and agrees that the State shall protect the Contractor's proprietary and confidential information and any third party engaged by the State shall enter into a confidentiality agreement with the Contractor (or amend an existing one, as applicable) prior to the Contractor's release of the extract or report; and
- c) the State agrees not to contact, or to engage or permit a Plan Contractor to contact on the State's behalf, any Provider concerning the information in any reports or data extracts provided by the Contractor unless the contact is coordinated by the Contractor.
- d) in addition to their limited rights to use the Contractor's Proprietary Information and Confidential Information, the Contractor and the Contractor Affiliates shall also have the right to use and disclose other Claim-related data collected in the performance of services under this Agreement or any other agreement between the parties, so long as:
  - 1) The data is de-identified in a manner consistent with the requirements of HIPAA; or
  - 2) The data is used or disclosed for research, health oversight activities, or other purposes permitted by law. Contractor shall use appropriate safeguards to prevent use or disclosure of the information other than as provided for herein, and ensure that any agents or subcontractors to whom it provides such information agree to the same restrictions and conditions that apply to Contractor; or
  - 3) A Member has consented to the release of his or her individually identifiable data.

- 4) The data used or disclosed pursuant to subsections 1 through 3 above shall be used for a variety of lawful purposes including, but not limited to, research, monitoring, benchmarking and analysis of industry and health care trends.

#### **ARTICLE 15 - CLAIMS AUDIT**

- A. At the State's expense, the State shall have the right to audit Claims on the Contractor's premises, during regular business hours and in accordance with the Contractor's audit policy, which may be revised from time to time. A copy of the audit policy shall be made available to the State upon request.
- B. If the State elects to utilize a third-party auditor to conduct an audit pursuant to this Agreement and the Contractor's audit policy, the Contractor will agree to work with the third party auditor provided they are not paid on a contingency fee or other similar basis. An auditor or consultant must execute a confidentiality and Indemnification agreement with the Contractor pertaining to the Contractor's Proprietary and Confidential Information prior to conducting an audit.
- C. The State may conduct an audit once each calendar year and the audit may only relate to Claims processed during the current year or immediately preceding calendar year (the "Audit Period") and neither the State nor anyone acting on the State's or the Plan's behalf, shall have a right to audit Claims processed prior to the Audit Period. The scope of the audit shall be agreed to in writing by the Parties prior to the commencement of the audit. In the event a discrepancy in claims processing is discovered, the State reserves the right to request more detailed information that may span more than one audit period.
- D. The State shall provide to the Contractor copies of all drafts, interim and/or final audit reports at such time as they are made available by the auditor or consultants to the State. Any errors identified and/or amounts identified as owed to the State as the result of the audit shall be subject to the Contractor's review and approval prior to initiating any recoveries of Paid Claims pursuant to Article 18 of this Agreement. The Contractor reserves the right to terminate any audit being performed by or for the State if the Contractor determines that the confidentiality of its information is not properly being maintained or if the Contractor determines that the State or auditor is not following the Contractor audit policy.

#### **ARTICLE 16 - USE OF SUBCONTRACTORS**

- A. The Contractor is accountable for the Subcontractors' performance and liability.
- B. The Subcontractor's performance is held to the same performance standards and Subcontractor failure to perform places the Contractor at risk.
- C. The Contractor shall be responsible for all performance guarantee penalties (See Article 20) that may result from underperformance of the Subcontractor.

- D. The Contractor shall demonstrate to the State's satisfaction adequate oversight of any functions performed by or responsibilities assumed by Subcontractors and compliance with all federal and state laws, rules, and regulations.
- E. The Contractor shall obtain the State's approval of member-facing programs such as Vitals SmartShopper, COBRA, telemedicine, wellness incentive administrator, flu clinic administrator, and biometric health screening administrator.
- F. The Contractor shall provide the State with a minimum 90-day notice prior to engaging a Subcontractor that impacts the State's health benefit program and shall work closely with the State on communications relating to transition.

**ARTICLE 17 - CONTRACT ADMINISTRATION**

- A. The State shall be solely and directly liable for the payment of any and all benefits due and payable under the Program.
- B. The Contractor is providing administrative services only with respect to the portion of the Program described in the Benefit Booklet. The Contractor only has the authority granted it pursuant to this Agreement. The Contractor is not the insurer or underwriter of any portion of the Program, notwithstanding any monetary advances that might be made by the Contractor.
- C. The Contractor does not insure or underwrite the liability of the State under this Agreement. The Contractor is strictly an independent contractor. The Contractor has no responsibility or liability for funding benefits provided by the Program, notwithstanding any advances that might be made by the Contractor. The State retains the ultimate responsibility and liability for all benefits and expenses incident to the Program, including but not limited to, any state or local taxes that might be imposed relating to the Program.
- D. The Parties acknowledge that the portion of the Program described in the Benefit Booklet is a self-insured plan and as such is not subject to state insurance laws or regulations.
- E. The State shall ensure that sufficient amounts are available to cover Claims payments, the monthly Administrative Services Fee, and other fees or charges in accordance with the General Provisions of Form P-37, Section 5.
- F. The State shall reimburse the Contractor for the actual costs charged the Contractor by any external reviewer. The Contractor shall provide the actual costs charged by the Contractor as a part of the itemized weekly invoice.

**ARTICLE 18 - THE CONTRACTOR AS RECOVERY AGENT**

- A. The State grants to the Contractor the sole right, to pursue recovery of Paid Claims administered on behalf of Enrollees under this Agreement. The Contractor shall establish recovery policies, determine which recoveries are to be pursued, initiate and pursue

litigation when it deems this appropriate, incur costs and expenses and settle or compromise recovery amounts.

- B. The Contractor will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. If the Contractor would recover the overpayment amount through an automatic recoupment mechanism, the Contractor will not pursue such recovery if the overpayment was in the amount of twenty-five dollars (\$25.00) or less. If the Contractor would recover the overpayment amount through manual recovery, the Contractor will not pursue such recovery if the overpayment was in the amount of seventy-five dollars (\$75.00) or less. The dollar amounts in this section may be revised from time to time, upon agreement by the parties.
- C. Unless otherwise provided in EXHIBIT B, the Contractor shall charge a fixed percentage fee 25% (twenty-five percent) of gross subrogation recovery or, if outside counsel is retained, 15% (fifteen percent) of net recovery after a deduction for outside counsel fees for subrogation-related services. For these purposes, "subrogation-related services" are services in which the Contractor pursues recoveries to Enrollees by any other person, insurance company or other entity on account of any action, claim, request, demand, settlement, judgment, liability or expense that is related to a Claim for Covered Services. These fixed subrogation fees will be charged on all subrogation matters, including any that may have Claims incurred and paid in any prior Agreement Period. The Administrative Services Fee does not include any expenses associated with subrogation. Such subrogation expenses shall reduce amounts recovered for purposes of any adjustments applied toward the State's Claims as described in Article 4 of this Agreement.

#### ARTICLE 19 – ACCOUNT MANAGEMENT

- A. The Contractor agrees to implement a Dedicated Support Account Management Model. The Contractor will assign a seasoned Director level person, referenced for purposes of this agreement as the Sr. Account Director, as the State's dedicated resource overseeing all aspects of the strategic partnership and service delivery and who shall report directly to Contractor's President.
- B. The Contractor's overarching objective will be to ensure high levels of satisfaction with all aspects of the Contractor's performance and areas of operations, including but not limited to:
  - 1. Execution
  - 2. Strategic engagement
  - 3. Communication
  - 4. Engagement in programs and services
  - 5. Reporting and analytics.
  - 6. Value based purchasing
  - 7. Wellness services
  - 8. Performance guarantee results
  - 9. Claims processing system
  - 10. Subcontractor services
  - 11. Financial Invoicing and Tracking
- C. Contractor's Responsibilities will include:

1. Creation, delivery and execution of a project plan, including development of Contractor dedicated support model organization chart
2. Initial and on-going performance assessment
  - a. Initial performance review will utilize prior audits, status of open service issues, and feedback from State interviews about all aspects of service performance and the Contractor staff involved in supporting the State's account.
  - b. Subsequent assessment will use new Dedicated Support Model scorecards (described in Article 20), reporting and analytics, performance guarantee monitoring, surveys and other approaches as needed
3. Strategic consultation – in partnership with the State, identify opportunities to improve all aspects of performance and participation as well as identify communication needs and opportunities
4. Operational oversight
  - a. The Sr. Account Director will identify and work with a designated resource from each of the Contractor's operational areas and/or any subcontractor who performs work on behalf of the State.
  - b. The Sr. Account Director will require monthly metrics holding these areas to their committed service delivery

D. Contractor's Minimum Commitments will include:

1. **Meetings:** The Sr. Account Director is committed to attending monthly and quarterly meetings, in addition to developing regular weekly or bi-weekly check-in meetings with the State (either by phone or in person). Attendance at other regularly scheduled meetings or ad hoc meetings will be identified and scheduled as needed with the Sr. Account Director or other designated Contractor personnel.

Additionally, The State requires the Contractor and/or designated subcontractor, to attend open enrollment meetings at all State locations, as well as attendance at Agency and benefit fairs throughout the year.

2. **Calendar of Deliverables:** The Sr. Account Director, working with the State, will develop a calendar of deliverables (regularly scheduled reports, metrics, meeting attendance, etc.) and adhere to said schedule unless otherwise agreed to by the State.
3. **Metrics/Quality Control:** The Sr. Account Director will monitor Contractor metrics on a regular basis and report issues, concerns and trends to the State during regularly scheduled meetings. Ad hoc meetings for escalated items will be scheduled off-cycle as needed.
4. **Scorecards:** The Sr. Account Director shall work with the State to develop and implement a scorecard to measure the State's satisfaction with the Dedicated Support Model performance. The initial Dedicated Support Model scorecard will be approved by the State in 4Q2017 to establish the baseline for measurement. The

parties may mutually agree to amend the scorecard from time to time. The scorecard will then be used by the State to assess the Contractor's performance every six months.

5. It is understood and agreed that these minimum commitments may be increased or modified upon mutual agreement by the State and Contractor.

E. Rollout:

1. The Sr. Account Director will schedule working sessions with the State during 4Q2017 to implement the new dedicated support model. Meetings will begin shortly after Governor and Council approval.
2. Additionally, the following provisions shall apply:
  - a. The State will require an annual performance or "stewardship" meeting within 180 days after calendar year-end, at which time the Contractor will, as directed by the State, summarize the Contractor's performance for the prior year.
  - b. The Sr. Account Director shall remain constant, within the Contractor's control, for at least the first 18 months of the contact period. The Contractor shall not change assignment of the Sr. Account Director without a minimum of fourteen (14) days written notice of the change provided to the State. The State reserves the right to request assignment of a new Sr. Account Director and the Contractor shall make such change within 30 days of receipt of written notice from the State.
  - c. Additionally, the Contractor shall not change the Contractor operational lead staff members identified on the final Contractor Dedicated Support Model organization chart without a minimum of fourteen (14) days written notice of the change to the State. The State reserves the right to request assignment of the designated operational lead staff members and the Contractor shall make such change within 30 days of receipt of written notice from the State.

## ARTICLE 20 – PERFORMANCE GUARANTEES

A. General Conditions

1. The Performance Guarantees described in this Agreement shall be in effect for each term of the Agreement Period. The Schedule of Performance Guarantees contain the three categories:
  - a. Operations Performance Guarantees
  - b. Clinical Quality Measures and Withhold
  - c. Medical Trend Guarantee
2. The Contractor shall be required to meet Performance Guarantees as outlined in the Schedule of Performance Guarantees or shall pay the State the associated Penalty at Risk according to the applicable time period.

3. Measurement of Operations Performance Guarantees will be based one of the following methods unless mutually agreed otherwise:
  - a. The Contractor shall conduct an analysis of the data necessary to calculate a Performance Guarantees within its applicable timeframe.
  - b. The results of the State's audit of contractor performance.
  - c. The Dedicated Support Model Scorecard.
  - d. A documented event or occurrence at any point of time during the term of the Agreement
4. Any audits performed by the Contractor to test compliance with any of the Performance Guarantees shall be based on a statistically valid sample size with a 95% confidence level or on a demonstrated industry standard.
5. In the event the Agreement expires, the Contractor is obligated to make payment for any Performance Guarantees that apply to the final term of the Agreement Period.
6. For the purposes of calculating compliance with the Performance Guarantees contained in the Schedule of Performance Guarantees, if a delay in performance of, or inability to perform, a service underlying any of the Performance Guarantees is due to circumstances which are beyond the control of Anthem, including but not limited to any act of God, civil riot, floods, fire, acts of terrorists, or acts of war terrorism, such delayed or non-performed service will not count towards the measurement of the applicable Performance Guarantee.

**B. Payment and Reconciliation:**

1. All Operations Performance Guarantee or Medical Trend Guarantee penalties shall be paid to the State in the form of a check.
2. All annual performance guarantees measured on an annual basis shall be reconciled within 180 days of policy year-end.
3. All occurrence based performance guarantees shall be reconciled within 30 days of the occurrence.

**C. Schedule of Performance Guarantees**

1. Operations Performance Guarantees

Ref #	Category	Guarantee	Penalty at Risk
S1	Service	State's satisfaction with the implementation of the Dedicated Support Model including scorecard development and implementation and State's satisfaction with Year 1 performance as measured by the scorecard	\$50,000 for Year 1
S2	Service	State's satisfaction with each year's performance of the Dedicated Support Model as measured by the scorecard	\$50,000 for Year 2 and \$50,000 for Year 3

S3	Service	85% of member calls resolved on first call	\$20,000 per year
S4	Service	Average speed to answer <= 45 seconds	\$20,000 per year
S5	Service	Call abandonment rate < 3%	\$20,000 per year
S6	Service	95% of written inquiries received from plan participants responded to within ten (10) business days	\$25,000 per year
S7	Service	Service outage (website, customer service, etc.) of 24 hours or more, or any outages that exceed 4 hours that occur more frequently than twice per month unless caused by force majeure (ex. acts of God) other than routine maintenance.	\$2,000 per day, maximum \$20,000 per occurrence
S8	Service	Notification of service outage (website, customer service, etc.) at maximum within 4 business hours and notification of outage resolution within 2 business hours	\$10,000 per occurrence
O1	Operations	90% of paper claims received from plan participants not requiring clarification processed within 10 business days	\$25,000 per year
O2	Operations	Timeliness of non-investigated <sup>1</sup> claims paid (paper and electronic) - minimum of 90% within 14 calendar days	\$60,000 per year
O3	Operations	Timeliness of non-investigated claims paid (paper and electronic) - minimum of 99% within 30 calendar days	\$60,000 per year
O4	Operations	Financial accuracy of claims payments 99%	\$100,000 per year
O5	Operations	Payment accuracy of claims payments 97%	\$100,000 per year
O6	Operations	100% of all marketing materials not specific to plan enrollees must be pre-approved by the State prior to distribution to plan enrollees	\$20,000 per occurrence
O7	Operations	100% of all plan enrollee communications accurate	\$5/erroneous document up to \$75,000 penalty per contract year
O8	Operations	99% of eligibility updates received from the State processed within forty-eight (48) hours of receipt of a clean and complete eligibility file in an agreed upon format	\$50,000 per year
O9	Operations	Contractor will respond to all independent auditor requests for clarification, following claims audits within 30 calendar days	\$25,000 at risk per audit
O10	Operations	Timely and accurate implementation of all programs and program changes required by the State	\$5,000 per day, maximum \$100,000 per occurrence
O11	Operations	Documentation provided to the State of quality control testing prior to implementation of all programs and program changes	\$10,000 per occurrence
O12	Operations	Failure to issue any administrative invoice, including wellness invoicing, with the agreed upon supporting documentation within three (3) business days following the end of the month	\$500 per invoice per month
R1	Reporting	Settlement reports delivered within 180 days of policy	\$25,000 per year

		year-end	
R2	Reporting	95% of standard reports within 3 business days	\$25,000 per year
R3	Reporting	90% Adhoc reports within 7 business days	\$25,000 per year

<sup>1</sup> "Non-investigated" means a claim in which only the information presented was used to adjudicate the claim. (A "clean" claim would be an appropriate description.)

## 2. Clinical Quality Measures and Withhold

- a. The State shall **withhold 5 percent** of monthly payments to the Contractor to be earned and distributed according to the Contractor's performance relative to performance expectations for clinical quality priorities established by the State.
- b. The State shall annually reconcile withhold distributions on a contract year basis following assessment of Contractor performance to the specified contract standards. If the Contractor fails to meet defined performance expectations, the State may impose financial sanctions including, but not limited to, retention of all or a portion of the Withhold. If the Contractor meets all specified performance expectations, the State shall distribute the full amount of the withheld funds to the Contractor.
- c. Performance Expectations for Clinical Quality Priorities.
  - 1) The Contractor will be able to earn back withheld dollars in one of two ways. For a group of State-specified quality measures, the Contractor may either:
    - a) demonstrate performance expectation achievement; or
    - b) demonstrate a statistically significant improvement relative to its prior year performance.
  - 2) The Contractor's performance shall be assessed based on all of its New Hampshire commercial members (*i.e.*, not limited to State's plan members). The clinical quality priority measures will be specified annually by the State following consultation with the Contractor. For the **first year** (CY 2018) of the contract, the measures, their associated targets, and the measure-specific amount of withhold at risk will be as follows:

Measure	Performance Expectation*	Withhold at Risk
Adult BMI Assessment	88.64% (CY2015 HMO 50 <sup>th</sup> percentile)	1%
Annual Monitoring for Patients on Persistent Medications	84.25% (CY2015 HMO 50 <sup>th</sup> percentile)	1%
Asthma Medication Ratio (Total)	79.14% (CY2015 HMO 50 <sup>th</sup> percentile)	1%
Comprehensive Diabetes Care - Blood Pressure Control <140/90	76.17% (CY2015 HMO 75 <sup>th</sup> percentile)	1%
Controlling High Blood Pressure	76.39% (CY2015 HMO 75 <sup>th</sup> percentile)	1%

## 3. Medical Trend Guarantee

For each year of the Agreement Period, the Contractor agrees to the following Medical Trend Guarantees:

	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>
	(1/1/18 – 12/31/18)	(1/1/19 – 12/31/19)	(1/1/20 – 12/31/20)
Guaranteed Trend (%)	5.0%	5.0%	5.0%
Amount at Risk for not meeting Trend Guarantee	<b>_Up to 10_% of your administrative fee for all non-Medicare participants</b>	<b>_Up to 10_% of your administrative fee for all non-Medicare participants</b>	<b>_Up to 10_% of your administrative fee for all non-Medicare participants</b>

The Medical Trend Guarantees will apply to all claims incurred through all medical plans administered by the Contractor for all non-Medicare eligible Enrollees.

If the medical cost trend for any of the three years exceeds the medical trend guaranteed above, the Contractor will issue a credit (or other mutually agreed upon payment) to the State (Illustrated below) based on a percentage of the administrative service fee as stated EXHIBIT B, Section 3(b). Payment of Medical Trend Guarantees survives the term of this agreement through the reconciliation period and applies to all claims incurred during each policy period.

a. Calculation of Guaranteed Trend

The trend guarantee will be adjusted for significant benefits that are added or removed. Using total costs (including member cost sharing) for the trend analysis mitigates the need for plan value adjustments in most situations. However, when significant benefits are added or removed, such as In-vitro fertilization and bariatric surgery, an adjustment needs to be made since the total costs in the baseline period do not reflect this benefit.

A significant shift in the distribution of enrollment by plan design and/or significant change in offered plan designs as measured by a change in actuarial value of 5% will require a change in methodology to adjust for the impact on utilization due to plan design changes. The methodology for calculating actuarial value will be mutually agreed upon by the Parties.

b. Trend guarantee will be based on the following methodology:

The trend guarantee will apply to all claims incurred through all medical plans administered by the Contractor for all non-Medicare participants (active and retiree plans).

c. Administration and Settlement of Guarantee

- 1) A baseline claims cost will be established for each year using incurred medical claims on a per member per month ("PMPM") basis. This will be based on claims incurred in the prior year and paid through June of the following year by the State of New Hampshire. For example, the 2018 guarantee will be based on claims incurred in 2018 and paid through June of 2019. Claims will include amounts that are the responsibility of both the member and the State of New Hampshire so that results are not distorted by any plan design changes or other

cost sharing differences from year to year. In order to determine the baseline PMPM amount, the claims will be divided by the total number of enrolled members.

- 2) To promote a result that is not skewed by random fluctuation of catastrophic claims, the Contractor will remove Individual claims in excess of \$250,000 from both the baseline period and the experience period.
- 3) In order to accurately measure year over year trend levels the baseline claims cost must be developed using the same or a similar enrolled population each year. The demographic profile, driven by age, gender, contract class and area, of each year's enrollment will be used to determine whether the population is the same or similar. The demographic profile must be within 5% of the demographic profile of the prior year's enrollment for the Trend Guarantee to apply. The baseline medical costs will be adjusted to reflect the change in the demographic profile. The demographic profile for each year will be determined using a census from July of that same year.
- 4) If enrollment on July 1st of each policy year varies by +/- 10% from enrollment as of July 1st of the prior year, trend will be calculated using only membership continuously covered from January 1st of the prior year through December 31st of the policy year.
- 5) The Trend Guarantee will be adjusted each year to reflect benefits added or deleted including but not limited to new state or federal mandates not known at the time of the development of the Trend Guarantee.
- 6) Claims experience will be adjusted to remove the impact of catastrophic events such as a pandemic as defined by the World Health Organization.
- 7) The Observed Trend for each policy year will equal the medical claims incurred in that year as determined by the steps set forth within this section divided by the baseline claims.
- 8) If the Observed Trend is greater than the trend guarantee, the Contractor will issue a fee credit to the State of New Hampshire that will be calculated separately for each policy year as follows: Trend Guarantee Fee Schedule:
- 9) Should the Contractor not meet the Guarantee, the Contractor shall pay State a penalty based on the following fee schedule, as a Percentage of Annual Administrative Fees, referenced in EXHIBIT B, Section 3(b).

Trend Guarantee (In excess of 5%)	Percentage of Administrative Service Fee
Less than or equal to 1%	1.0%
Greater than 1% to 2.25%	2.5%
Greater than 2.25% to 3.75%	5.0%
Greater than 3.75% to 5.0%	7.5%
Greater than 5.0%	10.0%

The ASO fees subject to the Trend Guarantee include medical and care management program fees paid by the State of New Hampshire in each year.

Any Trend Guarantee settlement shall be finalized no later than eight months after the conclusion of each policy year with any applicable fee credits to occur no later than the end of the ninth month following each policy year.

10) Other Conditions

- a.) In order for the Trend Guarantee to apply, Contractor must be the sole medical carrier for the State of New Hampshire.
- b.) The Trend Guarantee assumes an effective date of January 1, 2018 and is applicable for each policy period from 2018-2020.
- c.) The performance guarantee shall be subject to verification by annual audit.

**ARTICLE 21 - ORDER OF PRECEDENCE / AGREEMENT DOCUMENTS**

A. This Agreement consists of the following documents in order of precedence:

- 1. State of New Hampshire Terms and Conditions, General Provisions, Form P-37, including Exhibit A, B, C, D, E, F, G and Appendices A and B.
- 2. Department of Administrative Services, Risk Management Unit, RFP 2017-192, Administration of Medical Benefits dated April 19, 2017, including Addenda 1, 2, 3, 4, and 5 and the Contractor's response to RFP 2017-192 are incorporated here within.

## EXHIBIT B: CONTRACT PRICE/LIMITATION ON PRICE/PAYMENT

This EXHIBIT B shall govern the Agreement Period and each Term of the Agreement Period. This EXHIBIT B shall supplement the terms and provisions of EXHIBIT A. Words defined in EXHIBIT A shall have the same meaning in this EXHIBIT B unless expressly defined otherwise herein. If there are any inconsistencies between the terms of EXHIBIT A and this EXHIBIT B, the terms of this EXHIBIT B shall control.

### Section 1. Agreement Period:

The terms and conditions of this EXHIBIT B shall apply to and govern the Agreement Period and each Term of the Agreement Period, including any extension thereof.

The initial Claim Incurred Date for purposes of this Agreement shall be the first date of the Agreement Period, except that the Contractor shall administer Claims on behalf of the State as provided in the Agreement for Covered Persons who are inpatients in a facility on and after the first date of the Agreement Period.

### Section 2. Claims Payment Method:

The State shall reimburse the Contractor for all Claims the Contractor pays for and on behalf of Enrollees in the Program. Contractor shall pay benefits for Claims incurred by Enrollees according to the terms of the Agreement. Contractor shall provide notice to the State via electronic means, or other means acceptable to the Parties, of the amount of Claims paid by Contractor no later than 12:00 p.m. on each Monday of the Agreement Period and the first Monday following the end of the Agreement Period (including any extensions thereof). The notice shall be for Claims paid during the week immediately preceding the date of notice. Contractor shall supply to the State supporting documentation, as mutually agreed to by the Parties, documenting the Claim payments made. The State shall issue payment to Contractor via wire transfer to a bank account specified by Contractor not later than close of business on Friday in same week as the State receives notice from Contractor. In the event any Monday or Friday falls on a holiday for the State and/or Contractor, notice shall be sent or payment shall be made on the next regular business day.

The State shall not issue payment to the Contractor for Claims paid based upon verbal instruction or information from the Contractor.

### Section 3. Administrative Services Fee:

#### A. Payment of Administrative Services Fee and Invoicing

1. Administrative Services Fees shall be billed to the State on a monthly basis.
2. The Contractor shall ensure that invoices, with supporting documentation, for all administrative and wellness program services performed or provided each month will be issued to the State no later than three (3) business days following the end of each month during the term of the Agreement. The State and the Contractor agree to identify and mutually agree upon the specific supporting documentation to accompany each monthly invoice issued.

3. The State shall Issue payment to the Contractor for Administrative Services Fees within fourteen (14) business days following receipt of the invoice and documentation from the Contractor.
4. The State shall not issue payment to the Contractor for the Administrative Services Fee based upon verbal instruction or information from the Contractor.

B. Amount of Administrative Services Fees

1. The Administrative Services Fee for the Agreement Period shall be as depicted in the chart below:

**ADMINISTRATIVE & PROGRAM FEES - MEDICAL**

Administrative & Program Fees: Active HMO and Active POS - All Plans			
	CY 2018 PEPM	CY 2019 PEPM	CY 2020 PEPM
Medical Administration / Claims Processing	\$23.00	\$23.00	\$23.00
Network Access/Leasing Fees	Included	Included	Included
Utilization Management Fees	Included	Included	Included
ID Cards	Included	Included	Included
Provider Directory	Included	Included	Included
Benefit Booklets/SPDs	*See below	*See below	*See below
Data and Performance Reporting	Included	Included	Included
Data Sharing	Included	Included	Included
Disease Management	Included	Included	Included
Medical Info Line/24x7 Nurse Line	Included	Included	Included
*Vitals SmartShopper*-Like Program	\$2.25	\$2.25	\$2.25
COBRA Administration	Included	Included	Included
Start Up/Implementation Costs	N/A	N/A	N/A
<b>All Inclusive Fee (PEPM)</b>	<b>\$25.25</b>	<b>\$25.25</b>	<b>\$25.25</b>

Administrative & Program Fees: Non-Medicare Retiree POS/PPO Plan			
	CY 2018 PEPM	CY 2019 PEPM	CY 2020 PEPM
Medical Administration / Claims Processing	\$23.00	\$23.00	\$23.00
Network Access/Leasing Fees	Included	Included	Included
Utilization Management Fees	Included	Included	Included
ID Cards	Included	Included	Included
Provider Directory	Included	Included	Included
Benefit Booklets/SPDs	*See below	*See below	*See below
Data and Performance Reporting	Included	Included	Included
Data Sharing	Included	Included	Included
Disease Management	Included	Included	Included
Medical Info Line/24x7 Nurse Line	Included	Included	Included
*Vitals SmartShopper*-Like Program	\$2.25	\$2.25	\$2.25
COBRA Administration	Included	Included	Included
Start Up/Implementation Costs	N/A	N/A	N/A
<b>All Inclusive Fee (PEPM)</b>	<b>\$25.25</b>	<b>\$25.25</b>	<b>\$25.25</b>

**Administrative & Program Fees: Medicare Retiree Plan**

	CY 2018 PEPM	CY 2019 PEPM	CY 2020 PEPM
Medical Administration / Claims Processing	\$23.00	\$23.00	\$23.00
Utilization Management Fees	Included	Included	Included
ID Cards	Included	Included	Included
Provider Directory	Included	Included	Included
Benefit Booklets/SPDs	*See below	*See below	*See below
Data and Performance Reporting	Included	Included	Included
Data Sharing	Included	Included	Included
Medical Info Line/24x7 Nurse Line	Included	Included	Included
COBRA Administration	Included	Included	Included
Start Up/Implementation Costs	N/A	N/A	N/A
<b>All Inclusive Fee (PEPM)</b>	<b>\$23.00</b>	<b>\$23.00</b>	<b>\$23.00</b>

2. In the event the State exercises the its right to extend the duration of this Agreement beyond the Agreement Period, the Parties shall agree not later than ninety (90) days prior to the commencement of any such extension to the amount of the Administrative Services Fee.

A. Reconciliation and Settlement

1. Reconciliation and Settlement. The Parties agree that Administrative Services Fees will be reconciled from time to time and settlements shall occur as defined herein. For purposes of all reconciliation and settlements, enrollment data supplied by the State shall be considered the "source of truth".
2. Fiscal Year Reconciliation and Settlement Calculations. The Parties agree that an interim reconciliation and settlement shall occur no later than thirty-one (31) days following the close of the State's Fiscal Year. The State's Fiscal Year is July 1 through June 30.
3. Calendar Year End Reconciliation and Settlement Calculation. The Parties agree that a final calendar year end reconciliation and settlement shall occur no later than ninety (90) days following the close of each calendar year.
4. Settlement Payments. If, based on the reconciliation and settlement calculations, the Contractor owes the State a settlement payment under the terms of the Agreement, then the Contractor shall pay the State said amount no later than thirty-one (31) days after the close of the State's Fiscal Year for the interim settlements and no later than ninety (90) days after the close of the calendar year for each year end settlement. If, based on the reconciliation and settlement calculations, the State owes the Contractor a settlement payment under the terms of this Agreement, then the State shall pay the Contractor said amount no later than thirty-one (31) days after the close of the State's Fiscal Year for the interim settlements and no later than ninety (90) days after the close of the calendar year for each year end settlement.

**Section 4. Fees on Claims Runout:**

There shall be no Administrative Services Fee for Claims Runout Services. Fees on Claims Runout means those Administrative Services Fee and other fees for services provided by Contractor following the Termination of the Agreement.

A. Claims Runout Services

1. Claim Processing. Contractor will process and pay Claims on behalf of the State any Claim covered by the State's Program which has a Claim Incurred Date during the Agreement Period (or portion thereof if the Agreement is terminated prior to the end of the Agreement Period), provided, however, that Contractor shall have no responsibility to process or pay any Claim with a Claim Incurred Date after the Agreement Period (or portion thereof if the Agreement is terminated prior to the end of the Agreement Period) or after the expiration of twelve (12) months following the Termination Date of this Agreement (the "Runout Period"), unless a different period is otherwise described in the Benefit Booklet.
2. Coordination of Benefit (COB). COB payments that are received by Contractor during the Claims Runout Period shall be credited to the State in accordance with the Agreement. All such payments received by Contractor after the end of the applicable Claims Runout Period will be retained by Contractor.
3. Right of Recovery. Recovery amounts recovered during the Claims Runout Period by Contractor shall be credited to the State in accordance with this Agreement. All such amounts received after the Claims Runout Period will be retained by Contractor.

**Section 5. Special Services:**

- A. External Review. Contractor shall make available to Enrollees External Review services once Enrollees have exhausted first and second level appeals. Contractor shall invoice the State, either in conjunction with the invoice for Administrative Services Fees or separately, the fees and costs associated with administration of External Review. Costs incurred for engaging the services of an Independent Review Organization ("IRO") shall be billed "at cost" to the State. Upon reasonable request by the State, Contractor shall supply to the State of copy of the IRO's Invoice.

**Section 6. Wellness Program Administrative Fees:**

- A. Upon implementation of the various components of the Wellness Programs as provided in Exhibit E, the Wellness Program Administrative Fee(s) shall be as follows:

**ADMINISTRATIVE & PROGRAM FEES - WELLNESS**

Administrative Fee - Wellness Program: ALL Active Plans*			
	CY 2018 PEPM	CY 2019 PEPM	CY 2020 PEPM
Customized Website	Included in Healthy Lifestyles or Mobile Health	Included in Healthy Lifestyles or Mobile Health	Included in Healthy Lifestyles or Mobile Health
Health Risk Assessment/Tool (HAT)	Included in Healthy Lifestyles or Mobile Health	Included in Healthy Lifestyles or Mobile Health	Included in Healthy Lifestyles or Mobile Health
HAT Reporting	Included in Healthy Lifestyles or Mobile Health	Included in Healthy Lifestyles or Mobile Health	Included in Healthy Lifestyles or Mobile Health

Member Communications	Included in Healthy Lifestyles or Mobile Health	Included in Healthy Lifestyles or Mobile Health	Included in Healthy Lifestyles or Mobile Health
Onsite Health Screenings (\$/screening) <sup>2</sup>	\$50.00	\$50.00	\$50.00
Wellness Promotion/Incentive Program <sup>3</sup>	\$0.53	\$0.54	\$0.55
Wellness Counseling	Included	Included	Included
Fitness Counseling	Included	Included	Included
Educational Sessions - Seminars	\$575 per seminar visit	\$575 per seminar visit	\$575 per seminar visit
Educational Sessions - Webinars	\$575 per seminar visit	\$575 per seminar visit	\$575 per seminar visit
Telephonic Coaching	\$2.05 PEPM + \$126 per participant	\$2.09 PEPM + \$126 per participant	\$2.14 PEPM + \$126 per participant
Workplace Influenza Vaccinations <sup>4</sup>	\$27.00	\$27.00	\$27.00
Start Up/Implementation Costs	N/A	N/A	N/A
Healthy Lifestyles	\$0.95	\$0.96	\$0.97
Mobile Health <sup>5</sup>	\$0.75	\$0.76	\$0.77
MyHealth Advantage Gold w/ Daily Reminders	\$0.60	\$0.61	\$0.62
Staying Healthy Reminders	\$0.35	\$0.36	\$0.37
<b>*These fees would apply for the Non-Medicare Retiree Plan.</b>			
NOTES:			
<p><sup>1</sup>Anthem provides the State with a master benefits booklet that describes the benefit program under the terms of the plan administered by Anthem. The State produces the SPD and may incorporate the benefits booklet. On behalf of the State, Anthem produces and maintains the master copy of the benefits booklet and makes amendments to the master copy incorporating approved changes.</p>			
<p><sup>2</sup>There is a \$100 per event set up fee and an \$8 per participant exit counseling fee for the biometric screening events. Anthem has arrangements with other subcontractors that are more cost effective and can be considered.</p>			
<p><sup>3</sup>Rate does not include cost for gift card activation. Activation cost is \$3.00 per card.</p>			
<p><sup>4</sup>Maxim administering</p>			
<p><sup>5</sup>The Mobile Health cost above includes the cost of the Amazon gift card (<i>shipping not included</i>). There is also an AMEX card option which would include an additional charge of \$5.99/card. AMEX cards do not have an expiration date.</p>			

1. The Wellness Administrative Fees shall be billed to the State on a monthly basis.
2. The Contractor shall provide the State with an invoice and other documentation as mutually agreed to by the Parties which display the services and costs which make up the Wellness Program Administrative Fee. The invoice and documentations shall be provided by the Contractor to the State no later than three (3) business days following the end of each month during the Agreement Period. The State shall issue payment to the Contractor for Administrative Services Fees within fourteen (14) business days following receipt of the invoice and documentation from the Contractor.

**EXHIBIT C: SPECIAL PROVISIONS**

There are no Special Provisions to this Agreement

Anthem's Initials:   
Date: 8/17/17

**EXHIBIT D: INCORPORATION OF RFP RESPONSE**

The Contractor's response to RFP 2017-192 is hereby incorporated by reference.

## EXHIBIT E: WELLNESS PROGRAM

The Contractor shall administer the State's Wellness Program and collectively bargained Wellness Program components or provisions as determined by the State. The Wellness Program components include, but are not limited to, the following:

- A. **Online Lifestyle Management Program:** The Contractor shall implement and support the management and operation of a voluntary online lifestyle management program that offers a health assessment tool (HAT), personalized online health coaching and resources for well-being as an interactive approach to help all subscribers to address key behaviors and set appropriate goals associated with identified health risks.
- a. The Contractor shall have the ability to track HAT completions and offer incentives only to subscribers eligible for the incentives. The Contractor shall transmit subscriber eligibility information and HAT completion data as requested by the State to other State approved vendors at no additional cost, ex. health reimbursement account and incentive administration data.
- B. **Biometric Screening Program:** The Contractor shall administer a voluntary biometric screening program that provides eligible subscribers the opportunity for screening by competent professional staff for Body Mass Index (BMI) – based on height and weight measurements, waist circumference, blood pressure, cholesterol, blood sugar. The Biometric Screening process shall include the following:
- a. Biometric screening staff shall:
- 1) provide a site visit 2-3 days prior to the screening event for calibration of equipment and inventory of supplies.
  - 2) arrive to the screening site on the date of the event 60 minutes prior to the screening start time.
  - 3) provide registration support on the day of the event.
  - 4) conduct the screenings and review the results with each participant, including providing education on managing any identified health issues and referring enrollees to further health management programs or their primary care provider for follow-up or maintaining current health status.
  - 5) provide each participant with screening results and other relevant health information.
  - 6) survey each participant, using a mutually approved survey tool, on their satisfaction of screening process and biometric screening staff member and provide completed surveys to the State upon completion of each event. The State reserves the right to request a staffing change as needed.
  - 7) return the screening room to the original configuration and state it was in when they arrived.

- b. The Contractor shall integrate the biometric screening program with the health promotion incentive program to allow subscribers to meet screening participation or outcomes-based incentives, as applicable.
  - c. The Contractor shall provide subscribers with alternatives to worksite biometric screenings to obtain biometric data including, but not limited to, physician offices and community urgent care locations. The alternative methods of screening shall also integrate with the health promotion incentive program to allow subscribers to meet screening participation or outcomes-based incentives, as applicable.
- C. **Health Promotion Incentive Program:** The Contractor shall administer a voluntary health promotion incentive program that offers payments per eligible subscriber per calendar year for participation in health activities as required by the State.
- a. The Contractor shall offer eligible subscribers with incentives for completing certain State-sponsored health education and well-being programs in various forms including, but not limited to consumer gift cards and debit cards that do not expire.
  - b. The Contractor shall accept data as necessary to track eligible subscriber activity, completion of activity, and reward including redemption of reward cashed in as required by and in accordance with program parameters
  - c. The State, through the Manager of Employee Relations, shall consult with all employee organizations as provided by their respective Collective Bargaining Agreements regarding the design and implementation of the program.
  - d. Nothing herein shall obligate the State to any specific level of incentives. The State will be solely responsible for funding the incentives used in administering the program.
- B. **Reporting:** The Contractor shall provide the State aggregate reporting to measure effectiveness of each Wellness Program component including, but not limited to, participation and satisfaction, on a monthly basis or as requested by the State. The State and the Contractor shall agree on the outcome measures to be contained in such reports.
- C. **Incentives:** Nothing herein shall obligate the State to any specific level of incentives. The State will be responsible for funding the incentives used in administering the program.
- D. **Promotion:** The Contractor shall promote the Wellness Program and all of its components by developing a State-approved marketing and educational campaign utilizing various media including print, email, and online multi-media designed to engage eligible subscribers to maximize participation in the program.
- a. Emails: Distributed monthly to eligible subscribers about health improvement/wellness services such as the HAT, lifestyle management programs, and incentive offerings.
  - b. Print: Distributed quarterly to eligible employee and retiree subscribers about health and wellness benefits. Each of the four (4) quarterly mailings per calendar year shall occur no more than 15 business days after the start of the quarter.

- c. **Reminders:** Distributed electronically as needed to remind subscribers who have partially completed or have not completed their HAT or other component of the Wellness Program.
- E. **On-Site Education:** Within seven business days of a request by the State, the Contractor shall provide staff to conduct on-site educational sessions about the Wellness Program and all of its components.
  - F. **Changes in Eligibility:** The State may, at any time during the term of the Agreement, alter the eligibility requirements of the Wellness Program, or any of its individual components. The State will provide as much notice as administratively possible of such change in eligibility. Upon changes in eligibility, all associated Per Subscriber Per Month (PSPM) administrative charges and payments shall adjust.
  - G. **Discontinuation:** The State may, at any time during the term of the Agreement, discontinue the Wellness Program or any of its components. The State will provide as much notice as administratively possible of such change. Upon termination, all associated Per Subscriber Per Month (PSPM) administrative charges and payments shall cease.
  - H. **New Hire Orientation:** The Contractor shall conduct periodic meetings for new hire orientations for the purpose of educating such employees regarding the State's health benefit plan including development and distribution of new hire packets that educate new employees on the Wellness Program, HAT, health benefits, and incentives. The new hire packets shall be approved by the State and be distributed by request within 14 business days to the State.
  - I. **Influenza Vaccination Program:** The Contractor shall administer a workplace influenza vaccination program during the months of September, October, and November. Specific program services and costs to be outlined and approved by the State.
  - J. **National Diabetes Prevention Program:** The Contractor shall administer the National Diabetes Prevention Program for active and non-Medicare retiree subscribers.
  - K. **Compliance:** The Contractor shall ensure that the Wellness Program and all of its components are compliant with federal and state laws and regulations including, but not limited to the Americans with Disabilities Act (ADA), Genetic Information Nondiscrimination Act (GINA), Health Insurance Portability and Accountability Act (HIPAA), and Affordable Care Act (ACA).
  - L. **Dedicated Health and Wellness Specialist:** The Contractor agrees to provide a dedicated Health and Wellness Specialist equal to 1 FTE to the State to support worksite health improvement and wellness services. The Health and Wellness Specialist shall be available Monday through Friday to State employees, retirees, and dependents (plan members).
    - a. The Health and Wellness Specialist should possess the following qualifications:
      - 1) Bachelor's degree from a recognized college or university with a major in community health nursing, health education, public health, or related field.
      - 2) Specialty certification in an area such as in Health Coaching, ACE Personal Trainer, Worksite Wellness Program Management, Athletics and Fitness Association of America, or registered Allied Health Profession.

- 3) Minimum of 1 year experience supporting and facilitating positive behavior change using coaching or motivational interviewing techniques.
  - 4) Ability to create clear, concise and effective educational, marketing and communication tools using web-based technology, print, multi-media, and social media provided by the Contractor and approved by the State such as webinars, websites, and on-demand recorded classes and presentations.
- b. Working in conjunction with the State's Wellness Administrator, the Health and Wellness Specialist job duties include:
- 1) developing, delivering, monitoring and evaluating any and all aspects of the State Employee and Retiree Health Benefit Plan Wellness Programs.
  - 2) serving as a health coach/educator developing, implementing and evaluating health promotion, prevention and condition programs for individuals and groups.
  - 3) fostering individual responsibility and individualized plans to maximize a member's ability to adhere to a care plan.
  - 4) making appropriate referrals, and implementing and monitoring health and wellness interventions for State of New Hampshire employees and other groups as identified.
  - 5) monitoring and evaluating the coaching program for overall quality and performance improvement and shall monitor and evaluate the coaching plans for individual members and groups.
  - 6) utilizing health assessment and biometric measures, when available, to assist members in managing self-care and setting goals.
  - 7) collaborating with other professionals in the development of program planning and care plans, including the State's Employee Assistance Program, Agency Human Resources personnel, the Division of Personnel, Bureau of Education and Training and other appropriate professionals.
  - 8) supporting peer activities and facilitation of worksite group fitness, yoga, or other wellness activities.
  - 9) teaching or leading health related wellness classes, including employee health education programs and the effective use of health and wellness benefits in groups or one on one with members.
  - 10) maintaining adherence to evidence based standards of practice for health and wellness services.
  - 11) developing, implementing, marketing and evaluating Health Benefit Committee Workgroup interventions consisting of the Contractor care management, wellness programs and medical benefits.

- 12) collaborating and maintaining communication with other public and private employers including the Contractor affiliates to share information about Wellness Plans, outcomes-based risk reduction programs, health benefits plan designs and wellness incentives to apply to State benefit design.
- 13) developing creative and effective strategies to achieve short term and long term objectives of the State Employee Health Improvement Plan using evidence and comparative research.
- 14) participating in an annual professional and technical performance review conducted by the State Wellness Program Administrator.
- 15) identifying ways to engage retirees with wellness programs, benefits, and group activity.
- 16) participating in and attend HBC meetings, HBC Workgroup meetings, wellness coordinator trainings, the Contractor vendor meetings, and additional meetings as requested.

## EXHIBIT F: VALUE-BASED PURCHASING

- A. Provider Contracting Partnership: The Contractor will inform the State every six months regarding the alternative contracting strategies being employed by the Contractor. This shall include receipt of reports which detail the portions of the State's population that are utilizing providers contracted in a certain manner. The State shall be notified of the Contractor's strategies regarding these alternative contracting methods and shall be notified when assessment of these strategies is completed.

The Contractor shall notify the State sixty (60) days in advance of facility and /or physician group contract negotiations taking place with Accountable Care Organizations (ACO) with State membership; as well as at the State's top five hospitals and physician groups, by volume. Once agreement has been reached between the Contractor and the ACO, facility and/or physician group, the Contractor agrees to provide the State with an estimated percentage change in contracting terms so that the State can perform financial impact analysis.

- B. Performance Payments. The Contractor may pay Performance Payments to Providers or Subcontractors as described in the definition of Paid Claim in this Agreement. The Contractor may perform a periodic settlement or reconciliation based on the Provider's or Subcontractor's performance and experience against established Performance Targets that would:

1. require the Provider or Subcontractor to repay a portion of a Performance Payment previously paid by the Contractor; or
2. require the Contractor to make additional payments.

The State acknowledges and agrees that it has no responsibility for additional payments to Providers or Subcontractors nor any right in any discounts or excess money refunded or paid to the Contractor from Providers or Subcontractors pursuant to such settlement/reconciliation arrangements, and neither it nor the Plan has any legal right or beneficial interest in such sums retained by the Contractor.

Similarly, if Providers or Subcontractors do not achieve established Performance Targets, the Contractor is not obligated to refund any amounts previously charged the State. In turn, if under any such settlement/reconciliation the Contractor is required to pay Providers or Subcontractors excess compensation for Member management performance, risk-sharing rewards, or other performance incentives, it shall not seek payment from the State or the Plan, and neither the State nor the Plan shall have any liability in connection with such amounts. Such Providers or Subcontractors may include Contractor Affiliates. In calculating any Member co-insurance amounts in accordance with the Benefits Booklet, the Contractor does not take into account these settlement/reconciliation arrangements.

The Contractor shall provide the State with detailed reports reflecting any additional administrative charges, member management performance, risk-sharing rewards or other incentive payments, per Capita payments or other provider payments that may be

charged to the State as part of any of the Contractor's Value Based or Provider Performance program. The State and the Contractor shall work together to design the content and establish the frequency of these reports.

- C. Provider Access. The Contractor shall make a reasonable effort to encourage primary care providers within the Contractor's New Hampshire network to extend their office hours as a way of increasing access to care for State employees. On an annual basis, the Contractor shall provide the State with a listing of primary care providers who offer non-standard hours. Non-standard hours shall mean weekdays after 6:00 PM and any weekend hours.
- D. In addition to the provisions above, the Contractor shall:
1. Agree to meet the requirements of each Value-Based Purchasing Specification contained in Appendix A. The Purchasing Specifications include:
    - a. Value-Based Activity Regarding Care Delivery
    - b. Enrollee Services
    - c. Claim Administration and Services
    - d. Other Reporting
  2. Agree to implement all plans, strategies, and timelines described in the Contractor's response to this RFP;
  3. Agree to develop with the State, by a date specified in the Contract, Improvement Goals and associated Measures related to the Contractor's performance of Contractor responsibilities and the Value-Based Purchasing Specifications contained in Appendix A.
  4. Identify and propose Improvement Goals for the State's prior review and approval no later than six weeks prior to the end of each Contract Year, including Measures and time frames for demonstrating that such Quality Improvement Goals are met;
  5. Implement, with the State's approval, processes to achieve the Improvement Goals over the course of Contract Year;
  6. Ensure that key staff participate in meetings with the State and/or contracted providers or Subcontractors to develop strategies to ensure that the Improvement Goals are met;
  7. Participate in semi-annual meetings with the State during each Contract Year for the primary purpose of reviewing progress towards the achievement of the annual Improvement Goals and the Contractor's performance to contract standards. For the purposes of such meetings, the Contractor shall:

- a. Provide the State with a written update and presentation, detailing progress toward meeting the annual Improvement Goals, no later than fourteen business days prior to each semi-annual meeting;
  - b. Review its Contract performance with regards to the requirements of the annual Improvement Goals;
  - c. Collaborate in advance with the State to develop a presentation of the annual Improvement goals' results to ensure targeted messages are clear and concise for the broader audience;
  - d. Meet with the State at the time and place requested by the State;
  - e. If the State determines that the Contractor is not in compliance with the requirements of the annual Improvement Goals, prepare and submit a corrective action plan to the State for its approval.
8. Cooperate in any audits that may be required and conducted by the State, or its designee.

E. The State's Responsibilities. The State shall designate the Commissioner of the Department of Administrative Services (DAS), or his or her designee(s), to act as a liaison between the Contractor and the State for the duration of the Contract. The State reserves the right to change its representative, at its sole discretion, during the term of the Contract, and shall provide the Contractor with written notice of such change. The State representative shall be responsible for:

1. Representing the State on all matters pertaining to the Contract. The representative shall be authorized and empowered to represent the State regarding all aspects of the Contract;
2. Monitoring compliance with the terms of the Contract;
3. Responding to all inquiries and requests related to the Contract made by the Contractor, under the terms and in the time frames specified by the Contract;
4. Meeting with the Contractor's representative on a periodic or as-needed basis and resolving issues which arise, and

F. In addition to the provisions above, the State shall:

1. Monitor and evaluate the Contractor's compliance with the terms of the Contract;
2. In consultation with the Contractor, develop a Performance Indicator Dashboard to assemble performance indicators that assess important dimensions of the Contractor's performance, identify which Dashboard measures will be linked to the Performance Withhold (See Exhibit A, Article 20, sections C2 and C3 Clinical Quality Measures and Withhold), and identify the standards by which the Contractor's performance will be assessed on each measure;
3. Meet with the Contractor at a minimum of twice a year for formal contract management meetings to comprehensively assess the performance of the Contractor relative to the annual Improvement Goals and the performance of the Contractor on Performance Dashboard measures and according to specified performance standards;

4. Review reports submitted by the Contractor. The State shall determine the acceptability of the reports. If they are not deemed acceptable, the State shall notify the Contractor and explain the deficiencies and require resubmission;
5. Request additional reports that the State deems necessary for purposes of monitoring and evaluating the performance of the Contractor under the Contract;
6. Perform periodic programmatic and financial reviews of the Contractor's performance of responsibilities. This may include, but is not limited to, on-site inspections and audits by the State or its agent of both the Contractor's and Providers' records;
7. Give the Contractor prior notice of any on-site visit by the State or its agents to conduct an audit, and further notify the Contractor of any records which the State or its agent may wish to review;
8. Inform the Contractor of the results of any performance evaluations conducted by the State and annually complete the reconciliation of withheld funds consistent with Exhibit A, Article 20, section C2 and C3 Clinical Quality Measures and Withhold and Performance Guarantees;
9. Inform the Contractor of any dissatisfaction with the Contractor's performance and include requirements for corrective action, and

## EXHIBIT G: REQUIRED PROTECTION OF CONFIDENTIAL INFORMATION

In performing its obligations under the Agreement, Contractor, inclusive of any subsidiaries and related entities shall gain access to State Confidential information and with respect to such will comply with the following terms and conditions. Protection of State Confidential Information shall be an integral part of the business activities of Contractor. Contractor shall take steps to prevent the inappropriate or unauthorized use of State data and information.

1. Definitions
  - a. Confidential Information. Personally identifiable information (PII), and other personal private, and/or sensitive information or data as defined under applicable law.
2. Contractor Responsibilities
  - a. Confidential Information obtained by Contractor shall remain the property of the State and shall at no time become the property of Contractor unless otherwise explicitly permitted under the Agreement.
  - b. Contractor shall develop and implement policies and procedures to safeguard the confidentiality, integrity and availability of the State's Confidential Information.
  - c. Contractor shall not use the State's Confidential Information developed or obtained during the performance of, or acquired or developed by reason set forth within the Agreement, except as necessary for Contractor's performance under the Agreement, or unless otherwise permitted under the Agreement.
  - d. In the event Contractor stores Confidential Information, such information shall be encrypted by Contractor both at rest and in motion.
  - e. Contractor shall have, and shall ensure that any Subcontractors or related entities have, reasonable security measures in place for protection of the State's Confidential Information. Such security measures shall comply with HIPAA and all other applicable State and federal data protection and privacy laws.
3. Controls. Contractor shall, and shall ensure that any Subcontractors or related entities use at all times proper controls for secured storage of, limited access to, and rendering unreadable prior to discarding, all records containing the State's Confidential Information. Contractor shall not store or transfer Confidential Information collected in connection with the services rendered under this Agreement outside of the North America. This includes backup data and disaster recovery locations.
4. Breach Notification.
  - a. Contractor shall notify the State of any security breach, or potential breach of Contractor or any Subcontractors or related entities, that jeopardizes, or may jeopardize the State's Confidential Information. For purposes of reporting under this Section, security breach or potential breach shall be limited to the successful or attempted unauthorized access, use, disclosure, modification, or destruction of information, or the successful or attempted interference with system operations in an information system, that compromises the security, confidentiality or integrity of such Confidential Information consistent with applicable laws. For purposes of clarity, potential breaches shall not include incidents that do not compromise the security, confidentiality or integrity of the State's Confidential Information

consistent with applicable laws, such as ping and other broadcast attacks on Contractor's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above.

- b. Contractor shall notify the State of a security breach, or potential breach of Contractor or any Subcontractors or related entities upon discovery. Contractor will treat a security breach or potential breach as being discovered as of the first day on which such incident is known to Contractor, or by exercising reasonable diligence, would have been known to Contractor. Contractor shall be deemed to have knowledge of a security breach or potential breach if such incident is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is an employee, officer or other agent of Contractor.
  - c. A report of the security breach or potential breach of Contractor or any Subcontractors or related entities shall be made and include all available information. Contractor shall: make efforts to investigate the causes of the security breach or potential breach; promptly take measures to prevent any future breach; and mitigate any damage or loss. In addition, Contractor shall inform the State of the actions it is taking, or will take, to reduce the risk of further loss to the State.
  - d. All legal notifications required as a result of a breach of information, or potential breach, collected pursuant to this Agreement shall be made at the Contractor's cost and coordinated with the State to the extent practicable.
5. Liability and Damages. In addition to Contractor's liability as set forth elsewhere in the Agreement, if Contractor or any of its Subcontractors or related entities is determined by forensic analysis or report, to be the likely source of any loss, disclosure, theft or compromise of State's Confidential Information, the State shall recover from Contractor all costs of response and recovery resulting from the security breach or potential breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services. A security breach or potential breach may cause the State irreparable harm for which monetary damages would not be adequate compensation. In the event of such an incident, the State is entitled to seek equitable relief, including a restraining order, injunctive relief, specific performance and any other relief that may be available from any court, in addition to any other remedy to which the State may be entitled at law or in equity. Such remedies shall not be deemed exclusive, but shall be in addition to all other remedies available at law or in equity, subject to any express exclusion or limitations in the Agreement to the contrary.
6. Data Breach Insurance. In addition to Contractor's insurance obligations as set forth in the form contract P-37, Contractor shall carry cybersecurity insurance coverage for unauthorized access, use, acquisition, disclosure, failure of security, breach of Confidential Information, privacy perils, in an amount not less than \$10 million per annual aggregate, covering all acts, errors, omissions, at minimum, during the full term of this Agreement. Such coverage shall be maintained in force at all times during the term of the Agreement and during any period after the termination of this Agreement during which Contractor maintains State Confidential Information.

7. Data Recovery. Contractor shall be responsible for ensuring backup and redundancy of the State's Confidential Information for recovery in the event of a system failure or disaster event within Contractor's data storage systems. Contractor shall ensure that its Subcontractor or related entities provide similar backup and redundancy of the State's Confidential Information.
8. Return or Destruction of Confidential Information. Upon termination of the Agreement for any reason, Contractor shall:
  - a. Retain only that Confidential Information which is necessary for Contractor to continue its proper management and administration or to carry out its legal responsibilities;
  - b. Destroy, in accordance with applicable law and Contractor's record retention policy that it applies to similar records, the remaining Confidential Information that Contractor still maintains in any form;
  - c. Continue to use appropriate safeguards and comply with applicable law to prevent use or disclosure of the Confidential Information, other than as provided for in this Section, for as long as Contractor retains the Confidential Information;
  - d. Not use or disclose the Confidential Information retained by Contractor other than for the purposes for which such Confidential Information was retained and subject to the same conditions set out in this Agreement which applied prior to termination; and
  - e. Destroy in accordance with applicable law and Contractor's record retention policy that it applies to similar records, the Confidential Information retained by Contractor when it is no longer needed by Contractor for its proper management and administration or to carry out its legal responsibilities.
9. Survival. This Exhibit G *Required Protection of Confidential Information* shall survive termination or conclusion of the Agreement.

**APPENDICES**

Appendix A Value-Based Purchasing Specifications

Appendix B Business Associate Agreement

Anthem's Initials:   
Date: 8/17/17

## APPENDIX A: VALUE-BASED PURCHASING (VBP) SPECIFICATIONS

### Specification Contents:

- A. Primary Care Transformation
- B. Value-Based Payment (Alternative Payment Models)
- C. Performance Measurement
- D. Clinical Performance Data
- E. Engaging Members in Improving Care and Health Status
- F. Quality Improvement
- G. Utilization Management
- H. Clinical Pathways and High-Cost Condition Management Programs
- I. Provider Network and Access
- J. Behavioral Health Services
- K. Member Services

All work conducted pursuant to the following VBP Specifications is subject to review and approval by the State. The State may require the Contractor to take corrective action if it finds the Contractor is not providing services in conformance with the Value-Based Purchasing specifications.

A. Primary Care Transformation

1. The Contractor shall support primary care transformation, ensuring that the level and method of compensation support Patient-Centered Medical Home primary care infrastructure, through the use of enhanced fee schedules, supplemental payments and/or primary care capitation.
  - a. The Contractor shall report annually on specific steps it has taken to support transformed primary care practice, including through value-based payment arrangements.
2. Primary Care Clinician. The Contractor shall ensure that each Member, including those Members enrolled in HMO, PPO and POS products, has an identified Primary Care Clinician (PCC) and that the PCC establishes a relationship with every attributed Member if one does not already exist at the time of enrollment.
  - a. The Contractor shall annually report on the percentage of Members electing a PCC.
3. Patient-Centered Medical Home (PCMH). The Contractor shall encourage its contracted primary care practices to operate as high-functioning Patient-Centered Medical Homes.
  - a. The Contractor's contracted PCMHs shall be encouraged to provide patient-centered, team-based care across appropriate disciplines, including behavioral health, in part through the application of a common, shared care plan and clinical information exchange.
  - b. The Contractor shall ensure providers are knowledgeable in the clinical evidence for patient-centered team-based care and are increasingly practicing in such manner over the term of the contract.
  - c. The Contractor shall support PCMHs with needed data, not limited to high-risk patient lists, costs of referral providers, information regarding non-primary care utilization (e.g., inpatient care, emergency and urgent care services), quality information, utilization measures and cost measures for attributed Members.
  - d. The Contractor shall hold PCMHs accountable for performance, including for operating as a PCMH and for quality and cost efficiency.
  - e. The Contractor shall annually report on the percentage of Members electing a PCC that operates as a PCMH.
4. PCMH care coordination. The Contractor shall ensure the provision of care coordination by PCMHs for patients at high-risk of future intensive service use. Because care coordination is frequently provided by entities in addition to PCMHs, including hospitals, behavioral health providers, ACOs and the Contractor, the Contractor shall ensure these efforts are coordinated and not duplicative. See Section H below for language specific to Contractor care coordination activity.

B. Value-Based Payment (Alternative Payment Models)

1. Population-based contracting (total cost of care). The Contractor in coordination with and on behalf of the State shall pursue population-based shared risk ACO contracts with providers serving a substantial number of Members.
  - a. The contract shall be a total cost of care contract that includes nearly all, if not all, covered services, including physician services, hospital services and prescription drugs.
  - b. The distribution of any shared savings shall be contingent on achievement of clinical quality performance expectations, with greater reward for higher levels of demonstrated meaningful quality improvement over time.
  - c. To support providers entering into population-based contracts with the Contractor, the Contractor shall furnish claim data to the contracting provider entity in a manner approved by the State.
  - d. By the end of Contract Year One, claims for at least 30% percent of Members shall be covered under a multi-year population-based contract with risk sharing arrangements that meets standards identified by the State in consultation with the Contractor.
2. Pay providers differentially according to performance. Contractor shall evaluate and implement successful programs to differentiate providers who meet or exceed state or national standards for quality and efficiency. Payment to effective and efficient providers should reflect their performance. Examples include quality-based incentive payments, differential fee schedules, and fee increases at risk based on provider performance.
3. Develop episode-based payment strategies. Contractor shall work with the State and its provider network to evaluate and implement episode-based payment strategies designed to bundle a set of services together that are related to a defined condition or treatment (e.g., knee replacement surgery). Priority shall be placed on referral services delivered by providers not participating in a population-based contract on behalf of the State and with high Member service volume.
4. Design payment and coverage approaches that cut medically unnecessary spending while not diminishing quality, including by reducing unwarranted payment variation. Contractor shall evaluate, and propose to the State for implementation, successful approaches to payment designed to cut medically unnecessary spending while not diminishing quality. Examples include, but are not limited to, reference pricing, non-payment for avoidable complications and hospital-acquired infections, lower payment for non-indicated services and warranties on discharges for patients who undergo procedures.

#### C. Performance Measurement

1. Aligned measure set. If so directed by the State, the Contractor shall collaborate with New Hampshire providers, payers and employer purchasers to adopt an aligned set of performance measures to which Network Providers will be held accountable, including commonly defined measures in each of the following domains: a) access, b) quality, c) patient experience, e) service utilization, and f) cost.

2. Contractor health informatics. The Contractor shall perform analysis of claims and clinical data to identify a) population characteristics, b) variations in care delivery, costs and avoidable complications, c) provider deviation from practice guidelines and/or Clinical Pathways, d) patients at risk for future high-intensity service use. Results shall be presented to the State in writing and during meetings with Interpretation and recommendations.
3. Contractor-level measurement. The Contractor shall measure performance across all provider types and providers with meaningful volume for the Contractor's book of business. For high-volume providers, the Contractor shall create provider profile reports for use in network management and Quality Improvement (QI) activity. Results shall be presented to the State in writing and during meetings with interpretation and recommendations.
4. Provider-level measurement. The Contractor shall require contracted providers to measure performance at the clinician, practice team and/or practice site, and organizational levels.
5. Population measurement adjustment. The Contractor shall apply clinical risk adjustment techniques when measuring provider performance.

D. Clinical Performance Data

1. The Contractor shall annually report its complete HEDIS data set inclusive of CAHPS, and including State-specific data for claims-based measures, and total Contractor New Hampshire commercial book-of-business data, including enrollment, quality, Member satisfaction, and utilization data. Such a report shall be provided and presented to the State no later than July 1 of each year for performance during the preceding calendar year.
2. The Contractor shall collect and report to the State on performance using the aligned measure set referenced above in C.1, including performance of high-volume providers.
3. The Contractor shall report on performance related to annual Quality Improvement Goal achievement, consistent with the terms of the Goals and Measures approved by the State.

E. Engaging Members in Improving Care and Health Status

1. The Contractor shall collaboratively design and implement a State-approved strategy for activating Members to manage their health and to be prudent purchasers of health care through education, including health care and health insurance literacy education and through health promotion activities.
2. The Contractor shall provide education to Members on the important role a Member-PCC relationship plays in their health to encourage Member PCC selection, even when not required under the plan design.
3. The Contractor shall provide education to Members on how to access and use comparative provider price and quality information including but not limited to information available at <https://nhhealthcost.nh.gov/>.

4. The Contractor shall promote use of behavioral health services programs to support behavioral health and wellness to Members and remove the social stigma associated with behavioral health illness and services. Such efforts shall also make mention of the State's Employee Assistance Program and how its services may be accessed.
5. The Contractor shall evaluate the impact of health promotion programs and act on such information by adding, eliminating, or altering programs, based on such evaluations. At a minimum, evaluations should study effectiveness/impact, attendance and Member satisfaction resulting from such programs. The plan shall demonstrate that such findings were used in a meaningful way to improve the quality of health promotion programs.

F. Quality Improvement (QI)

1. Organizational arrangements and responsibilities for QI process are clearly defined and assigned to appropriate individuals. It is clearly indicated which persons are physicians or other clinicians.
2. There is an annual QI work plan for New Hampshire, submitted to the State, that includes the following:
  - a. Objectives, scope and planned projects or activities for the year;
  - b. Planned monitoring of previously identified issues, including tracking of issues over time; and
  - c. Planned evaluation of the QI program.
3. Hospital Quality Improvement. The Contractor shall develop a program to manage quality of care provided by network hospitals. At a minimum, such a program shall include:
  - a. Identification of data-driven opportunities to improve quality; and
  - b. Collection of Leapfrog survey responses from hospitals.

Using this, and other available information, the Contractor shall actively manage its contracted network hospitals. If the Contractor identifies deficiencies in data obtained through this process, the Contractor shall take appropriate actions (e.g., plan of correction and follow-up, financial penalties) with such hospitals.

4. Clinician Quality Improvement. The Contractor shall develop a program to manage quality of care provided by network primary care, specialty care physicians and non-physician behavioral health clinicians. At a minimum, such a program shall focus on data-driven opportunities to improve quality through active management of network physicians. If the Contractor identifies deficiencies in data obtained through this process, the Contractor shall take appropriate actions (e.g., plan of correction, financial penalties) with such clinicians.
5. Health Information Exchange. Contracted physician, behavioral health and hospital providers shall be encouraged to use real-time electronic clinical information exchange across all care settings.

#### G. Utilization Management

1. The Contractor shall have policies and procedures in place to evaluate the appropriate use of new medical technologies or new applications of established technologies, including medical procedures, drugs, and devices, as well as long-standing treatments. Procedures should include careful consideration of Comparative Effectiveness Research in order to a) protect the health and safety of Members, and b) reduce unnecessary spending.
2. The Contractor shall have a process for assessing patient compliance with prescriptions.
3. The Contractor shall have a process for assessing under-utilization and over-utilization.
4. The Contractor shall produce an annual report of the findings on quality and utilization measures and completed or planned interventions to address under or over-utilization patterns of care for physical and behavioral health, including pharmaceutical use. The following measures set shall be reported in the annual report:
  - a. Potentially preventable hospitalizations, including readmissions, and
  - b. Potentially avoidable emergency department visits.
5. The Contractor shall annually track programs that traditionally include utilization management/review so that it can be reviewed by the State, e.g., prior approval of advanced imaging, prior approval of physical therapy. The Contractor shall annually identify and report to the State the cost-effectiveness of such activity, and opportunities to improve program effectiveness.

#### H. Clinical Pathways and High-Cost Condition Management Programs

1. The Contractor shall be accountable for adopting and using Clinical Pathways or explicit criteria that are based on reasonable scientific evidence and reviewed by Contractor-contracted providers. The Contractor shall implement a process for updating the guidelines periodically and for communicating the Clinical Pathways to the Contractor's network. The Contractor shall assess provider performance against the Clinical Pathways and act on the performance results. The results of the assessment and ensuing action shall be reported to the State annually.
2. Contracted providers shall be required to specify and implement Clinical Pathways reflective of evidence-based practice, designed to maximize patient health status, clinical outcomes and efficiency, and to eliminate overuse. For example, a Clinical Pathway may include treatment steps for treating an individual with COPD.
3. The Contractor shall develop and implement a program of care coordination for Members one or more high-cost, high-frequency conditions or diseases to maximize their health status and ensure appropriate service utilization. The Contractor shall implement such programs based on a) the profile of high-risk Members, and b) the prevalence of associated conditions and diseases in the enrolled population. Such conditions and diseases might include: High-Risk Pregnancy, Chronic Obstructive Pulmonary Disease, Diabetes, Depression, Cardiovascular Disease, Low Back Pain, and/or Hypertension.

4. The Contractor shall stratify high-risk Members based on consideration of clinical and social determinant-of-health factors.
    - a. The Contractor shall report annually on its method for stratifying the Member population to identify potentially high-cost Members, including how it is capturing and considering social-determinant-of-health factors.
- I. Provider Network and Access
1. The Contractor maintains and monitors a network of qualified providers in sufficient numbers, mix, and geographic locations throughout the state, and where appropriate in regions contiguous to the state, for the provision of all covered services.
    - a. The Contractor will maintain the following geographic access standards from the individual patient's residence:
      - i. Hospital – Licensed medical-surgical, pediatric, obstetrical and critical care services associated with acute care hospital services within 45 miles
      - ii. Primary Care – Two open-panel primary care providers within 15 miles
      - iii. Outpatient mental health and substance use treatment – One provider within 25 miles
      - iv. Specialist Care – One provider within 45 miles for: Allergists, Cardiologists, General surgeons, Neurologists, Obstetrician/gynecologists, Oncologists, Ophthalmologists, Orthopedists, Otolaryngologists, Psychiatrists, and Urologists
    - b. The Contractor shall adopt NH Insurance Department (NHID) standards of access for all other services and maintain provider network data and shall submit provider network data to the State annually. The provider network data will support Member PCC selection and shall therefore include an accurate provider directory.
  2. The Contractor shall establish and comply with access standards that are no longer than the following (standards shall be measured from the initial request for an appointment):
    - a. Emergency medical care shall be available twenty-four (24) hours per day, seven (7) days per week.
    - b. Urgent, symptomatic office visits shall be available within twenty-four (24) hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not emergent.
    - c. Non-urgent, symptomatic (i.e., routine care) office visits, including behavioral health services, shall be available within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.
    - d. Non-symptomatic (i.e., preventive care) office visits within ninety (90) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

- e. Transitional health care services by a PCC shall be available for clinical assessment and care planning within 48 hours of discharge from Inpatient or Institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.

The Contractor shall report on compliance with these requirements in a manner and frequency defined by the State after consultation with the Contractor. Failure to meet network or appointment access standards may, at the State's sole discretion, result in sanctions.

3. Within the first 12 months of the contract start, the Contractor shall provide the State with information on strategic options for implementing Centers of Excellence, and including options regarding how to engage Members if a Centers of Excellence program is implemented voluntarily for members. Should the State decide to pursue a Centers of Excellence program, the Contractor will support the State by creating such a program.

#### J. Behavioral Health Services

1. The Contractor shall provide direct access without referral to behavioral health service providers within the network and communicate such availability to Members.
2. The Contractor shall employ a process to ensure that early detection and referral for depression and/or substance use problems in Members occurs and that primary care physicians are adequately trained to perform, code and bill such screenings.
3. Treatment shall be delivered based upon clinical assessment of individual patient need.
4. The Contractor shall take action to support the advancement of integrated care that addresses behavioral health needs and social determinants of health concurrently with physical health needs. The Contractor shall do so:
  - a. Through innovative contracting and payment models that support integrated care in both co-located and non-co-located arrangements and foster joint accountability for physical and behavioral health needs;
  - b. Through training and technical assistance opportunities regarding best practice in integrated care, including but not limited to the Collaborative Care Model, and
  - c. Protocols for provider information exchange of behavioral health data to support improved patient care, as permitted by law.
5. The Contractor shall address New Hampshire's opioid epidemic by a) making conformance with the New Hampshire Board of Medicine guidelines for physicians who prescribe opioids a contractual requirement, and b) facilitating Member access to Medication-Assisted Treatment and other appropriate modalities of care.

#### K. Member Satisfaction

1. The Contractor shall actively seek and utilize input from consumers as an integral part of its quality management programs. Consumer input must include data obtained from individuals who are either chronically ill or who utilize a substantial amount of services. The Contractor must also obtain input from information available within the plan including,

but not limited to, data on the resolution of member inquiries, complaints, grievances and appeals as well as from at least one of the following sources:

- a. Member focus groups;
  - b. Member surveys (telephone and/or mail or email), and
  - c. Open meetings to obtain Member Input.
2. The Contractor shall provide quarterly reports summarizing member satisfaction survey results.

## APPENDIX B: BUSINESS ASSOCIATE AGREEMENT

The Contractor Identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 and those parts of the HITECH Act applicable to business associates. As defined herein, "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean Contractor. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this Agreement shall mean the State of New Hampshire Department of Administrative Services Employee and Retiree Health Benefit Program. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

### BUSINESS ASSOCIATE AGREEMENT

#### 1. Definitions

- a. The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.
- b. All terms not otherwise defined herein shall have the same meaning as those set forth in the HIPAA Rules.

#### 2. Privacy and Security of Protected Health Information (PHI)

##### a. Permitted Uses and Disclosures

- i. Business Associate shall not use, disclose, maintain or transmit PHI except as reasonably necessary to provide the services set forth in this Agreement or any agreement between the parties, or as required by law.
- ii. Business Associate is authorized to use PHI to de-identify the information in accordance with 45 CFR 164.514(a)-(c). Business Associate shall de-identify the PHI in a manner consistent with HIPAA Rules. Uses and disclosures of the de-identified information shall be limited to those consistent with the provisions of this Agreement.
- iii. Business Associate may use PHI as necessary to perform data aggregation services, and to create Summary Health Information and/or Limited Data Sets. Contractor shall use appropriate safeguards to prevent use or disclosure of the information other than as provided for herein, shall ensure that any agents or subcontractors to whom it provides such information agree to the same restrictions and conditions that apply to Contractor, and not identify the Summary Health Information and/or Limited Data Sets or contact the individuals other than for the management, operation and administration of the Plan.

- iv. Business Associate may use and disclose PHI (a) for the management, operation and administration of the Plan, (b) for the services set forth in the ASO Agreement, which include (but are not limited to) Treatment, Payment activities, and/or Health Care Operations as these terms are defined in this Agreement and 45 C.F.R. § 164.501, and (c) as otherwise required to perform its obligations under this Agreement and the ASO Agreement, or any other agreement between the parties provided that such use or disclosure would not violate the HIPAA Regulations.
  - v. Business Associate may disclose, in conformance with the HIPAA Rules, PHI to make disclosures of De-identified Health Information, Limited Data Sets, and Summary Health Information. Contractor shall use appropriate safeguards to prevent use or disclosure of the information other than as provided for herein, ensure that any agents or subcontractors to whom it provides such information agree to the same restrictions and conditions that apply to Contractor, and not identify the De-identified Health Information, Summary Health Information and/or Limited Data Sets or contact the individuals. Business Associate may also disclose, in conformance with the HIPAA Regulations, PHI to Health Care Providers for permitted purposes including health care operations.
  - vi. Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of Business Associate. To the extent Business Associate discloses PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (a) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (b) an agreement from such third party to notify Business Associate of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.
  - vii. To the extent practicable, Business Associate shall not, unless such disclosure is reasonably necessary to provide services outlined in the Agreement, disclose any PHI in response to a request for disclosure on the basis it is required by law without first notifying Covered Entity. In the event Covered Entity objects to the disclosure it shall seek the appropriate relief and the Business Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.
- b. Minimum Necessary. Business Associate will, in its performance of the functions, activities, services, and operations specified above, make reasonable efforts to use, to disclose, and to request only the minimum amount of PHI reasonably necessary to accomplish the intended purpose of the use, disclosure, or request, except that Business Associate will not be obligated to comply with this minimum-necessary limitation if neither Business Associate or Covered Entity is required to limit its use, disclosure, or request to the minimum necessary under the HIPAA Rules. Business Associate and Covered Entity acknowledge that the phrase "minimum necessary" shall be interpreted in accordance with the HITECH Act and the HIPAA Rules.

- c. Prohibition on Unauthorized Use or Disclosure. Business Associate may not use or disclose PHI except (1) as permitted or required by this Agreement, or any other agreement between the parties, (2) as permitted in writing by Covered Entity, or (3) as authorized by the individual or (4) as Required by Law. This agreement does not authorize Business Associate to use or disclose Covered Entity's PHI in a manner that would violate the HIPAA Rules if done by Covered Entity, except as permitted for Business Associate's proper management and administration as described herein.

3. Information Safeguards

- a. Privacy of Protected Health Information. Business Associate will develop, implement, maintain, and use appropriate administrative, technical, and physical safeguards to protect the privacy of PHI. The safeguards must reasonably protect PHI from any intentional or unintentional use or disclosure in violation of the Privacy Rule and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by this Agreement. To the extent the parties agree that the Business Associate will carry out directly one or more of Covered Entity's obligations under the Privacy Rule, the Business Associate will comply with the requirements of the Privacy Rule that apply to the Covered Entity in the performance of such obligations.
- b. Security of Covered Entity's Electronic Protected Health Information. Business Associate will comply with the Security Rule and will use appropriate administrative, technical and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic PHI that Business Associate creates, receives, maintains or transmits on Covered Entity's behalf.
- c. No Transfer of PHI Outside United States. Business Associate will not transfer PHI outside the United States without the prior written consent of the Covered Entity. In this context a "transfer" outside the United States occurs if Business Associate's workforce members, agents, or Subcontractors physically located outside the United States are able to, store, copy or disclose PHI.
- d. Subcontractors. Business Associate will require each of its Subcontractors to agree, in a written agreement with Business Associate, to comply with the provisions of the Security Rule; to appropriately safeguard PHI created, received, maintained, or transmitted on behalf of the Business Associate; and to apply the same restrictions and conditions that apply to the Business Associate with respect to such PHI.
- e. Prohibition on Sale of Protected Health Information. Business Associate shall not engage in any sale (as defined in the HIPAA rules) of PHI.
- f. Prohibition on Use or Disclosure of Genetic Information. Business Associate shall not use or disclose Genetic Information for underwriting purposes in violation of the HIPAA rules.
- g. Penalties for Noncompliance. Business Associate acknowledges that it is subject to civil and criminal enforcement for failure to comply with the HIPAA Rules, to the extent provided with the HITECH Act and the HIPAA Rules.

4. Compliance With Electronic Transactions Rule

- a. If Business Associate conducts in whole or part electronic Transactions on behalf of Covered Entity for which HHS has established standards, Business Associate will comply, and will require any Subcontractor it involves with the conduct of such Transactions to comply, with each applicable requirement of the Electronic Transactions Rule and of any operating rules adopted by HHS with respect to Transactions.

5. Individual Rights and PHI

a. Access

- i. Business Associate shall respond to an individual's request for access to his or her PHI as part of Business Associate's normal customer service function, if the request is communicated to Business Associate directly by the individual or the individual's personal representative. Business Associate shall respond to the request with regard to PHI that Business Associate and/or its Subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.
- ii. In addition, Business Associate shall assist Covered Entity in responding to requests made to Covered Entity by individuals to invoke a right of access under the HIPAA Privacy Regulation. Upon receipt of written notice (including fax and email) from Covered Entity, Business Associate shall make available to Covered Entity, or at Covered Entity's direction to the individual (or the individual's personal representative), any PHI about the individual created or received for or from Covered Entity in the control of Business Associate's and/or its Subcontractors for inspection and obtaining copies so that Covered Entity may meet its access obligations under 45 CFR 164.524, and, where applicable, the HITECH Act. Business Associate shall make such information available in an electronic format where required by the HITECH Act.

b. Amendment

- i. Business Associate shall respond to an individual's request to amend his or her PHI as part of Business Associate's normal customer service functions, if the request is communicated to Business Associate directly by the individual or the individual's personal representative. Business Associate shall respond to the request with respect to the PHI Business Associate and its Subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.
- ii. In addition, Business Associate shall assist Covered Entity in responding to requests made to Covered Entity to invoke a right to amend under the HIPAA Privacy Regulation. Upon receipt of written notice (including fax and email) from Covered Entity, Business Associate shall amend any portion of the PHI created or received for or from Covered Entity in the custody or control of Business Associate and/or its Subcontractors so that Covered Entity may meet its amendment obligations under 45 CFR 164.526.

c. Disclosure Accounting

- i. Business Associate shall respond to an individual's request for an accounting of disclosures of his or her PHI as part of Business Associate's normal customer service function, if the request is communicated to the Business Associate directly by the individual or the individual's personal representative. Business Associate shall respond to a request with respect to the PHI Business Associate and its Subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.
- ii. In addition, Business Associate shall assist Covered Entity in responding to requests made to Covered Entity by individuals or their personal representatives to invoke a right to an accounting of disclosures under the HIPAA Privacy Regulation by performing the following functions so that Covered Entity may meet its disclosure accounting obligation under 45 CFR 164.528:
  - iii. Disclosure Tracking. Business Associate shall record each disclosure that Business Associate makes of individuals' PHI, which is not excepted from disclosure accounting under 45 CFR 164.528(a)(1).
  - iv. Disclosure Information. The information about each disclosure that Business Associate must record ("Disclosure Information") is (a) the disclosure date, (b) the name and (if known) address of the person or entity to whom Business Associate made the disclosure, (c) a brief description of the PHI disclosed, and (d) a brief statement of the purpose of the disclosure or a copy of any written request for disclosure under 45 Code of Federal Regulations §164.502(a)(2)(ii) or §164.512. Disclosure Information also includes any information required to be provided by the HITECH Act.
  - v. Repetitive Disclosures. For repetitive disclosures of individuals' PHI that Business Associate makes for a single purpose to the same person or entity (including to Covered Entity or Employer), Business Associate may record (a) the Disclosure Information for the first of these repetitive disclosures, (b) the frequency, periodicity or number of these repetitive disclosures, and (c) the date of the last of these repetitive disclosures.
  - vi. Exceptions from Disclosure Tracking. Business Associate will not be obligated to record Disclosure Information or otherwise account for disclosures of PHI if Covered Entity need not account for such disclosures under the HIPAA Rules.
  - vii. Disclosure Tracking Time Periods. Unless otherwise provided by the HITECH Act and/or any accompanying regulations, Business Associate shall have available for Covered Entity the Disclosure Information required by Section 3.j.iii.2 above for the six (6) years immediately preceding the date of Covered Entity's request for the Disclosure Information.

d. Confidential Communications

- i. Business Associate shall respond to an individual's request for a confidential communication as part of Business Associate's normal customer service function, if the request is communicated to Business Associate directly by the individual or the individual's personal representative. Business Associate shall respond to the request with respect to the PHI Business Associate and its Subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation. If an individual's request, made to Business Associate, extends beyond information held by Business Associate or Business Associate's Subcontractors, Business Associate shall refer individual to Covered Entity. Business Associate assumes no obligation to coordinate any request for a confidential communication of PHI maintained by other business associates of Covered Entity.
- ii. In addition, Business Associate shall assist Covered Entity in responding to requests to it by individuals (or their personal representatives) to invoke a right of confidential communication under the HIPAA Privacy Regulation. Upon receipt of written notice (including fax and email) from Covered Entity, Business Associate will begin to send all communications of PHI directed to the individual to the identified alternate address so that Covered Entity may meet its access obligations under 45 CFR 164.524.

e. Restrictions

- i. Business Associate shall respond to an individual's request for a restriction as part of Business Associate's normal customer service function, if the request is communicated to Business Associate directly by the Individual (or the individual's personal representative). Business Associate shall respond to the request with respect to the PHI Business Associate and its Subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.
- ii. In addition, Business Associate shall promptly, upon receipt of notice from Covered Entity, restrict the use or disclosure of individuals' PHI, provided the Business Associate has agreed to such a restriction. Covered Entity agrees that it will not commit Business Associate to any restriction on the use or disclosure of individuals' PHI for treatment, payment or health care operations without Business Associate's prior written approval.

6. Breach

- a. Business Associate shall report to Covered Entity, in writing, any use or disclosure of PHI in violation of the Agreement promptly upon discovery of such incident, including any Security Incident involving PHI, ePHI, or Unsecured PHI as required by 45 CFR 164.410. Such report shall not include instances where Business Associate inadvertently misroutes PHI to a provider, as long as the disclosure is not a Breach as defined under 45 CFR § 164.402. The parties acknowledge and agree that attempted but Unsuccessful Security Incidents (as defined below) that occur on a daily basis will not be reported. "Unsuccessful Security Incidents" shall include, but not be limited to, pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service

and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of PHI.

- b. Business Associate shall report a Breach or a potential Breach to Covered Entity upon discovery of any such incident. Business Associate will treat a Breach or potential Breach as being discovered as of the first day on which such incident is known to Business Associate, or by exercising reasonable diligence, would have been known to Business Associate. Business Associate shall be deemed to have knowledge of a Breach or potential Breach if such incident is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Breach, who is an employee, officer or other agent of Business Associate. If a delay is requested by a law-enforcement official in accordance with 45 CFR § 164.412, Business Associate may delay notifying Covered Entity for the applicable time period. Business Associate's report will include at least the following, provided that absence of any information will not be cause for Business Associate to delay the report:
- i. Identify the nature of the Breach, which will include a brief description of what happened, including the date of any Breach and the date of the discovery of any Breach;
  - ii. Identify the scope of the Breach, including the number of Covered Entity members involved as well as the number of other individuals involved;
  - iii. Identify the types of PHI that were involved in the Breach (such as whether full name, Social Security number, date of birth, home address, account number, diagnosis, or other information were involved);
  - iv. Identify who made the non-permitted use or disclosure and who received the non-permitted disclosure;
  - v. Identify what corrective or investigational action Business Associate took or will take to prevent further non-permitted uses or disclosures, to mitigate harmful effects, and to protect against any further Breaches;
  - vi. Identify what steps the individuals who were subject to a Breach should take to protect themselves;
  - vii. Provide such other information as Covered Entity may reasonably request.
- c. Security Incident. Business Associate will promptly upon discovery of such incident report to Covered Entity any Security Incident of which Business Associate becomes aware. Business Associate will treat a Security Incident as being discovered as of the first day on which such incident is known to Business Associate, or by exercising reasonable diligence, would have been known to Business Associate. Business Associate shall be deemed to have knowledge of a Security Incident if such incident is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Security Incident, who is an employee, officer or other agent of Business Associate. If any such Security Incident resulted in a disclosure not permitted by this Agreement or Breach of Unsecured PHI, Business Associate will make the report in accordance with the provisions set forth above.

- d. Mitigation. Business Associate shall mitigate, to the extent practicable, any harmful effect known to the Business Associate resulting from a use or disclosure in violation of this Agreement.
- e. Breach Notification to Third Parties. Business Associate will handle breach notifications to individuals, the United States Department of Health and Human Services Office for Civil Rights, and, where applicable, the media. Should such notification be necessary, Business Associate will ensure that Covered Entity will receive notice of the breach prior to such incident being reported.

7. Term and Termination

- a. The term of this Agreement shall be effective as of September 13, 2017, or Governor and Executive Council approval, and shall terminate on December 31, 2020 or on the date covered entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.
- b. In addition to general provision # 10 of this Agreement the Covered Entity may, as soon as administratively feasible, terminate the Agreement upon Covered Entity's knowledge of a material breach by Business Associate of the Business Associate Agreement set forth herein as Appendix B. Prior to terminating the Agreement, the Covered Entity may provide an opportunity for Business Associate to cure the alleged breach within a reasonable timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity may report the violation to the Secretary.
- c. Upon termination of this Agreement for any reason, Business Associate, with respect to PHI received from Covered Entity, or created, maintained or received by Business Associate on behalf of Covered Entity, shall:
  - i. Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;
  - ii. Destroy, in accordance with applicable law and Business Associate's record retention policy that it applies to similar records, the remaining PHI that Business Associate still maintains in any form;
  - iii. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI;
  - iv. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out in this Agreement which applied prior to termination; and
  - v. Destroy in accordance with applicable law and Business Associate's record retention policy that it applies to similar records, the PHI retained by Business Associate when it is no longer needed by Business Associate

for its proper management and administration or to carry out its legal responsibilities.

- d. The above provisions shall apply to PHI that is in the possession of any Subcontractors of Business Associate. Further Business Associate shall require any such Subcontractor to certify to Business Associate that it has returned or destroyed all such information which could be returned or destroyed.
- e. Business Associate's obligations under this Section 7.c. shall survive the termination or other conclusion of this Agreement.

#### 8. Covered Entity's Responsibilities

- a. Covered Entity shall be responsible for the preparation of its Notice of Privacy Practices ("NPP"). To facilitate this preparation, upon Covered Entity's request, Business Associate will provide Covered Entity with its NPP that Covered Entity may use as the basis for its own NPP. Covered Entity will be solely responsible for the review and approval of the content of its NPP, including whether its content accurately reflects Covered Entity's privacy policies and practices, as well as its compliance with the requirements of 45 C.F.R. § 164.520. Unless advance written approval is obtained from Business Associate, Covered Entity shall not create any NPP that imposes obligations on Business Associate that are in addition to or that are inconsistent with the HIPAA Rules.
- b. Covered Entity shall bear full responsibility for distributing its own NPP.
- c. Covered Entity shall notify Business Associate of any change(s) in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such change(s) may affect Business Associate's use or disclosure of such PHI.

#### 9. Miscellaneous

- a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the HIPAA Rules as in effect or as amended.
- b. Amendment. Covered Entity and Business Associate agree to take action to amend the Agreement as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.
- c. Business Associate shall make available all of its internal practices, policies and procedures, books, records and agreements relating to its use and disclosure of Protected Health Information to the United States Department of Health and Human Services as necessary, to determine compliance with the HIPAA Rules and with this Appendix B.
- d. Interpretation. The parties agree that any ambiguity in the Agreement shall be interpreted to permit compliance with the HIPAA Rules.
- e. Severability. If any term or condition of this Appendix B or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or

condition; to this end the terms and conditions of this Appendix B are declared severable.

- f. Survival. Provisions in this Appendix B regarding the use and disclosure of PHI, return or destruction of PHI, confidential communications and restrictions shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Appendix B.

The State of New Hampshire Employee  
and Retiree Health Benefit Program



Signature of Authorized Representative

CHARLES M. ARLINGHAUS

Name of Authorized Representative

Commissioner

Title of Authorized Representative

8/25/17

Date

Anthem Health Plans of NH, Inc. d/b/a  
Anthem Blue Cross and Blue Shield of NH



Signature of Authorized Representative

LISA M. GUENTHER

Name of Authorized Representative

President

Title of Authorized Representative

8/17/17

Date