Maryland Association of Health Underwriters

National Association of Insurance and Financial Advisors of Maryland

A HEALTH INSURANCE EXCHANGE FOR MARYLAND?

Comparing Massachusetts and Maryland

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I. Background and Overview

In April 2006, the state of Massachusetts passed -- and has since implemented -- the most dramatic health care reform the U.S. had ever seen at the state level. This broad health reform included a mandate on individuals to purchase health insurance and over $800 million annually in funds dedicated to subsidizing low income individuals to purchase insurance. It also included a new concept for selling insurance to individuals and small businesses: the Commonwealth Choice program offered through the Commonwealth Health Connector.

The Commonwealth Choice plan took a fragmented non-group market and organized it into a shopping format that was easy for consumers to access and to understand through the Connector. Enrollees were offered a choice of three levels of plan generosity (Bronze, Silver and Gold) with offerings from six different insurers at each level. They could use brokers or shop directly through the Connector's award-winning website, www.mahealthconnector.org. To date, Commonwealth Choice has been a major success in the nongroup market, with roughly 20,000 enrollees, or about 25% of that total market (and about 50% of new enrollees since health reform). Its impact in the small group market has been much more limited, with only a handful of small businesses enrolled.

The Commonwealth Choice program was the result of a major government intervention by the newly appointed Commonwealth Health Connector. In establishing the Commonwealth Choice program, the Connector built upon an existing intermediary (third party administrator) in the small group insurance market, which acted as a "subconnector" to undertake many of the administrative aspects of the Commonwealth Choice program. But the program went far beyond anything that the subconnector would have been able to do on its own.

The success of the reform generally, and the Connector specifically, in Massachusetts has motivated similar approaches both at the Federal level and in other states. Virtually every current proposal for reform at the state and Federal level includes some form of "exchange" that would organize and sell health insurance in the non-group and small group markets. The popularity of this approach raises the important question of whether the Massachusetts model can be replicated – and how much government involvement is required to make that a reality. The answer will clearly vary from place to place, and with the details of the proposed exchange.

In this report, we evaluate the possibility of setting up an exchange in Maryland. We begin with a detailed description of the non-group and small group markets in Massachusetts before health reform. We then discuss health reform in that state, discussing both the establishment of the Connector and its early role in health reform. We next turn to an evaluation of the non-group and small group markets in Maryland, and in particular the much more significant role played by intermediaries in that state. In many senses, intermediaries in Maryland play a role much like the Connector plays in Massachusetts. This makes the transition to an exchange much less onerous in Maryland. On the other hand, there are a number of important policy issues which must be addressed before moving to an exchange environment in Maryland, in particular the government role in selectively contracting with insurers through the Connector.

This report was commissioned by the National Association of Insurance & Financial Advisors of Maryland ("NAIFA-MD") and the Maryland Association of Health Underwriters ("MAHU"). This commission followed on a request from Maryland legislative leaders to these organizations to compare the capabilities of the Massachusetts Connector with those of the current, private sector based system of distributing health insurance in Maryland. The scope of the study, and of this report, is limited. It does not examine the entire health insurance distribution system in detail. Rather, the report compares the principal functions of the Connector with similar functions available through certain third party administrators (TPAs) in Maryland. While TPAs play a prominent role in the Maryland health insurance market, they are not an exclusive distribution channel for health insurance in that State.

II. Overview of the Massachusetts Non-Group and Small Group Health Insurance Markets Prior to Health Reform

This section provides an overview of the Massachusetts non-group (i.e., individual) and small group health insurance markets prior to the 2006 health reform law. It provides context for the changes to the health reform law in Massachusetts and the role of the Connector, including a review of the regulatory environment, the number of carriers, the general profile of the markets (e.g., membership, types of products offered), the role of health insurance brokers, and the role of intermediaries.

Non-Group Market

Regulatory Environment

Unlike most states, the Commonwealth's non-group market prohibited insurers from using an individual's health status to base premiums (i.e., no medical underwriting); required guaranteed issue; allowed for continuous open enrollment; placed limits on the types and duration of exclusions for pre-existing conditions and waiting periods; and used a modified community rating system that limited the spread in premiums among members of a health plan. Non-group rates were set on a calendar year basis, subject to review and approval by the state's Division of Insurance.

The modified community rating system restricted the difference in premiums that could be charged to enrollees through the use of a 2:1 rate band, and limited the types of rating factors that could be used to set the premiums. In effect, the state's insurers could charge older applicants no more than twice the premium for the same health plan that they charged younger applicants.

Health insurance brokers, also known as producers, are licensed by the state to assist individuals and employers (groups) with the purchase of insurance from health carriers. Brokers are not agents of the insurance companies, but are agents for the purchaser (i.e., employer or individual consumer). Brokers are typically paid through retention of a portion of the premium. Brokers obtain premium quotes, advise the individual or employer of their health plan options, explain benefits, assist with enrollment, and may be called upon during the year to help resolve problems or otherwise serve as the individual's or the employer's ombudsman with the health insurer. Brokers may also provide compliance-related services on behalf of their clients.

Intermediaries, also known as third party administrators or general agents, are also licensed and regulated by the state. They provide administrative services, including enrollment, premium billing and collection, mid-year changes in enrollment, COBRA administration, and other administrative services. Unlike brokers, intermediaries do not sell insurance, although many intermediaries also have a brokerage business that does sell insurance. In the non-group and small group markets, intermediaries handle a number of administrative functions that for large employers are usually handled by the health carrier or the employer's human resources staff. Intermediaries are typically paid by the health carrier through retention of a portion of the premium.

The state also dictated the schedule of benefits and cost sharing of health plans sold in the non-group market. Carriers could offer two HMO plans, with the major difference between the two plans being the level of co-payments and the presence or absence of prescription drug coverage; and two PPO plans -- one with a $250 deductible that included prescription drug coverage and another with a $5,000 deductible without prescription drug coverage. Most carriers offered only the HMO plans.

Also in contrast to most states, self-employed individuals (i.e., "groups of one") in Massachusetts were allowed to purchase coverage in the Massachusetts small group market. In most states, including Maryland, small group rules do not allow self-employed to purchase insurance in the small group market, and instead must turn to the non-group market to obtain health insurance.

Prior to Massachusetts' health reform law, each carrier's non-group business was pooled separately from the carrier's small group business. Premiums for non-group plans were based on the claims experience of the carrier's non-group membership; while premiums for small group plans were based on the claims experience of the carrier's small group membership. The 2006 health reform law required carriers to merge these two markets into a combined non-group and small group risk pool for the purpose of establishing premiums.

Carriers

Ten carriers offered insurance in the state's non-group market. However, approximately 80% of non-group members were covered by Blue Cross Blue Shield of Massachusetts (BCBS-MA) and 15% were covered by Harvard Pilgrim Health Care (HPHC).

Membership

In 2006, approximately 45,000 people were covered in Massachusetts' non-group market, representing less than one percent of the Commonwealth's population. This was due in part to the ability of self-employed individuals to purchase coverage in the small group market, but also due to premiums in the Massachusetts non-group market being the highest in the country.[1]

On average, individuals purchasing coverage in the state's non-group market were older and sicker than those covered in the small group market. A 2006 comparison of the non-group and small group markets revealed that average monthly claims costs for the 45,000+/- members of the non-group market were 43% higher than the average monthly claims costs for the 750,000+/- people insured in the small group market. Medical claims in the non-group market averaged

[1] According to the AHIP Center for Policy and Research's December 2007 report, "Individual Health Insurance 2006 – 2007: A Comprehensive Survey of Premiums, Availability, and Benefits," premiums for non-group coverage in Massachusetts were the highest in the nation, more than three times above the national average (http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf).

$375 per member per month (PMPM) in 2005 compared to $262 PMPM in the small group market.[2]

Over 90% of the people insured in the non-group market were enrolled in an HMO plan, with membership roughly split between the two types of HMO plans available. Fewer than 10% of members were enrolled in a PPO plan.

Role of Brokers and Intermediaries

Health insurance brokers and intermediaries did not play a role in the Massachusetts non-group market prior to the 2006 health reform law. Carriers did not pay commissions to brokers for non-group business; the types of health coverage available was strictly limited and highly regulated; and one carrier covered the majority of non-group members. Individuals in the non-group health insurance market purchased coverage directly from the health carriers.

Small Group Market

Regulatory Environment

Unlike the state's non-group market, which greatly restricted the types of health plans offered by carriers and subjected the rates to approval by the Division of Insurance, the Commonwealth's small group market allowed carriers to offer a broad range of products. Health plans and premiums were subject to "file and use" rules of the Division of Insurance, as opposed to the "file and approve" requirements in the non-group market.

However, the regulations and rating rules in the small group market were virtually identical to those in the state's non-group market. Medical underwriting was not allowed; limits were placed on pre-existing condition exclusions and waiting periods; plans were sold on a guaranteed issue and guaranteed renewal basis; and modified community rating rules restricted the variation in rates to no more than 2:1.

Age was the primary rating factor in the small group market, just as it was in the state's non-group market. However, carriers were also allowed to use industry, group size and participation level[3] in setting rates. All of these rating factors were subject to the 2:1 rate band. Outside of the 2:1 band, carriers were allowed to make rate adjustments for area (i.e., geographic location of

[2] "Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets," Massachusetts Division of Insurance, prepared by Gorman Actuarial, LLC, December 2006.

[3] The participation level that could be used as a rating factor is separate and apart from the underwriting requirements that carriers used in the small group market. In general, carriers would not offer small group policies to groups of five or fewer employees unless 100% of eligible (and not exempt) employees participated, and would not offer small group policies to groups of six or more employees if fewer than 75% of eligible (and not exempt) employees participated. Exemptions were typically limited to employees covered through their spouse.

the group), participation in wellness programs, and were permitted to offer a discount to groups that used an intermediary. Carriers used only the area adjustment as a rating factor in the small group market, and did not use wellness participation or offer a discount if the business was placed through an intermediary.

Carriers

Ten carriers actively participated in the small group market. Unlike the non-group market -- which was dominated by BCBS-MA -- the small group market was relatively competitive. BCBS-MA covered close to 50% of the small group market, while HPHC and Tufts Health Plan each covered approximately 18% of the market. In addition, four regional HMOs -- Fallon Community Health Plan, Health New England, ConnectiCare, and Neighborhood Health Plan -- had a combined market share of roughly 10%. Table 1 displays the market share for carriers with at least 5,000 covered lives in the Massachusetts small group market in 2005, the year prior to enactment of the health reform law.

Table 1
Massachusetts Small Group Membership by Carrier
December 2005

Insurer	Members	Percentage of Small Group Market
BCBS-MA	357,588	47%
Tufts Health Plan	136,083	18%
HPHC	135,233	18%
Fallon Community Health Plan	35,037	5%
Health New England	24,831	3%
MEGA Life and Health	14,686	2%
Mid-West National	14,638	2%
United Healthcare	11,642	2%
Neighborhood Health Plan	10,744	1%
ConnectiCare	6,426	1%
All other carriers	13,024	2%
Total	759,922	

Membership

The 760,000 individuals covered in the Massachusetts small group market prior to health reform represented roughly 12% of the 6.4 million residents of the Commonwealth, or 16% of the 4.6 million people who were commercially insured (i.e., excluding Medicare and Medicaid enrollees). The majority of people in the small group market were enrolled in HMO plans (approximately 87%), which provided comprehensive coverage with relatively modest cost sharing and no deductibles or co-insurance.

Role of Brokers and Intermediaries

In contrast to the non-group market, brokers played a significant role in the small group market, as did intermediaries for a sub-set of the small group market. The role of intermediaries in Massachusetts' small group market was segmented by carrier and by the size of the group.

With the notable exception of BCBS-MA, most health insurers operating in Massachusetts[4] required groups with five or fewer employees to utilize the services of an intermediary for premium quoting, enrollment, premium billing and collection, change in status, late payment and termination letters, COBRA, renewals, and other administrative functions.

There were three main intermediaries operating in the state -- Massachusetts Business Association (MBA Group), Northeast Business Trust (NBT), and Small Business Service Bureau (SBSB).[5] In addition, a few smaller entities (e.g., chambers of commerce) performed intermediary-like services in the small group market.

In addition to handling enrollment, premium billing and collection, and other account management functions, the intermediaries assisted small employers with ancillary lines of coverage, including dental, vision, disability, and life insurance. This allowed an employer to receive one bill and have one point of contact for all of its employee benefits.

The intermediary would send a single bill that included the premiums due for the various types of insurance offered by the employer. The intermediary would then distribute the employer's payment to the appropriate carriers.

Small employers with six or more employees did not use an intermediary,[6] but almost all used a broker to assist with the purchase of health insurance. Brokers in this segment of the small group market placed business directly with the health carriers. While brokers would assist the account throughout the year as issues arose, many of the administrative services that were handled by intermediaries in the one-to-five life groups were handled directly by the carriers for groups of six or more employees (e.g., premium billing and collection, change in status, late payment letters, termination letters, etc.). Brokers focused primarily on obtaining quotes and reviewing plan options with employers during the annual renewal process.

As noted at the top of this section, BCBS-MA did not use intermediaries, but serviced all small group accounts, including groups of five or fewer employees, using in-house staff. In addition,

[4] MEGA Life and Health and Mid-West National had a network of sales people and did not use the services of the intermediaries. One carrier, Fallon Community Health Plan (FCHP), allowed groups of five or less the option of writing business through an intermediary or directly with FCHP.

[5] In 2008, MBA Group and NBT merged operations.

[6] Intermediaries were allowed by the carriers to service groups of six to nine employees. However, brokers typically dealt directly with carriers for these groups and did not use intermediaries.

unlike the other insurers in the market, BCBS-MA did not pay commissions to brokers for groups with five or fewer employees. For groups of six or more employees, BCBS-MA operated much like the other carriers in the market with regard to the use of brokers, including paying commissions and bonuses.

According to the largest intermediary, approximately two-thirds of employers in this market segment (i.e., five or fewer employees) utilized the services of a broker in purchasing health insurance. Of those that did not use a broker, most were self-employed (i.e., groups of one).[7] The intermediaries paid commissions to approximately 2,000 brokers that were active in the small group market. Brokers tended to utilize the services of one intermediary to place all of their small group business.

The commissions paid to brokers are not the same across all carriers, and the amount typically varies based on the volume of premiums generated by the broker. In general, brokers are paid between 3.5% and 4.5% of premiums in the Massachusetts small group market, although the percentage tends to decline as the broker's total volume of premiums with a carrier increases.

In addition, prior to health reform, the intermediaries added a surcharge of approximately $10 per employee per month to service the small group accounts. Since 2007, intermediaries' fees are either paid through retention of a portion of the premium, or the intermediaries' fees are added to the premium.

Key Points

Prior to the 2006 health reform law, the Massachusetts non-group and small group markets were pooled separately and subject to different rules; primarily in terms of the types of health plans that could be sold in each market. Employers and consumers in both markets did not have a central source of information to compare plans and premiums, there was a general lack of transparency, and the non-group market was dominated by one carrier.

Non-Group Market

- Health plan options were strictly limited and plan designs were highly regulated;
- Most people received coverage from one carrier, BCBS-MA;
- Brokers and intermediaries did not play a role;
- Premiums were the highest in the country; and
- There was no central source for consumers to compare plans and premiums.

Small Group Market

- Employers were offered a broad choice of health plans from a number of carriers;
- No single carrier controlled more than 50% of the market;
- Brokers played a central role in helping employers purchase coverage for their employees;

[7] Interview with Jeff Rich, Managing Principal, MBA Group.

- Intermediaries served small groups with five or fewer employees;
- The market's largest insurer (BCBS-MA) did not work with any of the intermediaries;
- Brokers placed business directly with health carriers and did not use intermediaries for groups of six or more employees; and
- There was no central source of information for employers and consumers to compare plans and premiums.

III. Health Reform and the Role of the Massachusetts Health Connector

A central component of the Massachusetts health reform law of 2006 was the establishment of the Massachusetts Health Insurance Connector Authority (the Connector), a quasi-public agency responsible for implementing much of the state's health reform law. The principle focus of this analysis is the role of the Connector in the commercial non-group and small group markets. However, the Connector has a number of other responsibilities, including administering a publicly-subsidized health coverage program for lower-income adults, promulgating regulations, and conducting a public information campaign to advise residents and businesses about the state's health reform law.

Establish and administer publicly-subsidized health plan

One of the most significant responsibilities handed the Connector was the establishment and administration of Commonwealth Care, a publicly-subsidized health insurance plan for lower-income adults. Commonwealth Care is available to adult residents of Massachusetts with income at or below 300% FPL who do not have access to subsidized health coverage (e.g., Medicaid, Medicare, employer-sponsored insurance, etc.).

The Commonwealth Care program is separate and distinct from commercial insurance offered through the Connector and is limited to adults only. Children of parents eligible for Commonwealth Care are typically covered by the state's Medicaid program (MassHealth).

The state legislature created Commonwealth Care as a public health insurance program for lower-income adults and directed the Connector to solicit proposals from the four Medicaid managed care organizations (MCOs) under contract with the state at the time of the law's passage. This approach was taken out of recognition that the two largest MCOs were also the two largest safety net providers, and some of the funding for Commonwealth Care was being redirected from funding that had been going directly to support these safety net providers.

An alternative approach -- and one that is more commonly discussed as part of national health reform -- is to use public funds to subsidize the premiums for lower-income individuals to help them purchase coverage in the commercial health insurance market.[8]

[8] In the small group market, Massachusetts has a premium subsidy program that is available to eligible lower-income individuals who work for small employers that offer employer-sponsored insurance. Under the Commonwealth's Insurance Partnership (IP) program -- which is similar to Maryland's Health Insurance Partnership program -- small employers that newly offer insurance to their employees can receive a state subsidy for a portion of the employer's share of the premiums, while eligible lower-income employees receive a subsidy for a portion of their share of the premiums. The Massachusetts IP program is available only to small employers that previously did not offer employer-sponsored insurance or to lower-income employees who are newly hired or who were not previously eligible for a small employer's health insurance. Similar eligibility rules are in place for the Maryland Health Insurance Partnership program, but this program is limited to employers with two-to-nine employees.

Under this model, as an individual's income increases, the amount of public assistance declines but he or she can remain covered by the same health plan even if the individual is no longer eligible for subsidized insurance. Under the Commonwealth Care program, once someone becomes ineligible for the public subsidy they lose their health coverage and must purchase a policy in the commercial market.

The Connector is responsible for determining the schedule of benefits and point-of-service cost sharing, setting the members' share of the monthly premium, negotiating rates with health carriers, and overseeing all aspects of the program. This includes, but is not limited to, setting up a process for enrolling individuals, facilitating health plan selection by enrollees, premium billing and collection, and day-to-day customer service.

Commonwealth Care was rolled out in two phases. Individuals with income at or below 100% FPL started to enroll in October 2006 (which allowed for a November 1, 2006 effective date), while those with income between 100% - 300% FPL began enrolling in January 2007 (with a February 1, 2007 effective date). At its peak, close to 180,000 adults were enrolled in the Commonwealth Care program. As of September 2009, approximately 150,000 adults are enrolled.

Regulatory Role

The Connector has a number of regulatory responsibilities, including:

- Determining what constitutes "minimum creditable coverage" for the purpose of meeting the individual mandate for all adult residents to maintain health coverage;
- Developing the affordability schedule to determine whether an individual is exempt from the individual mandate based on income;
- Setting the penalty schedule for individuals who are not exempt from the mandate and who choose not to maintain health coverage;
- Establishing regulations pertaining to the requirement that employers offer a Section 125 plan to their employees; and
- Working with the state's Division of Insurance to set standards regarding the "Young Adults Plan," which commercial insurers are permitted to sell only through the Connector to people age 18 to 26 that do not have access to employer-sponsored insurance.

Public Information

With all of the changes brought about by the state's health reform law, the Connector assumed a lead role in serving as an information resource for employers, employees and residents of the Commonwealth. This public information campaign included paid advertisements, public service announcements, public information sessions held across the state, establishing a toll-free number and staffing a public information unit, developing a web site, and producing an array of print and on-line media to educate residents, employers, insurers and others about their responsibilities under the new law.

Distribution Channel for Commercial Health Insurance

A major part of the 2006 health reform law was the merging of the state's non-group and small group markets. As previously discussed, the non-group market was highly regulated and plan options were strictly limited. The 45,000+/- people covered in the non-group market had significantly higher average health care costs than did the roughly 760,000 people in the small group market. As a result, premiums were much higher in the non-group market than they were in the small group market.

With an individual mandate to maintain health coverage, state lawmakers merged the markets as a way to reduce the cost of non-group insurance without (they hoped) adversely affecting the premiums in the small group market. The broad choice of health plans that had previously been available only to small groups was now available to non-group purchasers.

The Connector's role in the newly merged market is to facilitate the availability, choice, and purchase of health insurance products for eligible individuals and small groups. To meet this role, the Connector established the Commonwealth Choice program, which began offering non-group commercial insurance in July 2007 and small group coverage on a pilot basis in January 2009.

The core concept behind the establishment of the Connector is to promote and enable a competitive and transparent market for buying and selling non-group and small group health insurance. The Connector serves as a distribution channel of commercial insurance and a market organizer that provides consumers with the ability to shop for health insurance from a number of insurers offering a broad range of health plans. The Connector is not a purchasing collaborative, but rather an alternative health insurance distribution channel.

The Connector is also responsible for setting up a process for employees who are not offered employer-sponsored insurance to reduce their net cost of health insurance premiums by using an employer's Section 125 plan to pay for coverage. An employer can set up a Section 125 plan and designate the Connector, thereby enabling non-benefits eligible employees to purchase non-group insurance from the Connector and pay their premiums through payroll deductions on a pre-tax basis. This method of paying premiums can reduce the real cost of insurance by 40%.[9]

In theory, the Connector would also serve as a "payment aggregator" that enables an individual or family to combine contributions from multiple sources (e.g., two employers) to pay for coverage. The proponents of an exchange also contended that the Connector would enable coverage to be portable among employers within the state and to be retained by individuals during periods of unemployment, part-time employment or self-employment.[10]

[9] Savings estimate assumes marginal federal tax bracket of 28%, state income tax of 5.3%, and FICA savings of 7.65%.

[10] "The Massachusetts Approach: A New Way to Restructure State Health Insurance Markets And Public Programs," Haislmaier and Owcharenko, *Health Affairs*, November/December 2006.

Filling a Void in the Massachusetts Market

Prior to health reform there was no central source of information or clearinghouse that allowed individuals and employers to shop for coverage across the major insurers in the market. A prime role for the Connector was to fill this void and serve as an impartial source of health insurance information for individuals and small employers, allowing people to compare plans, obtain quotes, and enroll in coverage.

For the smallest groups (i.e., five or fewer employees), intermediaries had offered brokers and employers a central point of access to shop for coverage from a number of carriers. However, the largest carrier in the market, Blue Cross Blue Shield of Massachusetts, did not use intermediaries. Individuals wishing to purchase coverage from BCBS-MA had to go directly to the carrier to review plans, obtain quotes and purchase insurance.

For groups of six or more employees, there was no central source of information that allowed employers to compare benefits, plans and premiums. In order to compare plans and premiums, brokers would obtain information from each carrier and present that information to employers.

More importantly, there was no public, consumer-facing, centralized source of information that individuals and employers could access to compare health plans and premiums. For employers, comparing plans and premiums was -- and still primarily is -- handled by brokers, acting on behalf of their clients. For individuals, there was no resource available to allow a consumer to evaluate health plans, compare premiums, and purchase insurance.

This lack of transparency was considered an impediment to competition and a hindrance to engaging consumers in the purchase of health insurance. With the individual mandate now requiring Massachusetts residents to obtain and maintain health insurance, and with individuals facing a financial penalty for not having health coverage, providing residents with a place to shop for insurance was a key component of the state's health reform law.

The Connector was envisioned as a mechanism to promote transparency and simplify administrative processes. Individuals and small groups could shop for coverage from a range of carriers offering a number of health plans, complete a standard enrollment form, and interact with a single administrative entity to pay premiums and manage their health insurance accounts.

In addition to serving as a resource center, the Connector was required to give its "Seal of Approval" to the health plans that it sold. The Seal of Approval designation meant that the health plans offered consumers "quality and value," based on standards set by the Connector.

Implementing Commonwealth Choice

Using a public procurement process, the Connector solicited proposals from insurers and selected a range of health plans to be sold through the Connector. Of the ten health carriers that submitted proposals, the Connector's Seal of Approval was awarded to health plans offered by

six carriers,[11] each of whom initially sold seven health plans through the Connector. All of the plans offered through the Connector are HMOs, the predominant health plan purchased in Massachusetts.

With the Massachusetts non-group market changing from one that strictly limited plan choice to one in which individuals could choose from dozens of health plans, the Connector decided to offer "structured choice," instead of offering all of the health plans sold by the carriers.

The decision to limit the number of carriers and the number of health plans that each carrier could offer through the Connector was based on a number of factors, including: (1) the statutory requirement that the Connector could sell only those health plans that met its Seal of Approval criteria; (2) the belief that health carriers would offer more competitively priced products if only a subset of their plans were available through the Connector; and (3) the Connector's concern that unlimited choice could be confusing for consumers.

The Connector groups health plans into three levels -- Gold, Silver, Bronze -- based on their actuarial value, which reflects the amount of an average person's health care costs that the plan would cover. A fourth level, Young Adults Plans (YAP), is available to individuals age 18 to 26 who do not have access to employer-sponsored insurance. The YAP plans, which by state law may only be sold though the Connector and are not available directly from the carriers, include a slightly slimmer level of benefits than do the Bronze level plans.

The grouping of plans based on their actuarial value was designed to allow individuals and small employers the ability to compare plans that are relatively equivalent in terms of coverage, even though the specific cost sharing of each plan may differ. For example, one carrier's Silver level plan may have an upfront deductible and co-payments while another carrier's Silver level plan may not have a deductible but uses co-insurance instead of co-pays. Because the health plans at each level are comparable in terms of benefits and overall coverage, the consumer is able to focus on differences in premiums, provider networks, carrier reputation, and additional benefits that may be offered by the carriers (e.g., dental coverage, coverage for alternative therapies, fitness reimbursements).

While the Connector limited the number of health plans available through the Commonwealth Choice program, the health carriers sell a broad range of health plans -- including PPO, POS and HDHP plans, as well as other HMO plans -- in the market outside the Connector. In addition, with the exception of the YAP plans, the health plans offered through the Connector are offered directly -- or via an intermediary -- by the carriers.

The rating rules are the same inside and outside the Connector. That is, health plans sold through the Connector are subject to the same regulatory requirements as those sold outside the

[11] The six health plans selected by the Connector represented over 90% of the small group/non-group market -- Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan, and Tufts Health Plan.

Connector, and there is no difference in the premium charged for a health plan based on the distribution channel used by the purchaser.

With the introduction of the Connector as a new health insurance distribution channel, the intermediaries also began servicing the non-group market. Prior to the 2006 health reform law and the establishment of the Connector, intermediaries did not sell non-group insurance.

The Role of the Sub-Connector

To handle a range of administrative functions for the Commonwealth Choice program, the Connector procured the services of an intermediary (i.e., Sub-Connector), which serves as the interface between the carriers and the consumers, employers and brokers that purchase coverage from the Connector.

The Sub-Connector provides pre- and post-enrollment customer service, including:

- Distributing health plan benefits summaries and enrollment information to individuals, employers and brokers;
- Responding to inquiries via phone, mail and e-mail;
- Processing applications and verifying enrollment information;
- Transmitting enrollment information to the carriers and to the Connector;
- Issuing bills and collecting premiums;
- Remitting premiums to the carriers;
- Distributing commissions to brokers;
- Distributing administrative fees to the Connector;
- Facilitating the establishment of Section 125 plans with employers and billing employers for the employees that use payroll deduction to pay premiums;
- Providing notification of delinquent payment and cancellation of coverage due to non-payment of premiums; and
- Renewing accounts.

With the exception of the new Section 125 plan requirement, the Sub-Connector's tasks were similar to those that the intermediaries provide for a sub-set of the small group market (i.e., employers with five or fewer employees) prior to the health reform law.

Selecting a Sub-Connector

The Connector's decision to select one intermediary -- instead of multiple intermediaries -- to serve as the Sub-Connector for the Commonwealth Choice program was based on the market conditions at that time and the complexity of establishing a new way for individuals to purchase health insurance. Prior to health reform, the Massachusetts market did not have an administrator or intermediary serving non-group purchasers. The merging of the non-group and small group markets expanded the product offerings available to non-group purchasers, and the Connector was responsible for setting up a mechanism to enable consumers to shop for insurance.

As noted previously, the three main intermediaries serving the lower-end of the small group market did not offer health plans from the state's largest insurer (BCBS-MA). As a result, the entity that won the competitive procurement process to serve as the Sub-Connector -- the Small Business Service Bureau (SBSB) -- needed to establish contractual relationships with each of the six health carriers offered by the Connector, including Blue Cross Blue Shield of Massachusetts. The Sub-Connector also needed to set up the infrastructure and electronic data interchanges necessary to generate quotes[12] and handle all of the administrative tasks, including the establishment of a call center to assist consumers before, during and after enrollment.

Consideration was given to using multiple intermediaries as Sub-Connectors. However, the decision to select a single entity reflected the reality of the major changes taking place in the non-group market, the desire to streamline administrative processes, and a recognition that the state's largest health insurer would need to establish a working relationship with an intermediary. The Connector was establishing a new way to purchase health insurance, not replicating or replacing an existing way. As a result, one Sub-Connector was awarded a contract to assist with the administration of the Commonwealth Choice program.

Developing a Web Site and Central Point of Access

In addition to selecting a single entity to handle most of the administrative tasks, the Connector established a public web site (www.mahealthconnector.org) to serve as a central point of access for individuals looking to obtain information about their health insurance options. The Connector's web site allows consumers to compare health plans, obtain premium quotes, and complete the enrollment process on-line. The Appendix to this report includes screen shots from the Health Connector's web site that displays some of the information and functionality that is available to the general public.

Prior to health reform, there was no public web site that included this type of information or that allowed people to enroll on-line, although the BCBS-MA web site allowed non-group purchasers to compare the limited number of plans that were available and obtain premium quotes. In addition, brokers serving the small group market could obtain health plan information and generate premium quotes for many health carriers' plans through the intermediaries' web sites or by accessing each health plans web site. As noted previously, BCBS-MA did not use intermediaries and information on BCBS-MA plans was only available from the carrier.

Serving the Non-Group and Small Group Markets

Non-Group Market

The Connector began offering health insurance to non-group purchasers in May 2007, for a July 1, 2007 effective date. The small group offering was made available on a limited basis, through a select group of brokers, starting in December 2008, with a February 1, 2009 effective date.

[12] Almost all Massachusetts carriers adjust their premiums on a monthly basis, which requires the generation of a new rate file to be loaded each month in order for the correct premiums to be quoted.

Non-group purchasers may choose any of the health plans available through the Connector. In addition, employees who are not offered employer-sponsored insurance but who work for an employer who has set up a Section 125 plan with the Connector can pay their health insurance premiums on a pre-tax basis using payroll deduction.

As of September 2009, there were 16,724 individuals purchasing health insurance through the Connector, covering roughly 21,500 lives. Eight percent -- or 1,300 subscribers -- were using a Section 125 plan to pay their premiums through payroll deduction. The total non-group market membership in Massachusetts was estimated to be 86,000, as of March 2009.[13]

Prior to health reform, the non-group market was dominated by BCBS-MA, which covered 80% of enrollees. In contrast, individuals purchasing non-group insurance through the Connector are more broadly distributed across the six carriers, with no single carrier covering more than 27% of subscribers. Table 2 displays the Connector's non-group membership by carrier.

Table 2
Commonwealth Choice Non-Group Subscribers by Carrier
September 2009

Carrier	Subscribers	Percentage
Blue Cross Blue Shield of MA	4,616	27%
Neighborhood Health Plan	3,827	23%
Harvard Pilgrim Health Care	3,671	22%
Fallon Community Health Plan	3,266	20%
Tufts Health Plan	813	5%
Health New England	531	3%
Total	16,724	

Small Group Market

The Connector's small group offering, called the Contributory Plan, is designed to provide employees with the opportunity to select from a number of health insurers and health plans. Providing small group employees with a choice of health plans represents a significant change in the way small employers are able to offer health insurance to their employees. In the Massachusetts small group market, virtually all small employers offer one health plan to their employees, and carriers do not allow a small employer to offer their employees a health plan from a competing carrier.

Under the Connector's Contributory Plan, an employer selects a coverage tier (i.e., Gold, Silver, or Bronze), contributes at least 50% of the premium for a specific health plan within that tier, and then allows employees to enroll in any health plan within that coverage tier. To protect against adverse risk selection -- i.e., employees with greater health care needs opting for more comprehensive coverage and younger and/or healthier workers choosing less comprehensive coverage -- employees are not allowed to enroll in a health plan in a different coverage tier.

[13] "Health Care in Massachusetts: Key Indicators," Massachusetts Division of Health Care Finance and Policy, August 2009.

For example, an employer selects the Silver level and sets his contribution based on the premiums for the BCBS-MA Silver level plan. Employees may select the BCBS-MA Silver level plan or take the employer's contribution and select a health plan offered by a different carrier within the Silver level. Employees are not allowed to "buy down" to the Bronze level or "buy up" to the Gold level.

The Connector's Contributory Plan was modeled after the Connecticut Business and Industry Association's (CBIA) Health Connections program, a private sector health insurance exchange available to employers with at least three but no more than 100 employees. CBIA's Health Connections program allows employers to offer their employees health plans from four different carriers, with the plans grouped into two suites or levels of plan designs. The plan designs differ primarily around the amount of member cost sharing.

The Connector launched the Contributory Plan on a pilot basis through a limited number of brokers in early 2009. Brokers are paid a commission by the Connector for groups that purchase coverage through the Connector.

As of September 2009, there were 38 small employers purchasing coverage through the Connector, covering 127 employees. Across the state, thousands of small employers provide health insurance that covers approximately 750,000 individuals.

The low number of employers that have opted for the Connector's Contributory Plan is due to a number of reasons, in particular:

- The lack of a true value proposition for small employers (i.e., there are no real premium savings to be achieved);
- The decision by Blue Cross Blue Shield of Massachusetts to apply a 10% load to the premiums by using a participation rating factor (i.e., BCBS-MA health plans purchased through the Connector's Contributory Plan are roughly 10% more expensive than the same plans purchased by a small employer directly from BCBS-MA);
- The limited number of brokers (19) participating in the pilot;
- Broker commissions paid by the Connector (2.5% of premium) are lower than those paid by the carriers (3.5% - 4.5%); and
- The carriers desire to maintain their market share in a relatively competitive small group market, rather than have their accounts opt for an exchange model in which the carriers are likely to retain only a portion of the account's members.

<u>Connector Revenues and Expenses</u>

The Connector is a quasi-public agency established by the Massachusetts legislature, which appropriated $25 million to fund the Connector's start-up costs. Ongoing operations are funded through retention of a percentage of the health insurance premiums of both the publicly-subsidized (Commonwealth Care) and commercial (Commonwealth Choice) health plans sold by the Connector.

The majority of the Connector's start-up funds were spent establishing and operating the Commonwealth Care program, which began enrolling individuals in October 2006, nine months before the Commonwealth Choice program commenced.

For the Commonwealth Care program, the Connector contracts with the state's Medicaid program (MassHealth) to determine member eligibility; and the Connector contracts with a third-party administrator to provide enrollment assistance, premium billing and collection, and other administrative functions. In its first year of operation, FY 2007, the Connector spent over $11 million on eligibility, enrollment, premium billing and collection, and administration of the Commonwealth Care program. This figure includes only the cost of contracting with MassHealth the outside vendor hired to assist with the administration of Commonwealth Care, and does not include Connector staff and other resources devoted to this program.

The Connector spent over $5 million on marketing and advertising during its first two years. These funds were used to promote the Commonwealth Care and Commonwealth Choice programs, as well as to provide residents and employers with information on the state's health reform law.

With regard to the Commonwealth Choice program, over $2 million was spent during the first two years on the development of the web site that allows people to shop for coverage, compare plans, obtain premium quotes and enroll on-line (www.mahealthconnector.org). In addition, $1.3 million was paid to SBSB (i.e., the Sub-Connector) to administer the Commonwealth Choice program.

With both programs up and running, the Connector is now funded solely through retention of a percentage of the health plans' premiums. In FY 2010, the Connector will retain 3.75% of the premiums for Commonwealth Care and 4.5% of the premiums for Commonwealth Choice. The Connector anticipates generating $26.9 million from the Commonwealth Care program based on year-end projected enrollment of 165,000 members; and $3.8 million from the Commonwealth Choice program based on year-end projected enrollment of 24,500 members.

The revenue retained from Commonwealth Choice premiums is used to pay SBSB to administer the program and pay broker commissions if a broker assists with the purchase of insurance. Any remaining revenues are used to support the Connector's ongoing operations.

Key Points

1. The Massachusetts legislature established a separate publicly-subsidized health insurance program, distinct from commercial health insurance. This required the Connector to operate and administer two different and mutually exclusive programs. An alternative approach would be to provide subsidies to help people purchase commercial insurance and not establish a stand-alone public health plan for lower-income individuals.

2. Prior to health reform, intermediaries provided small employers (i.e., businesses with five or fewer employees) with a broad range of health plan options from a number of carriers.

However, they did not serve the non-group market and did not offer coverage from the state's largest insurer (BCBS-MA).

3. Major changes to the state's non-group health insurance market -- in particular the expansion of health plan choices and the merging of the non-group and small group markets -- along with the individual mandate created the need for a means by which consumers could evaluate health plan choices and purchase insurance.

4. Prior to health reform, there was no central source of information that offered consumers a way to compare health plans, obtain quotes, and sign up for coverage. To improve transparency and promote competition in the market, the Connector established a web site (www.mahealthconnector.org) and a customer service center that allows consumers to compare health plans and premiums, and purchase health insurance.

5. The Connector's offering of health plans from Blue Cross Blue Shield of Massachusetts, the dominant carrier in the market, along with five other health carriers, provided consumers and small employers with a central source from which they can select a health plan from the major insurers in the Commonwealth's non-group/small group market.

6. The decision by the Connector to offer a limited number of health plans from a sub-set of carriers operating in the Massachusetts non-group and small group market was due in part to the statutory requirement that the Connector offer only those health plans that provide "value and quality," as determined by the Connector. An alternative approach would be for the Connector to serve as a clearinghouse for all health plans and all carriers licensed to sell insurance in the Commonwealth. Under this model, the Connector would function more as a market organizer than an entity that endorses certain health plans and carriers.

IV. Maryland's Non-Group and Small Group Health Insurance Markets

This section provides an overview of Maryland's non-group and small group health insurance markets, including a description of the regulatory environment, the number of carriers, and a discussion of the role of brokers and intermediaries.

Non-Group Market

Unlike Massachusetts, the non-group health insurance market in Maryland allows for medical underwriting, which permits carriers to offer coverage only to those individuals who pass their screening criteria. Applicants can be denied coverage, charged higher premiums, or have limitations placed on what is covered based on their health status.[14]

The Maryland Health Care Commission estimates that 15% - 20% of all non-group applicants are denied coverage, offered insurance but charged a higher premium, or offered a health plan with benefit limitations due to the applicant's health status. There is no guaranteed issue requirement, and carriers are not required to sell a standardized health policy, although Maryland law includes a number of benefits mandates, depending on the type of insurance purchased (e.g., HMO, PPO, indemnity).

Seven carriers operate in the non-group market, and in 2007 there were roughly 159,000 individuals covered,[15] or almost 3% of the state's 5.6 million residents. The market is relatively competitive in terms of the range of carries and health plans available. However, CareFirst -- the regional Blue Cross Blue Shield carrier -- is the dominant insurer, covering upwards of 75% of people purchasing non-group insurance.

The premiums for applicants who pass medical underwriting and are offered coverage in the non-group market are lower than the national average for non-group insurance. The 2007 AHIP study[16] reported that the average annual premium for an individual in Maryland's non-group market was $2,208, compared to the national average of $2,613; Maryland's non-group family premiums averaged $5,055 per annum, compared to the national average of $5,799.

Individuals who are denied coverage, quoted a higher premium, or who face benefit limitations based on their health status may be eligible for coverage in the state's high risk pool, the Maryland Health Insurance Plan (MHIP). MHIP is funded through assessments on Maryland hospitals (which account for approximately 61% of revenues), member premiums (which make up approximately 37% of revenues) and a limited amount of federal funding (approximately 2% of revenues). The state contracts with CareFirst to administer the program on a self-funded basis

[14] Pre-existing condition exclusions are not allowed in an HMO plan.

[15] Source, Maryland Insurance Administration.

[16] AHIP's 2009 report on individual health insurance does not include information on Maryland's non-group market premiums.

(i.e., the state does not purchase insurance from CareFirst). As of November 2009, MHIP covered 17,135 individuals.

MHIP premiums are capped at 150% of the cost of non-group market health policies, and premiums are based on the benefit plan selected, the rate basis type (e.g., individual or family coverage), and the age of the applicant. Premium subsidies are available on a sliding scale for applicants with income up to 300% FPL.

Four plan options are available under MHIP -- one HMO plan, two PPO plans, and a high deductible health plan. The covered benefits are the same under all four options, but cost-sharing varies. There is a six-month pre-existing condition waiting period that applies to newly enrolled MHIP members who lack recent prior health coverage. Individuals subject to the waiting period can remove it by paying an additional cost equal to 50% of the premium for 12 months.

Small Group Market

In contrast to the non-group market, Maryland's small group market does not allow medical underwriting and utilizes a modified community rating system that limits health insurance premiums to a 2.8 to 1 rate band. Carriers may only use age and place of residence (i.e., geographic location of the business) as rating factors.[17] All small group health plans are offered on a guaranteed issue and guaranteed renewal basis. Pre-existing condition limitations and exclusions are not permitted.

The state requires that a comprehensive set of services, called the Comprehensive Standard Health Benefit Plan (CSHBP), be included in all small group policies. The CSHBP -- which is set each year by the Maryland Health Care Commission -- establishes a minimum level of insurance, including the benefits covered and member cost sharing, that all small group plans must provide. However, almost all employers purchase health benefits that exceed the CSHBP minimum.

While eight carriers participate in the Maryland small group market, the top two insurers -- CareFirst and United HealthCare -- cover about 85% of enrollees.[18] Approximately 428,000 people are insured in Maryland's small group market, or approximately 7.6% of the state's population.

[17] Effective July 1, 2010, small employers buying a group health plan for the first time may be subject to an increase or decrease in premium based on the health status of the group. The adjustment may not exceed 10% in the first year, 5% in the second year, and 2% in the third year. No adjustment is allowed beyond the third year.

[18] Source, "Small Group Market Report," Maryland Health Care Commission presentation to the Joint Committee on Health Care Delivery and Financing, October 14, 2008.

Maryland's small group definition includes employers with at least two and no more than 50 employees. Self-employed individuals are not permitted to purchase coverage in the small group market, although the state allows association plans to be sold, through which self-employed individuals may obtain coverage. Association plans are not subject to most state health insurance regulations, and an estimated 25,000 Maryland residents are covered by association plans.

Health insurance premiums in Maryland's small group market are among the highest in the nation. Based on AHIP's 2009 small group insurance report, Maryland's average annual premiums were $4,968 for individual coverage and $13,092 for family coverage, compared to the US average of $4,152 and $10,956, respectively.[19]

The difference in premiums between Maryland's non-group and small group markets is due in large measure to the different rating rules that apply in each market. In particular, carriers in the non-group market are permitted to deny coverage, charge higher premiums or impose pre-existing condition exclusions to individuals based on their health status. In addition, the health plans sold in the small group market must meet a minimum standard in terms of benefits covered and cost sharing allowed (i.e., CSHBP). There is no comparable minimum standard in the non-group market.

In an effort to encourage more small businesses to offer health insurance to their employees, the state recently introduced the Health Insurance Partnership, a premium subsidy program available to small firms that employ between two and nine full-time employees. Employers may be eligible to receive a subsidy of up to 50% of the premium through the Health Insurance Partnership if they have not offered a group health plan during the previous 12 months and they meet the program's wage requirements. Eligible employers must also establish a Section 125 payroll deduction plan, and the group health plan must include a wellness benefit.

As of October 2009, approximately 1,045 individuals were covered through the Health Insurance Partnership.

Role of Brokers and Intermediaries

Non-Group Market

Individuals looking to obtain health coverage in Maryland's non-group market have essentially three ways to purchase insurance -- through a broker, using an on-line brokerage service such as vimo.com, ehealthinsurance.com, or gethealthinsurance.com, or directly from a health carrier. An individual's monthly premium is not affected by the way in which he or she purchases insurance.

[19] Source, AHIP Center for Research and Policy, March 2009 report, "Small Group Health Insurance in 2008."

Approximately 2,000 brokers actively sell health insurance in Maryland's non-group and small group markets.[20] Brokers provide individuals with information on their health insurance options, assist with the completion of the carriers' application and the underwriting process, and submit the application materials to the health carrier on behalf of the applicant.

For individuals that use a broker to assist in procuring non-group health coverage, Maryland intermediaries play a key role by providing brokers with a central point of access for most of the health plans offered by most of the insurers operating in the state's non-group and small group markets. The intermediaries offer a centralized source of information, which allows for a more streamlined and standardized way for brokers to compare health plans, generate premium quotes across multiple carriers, process enrollment, and provide ongoing account management during the year.

Brokers can enter basic demographic information about an applicant (e.g., age, sex, residence) on the intermediaries' web sites to generate premium quotes from a number of carriers, as well as access detailed benefits information on the health plans (i.e., summary of benefits covered, co-payments, deductibles, etc.). The web-based applications also allow brokers to review only those plans that include specific benefit features (e.g., PPO plans with a $1,000 deductible; or HMO plans that do not include an upfront deductible; or HSA-compliant high deductible health plans).

The Appendix to this report includes screen-shots taken from the web sites of two Maryland intermediaries; Group Benefit Services (GBS) and Kelly and Associates Insurance Group (KELLY), which display the types of information available to brokers. These sites are not currently available to individual consumers who do not utilize the services of a broker. However, GBS officials report that they are planning on making its web-based tools available to the general public in 2010, and KELLY could allow public access to its site, as well. In addition, the intermediaries have a brokerage business that sells health insurance directly to individuals.

If the carrier approves the application, brokers either place the business through one of Maryland's three main intermediaries -- BenefitMall, Group Benefit Services, and Kelly and Associates Insurance Group -- or directly with the carrier. If an intermediary is used, the intermediary is responsible for administering the account (see below for overview of administrative services performed by Maryland's intermediaries), while the carrier manages the health benefits and adjudicates claims on behalf of the enrollee.

Approximately 50% of non-group business is placed directly with the carriers, with the rest placed through brokers/intermediaries or purchased through the web.

[20] There are several thousand more people who are licensed to sell health insurance. However, health insurance is not their primary line of business (e.g., financial advisors, property and casualty insurance brokers, home and auto insurance agents).

Small Group Market

In the small group market, an estimated 90% or more of Maryland employers utilize the services of a broker for their employer-sponsored health insurance, as well as for other benefits they may provide to their employees (e.g., dental, vision, disability, life insurance). The broker evaluates different health plans, obtains premium quotes, and presents health insurance options to the employer.

As is often the case in the non-group market, brokers tend to utilize the services of an intermediary to produce information on health plan options, generate premium quotes and compare health plans from the various health insurers. The intermediaries' web sites provide brokers with a central point of access, as well as standardized enrollment forms and processes that allow brokers to evaluate and compare benefit options and premiums for their employer clients.

After the employer decides which carrier and health plan to offer to his or her employees, the broker will then place the business with an intermediary to service the account. Brokers tend to place all of their business with one of the three main intermediaries. After the employer has selected a health plan for his or her employees, the intermediaries' web sites are then made available to the employees to review the health plan and enroll in coverage.

In addition to the pre-sale services noted above, intermediaries provide ongoing administration and account management throughout the year, including:

- Processing applications and transmitting enrollment information to the carriers;
- Premium billing, collection and reconciliation;
- Remitting premiums to the health carriers;
- Distributing commissions to brokers;
- Responding to inquiries from policyholders, employers and brokers, via phone, mail and e-mail;
- Notifying employers and individual policyholders of delinquent payments, and cancellation of coverage due to non-payment of premiums;
- Processing mid-year changes in enrollment (e.g., adding a new employee, adding a dependent, changes in coverage from individual to family);
- Issuing temporary health plan ID cards;
- Administering COBRA; and
- Other administrative responsibilities typically associated with the maintenance and management of an account.

Brokers and intermediaries also service other lines of employer-sponsored insurance. For example, employers that provide dental coverage, vision benefits or disability insurance to their employees often have these lines of coverage administered by the same broker and serviced by the same intermediary that handle their health insurance. This enables the employer to receive a single bill from the intermediary, with the premiums for the various types of insurance itemized. The employer cuts one check to the intermediary, who is then responsible for paying each carrier the appropriate premium.

Brokers' commissions vary by carrier and by product type, and there are slight differences between the commissions paid in the non-group market vis-à-vis the small group market. Many carriers in the market have moved from paying brokers based on a percentage of premiums to a flat per subscriber per month fee. The monthly fees range from approximately $20 - $25 per subscriber per month, or roughly 3% - 5% of premium. Carriers that continue to pay on a percentage basis are paying brokers approximately 4% - 5% of premiums.

In addition, the intermediaries retain a percentage of the premium for the administrative services that they provide on behalf of the carriers. The intermediaries' fee is approximately 2% of premiums.

The employer's monthly premium is not affected by the way it purchases health insurance or by the intermediary that services the account.

Key Points

1. A number of health carriers offering a range of health plans compete in Maryland's non-group and small group health insurance markets. CareFirst is the dominant carrier, insuring the majority of people in the non-group and small group markets.

2. Medical underwriting in the non-group market holds down the average cost of insurance but limits the ability of people with health issues to obtain coverage. The state has established a high risk pool for individuals who are denied coverage, quoted higher premiums or subject to coverage limitations or exclusions based on their health status.

3. Intermediaries have developed robust infrastructure, technical capabilities and customer service centers that are used by brokers, employers and health carriers to provide a central point of access and streamlined administrative services for the non-group and small group markets.

4. The availability of public web sites -- e.g., vimo.com, ehealthinsurance.com, gethealthinsurance.com -- provide a central point of contact for consumers to purchase health insurance. However, with over 100 plans to choose from, consumers may find it difficult to compare plans based on their relative value and the benefits covered.

5. Health plans offered in the small group market must meet minimum standards set by the Maryland Health Care Commission. In contrast, policies sold in the non-group market do not need to meet a minimum threshold pertaining to the benefits covered and the cost sharing allowed.

V. Differences Between the Massachusetts Connector and the Maryland Market

Two Maryland intermediaries participated in this study, Group Benefit Services, and Kelly and Associates Insurance Group. A review of the services provided by these intermediaries -- in concert with services provided by brokers in the non-group and small group markets -- reveals that they either currently provide or have the capacity to provide virtually all of the services that the Connector provides in the Massachusetts market.

In addition, Maryland brokers and intermediaries offer a number of other services for small employers that the Connector does not provide. For example, the intermediaries' ability to send an employer one bill for different types of employer-sponsored insurance (e.g., dental, vision, life, disability) helps streamline the administration of employee benefits for small employers. More recently, intermediaries have started to administer employers' payroll, providing small firms with a single entity to handle their payroll and employee benefits administration.

The intermediaries also administer COBRA on behalf of small employers, and they have played a crucial role in implementing the federal COBRA subsidy program that was part of the American Recovery and Reinvestment Act of 2009 (ARRA). Under ARRA's COBRA subsidy program, individuals who are involuntarily terminated from work between September 2008 and December 2009 are allowed to maintain their health coverage through their former employer and pay only 35% of the premium for nine months. The employer covers the rest of the premium, which is then reimbursed to the employer through a tax credit by the federal government.

In Maryland, the intermediaries administered this program on behalf of their employer accounts. This means billing and collecting the former employees' share of the premium, billing and collecting the employers share, and remitting the full premium to the health plan, as well as handling all of the notification, administration and compliance requirements.

The Maryland intermediaries reviewed as part of this analysis have established web-based applications that allow for on-line health plan comparisons, premium quoting, enrollment and account management for the non-group and small group markets in Maryland. By comparison, prior to the Massachusetts health reform law and the establishment of the Connector, there were no comparable private sector entities that provided these types of services across the Commonwealth's non-group and small group markets.

The Massachusetts intermediaries that were in business prior to the state's health reform law provided comparable services for only a sub-set of the market (i.e., employers with five or fewer employees). However, even for this group of small employers, the dominant carrier in the Massachusetts market, Blue Cross Blue Shield of Massachusetts, was not offered through the intermediaries. In the non-group market, there was no central point of access for individuals looking to purchase health insurance.

There are, however, a few noteworthy differences between the services provided by the Maryland intermediaries and those provided by the Massachusetts Connector.

First, the Connector provides "structured choice" and sells only those health plans that have received the Connector's Seal of Approval, which serves as an endorsement for these health plans. The Connector does not offer all of the health plans that the carriers offer, nor does it offer coverage from all health carriers that sell non-group/small group insurance in the Commonwealth.

In Maryland, the intermediaries administer most of the health plans available from most health carriers operating in the non-group and small group markets. Offering health plans from most of the carriers provides consumers and small employers with a broader choice of health plans and health carriers. On the other hand, unlimited choice can be confusing or overwhelming for consumers, particularly for individuals who are not familiar with health insurance vernacular.

Second, the manner by which the health plans are grouped by the Connector -- Gold, Silver and Bronze, based on the plans' actuarial value -- provides consumers with the ability to compare plans in terms of their relative value. By instituting a grouping structure and organizing the market, consumers are better able to focus on differences in premiums, provider networks, carrier reputation, and any additional benefits that may be offered by the carriers (e.g., dental coverage, coverage for alternative therapies, fitness reimbursements).

In contrast, Maryland's intermediaries do not offer consumers a public web site for individuals to evaluate their health plan options, compare premiums and sign up for coverage. However, GBS plans on making its web site available to the general public in 2010, and KELLY could do so, as well. In the small group market, once an employer selects a health plan for his or her employees, the intermediaries' web sites are made available to employees to review the health plan benefits and to enroll in coverage.

In addition, Maryland consumers can obtain health plan information and apply for coverage through public sites such as vimo.com, ehealthinsurance.com, and gethealthinsurance.com. These public web sites offer coverage from most Maryland health insurers, and allow consumers to refine their search based on a few key attributes (e.g., plan type, monthly premiums, deductibles, co-insurance). However, there is no "relative value" filter or other means by which an individual might compare health plans across carriers based on the amount of an average person's health care costs that the plan would cover.

As a result, with over 100 health plans to choose from in the non-group market, consumers may find it difficult to effectively evaluate their health plan options without the assistance of a broker or someone familiar with the differences across health plans.

In addition, Maryland has not established a minimum benefits standard for non-group coverage in the same manner that it has set a minimum standard for the small group market. The Comprehensive Standard Health Benefit Plan (CSHBP) establishes a floor for coverage in Maryland's small group market, including the benefits covered and the cost sharing allowed. The CSHBP provides small employers with a base level of coverage to which other health plans may then be compared.

In Massachusetts, the Connector is responsible for setting Minimum Creditable Coverage (MCC) standards for the purpose of meeting the state's individual mandate. While insurers are not prohibited from selling policies that fall below the minimum, carriers must clearly indicate whether or not a health plan meets the state's minimum standards. The MCC requirement sets a floor for coverage, in terms of benefits covered and member cost sharing.

The table below summarizes the key functions of an exchange, the role played by the Massachusetts Connector, and how the existing Maryland market operates with respect to those functions.

Functions of an Exchange	Massachusetts Connector	Maryland Market
1. Enhance transparency by establishing a central source of information and centralized shopping point for consumers	Establishment of public web site and customer service center has enhanced market transparency for the health plans and carriers available through the Connector. Consumers can compare health plans and purchase insurance from six carriers, each offering a number of health plan options. However, not all carriers are available; and there are a limited number of health plans sold by the Connector. The health insurance market outside of the Connector offers individuals and small employers with a wider range of health insurance options.	Consumers can shop for insurance from multiple carriers through public web sites; or working through a broker. Public web sites do not provide a standard way to compare health plan options based on relative value; and benefits covered may vary significantly across carriers and health plans. Brokers, working through intermediaries, are able to access a central source of information and centralized shopping point. Intermediaries' web-based tools are not currently available to general public, although they could be and at least one intermediary plans on providing a public portal for individual purchasers to compare plans and sign-up for coverage.

Functions of an Exchange	Massachusetts Connector	Maryland Market
2. Improve competition among health carriers by providing consumers with a simplified way to compare plans and premiums	Health plans are grouped into three categories based on actuarial value, which reflects the amount of an average person's health care costs that the plan would cover. All health plans offered through the Connector include comprehensive coverage. Key difference among health plans is the amount of cost sharing (i.e., co-pays, co-insurance, deductibles) and provider networks.	Public web sites do not provide standard ways to compare health plan options based on relative value, and benefits covered may vary significantly across carriers and health plans. Intermediaries' web sites provide brokers and employers with a central point of access for most health carriers and most health plans sold in the Maryland non-group and small group markets. Functionality exists with the intermediaries to group health plans and standardize ways to compare health plans across carriers.
3. Promote consumer choice of health plans by organizing and structuring the market	Connector organizes and structures the market based on health plans' actuarial value. However, the Connector sells only a sub-set of health plans available in the market.	Maryland market not currently structured and organized around the relative value of health plans. Functionality exists (see above).

Functions of an Exchange	Massachusetts Connector	Maryland Market
4. Standardize health plan enrollment and administrative processes	Connector provides a central point of access for individuals to purchase coverage, as well as standardized enrollment and account management (e.g., premium billing and collection, etc.).	Intermediaries provide standardized enrollment and administrative processes for health insurance, as well as ancillary lines of coverage (e.g., dental, vision, life, disability insurance). The intermediaries' services are available to people and employers who purchase health insurance through a broker.
5. Aggregate contributions from multiple sources to enable non-traditional workers (e.g., seasonal, temporary, part-time, contractors) to pay health insurance premiums on a pre-tax basis	Employees not offered employer-sponsored insurance can pay non-group premiums using employer's Section 125 plan. However, aggregating contributions from multiple employers for one individual is not currently available.	Not currently available for non-benefits eligible workers wishing to pay non-group premiums on a pre-tax basis. Aggregating premiums from multiple sources for one individual is possible. Intermediaries have recent experience administering federal COBRA subsidy program, which required intermediaries to bill an individual for a portion of the premium (35%), collect the remainder of the premium from the individual's former employer, and remit the premium to the health plan.

Functions of an Exchange	Massachusetts Connector	Maryland Market
6. Provide premium assistance to help lower-income individuals purchase commercial insurance	Connector has established separate health insurance program for lower-income adults. Subsidies for commercial insurance not offered through the Connector. Premium subsidy program for small employers with lower-income employees available through a separate state agency, but not available through the Connector.	Not currently available in Maryland non-group market. New premium subsidy program for small employers (2 – 9 employees) with lower-income employees administered directly by health carriers. Functionality exists with intermediaries (see above regarding federal COBRA subsidy program).
7. Facilitate a switch to defined contribution model for employer-sponsored insurance	Not currently allowed based on Connector's policies, but infrastructure exits to facilitate defined contribution model.	Infrastructure exists, but medical underwriting in Maryland's non-group market hinders large-scale move from a defined benefit to a defined contribution model.

VI. Key Issues to Consider

Whatever the fate of national health reform, state governments will inevitably continue to play a lead role in implementing public health coverage programs and regulating commercial insurance. As Maryland policymakers weigh various options to reduce the number of uninsured residents and improve the availability and affordability of health coverage, there are a number of key issues to consider. In particular, the success that Massachusetts has achieved in extending health coverage to almost all of its residents, and the prominent role of the Massachusetts Health Connector, has highlighted the potential value of a health connector or an insurance exchange in helping to organize the market, enhance transparency, improve competition and administer a public subsidy program for lower-income individuals.

However, as discussed in this report, there are significant and relevant differences between the Massachusetts non-group and small group markets prior to the state's 2006 health reform law and Maryland's existing non-group and small group markets. These differences should be recognized and taken into consideration as policymakers contemplate statutory and regulatory changes designed to reduce the number of uninsured and improve the functioning of the insurance market.

With regard to the establishment of an insurance exchange, the capabilities of the intermediaries reviewed for this report reveal that Maryland is well-positioned to leverage the existing private sector infrastructure rather than expend scarce public resources to establish a new public entity to help organize and structure the market, enhance transparency, improve competition and subsidize the purchase of commercial insurance.

This is not to suggest there is no role for government in improving the availability and affordability of health coverage. The question is how can Maryland best take advantage of the infrastructure that currently exists in the small group and non-group markets. As policymakers evaluate policy options to improve the functioning of the commercial non-group and small group markets, and in particular the pros and cons of establishing a health insurance exchange, the following issues should be considered.

1. Is there a central point of access for consumers to compare health plans from multiple health carriers and purchase health insurance?

   Consumers in Maryland have two ways in which they can shop for health insurance from a range of carriers and choose among health plans offered by the major insurers in the marketplace; through a broker or on their own through existing public web sites.

   Utilizing the technical resources developed and operated by the intermediaries, brokers in Maryland help individuals and small employers compare plans, generate premium quotes, and purchase insurance for most health insurers in the Maryland non-group and small group markets. At the present time, the intermediaries' web-based tools are available only to brokers, employers and their employees. While these web-tools and are not accessible by the general public who wish to purchase insurance without using a broker,

they could be if the intermediaries choose to make them available. One intermediary has indicated plans to make available its web-based tools to the general public.

Consumers who do not work with a broker can obtain health plan information, obtain premium quotes and purchase coverage from the major health insurers in the state by accessing a number of publicly-available health insurance web sites.

2. Is the market organized to allow consumers the ability to compare health plans of relatively equivalent value and make informed choices regarding the purchase of health insurance?

   The public web sites allow consumers a number of ways to winnow their choices based on various plan design features. However, there is no standardized way for consumers to compare plans based on the health plans' relative value. In addition, because there is no baseline or minimum benefits package in the non-group market -- as there is in the Maryland small group market. As a result, consumers must sort through the details of each health plan's benefits in order to determine what is, and what isn't, covered.

   Brokers are able to counsel individual purchasers and small employers on the relative merits of different health plans and different carriers. And the intermediaries' web sites provide a number of tools to enable brokers to evaluate different health plan options and compare premiums.

3. If there isn't a way for consumers to compare plans of equal value, how might this be accomplished?

   One way Massachusetts' Connector helps consumers compare plans of relative value is by grouping the health plans that it offers into three tiers -- Gold, Silver and Bronze -- based on their relative actuarial value. This information becomes part of the filtering criteria that a consumer uses to compare plans of relatively equal value that may have different types of cost sharing (e.g., deductibles, co-insurance, co-payments). Maryland might consider a similar approach to help consumers.

   Another option, although outside the primary focus of this report, might be for Maryland to consider establishing a non-group equivalent of the Comprehensive Standard Health Benefit Plan (CSHBP) that is currently used as a benchmark in the state's small group market. The Maryland Health Care Commission (MHCC), which is responsible for establishing the CSHBP, might be a logical entity to assume responsibility for establishing a non-group standard benefits package.

   Carriers might then be required to disclose whether or not a health plan meets this minimum benefits package. For those health plans that do not satisfy the minimum criteria, a carrier would be required to articulate the ways in which the benefits package does not meet the base level of coverage. This is comparable to the disclosure required in Massachusetts with regard to the state's minimum creditable coverage requirements.

4. Do Maryland's intermediaries have the infrastructure and capabilities to help organize and structure the market?

   Maryland's intermediaries have the infrastructure and capabilities to help organize and structure the Maryland non-group and small group markets. They have established relationships with most of the health carriers, have invested in technology to allow consumers to compare health plans, and have established customer service units that would enable the intermediaries to play a key role in efforts to improve the organization and structure of the market.

5. What role, if any, might state government play in promoting greater organization and structure in the market?

   Through its role as regulator of the non-group and small group markets, state government can play a key role in helping to improve the organization and structure of the market. As noted above, state government might consider establishing a minimum benefits package for the non-group market, which consumers could use as a benchmark to evaluate and compare health plans.

   Alternatively, or in addition, state government could require carriers to quantify the actuarial value of their health plans and include that information as part of a standardized benefits summary that can help consumers make more informed choices.

   Neither one of these recommendations is to suggest the need for an individual mandate regarding the purchase of health insurance, which is not part of this analysis. But rather, these recommendations are designed to help consumers who choose to purchase health insurance make more informed choices.

6. Is the market sufficiently transparent and competitive?

   At least seven carriers are active participants in the Maryland non-group and small group markets, and health plan information is readily available through public web sites. While the dominant carrier in the market insures a majority of individuals, there are a wide range of health plans and carriers from which to choose.

7. What role, if any, might state government play in promoting a more transparent and competitive health insurance market?

   State government could promote a more transparent market by establishing a standard format by which health carriers display benefits information, as well as require carriers to display the relative actuarial value of each of their health benefit plans. This information might then be used by consumers, through tools available on the public web sites and/or through the intermediaries' web sites, to compare health plans.

State regulators can also protect consumers and improve transparency by monitoring the market and making certain that information is provided in a fair, accurate and understandable fashion. These market conduct exams will be particularly important if there is an individual mandate as part of Federal health reform.

8. Can intermediaries administer public subsidies to help lower-income individuals purchase commercial insurance in the non-group and/or small group markets?

   As most recently demonstrated by their experience administering the Federal COBRA subsidy program for unemployed individuals, the two intermediaries reviewed as part of this report have the ability to aggregate contributions from multiple parties for a single individual. Under the federal COBRA subsidy program, the intermediaries handled the billing, collection and reconciliation of premiums, and tracked the eligibility of the people participating in this subsidy program. The intermediaries billed the individual subscriber for his share of the premium and the former employer for their share of the premium. This experience should prove particularly useful under the Federal proposal, or a state initiative, to subsidize the purchase of commercial insurance for lower-income individuals.

Appendix

1. **Screen shots from Massachusetts Health Connector web site**
2. **Screen shots from Kelly and Associates Insurance Group web site**
3. **Screen shots from Group Benefit Services web site**

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News: "E-Pay" for Commonwealth Choice members.

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Commonwealth Choice offers many options from brand-name health insurance plans. They all carry our Seal of Approval for quality and value.

Commonwealth Care is low or no-cost health insurance for people who qualify.

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*Optimize your Health Connector experience with Internet Explorer 7.0 or Firefox 3.0

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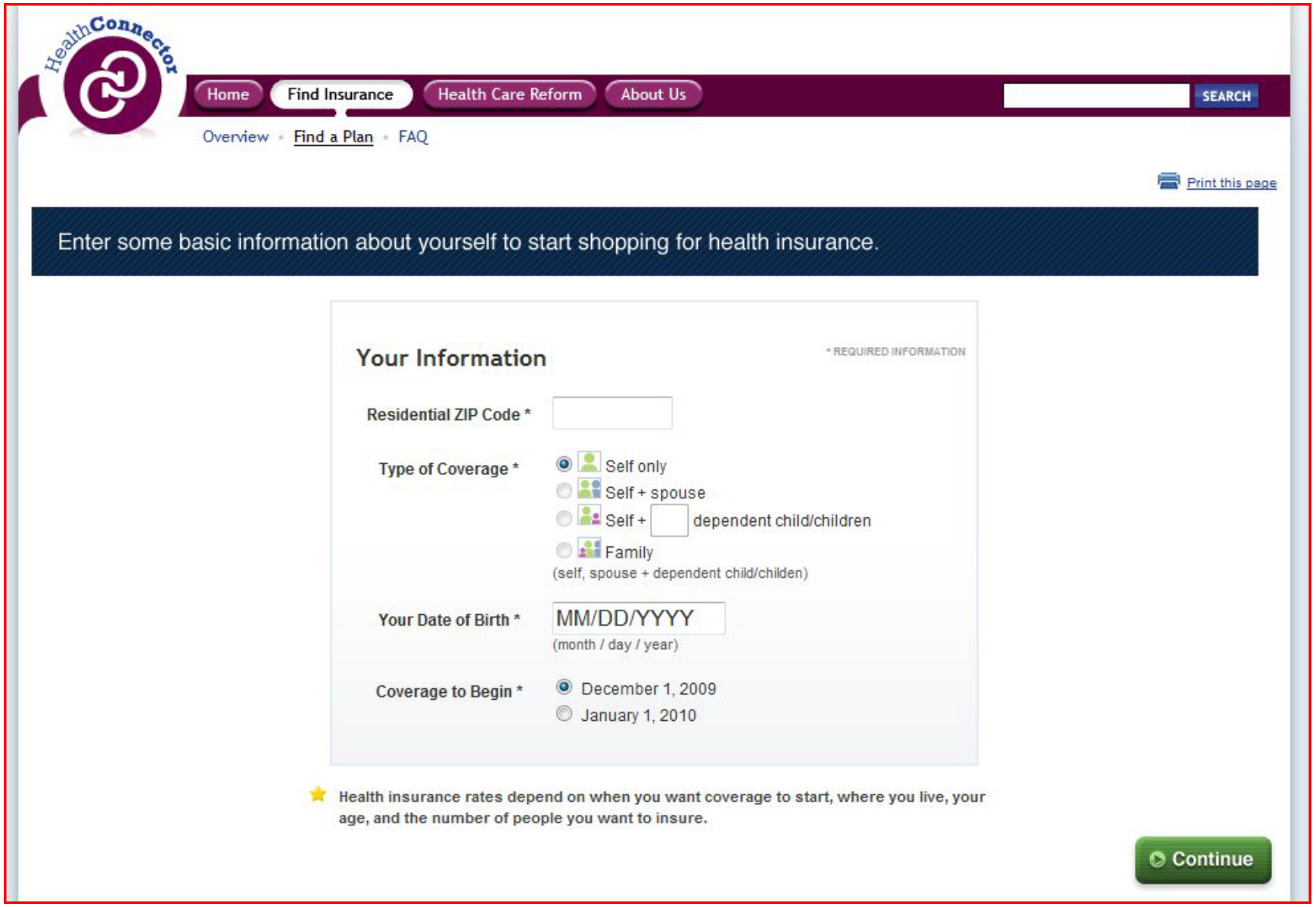
The Health Connector is an independent state agency that helps Massachusetts residents find health care coverage. Read more about us.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Type of Coverage *
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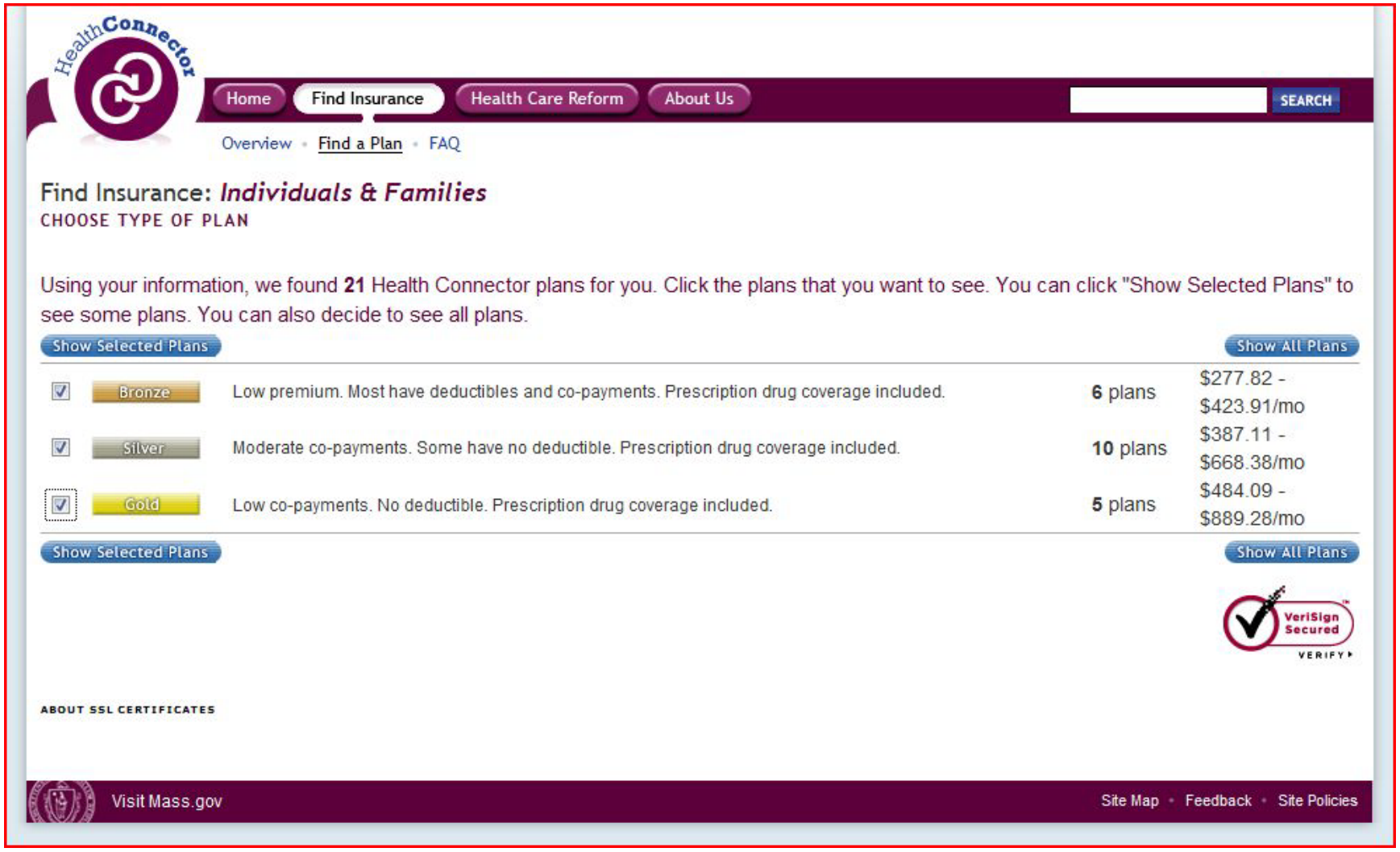
Self + spouse
Self + dependent child/children
Family
(self, spouse + dependent child/children)
Your Date of Birth *
MM/DD/YYYY
(month / day / year)
Coverage to Begin *
December 1, 2009
January 1, 2010
Health insurance rates depend on when you want coverage to start, where you live, your age, and the number of people you want to insure.
Continue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CHOOSE TYPE OF PLAN
Using your information, we found 21 Health Connector plans for you. Click the plans that you want to see. You can click "Show Selected Plans" to see some plans. You can also decide to see all plans.
Show Selected Plans
Show All Plans
Bronze
Low premium. Most have deductibles and co-payments. Prescription drug coverage included.
6 plans
$277.82 - $423.91/mo
Silver
Moderate co-payments. Some have no deductible. Prescription drug coverage included.
10 plans
$387.11 - $668.38/mo
Gold
Low co-payments. No deductible. Prescription drug coverage included.
5 plans
$484.09 - $889.28/mo
Show Selected Plans
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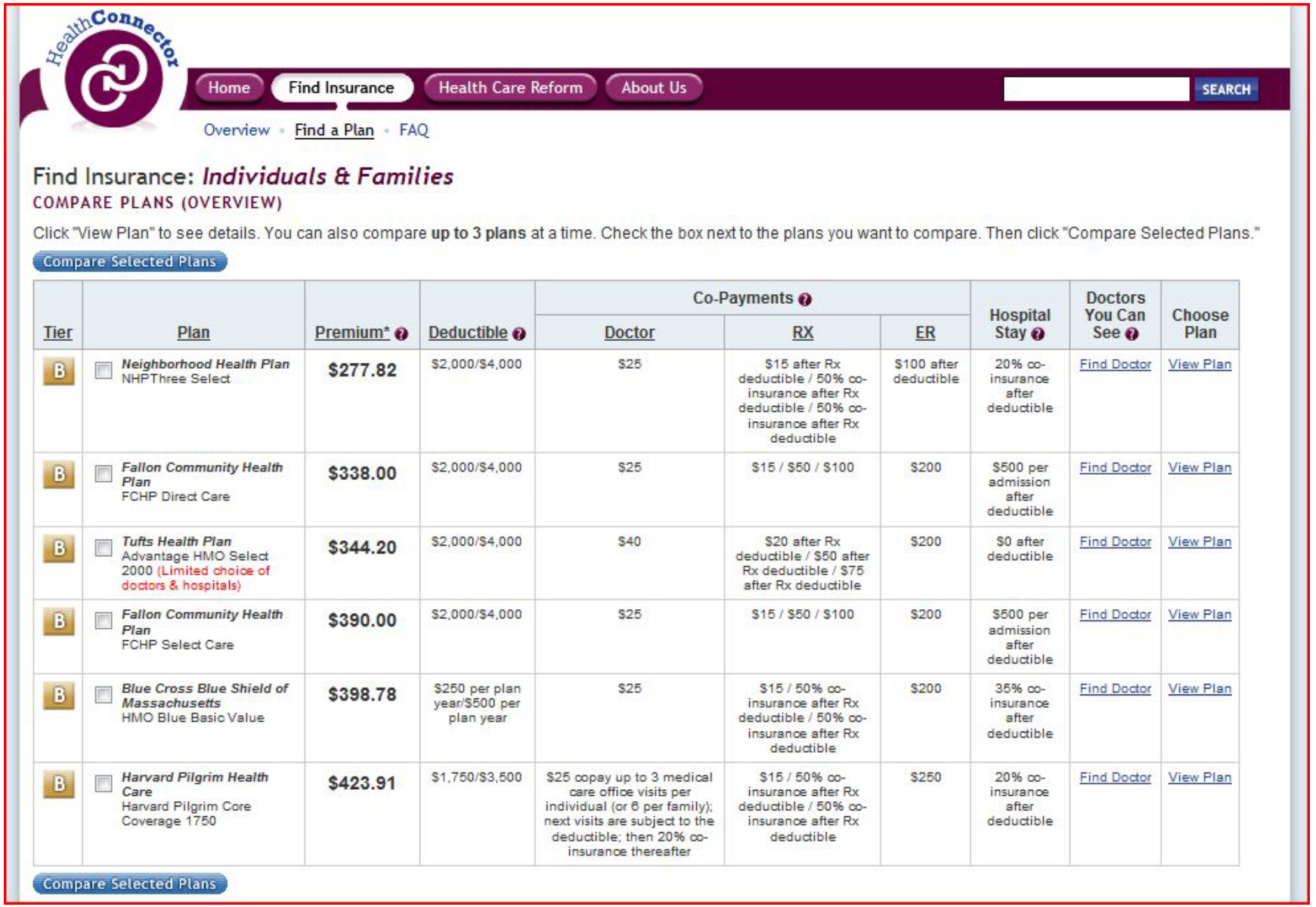
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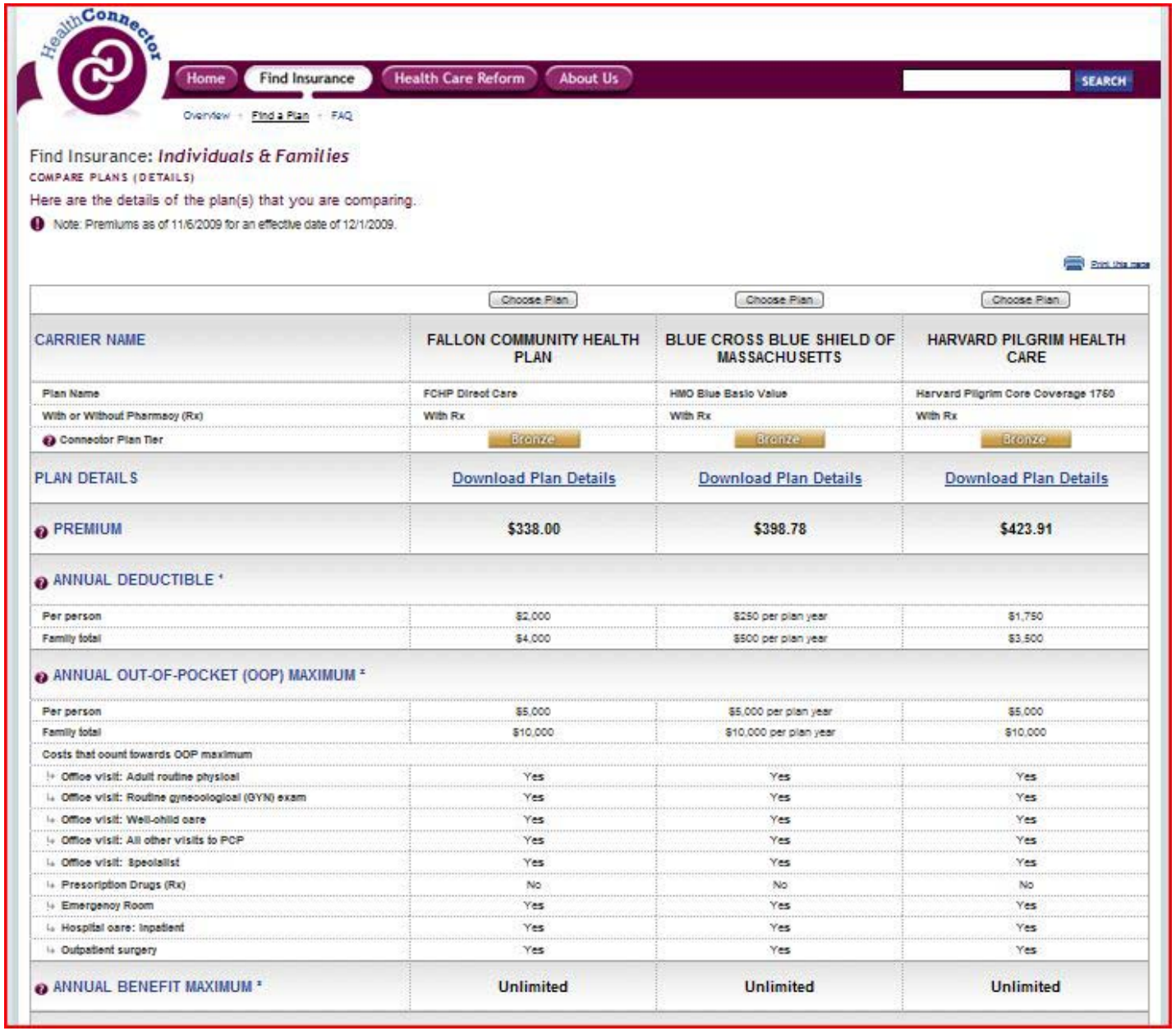
COMPARE PLANS (OVERVIEW)
Click "View Plan" to see details. You can also compare up to 3 plans at a time. Check the box next to the plans you want to compare. Then click "Compare Selected Plans."
Compare Selected Plans
Tier | Plan | Premium* | Deductible | Co-Payments: Doctor | RX | ER | Hospital Stay | Doctors You Can See | Choose Plan
B | Neighborhood Health Plan NHPThree Select | $277.82 | $2,000/$4,000 | $25 | $15 after Rx deductible / 50% co-insurance after Rx deductible / 50% co-insurance after Rx deductible | $100 after deductible | 20% co-insurance after deductible | Find Doctor | View Plan
B | Fallon Community Health Plan FCHP Direct Care | $338.00 | $2,000/$4,000 | $25 | $15 / $50 / $100 | $200 | $500 per admission after deductible | Find Doctor | View Plan
B | Tufts Health Plan Advantage HMO Select 2000 (Limited choice of doctors & hospitals) | $344.20 | $2,000/$4,000 | $40 | $20 after Rx deductible / $50 after Rx deductible / $75 after Rx deductible | $200 | $0 after deductible | Find Doctor | View Plan
B | Fallon Community Health Plan FCHP Select Care | $390.00 | $2,000/$4,000 | $25 | $15 / $50 / $100 | $200 | $500 per admission after deductible | Find Doctor | View Plan
B | Blue Cross Blue Shield of Massachusetts HMO Blue Basic Value | $398.78 | $250 per plan year/$500 per plan year | $25 | $15 / 50% co-insurance after Rx deductible / 50% co-insurance after Rx deductible | $200 | 35% co-insurance after deductible | Find Doctor | View Plan
B | Harvard Pilgrim Health Care Harvard Pilgrim Core Coverage 1750 | $423.91 | $1,750/$3,500 | $25 copay up to 3 medical care office visits per individual (or 6 per family); next visits are subject to the deductible; then 20% co-insurance thereafter | $15 / 50% co-insurance after Rx deductible / 50% co-insurance after Rx deductible | $250 | 20% co-insurance after deductible | Find Doctor | View Plan
Compare Selected Plans



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Find Insurance: *Individuals & Families*

COMPARE PLANS (DETAILS)

Here are the details of the plan(s) that you are comparing.

Note: Premiums as of 11/6/2009 for an effective date of 12/1/2009.

Print this page

	Choose Plan	Choose Plan	Choose Plan
CARRIER NAME	FALLON COMMUNITY HEALTH PLAN	BLUE CROSS BLUE SHIELD OF MASSACHUSETTS	HARVARD PILGRIM HEALTH CARE
Plan Name	FCHP Direct Care	HMO Blue Basic Value	Harvard Pilgrim Core Coverage 1760
With or Without Pharmacy (Rx)	With Rx	With Rx	With Rx
Connector Plan Tier	Bronze	Bronze	Bronze
PLAN DETAILS	Download Plan Details	Download Plan Details	Download Plan Details
PREMIUM	$338.00	$398.78	$423.91
ANNUAL DEDUCTIBLE *			
Per person	$2,000	$250 per plan year	$1,750
Family total	$4,000	$500 per plan year	$3,500
ANNUAL OUT-OF-POCKET (OOP) MAXIMUM *			
Per person	$5,000	$5,000 per plan year	$5,000
Family total	$10,000	$10,000 per plan year	$10,000
Costs that count towards OOP maximum			
Office visit: Adult routine physical	Yes	Yes	Yes
Office visit: Routine gynecological (GYN) exam	Yes	Yes	Yes
Office visit: Well-child care	Yes	Yes	Yes
Office visit: All other visits to PCP	Yes	Yes	Yes
Office visit: Specialist	Yes	Yes	Yes
Prescription Drugs (Rx)	No	No	No
Emergency Room	Yes	Yes	Yes
Hospital care: Inpatient	Yes	Yes	Yes
Outpatient surgery	Yes	Yes	Yes
ANNUAL BENEFIT MAXIMUM *	Unlimited	Unlimited	Unlimited

ROUTINE MEDICAL OFFICE VISITS

Subject to deductible	No	No	No for first 3 medical care office visits per individual (or 6 per family); yes for subsequent visits
↳ Adult routine physical	$0	$15	$25 copay up to 3 medical care office visits per individual (or 6 per family); next visits are subject to the deductible; then 20% co-insurance thereafter
↳ Routine gynecological (GYN) exam	$0	$15	$25 copay up to 3 medical care office visits per individual (or 6 per family); next visits are subject to the deductible; then 20% co-insurance thereafter
↳ Well-child care	$0	$15	$25 copay up to 3 medical care office visits per individual (or 6 per family); next visits are subject to the deductible; then 20% co-insurance thereafter

ROUTINE VISION

Subject to deductible	No	No	No for first 3 medical care office visits per individual (or 6 per family); yes for subsequent visits
↳ Routine vision exam	$25	$15	$25 copay up to 3 medical care office visits per individual (or 6 per family); next visits are subject to the deductible; then 20% co-insurance thereafter
↳ One vision exam per	12 months	24 months	24 months

OTHER PRIMARY CARE PROVIDER (PCP) OFFICE VISITS

Subject to deductible	No	No	No for first 3 medical care office visits per individual (or 6 per family); yes for subsequent visits
↳ Other PCP office visits	$25	$25	$25 copay up to 3 medical care office visits per individual (or 6 per family); next visits are subject to the deductible; then 20% co-insurance thereafter

SPECIALIST OFFICE VISITS

Subject to deductible	No	No	No for first 3 medical care office visits per individual (or 6 per family); yes for subsequent visits
↳ Specialist	$40	$40	$25 copay up to 3 medical care office visits per individual (or 6 per family); next visits are subject to the deductible; then 20% co-insurance thereafter

LABORATORY + IMAGING: OUTPATIENT

Subject to deductible	Yes	Yes	Yes
↳ Diagnostic lab	$0 after deductible	35% co-insurance after deductible	20% co-insurance after deductible
Subject to deductible	Yes	Yes	Yes
↳ Diagnostic X-ray	$0 after deductible	35% co-insurance after deductible	20% co-insurance after deductible
Subject to deductible	Yes	Yes	Yes
↳ Diagnostic CT/ MRI/ MRA/ PET scan	$0 after deductible	35% co-insurance after deductible	20% co-insurance after deductible

PRESCRIPTION DRUGS (RX)

Subject to deductible [1]	No	No	No
Separate Rx deductible	None	$250 per member per plan year, $500 per family per plan year (applies to Tiers 2 and 3 only)	$250 per individual, $500 per family (for Retail Tiers 2 and 3 only)
Retail drugs (up to 30 day supply)			
↳ Tier 1 (primarily generic focused)	$15	$15	$15
↳ Tier 2 (primarily preferred brand)	$50	50% co-insurance after Rx deductible	50% co-insurance after Rx deductible
↳ Tier 3 (primarily non-preferred brand)	$100	50% co-insurance after Rx deductible	50% co-insurance after Rx deductible
↳ Special rules/features	N/A	BlueValue Rx formulary	N/A
Mail order drugs (up to 90 day supply)			
↳ Tier 1 (primarily generic focused)	$30	$30	$30
↳ Tier 2 (primarily preferred brand)	$100	50% co-insurance after Rx deductible	50% of cost
↳ Tier 3 (primarily non-preferred brand)	$200	50% co-insurance after Rx deductible	50% of cost
↳ Special rules/features	N/A	BlueValue Rx formulary	Rx deductible does not apply to mail order drugs

EMERGENCY

Subject to deductible	No	No	No
↳ Emergency room (waived if admitted)	$200	$200	$250
Subject to deductible	Yes	Yes	Yes
↳ Ambulance	$0 after deductible	35% co-insurance after deductible	20% co-insurance after deductible

HOSPITAL CARE - INPATIENT

Subject to deductible	Yes	Yes	Yes
↳ Inpatient hospitalization (semi-private room and board)	$500 per admission after deductible	35% co-insurance after deductible	20% co-insurance after deductible
↳ Physician services	$0 after deductible	35% co-insurance after deductible	20% co-insurance after deductible
Skilled nursing facility (SNF)	$500 per admission after deductible	35% co-insurance after deductible	20% co-insurance after deductible
Skilled nursing facility (SNF) limits	100 days per calendar year	100 days per calendar year	100 days per calendar year
Rehabilitation hospital	$500 per admission after deductible	35% co-insurance after deductible	20% co-insurance after deductible
Rehabilitation hospital limits	100 days per calendar year	60 days per calendar year	60 days per calendar year

OUTPATIENT SURGERY: IN HOSPITAL OR SURGICAL DAY CARE UNIT

Subject to deductible	Yes	Yes	Yes
↳ Outpatient surgery	$250 after deductible	35% co-insurance after deductible	20% co-insurance after deductible

PHYSICAL THERAPY

Subject to deductible	Yes	No	No for first 3 medical care office visits per individual (or 6 per family); yes for subsequent visits
↳ Physical therapy	$25 after deductible	$40	$25 copay up to 3 medical care office visits per individual (or 6 per family); next visits are subject to the deductible; then 20% co-insurance thereafter
↳ Physical therapy limits (benefits may be combined with occupational therapy (OT) benefit)	60 visits per calendar year (PT/OT combined)	20 visits per calendar year (PT/OT combined)	20 visits per calendar year
Speech therapy limits	No day or dollar limit	No day or dollar limit	No day or dollar limit
Cardiac rehabilitation limits	No day or dollar limit	No day or dollar limit	No day or dollar limit

MENTAL HEALTH BENEFITS: BIOLOGICALLY-BASED CONDITIONS

Subject to deductible	No	No	No for first 3 mental health, drug, or alcohol rehabilitation office visits per individual (or 6 per family); yes for subsequent visits
Mental health outpatient office visit	$25	$25	$25 copay for up to 3 mental health, drug, or alcohol rehabilitation office visits per individual (or 6 per family); next visits are subject to the deductible; then 20% co-insurance thereafter
Subject to deductible	No	Yes	Yes
Mental health inpatient admission	$0	35% co-insurance after deductible	20% co-insurance after deductible

DURABLE MEDICAL EQUIPMENT (DME)

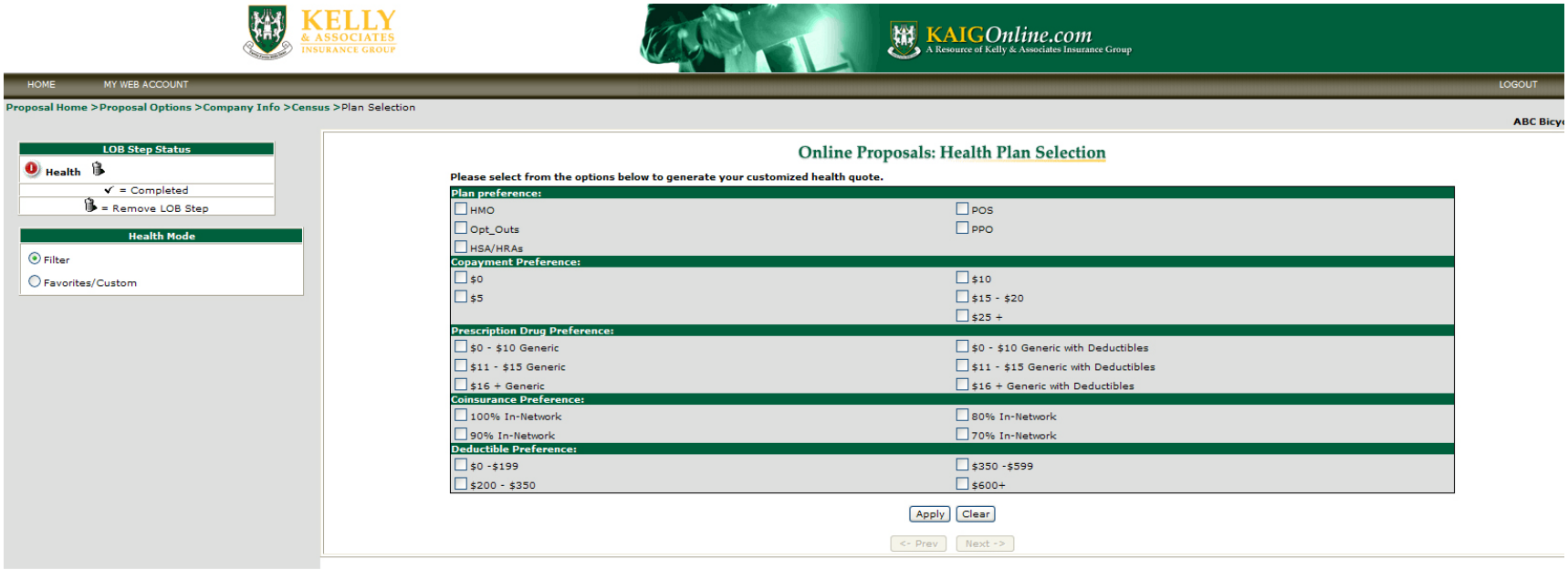
Subject to deductible [1]	Yes	Yes	Yes
Separate DME deductible	None	None	None
DME	$0 after deductible	35% co-insurance after deductible	20% co-insurance after deductible
DME limit	$1,500 per calendar year	$750 per calendar year	$1,000 per calendar year
PLAN DETAILS	Download Plan Details	Download Plan Details	Download Plan Details
	Choose Plan	Choose Plan	Choose Plan

[1] The "Annual Deductible" refers to the overall calendar year deductible. Some plans may have a separate deductible for specific benefits. For example, some plans may have a separate prescription drug (Rx) deductible.

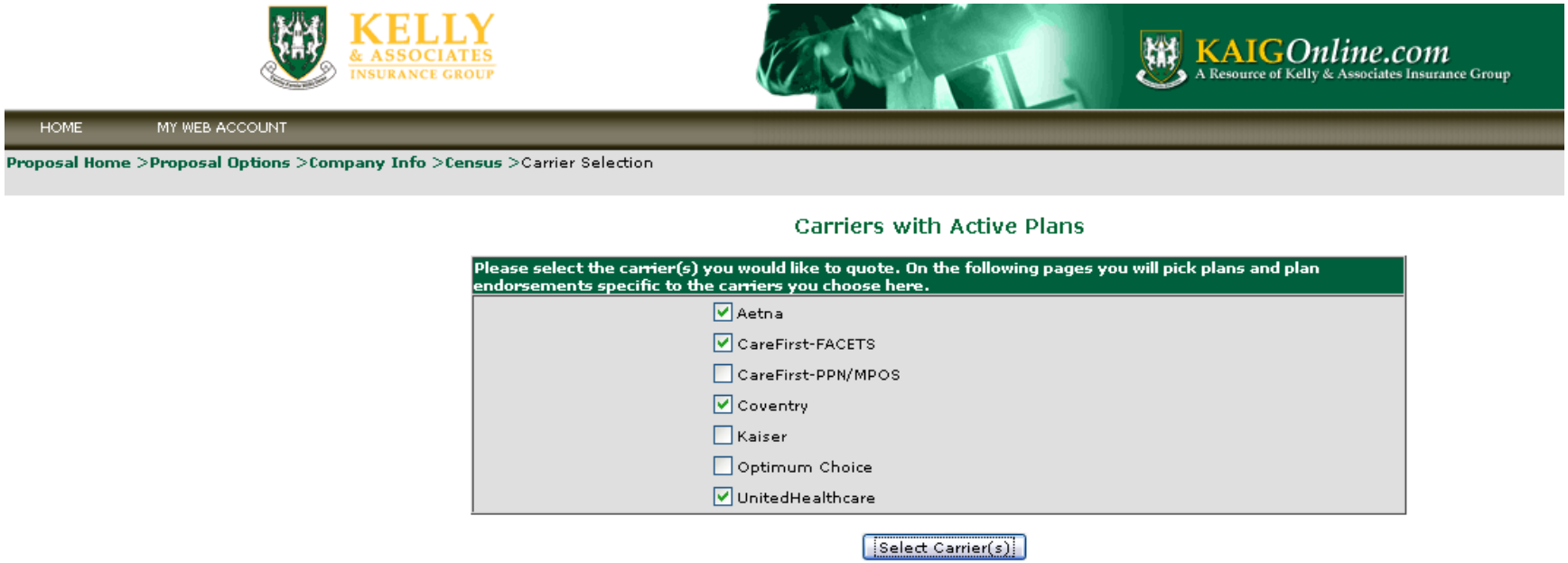
[2] The "Annual Out-of-Pocket Maximum" refers to the calendar year out-of-pocket maximum. In addition to the member costs for the nine services listed below, there may be other member costs that count towards the out-of-pocket maximum. Contact individual carriers if you have questions regarding the out-of-pocket maximum.

[3] The "Annual Benefit Maximum" refers to the calendar year annual benefit maximum.

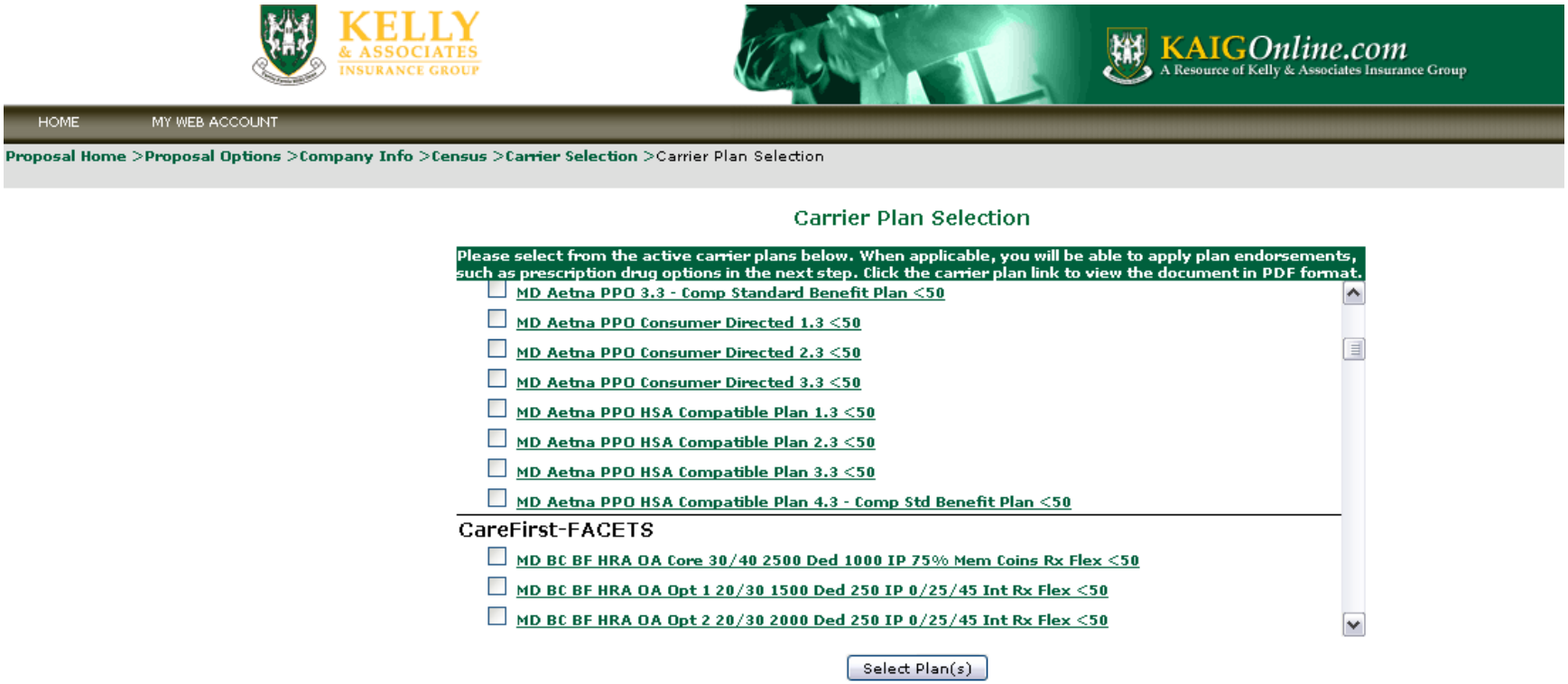
The information presented above, including all quoted prices, is a summary for informational purposes only. Review the evidence of coverage, insurance policy, and any other health plan contract documents available from the insurance carrier for a detailed description of coverage benefits, limitations and exclusions. Only the terms and conditions of coverage benefits listed in the policy are binding.



Filter Quoting Method – allows users to select plans based upon product type and plan design



Carrier Plan Selection Quoting Method – an alternate quoting method that allows user to select a specific plan



Carrier Plan Selection Quoting Method – plan selection page

Carrier Plan Selection Quoting Method – selected plans

Online Proposals: plan options

Proposal Information	
Group Name	Tim Test 2
Broker	
Effective Date	12/01/2009
Proposal Date	11/13/2009
County	Baltimore
ZIP	21030
SIC	4214
Group Average Age	26.4
Prepared By	Joe Broker

Carrier Average Age	
Carrier	**Average Age**
Aetna	26.00
CareFirst-FACETS	26.00
Coventry	26.00
UnitedHealthcare	Not Available

Health | All

Health Plans

Current Enrollment							full census
Carrier	**IND**	**P&C**	**PC2**	**H&W**	**FAM**	**MSI**	**TOTAL**
Aetna	6	0	1	0	0	N/A	7
CareFirst-FACETS	6	0	1	0	0	0	7
Coventry	6	0	1	0	0	0	7
UnitedHealthcare	6	1	0	0	0	0	7

Plan Options

Represents state mandated options **Represents options that include an inpatient Hospital Copay**

Print Unselect All

	Carrier/Plan Name	Template	Copay	Rx	Coinsurance	Deductible	Inpatient Hospital Copay	Monthly Health Premium
1	Aetna MD Aetna HMO Consumer Directed Pln 3.3 - Comp Std Benefit Plan <50	ATNA141	$30/$40 after ded	Rx: 75% after $2500 ded.		$2,500 Ind. / $5,000 Fam. Ded.	$1000 IP Copay after Ded.	$1,649.00
2	Aetna MD Aetna HMO HSA Compatible Plan 5.3 - Comp Std Benefit Plan <50	ATNA150	$30/$40 after ded	Rx: 75% after Rx/Med Ded		$2700 Ind/$5450 Fam Ded	$1000 IP Copay after Ded.	$1,233.00
3	Aetna MD Aetna HMO Plan 1.3 <50	ATNA136	$25/$40 Office Visit Copay	Rx: $10/$25/$50			$150 per day, 5 day max	$3,125.00
4	Aetna MD Aetna HMO Plan 2.3 - Comp Standard Benefit Plan <50	ATNA140	$30/40 Office Visit Copay	Rx: 75% after $2500 ded.			$1,000 Inpatient Hospital	$2,433.00

Output based upon plan selections

KAIGOnline|Online Proposal System|Cost Analysis Print View

KELLY & ASSOCIATES INSURANCE GROUP

301 International Circle
Hunt Valley, MD 21030
Phone: 410-555-5555 Fax: 410-555-5556

Proposal Information	
Group Name	ABC Bicycle
Broker	
Effective Date	12/01/2009
Proposal Date	11/13/2009
County	Baltimore
ZIP	21030
SIC	4214
Group Average Age	26.4
Prepared By	Joe Broker

Carrier Average Age	
Carrier	**Average Age**
Aetna	26.00
CareFirst-FACETS	26.00
Coventry	26.00
UnitedHealthcare	Not Available

Health Plans

Current Enrollment

Carrier	IND	P&C	PC2	H&W	FAM	MSI	TOTAL
Aetna	6	0	1	0	0	N/A	7
CareFirst-FACETS	6	0	1	0	0	0	7
Coventry	6	0	1	0	0	0	7
UnitedHealthcare	6	1	0	0	0	0	7

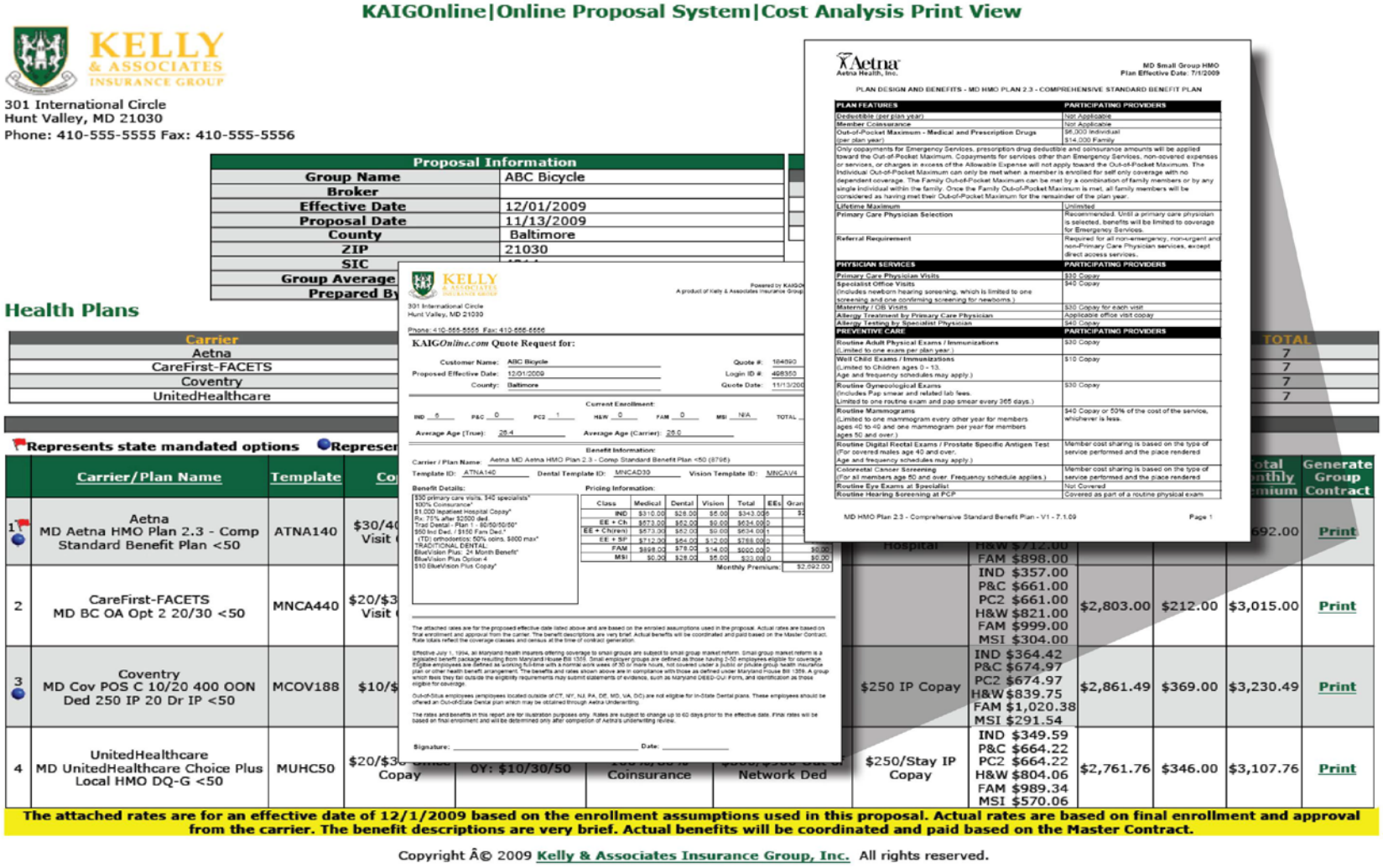
Plan Options

Represents state mandated options **Represents options that include an inpatient Hospital Copay**

	Carrier/Plan Name	Template	Copay	Rx	Coinsurance	Deductible	Inpatient Hospital Copay	Premium	Monthly Health Premium	Monthly Ancillary Premium	Total Monthly Premium	Generate Group Contract
1	Aetna MD Aetna HMO Plan 2.3 - Comp Standard Benefit Plan <50	ATNA140	$30/40 Office Visit Copay	Rx: 75% after $2500 ded.			$1,000 Inpatient Hospital	IND $310.00 P&C $573.00 PC2 $573.00 H&W $712.00 FAM $898.00	$2,433.00	$259.00	$2,692.00	Print
2	CareFirst-FACETS MD BC OA Opt 2 20/30 <50	MNCA440	$20/$30 Office Visit Copay	$10/$20/$30				IND $357.00 P&C $661.00 PC2 $661.00 H&W $821.00 FAM $999.00 MSI $304.00	$2,803.00	$212.00	$3,015.00	Print
3	Coventry MD Cov POS C 10/20 400 OON Ded 250 IP 20 Dr IP <50	MCOV188	$10/$20 OV	$0/25/50	100% / 80%	$400 Out of Network	$250 IP Copay	IND $364.42 P&C $674.97 PC2 $674.97 H&W $839.75 FAM $1,020.38 MSI $291.54	$2,861.49	$369.00	$3,230.49	Print
4	UnitedHealthcare MD UnitedHealthcare Choice Plus Local HMO DQ-G <50	MUHC50	$20/$30 Office Copay	0Y: $10/30/50	100%/80% Coinsurance	$300/$900 Out of Network Ded	$250/Stay IP Copay	IND $349.59 P&C $664.22 PC2 $664.22 H&W $804.06 FAM $989.34 MSI $570.06	$2,761.76	$346.00	$3,107.76	Print

The attached rates are for an effective date of 12/1/2009 based on the enrollment assumptions used in this proposal. Actual rates are based on final enrollment and approval from the carrier. The benefit descriptions are very brief. Actual benefits will be coordinated and paid based on the Master Contract.

Output that can be emailed to customers



Contracts and benefit summaries can be launched directly from our proposals

KELLY & ASSOCIATES INSURANCE GROUP

Prepared for: ABC Bicycle
Requested Effective Date: 12/01/2009
County/Zip: Baltimore / 21030

Agent: DATAWEB BROKER
Agency: KAIG
Phone: 0000000000

CENSUS

IND: 6 P&C: 0 PC2: 1 H&W: 0 FAM: 0 MSI: 0 Total: 7 True Average Age: 26.43
Carrier Average Age: 26.00

CareFirst BCBS BlueChoice/BluePreferred 4 Tier - Maryland

Plan/Endorsement Name	Coverage Class/Employee Count IND/ 6	P&C/ 0	PC2/ 1	H&W/ 0	FAM/ 0	MSI/ 0	Total Monthly Premium
BlueChoice HMO							
[ ] BlueChoice HMO Option 1 - $20/$30/$250	227.00	420.00	420.00	522.00	636.00	193.00	1782.00
[ ] BlueChoice HMO Option 2 - $20/$30/$0	256.00	474.00	474.00	589.00	717.00	218.00	2010.00
[ ] BlueChoice HMO Option 3 - $10/$20/$0	274.00	507.00	507.00	630.00	767.00	233.00	2151.00
[ ] BlueChoice HMO Option 4 - $5/$10/$0	286.00	529.00	529.00	658.00	801.00	243.00	2245.00
[ ] BlueChoice HMO Option 5 - Old Core $30/$40/$250	211.00	390.00	390.00	485.00	591.00	180.00	1656.00
[ ] BlueChoice HMO Option 6 - New Core $30/$40/$1000 w/out vision	205.00	379.00	379.00	472.00	574.00	174.00	1609.00
[ ] BlueChoice HMO Option 6 - New Core $30/$40/$1000 w/vision	206.00	381.00	381.00	474.00	577.00	175.00	1617.00
BlueChoice HMO Open Access							
[ ] BlueChoice HMO Open Access Option 1 - $20/$30/$250	239.00	442.00	442.00	550.00	669.00	203.00	1876.00
[ ] BlueChoice HMO Open Access Option 2 - $20/$30/$0	269.00	498.00	498.00	619.00	753.00	229.00	2112.00
[ ] BlueChoice HMO Open Access Option 3 - $10/$20/$0	286.00	529.00	529.00	658.00	801.00	243.00	2245.00
[ ] BlueChoice HMO Open Access Option 4 - $5/$10/$0	299.00	553.00	553.00	688.00	837.00	254.00	2347.00
BlueChoice Open Access Opt-Out							
[ ] BlueChoice Opt-Out Open Access Option 1 - $10/$20 80%	298.00	551.00	551.00	685.00	834.00	253.00	2339.00
[ ] BlueChoice Opt-Out Open Access Option 2 - $15/$25 80%	287.00	531.00	531.00	660.00	804.00	244.00	2253.00
[ ] BlueChoice Opt-Out Open Access Option 3 - $20/$30 80%	280.00	518.00	518.00	644.00	784.00	238.00	2198.00
[ ] BlueChoice Opt-Out Open Access Option 4 - $10/$20 60%	287.00	531.00	531.00	660.00	804.00	244.00	2253.00
[ ] BlueChoice Opt-Out Open Access Option 5 - $15/$25 60%	277.00	512.00	512.00	637.00	776.00	236.00	2174.00
[ ] BlueChoice Opt-Out Open Access Option 6 - $20/$30 60%	269.00	498.00	498.00	619.00	753.00	229.00	2112.00
BlueChoice Open Access Opt-Out Plus							
[ ] BlueChoice Opt-Out Plus Open Access Option 1 - $5/$10, 80% with $300 OON	309.00	572.00	572.00	711.00	865.00	263.00	2426.00
[ ] BlueChoice Opt-Out Plus Open Access Option 2 - $5/$10, 80% with $500 OON	288.00	533.00	533.00	662.00	806.00	245.00	2261.00
[ ] BlueChoice Opt-Out Plus Open Access Option 3 - $10/$20, 80% with $300 OON	297.00	549.00	549.00	683.00	832.00	253.00	2331.00
[ ] BlueChoice Opt-Out Plus Open Access Option 4 - $10/$20, 80% with $500 OON	276.00	511.00	511.00	635.00	773.00	235.00	2167.00
[ ] BlueChoice Opt-Out Plus Open Access Option 5 - $20/$30, 80% with $300 OON	279.00	516.00	516.00	642.00	781.00	237.00	2190.00
[ ] BlueChoice Opt-Out Plus Open Access Option 6 - $20/$30, 80% with $500 OON	258.00	477.00	477.00	593.00	722.00	219.00	2025.00
TOTALS FOR SELECTED PLAN OPTIONS	$	$	$	$	$	$	$

- A Prescription drug plan must be purchased with medical coverage. Refer to CareFirst BCBS GHMSI/BlueChoice Drug Proposal for rates as well as instructions for dual and triple combination options.
- RATES WILL BE BASED ON FINAL ENROLLMENT. COMPARE CENSUS QUOTED TO YOUR GROUP CENSUS.
- The Medicare rates quotes above are reserved for those individuals who are eligible by law and enrolled in Medicare Parts A & B.
- Group average age and product pricing are developed per carrier rules.
- CareFirst BlueCross BlueShield reserves the right to revise the rates if actual enrollment varies substantially from that used in the original rating, if applicable law or regulatory authority requires such revisions, or if the rates shown here vary from those of the carrier.

Please select if benefits should be contract or calendar year. If a box is not selected, benefits will default to contract year.
Exception: Groups with a 15th of the month effective date must have calendar year benefits for the first year.

☐ Contract Year Benefits
☐ Calendar Year Benefits

Accepted By: _____ _____ _____
Signature Date Print Name & Title

Alternate output that shows a comparison of all plans a carrier offers

Benefits Comparison — *compare benefits*

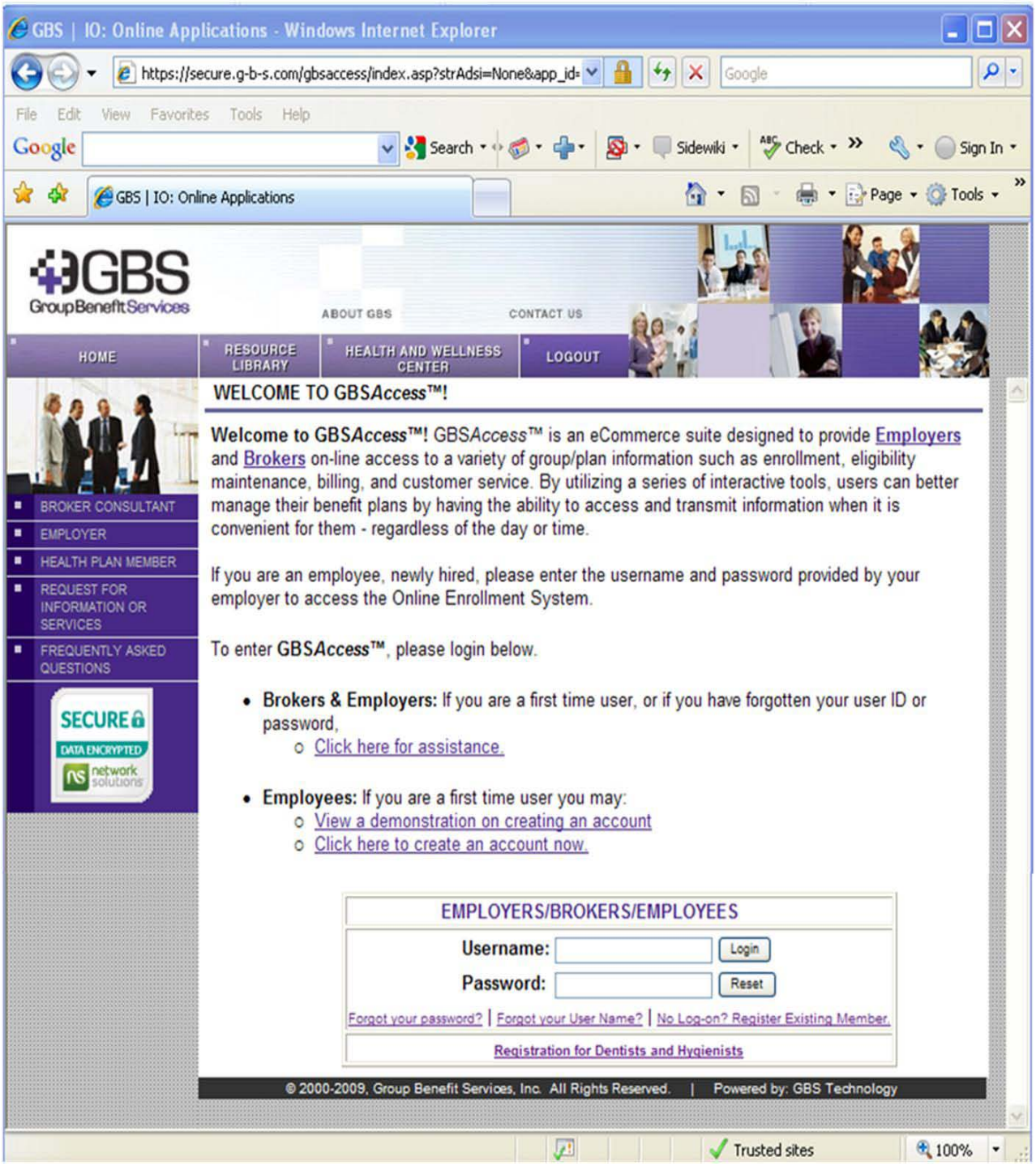
back

BENEFIT COMPARISON			
Plan Name:	**Standard Option HMO**	**High Option PPO**	
Benefits	**In Network Benefit Only**	**In-Network**	**Out-Of-Network**
Individual Deductible	N/A	$150	$250
Family Deductible	N/A	$300	$500
Individual Out-Of-Pocket Maximum	N/A	$1,000	$1,000
Family Out-Of-Pocket Maximum	N/A	$2,000	$2,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Inpatient Hospital Services	Covered in full	Subject to deductible and covered at 100% coinsurance	Subject to deductible and covered at 80% coinsurance
Outpatient Hospitalization	$25 copay per visit	$25 copay per visit, covered at 100% coinsurance	Subject to deductible and covered at 80% coinsurance
Primary Physician Office Visit	$10 copay per visit	Covered in full, after $10 copayment per visit	Subject to deductible and covered at 80% coinsurance
Specialist Physician Office Visit	$10 copay per visit	Covered in full, after $10 copayment per visit	Subject to deductible and covered at 80% coinsurance
Diagnostic X-Ray Lab	Covered in full after applicable copay	No deductible and covered at 100% coinsurance	No deductible and covered at 100% coinsurance
Prescription Drugs	$5 copay generic; $10 formulary listed brand; $25 non-formulary brand name (Mandatory generic plan)	$8 copay Generic, $15 copay brand (formulary), $30 copay brand (non-formulary)Mail Order 90 day supply of maintenance medications available for 2 times pharmacy copay.	$8 copay Generic, $15 copay brand (formulary), $30 copay brand (non-formulary). Mail Order 90 day supply of maintenance medications available for 2 times pharmacy copay.
Emergency Room	$50 copay per visit (waived if admitted)	$25 copay per visit ER, covered at 100% coinsurance. If admitted copay waived then, subject to deductible and coinsurance	$25 copay per visit ER, covered at 100% coinsurance. If admitted copay waived then, subject to deductible and coinsurance
Mental Health In-Patient	Covered in full	Subject to deductible and covered at 100% coinsurance	Subject to deductible and covered at 80% coinsurance
Mental Health Out-Patient	Visits 1-5: 20% copay; Visits 6-30: 35% copay; Visits 31+: 50% copay	Subject to deductible, then visits 1-5 covered at 80%, visits 6-30 covered at 65%, visits 31+ covered at 50%	Subject to deductible, then visits 1-5 covered at 80%, visits 6-30 covered at 65%, visits 31+ covered at 50%
Substance Abuse In-Patient	Covered in full	Subject to deductible and covered at 100% coinsurance	Subject to deductible and covered at 80% coinsurance
Substance Abuse Out-Patient	Visits 1-5: 20% copay; Visits 6-30: 35% copay; Visits 31+: 50% copay	Subject to deductible, then visits 1-5 covered at 80%, visits 6-30 covered at 65%, visits 31+ covered at 50%	Subject to deductible, then visits 1-5 covered at 80%, visits 6-30 covered at 65%, visits 31+ covered at 50%

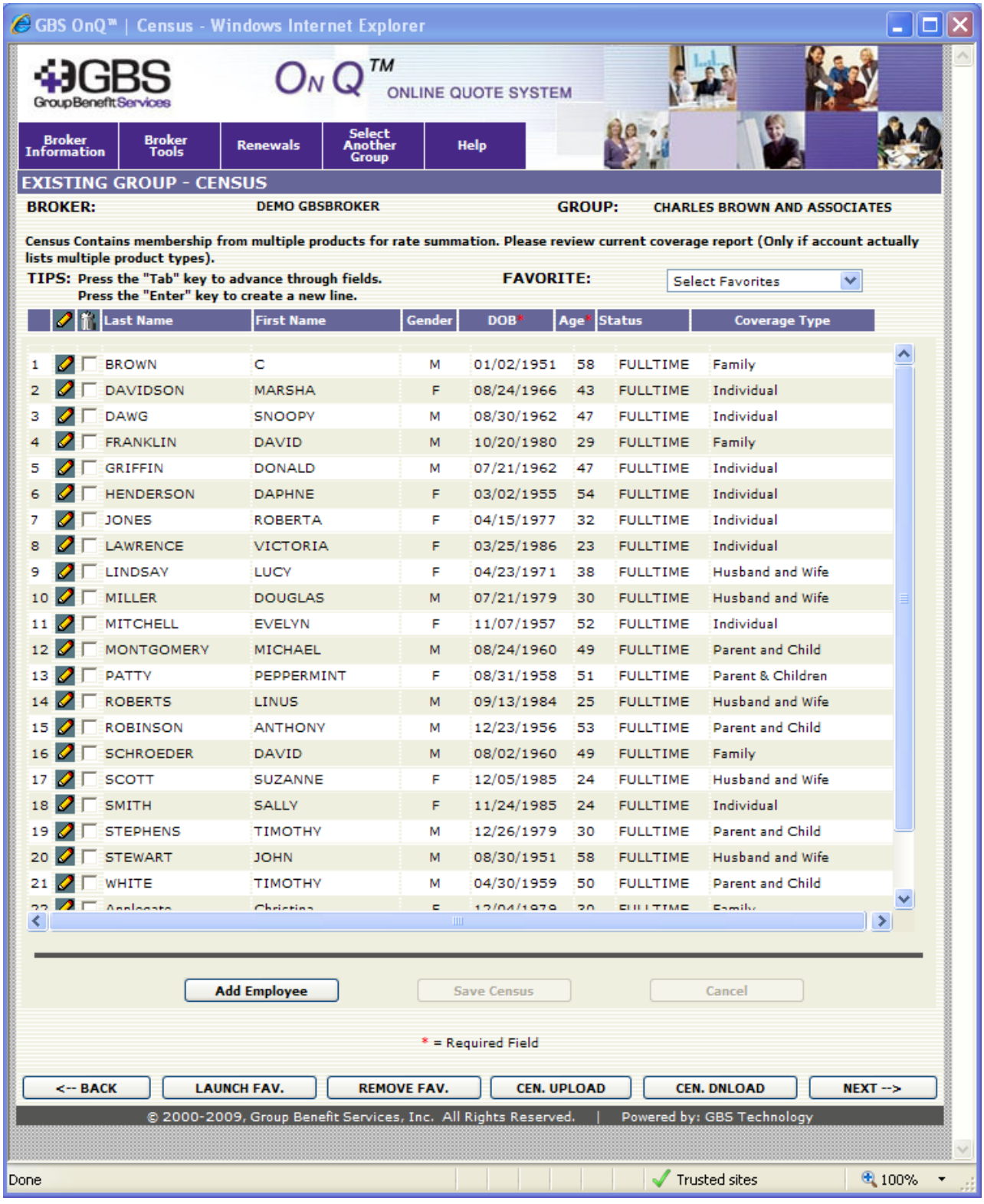
MONTHLY (12) EMPLOYEE CONTRIBUTIONS		
Plan Name:	**Standard Option HMO**	**High Option PPO**
Coverage Level	Employee Contribution	
Individual	$38.61	$79.67
Parent & Children	$55.34	$121.00
Husband & Wife	$69.53	$143.48
Family	$92.93	$191.79

Sample Benefit Comparison

GBSAccess Login Screen

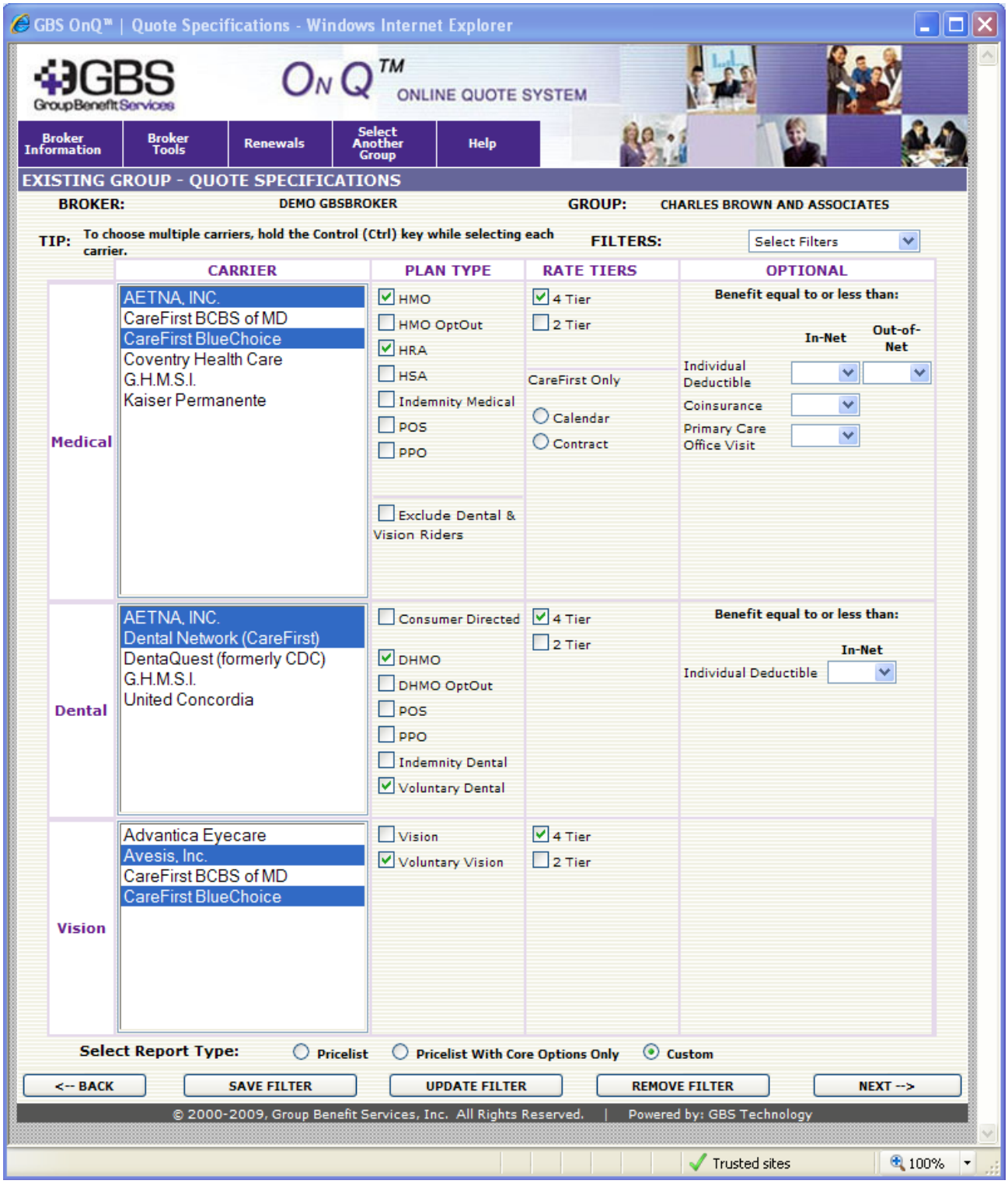


Census

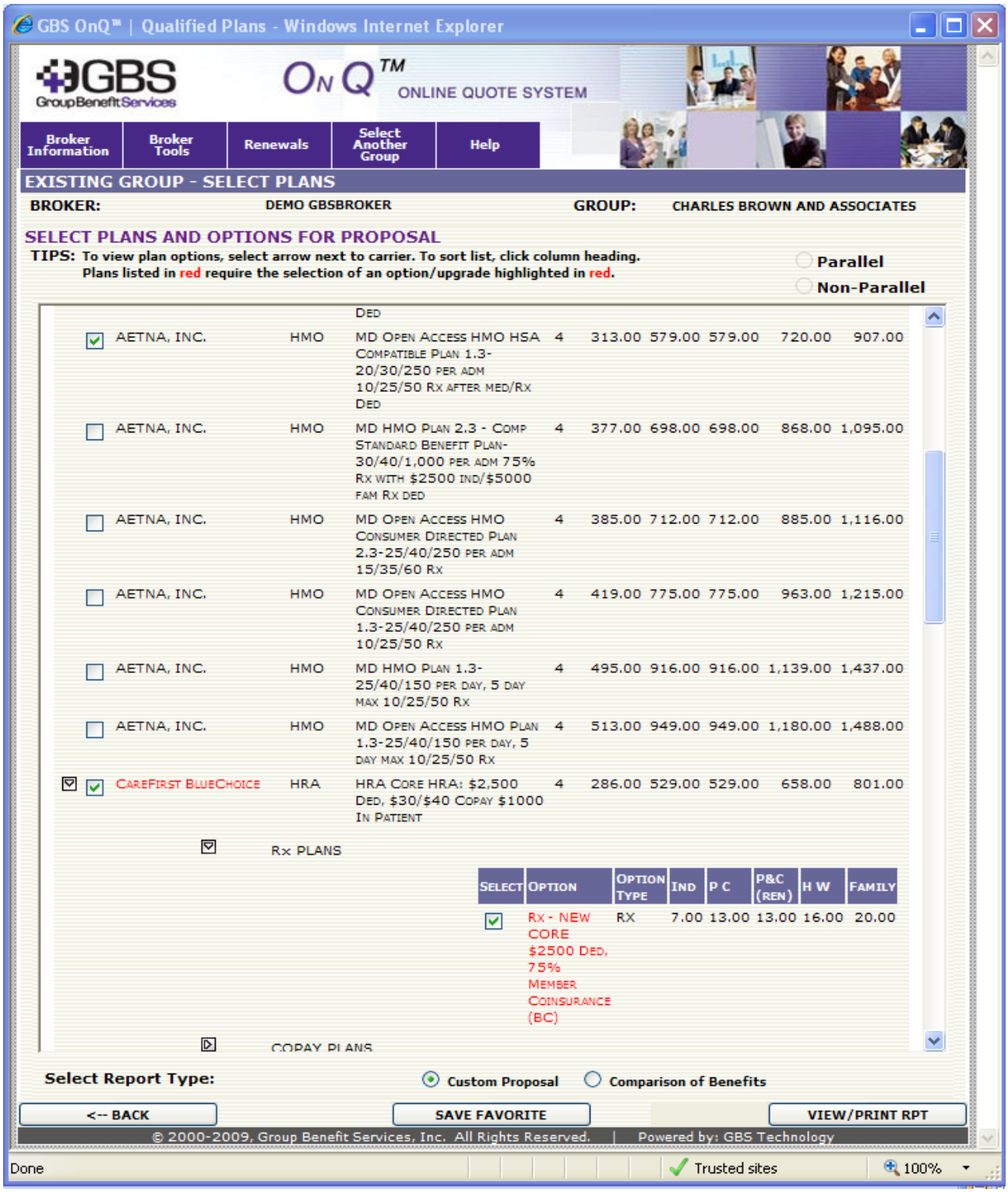


	Last Name	First Name	Gender	DOB*	Age*	Status	Coverage Type
1	BROWN	C	M	01/02/1951	58	FULLTIME	Family
2	DAVIDSON	MARSHA	F	08/24/1966	43	FULLTIME	Individual
3	DAWG	SNOOPY	M	08/30/1962	47	FULLTIME	Individual
4	FRANKLIN	DAVID	M	10/20/1980	29	FULLTIME	Family
5	GRIFFIN	DONALD	M	07/21/1962	47	FULLTIME	Individual
6	HENDERSON	DAPHNE	F	03/02/1955	54	FULLTIME	Individual
7	JONES	ROBERTA	F	04/15/1977	32	FULLTIME	Individual
8	LAWRENCE	VICTORIA	F	03/25/1986	23	FULLTIME	Individual
9	LINDSAY	LUCY	F	04/23/1971	38	FULLTIME	Husband and Wife
10	MILLER	DOUGLAS	M	07/21/1979	30	FULLTIME	Husband and Wife
11	MITCHELL	EVELYN	F	11/07/1957	52	FULLTIME	Individual
12	MONTGOMERY	MICHAEL	M	08/24/1960	49	FULLTIME	Parent and Child
13	PATTY	PEPPERMINT	F	08/31/1958	51	FULLTIME	Parent & Children
14	ROBERTS	LINUS	M	09/13/1984	25	FULLTIME	Husband and Wife
15	ROBINSON	ANTHONY	M	12/23/1956	53	FULLTIME	Parent and Child
16	SCHROEDER	DAVID	M	08/02/1960	49	FULLTIME	Family
17	SCOTT	SUZANNE	F	12/05/1985	24	FULLTIME	Husband and Wife
18	SMITH	SALLY	F	11/24/1985	24	FULLTIME	Individual
19	STEPHENS	TIMOTHY	M	12/26/1979	30	FULLTIME	Parent and Child
20	STEWART	JOHN	M	08/30/1951	58	FULLTIME	Husband and Wife
21	WHITE	TIMOTHY	M	04/30/1959	50	FULLTIME	Parent and Child

Quote Specifications



Plan Selection



Custom Proposal

Quote Specification and Census Summary

Prospect:	CHARLES BROWN AND	**SIC Code:**	7300 (BUSINESS SERVICES)		
Zip Code:	21201	**Effective Date:**	1/1/2010	**Broker:**	DEMO GBSBR
County:	Baltimore Co & City	**Date Prepared:**	12/07/2009	**Agency:**	No Affiliation
State:	Maryland	**Time Prepared:**	06:05 PM	**Phone:**	0

	Medical	Dental	Vision
Carrier Selections:	AETNA, INC. CareFirst BlueChoice (Contract Year) Coventry Health Care	AETNA, INC.	
Plan Type(s):	HMO HSA	DHMO Voluntary Dental	Voluntary Vision
Tier(s):	4 Tier	4 Tier	4 Tier

Enrollment Summary By Age Band

< 15 = 0	35-39 = 2	60-64 = 0
15-19 = 0	40-44 = 1	65-69 = 0
20-24 = 3	45-49 = 4	70-74 = 0
25-29 = 2	50-54 = 5	75+ = 0
30-34 = 5	55-59 = 2	Total# Enrolled = 24

The age bracket distribution and average age illustrated are based on the age of enrolled employees as of the proposed effective date and may be different for carriers that calculate age as of the end of the calendar year. Average age and rates may also vary if the census includes employees age 65 or over with parts A&B of Medicare for non-TEFRA groups (<20). Please verify carrier rating guidelines before quoting.

Average Age: 40.25

Census Listing

#	Name	Gender	DOB	Age	Coverage Type	Status
1	C BROWN	M	1/2/1951	58	Family	FULLTIME
2	MARSHA DAVIDSON	F	8/24/1966	43	Individual	FULLTIME
3	SNOOPY DAWG	M	8/30/1962	47	Individual	FULLTIME
4	DAVID FRANKLIN	M	10/20/1980	29	Family	FULLTIME
5	DONALD GRIFFIN	M	7/21/1962	47	Individual	FULLTIME
6	DAPHNE HENDERSON	F	3/2/1955	54	Individual	FULLTIME
7	ROBERTA JONES	F	4/15/1977	32	Individual	FULLTIME
8	VICTORIA LAWRENCE	F	3/25/1986	23	Individual	FULLTIME
9	LUCY LINDSAY	F	4/23/1971	38	Husband and Wife	FULLTIME
10	DOUGLAS MILLER	M	7/21/1979	30	Husband and Wife	FULLTIME
11	EVELYN MITCHELL	F	11/7/1957	52	Individual	FULLTIME
12	MICHAEL MONTGOMERY	M	8/24/1960	49	Parent and Child	FULLTIME
13	PEPPERMINT PATTY	F	8/31/1958	51	Parent & Children	FULLTIME
14	LINUS ROBERTS	M	9/13/1984	25	Husband and Wife	FULLTIME
15	ANTHONY ROBINSON	M	12/23/1956	53	Parent and Child	FULLTIME
16	DAVID SCHROEDER	M	8/2/1960	49	Family	FULLTIME
17	SUZANNE SCOTT	F	12/5/1985	24	Husband and Wife	FULLTIME

Plan Cost Comparison

Prospect: CHARLES BROWN AND ASSOCIATES **Date Prepared:** 12/07/2009
Effective Date: 1/1/2010 **Time Prepared:** 06:05 PM

Coverage Type	IND	P&C	P&C(ren)	H&W	FAM	Total Monthly Premium
Enrollment by Coverage Type	10	4	1	5	4	24
CARRIER AND PLAN DESCRIPTION	**MONTHLY RATES**					
AETNA, INC. **HMO -- 4 TIER**						
MD Open Access HMO HSA Compatible Plan 4.3-30/40/250 per adm & 15/35/60 Rx after med/Rx Ded	$232.00	$429.00	$429.00	$533.00	$672.00	
TOTAL:	**$232.00**	**$429.00**	**$429.00**	**$533.00**	**$672.00**	**$9,818.00**
Coventry Health Care **HMO -- 4 TIER**						
HRA $1200 HMO	$238.87	$442.42	$442.42	$550.43	$668.83	
Rx -- $15/$25/$50 copays - 250 ded	$77.37	$143.31	$143.31	$178.29	$216.64	
TOTAL:	**$316.24**	**$585.73**	**$585.73**	**$728.72**	**$885.47**	**$13,276.53**
CareFirst BlueChoice **HSA -- 4 TIER**						
HSA BlueFund HMO OA Upgrade 1: $1,200 Ded, $20/$30 Copay $250 In Patient	$290.00	$537.00	$537.00	$667.00	$812.00	
Rx - HSA HMO OA Upgrade 1: $1,200 Ded, $20/$30 Copay $250 In Patient; $0/$25/$45 Rx	$53.00	$98.00	$98.00	$122.00	$148.00	
TOTAL:	**$343.00**	**$635.00**	**$635.00**	**$789.00**	**$960.00**	**$14,390.00**
CareFirst BlueChoice **HMO -- 4 TIER**						
Opt. 6 - Core $30/$40/$1000	$319.00	$590.00	$590.00	$734.00	$893.00	
Rx - NEW CORE $2500 Ded, 75% Member Coin-surance (BC)	$7.00	$13.00	$13.00	$16.00	$20.00	
TOTAL:	**$326.00**	**$603.00**	**$603.00**	**$750.00**	**$913.00**	**$13,677.00**

Comparison of Benefits
Page 1

Comparison of Medical Benefits

Prospect: CHARLES BROWN AND ASSOCIATES
Effective Date: 1/1/2010
Date Prepared: 12/9/2009
Time Prepared: 3:02:28 PM

Carrier	CareFirst BlueChoice		Coventry Health Care		Kaiser Permanente	
Plan Type	HMO		HMO		HMO	
Plan	**Enhanced Opt. 2 w/ core vision - $20/$30**		**Coventry E**		**MD HMO SIG Plan 2 ($5/$10/$0 IP/$0 Rx Ded)**	
Upgrade(s)	- Dental DHMO OPTION 1 with Opt-Out - Rx - $15/$25/50, $250 Ded (BC) - BlueVision Plus $10 Copay 12 month benefit (BC)		- Rx -- $15/$25/$50 copays - 250 ded		- DC, $30 Preventative Dental	
	In-Network	***Out-of-Network***	***In-Network***	***Out-of-Network***	***In-Network***	***Out-of-Network***
General						
Individual Deductible	$0	N/A	$0	N/A	$0	N/A
Family Deductible	$0	N/A	$0	N/A	$0	N/A
Coinsurance	0%	N/A	N/A	N/A	0%	N/A
Copay	$20	N/A	$30	N/A	$5	N/A
Individual Out-of-Pocket Maximum	$3,300	N/A	None	N/A	Refer to Contract	N/A
Family Out-of-Pocket Maximum	$10,100	N/A	None	N/A	Refer to Contract	N/A
Lifetime Maximum	Unlimited	N/A	Unlimited	N/A	Unlimited	N/A
Medical Surgical						
Primary Care Office Visit	$20 copay	N/A	$30 copay	N/A	$5 copay	N/A
Specialists Office Visit	$30 copay	N/A	$40 copay	N/A	$10 copay	N/A
Well-Child Care Office Visit(1)	$10 copay	N/A	$10 copay	N/A	$10 copay	N/A
Diagnostic/Lab/X-Ray	$0 copay	N/A	$40 copay or 50% , whichever is less	N/A	$0 copay	N/A
Out-Patient Surgery	$20 copay	N/A	$40 copay	N/A	$10 copay	N/A
Hospital Services						
Inpatient Hospitalization	$0 copay	N/A	$250 per admission copay	N/A	$0 copay	N/A
Emergency Room	$35 copay, waived if admitted	Paid as In Network for emergency	$100 copay, waived if admitted	Paid as In Network for emergency	$35 copay, waived if admitted	Paid as In Network for emergency
Mental Health(2)						
Inpatient Hospitalization	$0 copay	N/A	$250 per admission copay	N/A	$0 copay	N/A
Inpatient Maximum	60 Days	N/A	60 Days	N/A	60 Days	N/A
Outpatient Physician	30% coinsurance	N/A	30% coinsurance	N/A	$20 per indiv visit; $10 per group visit	N/A
Outpatient Maximum	None	N/A	None	N/A	None	N/A
Prescription Drugs						
Deductible	$250 per person	N/A	$250 per person	N/A	$0 per person	N/A
Annual Maximum	None	N/A	None	N/A	None	N/A
Generics	Deductible; then $15 copay	N/A	Deductible; then $15 copay	N/A	$5 copay	N/A
Preferred Brand	Deductible; then $25 copay	N/A	Deductible; then $25 copay	N/A	$15 copay	N/A
Non-Preferred Brand	Deductible; then $50 copay	N/A	Deductible; then $50 copay	N/A	$15 copay	N/A
Other						
Dental	Included	Included	Not Included	Not Included	Included	N/A
Vision	Included	Included	Not Included	Not Included	Not Included	N/A

Remarks

*Whichever is greater.

(1) Refer to schedule regarding age limitations and covered services.

(2) Benefits may vary for substance abuse treatment and may require pre-treatment authorization. Refer to contract.

Plan will not pay for charges exceeding plan allowances for out-of-network services.

**Refer to proposal for minimum copay.

Comparison of Benefits
Page 2

Comparison of Medical Benefits

Prospect: CHARLES BROWN AND ASSOCIATES
Effective Date: 1/1/2010
Date Prepared: 12/9/2009
Time Prepared: 3:02:28 PM

Carrier		CareFirst BlueChoice		Coventry Health Care		Kaiser Permanente	
Plan Type		HMO		HMO		HMO	
Plan		Enhanced Opt. 2 w/ core vision - $20/$30		Coventry E		MD HMO SIG Plan 2 ($5/$10/$0 IP/$0 Rx Ded)	
Upgrade(s)		- Dental DHMO OPTION 1 with Opt-Out - Rx - $15/$25/50, $250 Ded (BC) - BlueVision Plus $10 Copay 12 month benefit (BC)		- Rx -- $15/$25/$50 copays - 250 ded		- DC, $30 Preventative Dental	
		In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Comparison of Medical Rates and Monthly Premiums							
COVERAGE TYPE	**# Enrolled**	**Monthly Rates**					
Individual	10	$491.00		$386.81		$510.79	
Parent & Child	4	$907.00		$716.45		$944.95	
Parent & Child(ren)	1	$907.00		$716.45		$944.95	
Husband & Wife	5	$1,129.00		$891.35		$1,174.81	
Family	4	$1,375.00		$1,083.08		$1,481.28	
Total	24	$20,590.00		$16,239.42		$21,631.82	

This chart is strictly a summary and is not intended as a contract or any part thereof. If there is a difference between this summary and the carrier Master contract and applicable amendments attached thereto, the carrier Master Contract and applicable amendments shall control. GBS shall not be bound by the benefits and/or exclusions listed in this chart, but rather, the benefits, services, exclusions and limitations listed in the carrier Master Contract and applicable amendments. Proposed rates are based on the group demographics and census provided. Rates are subject to change based on final enrollment and carrier underwriting requirements. Rates/plans may not be applicable if group has employees out of the service area. Please verify eligibility before enrolling for coverage.

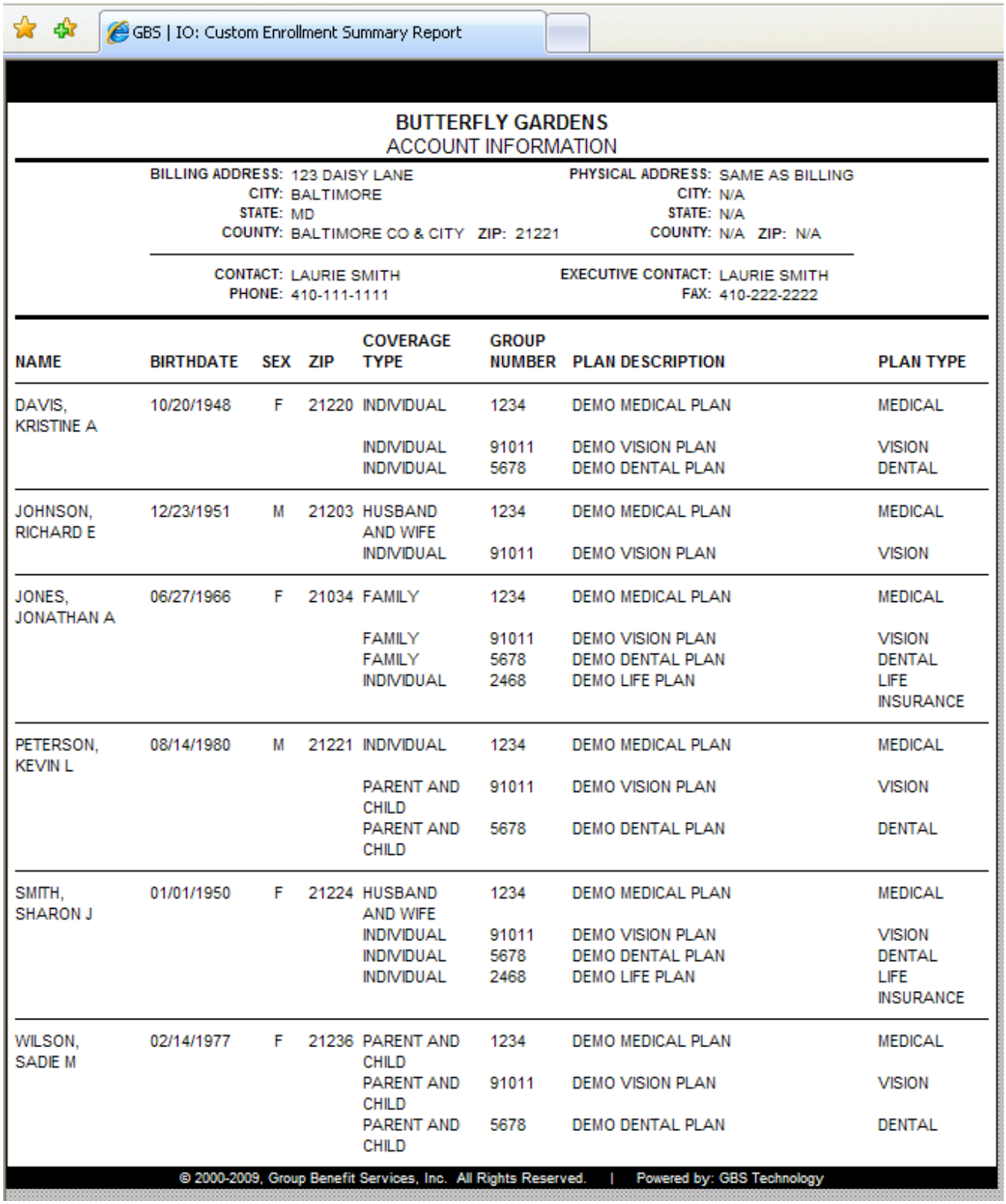
Renewing Accounts Report

RENEWING ACCOUNTS REPORT FOR DEMO GBSBROKER

[SORTED BY NAME]

ACCOUNT NAME	MARKET SIZE	GROUP #	PLAN DESCRIPTION	NEXT RENEWAL DATE	NUMBER ENROLLED
BUTTERFLY GARDENS					
Medical	01-50	1234	DEMO MEDICAL PLAN	01/01/2010	6
Dental	01-50	5678	DEMO DENTAL PLAN	01/01/2010	5
Vision	01-50	91011	DEMO VISION PLAN	01/01/2010	6
Life	01-50	2468	DEMO LIFE PLAN	01/01/2010	2
WIND CHASERS					
Medical	01-50	1234	DEMO MEDICAL PLAN	07/01/2010	2
Dental	01-50	5678	DEMO DENTAL PLAN	07/01/2010	2
Vision	01-50	91011	DEMO VISION PLAN	07/01/2010	2
Life	01-50	2468	DEMO LIFE PLAN	07/01/2010	1

Custom Enrollment Summary Report


GBS | IO: Custom Enrollment Summary Report

BUTTERFLY GARDENS
ACCOUNT INFORMATION

BILLING ADDRESS: 123 DAISY LANE
CITY: BALTIMORE
STATE: MD
COUNTY: BALTIMORE CO & CITY ZIP: 21221

PHYSICAL ADDRESS: SAME AS BILLING
CITY: N/A
STATE: N/A
COUNTY: N/A ZIP: N/A

CONTACT: LAURIE SMITH
PHONE: 410-111-1111

EXECUTIVE CONTACT: LAURIE SMITH
FAX: 410-222-2222

NAME	BIRTHDATE	SEX	ZIP	COVERAGE TYPE	GROUP NUMBER	PLAN DESCRIPTION	PLAN TYPE
DAVIS, KRISTINE A	10/20/1948	F	21220	INDIVIDUAL	1234	DEMO MEDICAL PLAN	MEDICAL
				INDIVIDUAL	91011	DEMO VISION PLAN	VISION
				INDIVIDUAL	5678	DEMO DENTAL PLAN	DENTAL
JOHNSON, RICHARD E	12/23/1951	M	21203	HUSBAND AND WIFE	1234	DEMO MEDICAL PLAN	MEDICAL
				INDIVIDUAL	91011	DEMO VISION PLAN	VISION
JONES, JONATHAN A	06/27/1966	F	21034	FAMILY	1234	DEMO MEDICAL PLAN	MEDICAL
				FAMILY	91011	DEMO VISION PLAN	VISION
				FAMILY	5678	DEMO DENTAL PLAN	DENTAL
				INDIVIDUAL	2468	DEMO LIFE PLAN	LIFE INSURANCE
PETERSON, KEVIN L	08/14/1980	M	21221	INDIVIDUAL	1234	DEMO MEDICAL PLAN	MEDICAL
				PARENT AND CHILD	91011	DEMO VISION PLAN	VISION
				PARENT AND CHILD	5678	DEMO DENTAL PLAN	DENTAL
SMITH, SHARON J	01/01/1950	F	21224	HUSBAND AND WIFE	1234	DEMO MEDICAL PLAN	MEDICAL
				INDIVIDUAL	91011	DEMO VISION PLAN	VISION
				INDIVIDUAL	5678	DEMO DENTAL PLAN	DENTAL
				INDIVIDUAL	2468	DEMO LIFE PLAN	LIFE INSURANCE
WILSON, SADIE M	02/14/1977	F	21236	PARENT AND CHILD	1234	DEMO MEDICAL PLAN	MEDICAL
				PARENT AND CHILD	91011	DEMO VISION PLAN	VISION
				PARENT AND CHILD	5678	DEMO DENTAL PLAN	DENTAL