

**SCOPE OF WORK
FOR AUDITING SERVICES FOR NJ PROTECT**

**(NEW JERSEY'S PREEXISTING CONDITION INSURANCE PROGRAM
REQUIRED BY THE FEDERAL PATIENT PROTECTION AND
AFFORDABLE CARE ACT)**

Date of issue	January 12, 2012
Q&A period closes	January 23, 2012
Closing date for quote	February 8, 2012
Quote opening	February 9, 2012

Scope of Work issued by:

**The Individual Health Coverage Program Board o/b/o NJ Protect
New Jersey Department of Banking and Insurance
20 West State Street
Trenton, NJ 08625-0325**

1.0 PURPOSE AND BACKGROUND INFORMATION

1.1 Purpose and Intent

This Scope of Work is being issued to solicit competitive quotes from financial auditing firms under contract with the New Jersey Department of Treasury, Division of Purchase and Property (Contracted Financial Auditing Firm), pursuant to Notice of Award T-2458 for the performance of financial audits (executed September 29, 2011). The intent is to award this Scope of Work to a single Contracted Financial Auditing Firm that responds with a competitive quote based upon the hourly rates set forth for T-2458, and that, in addition to having experience auditing administrative functions of a State agency, also has significant experience in the performance of financial and claims audits of health service corporations, health insurers or health maintenance organizations.

The purpose in awarding this Scope of Work for auditing services, as further described herein, is to determine whether: (1) carriers under contract with NJ Protect (subcontracted carriers) have properly collected premiums, paid claims and allocated administrative expenses to NJ Protect; (2) the claims and the allocated administrative expenses are in excess of premiums earned by the subcontracted carriers for NJ Protect; (3) total administrative expenses for the life of NJ Protect are ten percent or less of total program expenses, including those expenses paid through premiums; and (4) the reports carriers are required to file are reasonable and accurate.

The intent is to award a contract to a single firm to perform the carrier and administrative audits for the following time periods:

- January 1 through December 31, 2011;
- January 1 through December 31, 2012;
- January 1 through December 31, 2013; and
- through 2014 as necessary to address run-off following the termination of NJ Protect.

For each period, the audit must be completed no later than May 15 of the calendar year following the period being audited. The final audit report must be available for submission to HHS by June 30th of each year; the auditor must submit the final report to the IHC Program prior to that date.

1.2 Overview

1.2.1 Overview of establishment of the PCIP

The Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148 as amended by Pub. L. 111-152, enacted March 23, 2010, requires that every State have in place an insurance program to address the needs of individuals who have been turned down for health insurance in the non-group insurance market because of a preexisting condition. More specifically, the law authorized the Secretary of HHS to contract with States to establish temporary high risk pools, operated either by the States, or by HHS if a State chose not to establish its own temporary high risk pool. HHS refers to the temporary high risk pools, whether federally-run or state-run, as "Preexisting Condition Insurance Programs" (PCIPs).

HHS contracts with either a State agency or a private nonprofit for purposes of establishing a State-specific PCIP. The federal law requires that the PCIP provide coverage to individuals who: (a) have a preexisting condition; (b) have no creditable coverage for the prior six months; and, (c) are

citizens, or nationals or who are lawfully present in the United States. Further, the federal law requires that the coverage provided through a PCIP: (a) have an actuarial value of 65% of total allowed costs; (b) have premiums based on standard rates, with an age-rating at no greater than 4:1; (c) have an out-of-pocket limit no greater than that established for federally-defined high deductible health plans offered for use with health savings accounts; and (d) have no preexisting condition exclusions. In addition, HHS indicated a strong preference for building upon existing programs.

New Jersey elected to establish its own PCIP under the auspices of the Individual Health Coverage (IHC) Program. New Jersey's PCIP is referred to as NJ Protect.

1.2.2 Overview of the IHC Program

The IHC Program was established via legislation enacted on November 30, 1992, as part of a broad-based, three-part health insurance and health care reform initiative in New Jersey.¹ The IHC Program was created pursuant to P.L. 1992, Chapter 161 (the IHC Act), codified at N.J.S.A. 17B:27A-2 et seq. The IHC Program is designated to be in, but not of, the New Jersey Department of Banking and Insurance (DOBI).

The purpose of the IHC Program is to regulate the individual health insurance market to assure the availability of individual coverage. With respect to the issuance of individual health benefits plans:

- Carriers can not deny coverage to any individual who is a resident of New Jersey regardless of health, age, gender, occupation or any other factor unless the individual is eligible for coverage under a group benefits plan or Medicare.
- Carriers can not cancel an individual policy except for non-payment of premium or fraud.
- Community rating applies (age – within established ranges – is a permissible rating factor subject to a 3.5:1 ratio).
- Carriers may only offer standard health benefits plans designed by the IHC Program's Board and set forth in regulation, and a statutorily-specified Basic & Essential Plan.

1.2.3 Overview of New Jersey's PCIP – NJ Protect

New Jersey determined that the existing IHC Program's regulatory structure would provide a platform for the development of a PCIP without the need for either legislation or rule changes. The IHC Board sought to subcontract with carriers currently offering nongroup standard health benefits plans. In accordance with the contract between the IHC Board and the subcontracting carriers, the carriers offer an identified standard plan,² plus a rider that alters some of the features of the designated standard plan to bring the standard plan into compliance with the PCIP requirements. In particular, the rider:

- Eliminates the current 12-month preexisting condition exclusion period in its entirety.
- Eliminates cost-sharing requirements for preventive care services.

¹ The second component, referred to as the Small Employer Health Benefits Program, established by P.L. 1992, c. 162 (codified at N.J.S.A. 17B:27A-17 et seq.), is very similar to the IHC Program, although its focus is on small employer coverage. A third component has since been subsumed within the State's Children's Health Insurance Program, NJ FamilyCare. Neither component is relevant for purposes of this Scope of Work.

² Not all carriers elect to subcontract, and not all IHC Program standard plans satisfy the Federal requirements for coverage.

- Redefines how charges accumulate toward the maximum out-of-pocket requirements, specifically allowing coinsurance for prescription drug charges to accumulate, which does not normally occur under the IHC standard plans.
- Excludes coverage for elective abortions.
- Establishes a provision for termination of NJ Protect enrollment if NJ Protect enrollees enroll in other creditable coverage.

Applicants for NJ Protect must be residents of New Jersey plus meet the federally-defined PCIP eligibility requirements. The eligibility rules for NJ Protect differ slightly from the requirements for most PCIPs because New Jersey has a guaranteed issue/guaranteed renewable individual market, which means that no one is turned down for coverage based on a preexisting condition. Consequently, individuals are not required to prove that they were turned down for coverage, but rather, must provide evidence that they have a medical condition: (1) clinically present³ prior to the date of coverage, whether or not symptomatic or treated, and whether or not currently symptomatic or in a state of remission; (2) for which treatment has been or will be medically necessary and appropriate; and, (3) for which the subcontracted carrier would exclude medical expenses under non-NJ Protect coverage issued in New Jersey for individuals subject to a pre-existing condition exclusion. Other eligibility requirements are the same as for all other PCIPs, including the federal PCIP; that is, the applicant must be a citizen, national or legally present in the United States and the applicant can not have had creditable coverage within the prior six months.

PCIP products must be offered at a standard rate – meaning that the rate must be what would be offered to a healthy individual in the same market. Rates in the IHC Program are required to be modified community rated, without any adjustments for health status; however, carriers may rate based on age within a 3.5:1 band (age brackets are specified by the IHC Board). Because there is no underwriting based on health status, the DOBI has projected a “standard” rate for NJ Protect, suggesting a discount of approximately 30% below the rates carriers are offering on their standard IHC Program products. (Upon agreement with HHS, the discount factor may be changed over time.) Thus, the rates for NJ Protect are 30% below the rates set for a subcontracted carrier’s designated standard plan otherwise offered in the individual market. Current IHC standard plan rates and current NJ Protect rates are available online, respectively, at:

- http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcratepage_sp.pdf
- http://www.state.nj.us/dobi/division_insurance/njprotect/index.htm.

HHS initially allocated \$141,000,000 to New Jersey for the PCIP. The PCIP is reimbursed for claims exceeding premiums, and administrative costs, to the extent that administrative costs are not more than 10% of total program expenses for the life of the program. The original budget was based upon an assumption of rapid enrollment of 21,000 lives in NJ Protect, which would then hold steady with an annual 25% lapse rate until the remaining lives were transitioned into a to-be-developed health insurance exchange product in 2014. The budget has been revised several times as required in the contract between HHS and the IHC Program. The revised budgets reflect more current experience, and assumptions regarding much slower enrollment until the 2014 transition to

³Applicant must produce a written statement from a licensed practitioner specifying the condition. It should be noted that until August of 2011, the medical condition had to be considered chronic.

the health insurance exchange. The most recently-revised budget (which includes actual 2010 experience) is set forth in Appendix B.

The contract with HHS for NJ Protect (HHS contract) was executed July 30, 2010, as was a subcontract with Horizon Blue Cross and Blue Shield New Jersey (Horizon). Enrollment in NJ Protect began in August 2010, and as of October 11, 2011, 751 individuals were enrolled in NJ Protect, while 994 individuals were enrolled in NJ Protect since its inception (243 having disenrolled). Horizon was the initial carrier under contract for participation in NJ Protect, and has a significantly greater share of the enrollment to date. AmeriHealth Insurance Company entered into a subcontract in December 2010 to participate in NJ Protect beginning in March 2011. Additional IHC carriers could subcontract with the IHC Program to participate in NJ Protect, but to date none have expressed any interest. Horizon's two Plan C PPO options, and AmeriHealth's Plan C PPO option are all briefly described in Appendix C.

The subcontracting carriers submit monthly reports and requests for reimbursements to IHC Program staff, who also provide support for NJ Protect. NJ Protect staff collects information from the carriers' reports to provide data on a monthly basis to HHS in accordance with the HHS contract and upon HHS' request. In addition, NJ Protect is required to produce annual financial statements. The HHS contract, included in Appendix D, specifies certain ledger and supporting accounting records, among other things, to be maintained for NJ Protect. Upon receipt of a request for reimbursement from a carrier, NJ Protect staff submits an electronic request for payment to HHS' Payment Management System for release of funds. The funds are released by the Payment Management System electronically to a separate account established for NJ Protect, and then NJ Protect staff distributes the funds to the subcontracted carriers. A similar process occurs with respect to administrative expenses incurred by NJ Protect staff for the operations of NJ Protect.

At this time, IHC Program staff provides direct and indirect support for the operations of NJ Protect. The initial NJ Protect budgets allowed for an additional FTE to address NJ Protect operations in the event additional staffing was determined necessary; however, more recent budget updates only reflect current IHC (and DOBI) staff time allocated to NJ Protect.

1.3 Authority to Contract and Funding

The IHC Board has authority to enter into contracts on behalf of NJ Protect that are necessary and proper to carry out the provisions and purposes of its statutory responsibilities, including the selection of financial auditors and other professional services. Audit costs for NJ Protect are part of the administrative expenses of NJ Protect, and will be paid from the funds dedicated for New Jersey's PCIP.

1.4 Definitions

Notice of Award of T-2458 means the contract awarded pursuant to Request for Proposal issued by the New Jersey Department of Treasury, Division of Purchase and Property (the RFP having been issued on or about May 31, 2011 and identified as 12-X-22006), as a procurement for auditing services from financial auditing firms on behalf of the State and cooperative purchasing partners.

2.0 RESPONSE TO THIS SCOPE OF WORK (COMPETITIVE QUOTES)

2.1 General Requirements for a Competitive Quote

Firms submitting a competitive quote must demonstrate an understanding of the objectives that the project is intended to meet, the nature of the required work and the level of effort necessary to successfully complete the contract. The goal of the firm is to convince the Evaluation Committee, and ultimately, the NJ Protect Operations and Audit Committee (NJPOAC) that the firm's general approach and plan to undertake and complete the required project are appropriate and realistic. The firm must:

- (1). Identify the partner who will be responsible for the work required by this Scope of Work, including the partner's name, title, corporate address, email, telephone and facsimile number.
- (2). Identify the individual by name, title, corporate address, email, telephone and facsimile number who will serve as the point-of-contact at the firm and project manager for the contract awarded as a result of this Scope of Work, if different from the individual identified in (1) above.
- (3). Submit resumes or curriculum vitae setting forth the qualifications of the firm's management, professional and technical personnel who will work on this Scope of Work, if the project is awarded to the firm.
- (4). Provide a detailed description of the firm's approach to the project, including a straightforward, concise description of the firm's ability to satisfy the requirements of the Scope of Work, a detailed plan for completing the project, including the number of hours by category of work and by personnel that the firm anticipates will be required for each audit, and an estimated time line for completion of each audit.
- (5). Explain the general background, experience and qualifications of the firm, including: (a) experience the firm may have in auditing or administering similar governmental or quasi-governmental programs; and (b) experience of the firm with National Association of Insurance Commissioners (NAIC) annual statement reporting, auditing of insurance claims, premiums and investment income.
- (6). Provide a list, with contact information, of clients or organizations that can be used as references for work performed, particularly in health insurance-related areas.
- (7). Explain the methods the firm will use to segregate the time associated with the audits to be performed pursuant to this Scope of Work from the firm's other projects and normal book of business to ensure that NJ Protect is paying only for those expenses which actually relate to the NJ Protect audits.
- (8). Provide details regarding schedules, deliverables, and person-hour and/or labor category mix, with total number of person-hours by labor category proposed to complete the project, as required by the Notice of Award T-2458 RFP, section 1.2.1 (*Engagement Process*).
- (9). Describe the firm's policy with respect to reimbursement of actual out-of-pocket travel expenses (such as mileage and train fare), including any caps or limitations on travel expenses, as it relates to the audit of NJ Protect-contracted carriers. Please note: reimbursement for actual out-of-pocket travel expenses will be provided only with respect to audits performed at the location of a NJ Protect-contracted carrier, and further, NJ Protect will not authorize payment of any time-incurred travel expenses.

2.2 Additional Competitive Quote Information

2.2.1 *Expenses*

Contracted Financial Auditing Firms were required to provide firm fixed, all-inclusive hourly rates for purposes of Notice of Award T-2458. Accordingly, NJ Protect will not pay for expenses incurred by the firm, and interested firms should not include expenses incurred in their competitive quotes when responding to the Scope of Work, except that NJ Protect will consider providing compensation for out-of-pocket travel expenses but only to the extent that such expenses relate to the claims and administrative audits of NJ Protect-contracted carriers, and only for field work performed at the carrier's offices. Note: (a) NJ Protect will not authorize payment for any time-incurred travel expenses; and, (b) NJ Protect will authorize payment for mileage in accordance with Section H of the New Jersey Office of Budget and Management Circular 11-05 (11-05-OMB), and successor circulars as appropriate to the year in which the expenses are incurred.

2.2.2 *Subcontractors*

Competitive quotes that include subcontracting for any services directly related to performance of audit functions shall not be considered.

2.3 Correspondence

Interested parties shall submit all correspondence related to this Scope of Work to:

Rosaria Lenox, CPA
New Jersey IHC Program
20 West State Street, 11th Floor (*courier*)
PO Box 325 (*for regular mail*)
Trenton, New Jersey 08625-0325

E-mail address: Rosaria.lenox@dobi.state.nj.us
Fax: (609) 633-2030

Interested parties should not contact IHC Board members, the IHC Board's/NJ Protect's staff, or members of the NJPOAC regarding this Scope of Work, except as identified in this section or in the facsimile cover letter accompanying this Scope of Work.

2.4 Key Events for this Request for Proposal

2.4.1 *Question and Answer Period*

Written questions from Contracted Financial Auditing Firms will be accepted by regular mail, courier service, electronic mail or facsimile as directed in 2.3, no later than January 23, 2012. Only questions directly related to the content of this Scope of Work will be answered. Questions should reference the specific page number and section number of this Scope of Work to which the question relates, preferably in consecutive order.

A list of the relevant questions and responses thereto will be sent to the same list of Contracted Financial Auditing Firms as this Scope of Work was sent to, and will be posted to the DOBI website at:

http://www.state.nj.us/dobi/division_insurance/njprotect/index.htm

and

http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcmain.htm

Questions and responses, as posted, shall become part of this Scope of Work.

2.4.2 Addenda

In the event NJ Protect determines it is necessary to provide additional information to the Scope of Work, NJ Protect will distribute an addendum to the Scope of Work to all firms included in the distribution of the original Scope of Work, and the addendum will be incorporated within the Scope of Work. In addition, the addendum will be posted online as indicated in 2.4.1 above.

However, unless otherwise specified in the addendum, distribution of an addendum will not alter the deadline for delivery of a Response to the Scope of Work to NJ Protect. It is the sole responsibility of interested firms to be knowledgeable at all times about any and all addenda related to this Scope of Work.

2.4.3 Deadline for Submission of a Response to this Scope of Work

Notwithstanding section 1.2.1 of Notice of Award T-2458, interested firms must submit and NJ Protect must receive the Response to the Scope of Work no later than 4:00 P.M. on February 8, 2012, unless NJ Protect modifies the date as established in an addendum to this Scope of Work. NJ Protect will reject responses received after the required date and time. Responses will be opened February 9, 2012, at 9:00 A.M.

Interested firms must submit competitive quotes by mail or courier service, and include at least one (1) bound and one unbound copy of the response to the Scope of Work. The IHC Program cannot accept competitive quotes by email or facsimile in lieu of the hardcopy responses, but may request that firms submitting competitive quotes forward a copy by email subsequent to the opening of the responses. Firms may submit written notice of their decision not to offer a competitive quote at any time by any method.

2.5 Format

Interested firms must submit eight copies of their competitive quote to the address at section 2.3. The competitive quote must contain a clearly-identifiable “methodology” section specifically responding to the section 3.0 (scope of work), and a clearly-identifiable section that provides organizational and experience information, person-hours, and travel policies required in section 2.1. Addenda or attachments supporting the response should be easily identifiable, and included in a separate section at the end of the response. All competitive quotes must include page numbers, and the interested firm’s name on each page of the response.

3.0 SCOPE OF WORK

3.1 Audit Objectives

The objective of each annual audit with respect to administrative expenses of NJ Protect is to ensure that: administrative expenses and investment income have been appropriately allocated to NJ Protect; funds have been handled appropriately; and, funds have been accounted for and spent in furtherance of NJ Protect.

The objective of the annual audit with respect to premiums and claims is to determine the appropriateness of the premiums collected and claims paid for NJ Protect in order to validate the amount by which claims exceeded premiums, and thus, are reimbursable by HHS.

In addition, an objective of the audits is to validate the relationship between total administrative expenses and total program expenses.

A separate objective of the audit is to assure the reasonableness and accuracy of non-financial data reported by carriers on a monthly basis to IHC staff.

3.2 Audit Requirements

3.2.1 *Total Number of Audits and Audit Reports*

This Scope of Work requires performance of separate audits for each of the three calendar years ending December 31, 2011 through December 31, 2013, plus an audit of the run-out period following closure of NJ Protect, for a total of four separate audit reports.

3.2.2 *Audit Criteria*

The audit shall address whether:

- a. The handling of funds and accounting of funds related to NJ Protect has been appropriate;
- b. Administrative expenses for NJ Protect have been properly allocated and are reasonable, consistent with the requirements of the contract between the IHC Program and HHS;
- c. The annual financial statements of NJ Protect are fair and appropriate and fairly present the financial position of NJ Protect; and
- d. Direct program expenses have been properly recorded;
- e. Premiums were appropriately billed and collected for NJ Protect. The audit shall include a review of a subcontracting carrier's electronic data files, which must have sufficient detail to identify the dollar amounts of premiums by subscriber or contract number in order to determine whether the data, in total, agree to the premiums earned as reported by the subcontracting carrier for NJ Protect. The audit shall also include review of all of a subcontracting carrier's underwriting and premium records relating to the premiums earned on the electronic data files, including, but not limited to, subscriber applications, billing records, cash receipts and disbursement records, advance premium and premium receivable records and carrier rates, and reconciliations between information in the data files with information reported in the HHS PCIP Monthly Data Request (not attached hereto, but available upon request as an Excel document) and information submitted in the IHC Board-generated NJ Protect Reimbursement Request form;
- f. Claims were adjudicated and paid appropriately for NJ Protect. The audit shall include a review of a subcontracting carrier's: electronic data files, which shall have sufficient detail to identify the dollar amounts of claims paid, by claim and subscriber number, and the payment reference such as check or wire transfer number; and, all claim file and disbursement records relating to the claims paid on the data files, such as claims submission forms, provider invoices, pricing data, eligibility investigations, canceled checks and wire transfer documentation. The audit shall include a reconciliation, or review of carrier-generated reconciliations, if necessary, between the total claims paid per the data files requested and information reported in the HHS PCIP Monthly Data Request and information

submitted in the IHC Board-generated NJ Protect Reimbursement Request form, with an explanation of reconciling items.

- g. The carrier has appropriately allocated investment income to NJ Protect. The audit shall include review of: the subcontracting carrier's calculation of investment income allocated to NJ Protect.
- h. Monthly reports made by carriers to IHC Program staff for purposes of compliance with HHS reporting requirements are accurate and the data is verifiable with appropriately maintained documentation and systems transactions (i.e., enrollment data can be tied to applications, enrollments and denials, terminations, premiums collected, and claims). A copy of the HHS instructions for completing the monthly report is included in Appendix F.

The audit shall be made in consideration of the requirements set forth in the HHS contract, as well as the contract between NJ Protect and the subcontracting carriers (copies of the contracts are included in Appendix E). The audit should include a review of whether eligibility determinations and appeals thereof have been handled appropriately and whether the carrier has complied with NJ Protect protocols.

The Auditor shall proceed with the audit in a manner consistent with the Generally Accepted Auditing Standards established by the American Institute of Certified Public Accountants (AICPA).

3.2.3 General Audit Criteria

The auditor shall perform and include any additional items necessary for the completion of an annual audited statement, including recommendations which may improve the design or operation of internal control systems, and recommendations for appropriate corrective actions, if any.

The auditor shall proceed with each audit in a manner consistent with generally accepted government auditing standards issued by the Comptroller General of the United States and the Governmental Accounting Standards Board, applicable State rules, and applicable New Jersey Department of the Treasury circular letters and guidelines.

3.3 Auditor Criteria

3.3.1 General Qualifications and Specific Experience

The auditor must be an independent certified public accounting firm in good standing with the AICPA and in all states in which licensed to practice, with experience performing audits in conformance with generally accepted government auditing standards issued by the Comptroller General of the United States and the Governmental Accounting Standards Board. In addition to general financial audit experience, the auditor must have demonstrated experience with the National Association of Insurance Commissioners' annual statement reporting. The auditor also must have experience in auditing of insurance company claims and premium, including experience in determining: whether data in a health care record is supported by services listed on the claim for payment; whether data in an eligibility record supports eligibility of an insured on the date of service for the claim; and, whether claims have been paid for covered services.

3.3.2 Specific Performance Standards

The auditor must perform portions of the audits of NJ Protect at the NJ Protect offices where certain records for NJ Protect are maintained and staff is available to answer questions and provide information and documents required. NJ Protect's offices are located at 20 West State Street, Trenton, NJ, 08625. However, the auditor must perform portions of the audit at the offices of the carriers under contract with NJ Protect, where the documents and personnel necessary to provide information specific to premiums, claims and direct administrative expenses are located. Horizon's primary location is in Newark, New Jersey; AmeriHealth's primary location is in Cranbury, New Jersey.

The auditor must be available to meet:

- (1). at NJ Protect's offices in Trenton, New Jersey with the NJ Protect Operations and Audit Committee (NJPOAC) to discuss issues prior to beginning field work, and subsequent to presentation of each draft audit report to discuss the information in the report and respond to questions and comments;
- (2). in person or by telephone on a periodic basis with the NJPOAC, with and without NJ Protect's staff present, to discuss ongoing issues; and
- (3). in person upon request to present the audit report and respond to questions as to the findings.

For each calendar year to be audited, the auditor must complete the field work within 30 days after NJ Protect's staff and the subcontracted carriers provide the auditor with written notice of the availability of the respective records for review, and the auditor must present a substantially complete draft report to the NJPOAC within 30 days following completion of the field work. NJ Protect staff and the carrier(s) shall have materials available for audit no later than March 1 immediately following the close of the calendar year subject to audit. In accordance with the HHS contract, the IHC Board must submit completed audit reports to HHS by June 30 annually.

The auditor must be able and willing to provide the deliverables set forth in 3.4 below.

3.4 Deliverables and Other Evidence of Performance

3.4.1 *Draft Audit Reports*

Following completion of audit testing, the auditor shall provide recommendations and shall submit a draft audit report for review by the NJPOAC. The auditor shall discuss the findings of the audit with NJ Protect staff, and the NJPOAC. The auditor must submit reports by email to NJ Protect staff for distribution to NJPOAC members. Drafts shall be submitted no later than May 31 each year.

3.4.2 *Final Audit Reports*

Subsequent to the review of a draft report by the NJPOAC, the auditor shall produce at least 15 bound final audit reports for each period audited. Final audit reports shall be submitted no later than June 28 each year.

3.4.3 *Invoices, Time Records and Travel Expense Records*

Invoices should be submitted in accordance with section 2.3 of this Scope of Work on at least a monthly basis. The auditor may invoice for travel expenses, but if it does so, it shall invoice travel

expenses separately from its all-inclusive hourly rate. Payment will be made upon approval of the invoiced amounts.

Upon request, the auditor shall provide to staff time records and/or travel expense records pertaining to the auditor's employees that provide the services billed by the auditor in support of the invoice(s) submitted by each level of audit staff. The auditor shall make all requested records available within thirty (30) days following receipt of a request for the information.

4.0 SELECTION AND AWARD PROCESS

4.1 Process, Selection and Notice

An Evaluation Committee composed of three members of the IHC Board shall review the competitive quotes received and evaluate them based upon the evaluation criteria set forth in 4.2. The Evaluation Committee shall produce a written report setting forth its findings for consideration by the NJPOAC.

The NJPOAC shall consider the findings of the Evaluation Committee, and make a recommendation to the IHC Board on selection of an auditor. The IHC Board shall vote on whether to accept the recommendations of the NJPOAC. Ultimately, the selection will be based on the best interests of NJ Protect, balancing costs and technical merit.

Upon selection, the Executive Director for NJ Protect will notify all interested firms that submitted a response to the Scope of Work of the IHC Board's action, using the contact information available from each interested firm. NJ Protect will have no other notice responsibility to an unsuccessful firm. Any interested person may request the written report prepared by the Evaluation Committee and the minutes of the meeting(s) of the NJPOAC in which selection of an auditor was discussed and action in that regard was taken.

4.2 Criteria

The Evaluation Committee will review the competitive quotes and will evaluate the proposals on the basis of the factors set forth below:

- The general background, experience, and qualifications of the firm – 10%
- The specific experience of the firm in auditing insurance premiums, claims and investment income – 35%
- The qualifications of the firm's personnel who will be assigned to this project – 25%
- The demonstrated ability of the firm to complete the audits in a timely manner – 15%
- The cost – 15%

5.0 NJ PROTECT RIGHTS AND RESPONSIBILITIES

5.1 Work Papers and Records

In addition to the standards of section 3.8 of Notice of Award T-2458, NJ Protect, or its representatives, shall have access, upon request, to the firm's work papers and documentation at reasonable times during the contract period. Ownership of all data, material, and documentation (excluding work papers) originated and prepared for NJ Protect pursuant to this project shall belong exclusively to NJ Protect.

5.2 Additional Services, including Litigation Support

NJ Protect may request the auditor to provide support at meetings and other activities that may result from the work performed. With the exception of support provided for litigation and appeals, this support is within the scope of this project.

NJ Protect may request the auditor to provide documentation and other support in litigation or appeals involving NJ Protect's financial activities covered by this Scope of Work. This support is outside of this Scope of Work. However, NJ Protect will provide compensation to the auditor based upon the rates established in T-2458, and the level of expertise necessary to provide support in the litigation or appeals, as set forth in section 3.10 of the Notice of Award of T-2458.

5.3 Payment

Notwithstanding the provisions of section 5.22 of the Notice of Award of T-2458, which sets forth a specified schedule, payment will be disbursed only upon submission of invoices, following approval of the amounts invoiced.

6.0 SELECTED FIRM'S RESPONSIBILITIES

6.1 Confidentiality

The firm shall sign the confidentiality agreement set forth as Appendix A.

6.2 Work Papers and Records

In addition to the standards of section 3.8 of the Notice of Award T-2458, the auditor shall provide the staff of NJ Protect with access to all records, files and reports associated with NJ Protect during normal working hours within no more than three (3) business days following receipt of a request from NJ Protect staff for access to such a record, file or report. All records, files and reports associated with NJ Protect are and shall remain the property of the NJ Protect and are to be turned over to NJ Protect or the IHC Board, or to any successor organization or agency, should there be one.

The auditor shall maintain time records pertaining to individuals that provide the services billed by the firm for this Scope of Work, and shall make these records available to NJ Protect within thirty (30) days following receipt of a request for such records.

6.3 Support Services

The auditor must provide support upon request at meetings and other activities that may result from the work performed. With the exception of support services provided for litigation and appeals, this work is within the scope of this project, and the auditor shall not bill NJ Protect for the support services.

The auditor should also be prepared to support NJ Protect in litigation or appeals, whether initiated by NJ Protect or another party, with respect to NJ Protect's financial activities covered by this Scope of Work. This work is outside of the Scope of Work. The auditor shall bill NJ Protect in accordance with the hourly rates set forth by the firm for the Notice of Award of T-2458 and the

level of expertise necessary to support the litigation or appeal activity, consistent with section 3.10 of the Notice of Award of T-2458.

6.4 Timely Performance

The auditor shall begin work as soon as possible following the availability of NJ Protect’s records from both staff and subcontracted carriers, subject to the required meeting with the NJPOAC.

6.5 Billing

Notwithstanding the provisions of section 5.22 of that RFP which sets forth a specific schedule, payment will be disbursed only upon submission of invoices, and based solely upon the invoiced amounts. The auditor may use the state invoice or its own, but must be consistent in the form used, and must submit an invoice consistent with section 3.4.3 of this Scope of Work.

8.0 LIST OF ATTACHMENTS

- APPENDIX A: Confidentiality agreement
- APPENDIX B: Budget for NJ Protect
- APPENDIX C: Description of Plan Design
- APPENDIX D: Contract between HHS and the IHC Board/NJ Protect
- APPENDIX E: Exhibit 1 – Contract between Horizon and the IHC Board o/b/o NJ Protect
Exhibit 2 – Contract between AmeriHealth and the IHC Board o/b/o NJ Protect
- APPENDIX F: HHS Instructions for Completing Monthly Reports

APPENDIX A

Confidentiality Agreement

The auditor, its personnel and agents, shall maintain the confidentiality of all documents, records, and information received from the Board pursuant to the terms of this Contract, as well as any work papers, notes, and/or copies of documents, records, and information generated by the auditor.

The auditor, its personnel and agents, shall not disclose, discuss, or otherwise make available any documents, records, information, work papers, notes, or copies thereof except:

- (1) to the Board or its attorneys (and the auditor shall have no obligation to disclose its proprietary information);
- (2) as required by law, rule, regulation, subpoena or other administrative or legal process, or by applicable regulatory or professional standards or pursuant to court order or other binding legal precedent; or
- (3) as otherwise directed in writing by the Executive Director of the Board, subject to the other terms of this Agreement.

The foregoing restriction shall not apply to documents, records, information, work papers, notes, or copies thereof (i) that are in the public domain at the time the auditor receives it; (ii) that become a part of the public domain without breach of this Contract by the auditor; (iii) that are known to the auditor prior to their receipt from the Board; (iv) that are developed by the auditor independently of any disclosures previously made by the Board to the auditor of such information; or (v) that are disclosed in connection with litigation pertaining hereto.

If the auditor, any personnel of the auditor, or agent of the auditor who is required to report to the auditor, receives a subpoena or order, or becomes subject to any other legal requirement mandating disclosure of any document, record, or information covered by this confidentiality provision from any entity or person not authorized to receive such document, record, or information under the terms of this Contract, the auditor will, to the extent permitted by applicable law or regulation, notify the Executive Director of the Board and give the Board an opportunity to contest the subpoena, order, or other legal requirement before complying with it. The auditor shall provide at least ten (10) days' notice unless the time constraints contained within the subpoena, order, or other legal requirement time constraints make that unfeasible. Under no circumstances shall the auditor produce documents pursuant to any subpoena, order, or other legal requirement before the date specified therein.

Signature: _____

Date: _____

APPENDIX B

September 2011 Revised Budget

Administrative Costs					
Cost Category	Annual Administrative Costs				2014
	2010	2011	2012	2013	
Carrier Expenses	Actual	Projected	Projected	Projected	
Customer Service ¹	\$100,347	\$216,000	\$567,437	\$1,051,062	
Cost Controls ²	\$0	\$108,000	\$283,718	\$525,531	
Claims Administration ³	\$177,378	\$432,000	\$1,134,874	\$2,102,124	
IHC/NJ State Expenses					
Salary ⁴	\$0	\$10,000	\$10,000	\$10,000	
Employee Benefits ⁵	\$0	\$3,500	\$3,500	\$3,500	
Enrollment verification and appeals ⁶	\$0	\$0	\$0	\$0	
Legal ⁷	\$0	\$10,000	\$10,000	\$10,000	
Accounting ⁸	\$0	\$60,000	\$61,800	\$63,654	
Actuarial ⁹	\$0	\$5,000	\$5,000	\$5,000	
Other Consulting ¹⁰	\$0	\$0	\$0	\$0	
Office Expenses ¹¹	\$3,235	\$5,000	\$5,150	\$5,305	
TOTAL	\$280,960	\$849,500	\$2,081,479	\$3,776,175	

¹ Includes marketing, enrollment, enrollee information, customer service, premium processing.

² Includes utilization review.

³ Includes provider relations and contracting.

⁴ Allocated time of IHC Program staff.

⁵ Calculated as 35% of salary.

⁶ Now included in Member Services.

⁷ Services of the New Jersey Attorney General's Office.

⁸ Required audits.

⁹ Standard premium and projections.

¹⁰ Economic analyses.

¹¹ Phone, postage, copying, etc.

Table 2
Administrative and Claims Costs (September 2011)

Year	End of Year Enrollment	Premium Revenue	Total Claims	Administrative Costs	Total Claims Against Federal Fund Allotment
2010					
Plan Option 1					
Plan Option 2					
2010 TOTAL	230	\$258,823	\$911,649	\$280,959	\$933,785
2011					
Plan Option 1					
Plan Option 2					
2011 TOTAL	893	\$3,003,750	\$20,351,649	\$849,500	\$18,197,399
2012					
Plan Option 1					
Plan Option 2					
2012 TOTAL	1,869	\$7,890,918	\$53,229,312	\$2,081,479	\$47,419,873
2013					
Plan Option 1					
Plan Option 2					
2013 TOTAL	2,842	\$14,616,328	\$100,269,926	\$3,565,962	\$89,219,561
2014					
2014 TOTAL	0	\$0	\$10,510,618	\$210,212	\$10,720,830
TOTAL		\$25,769,819	\$185,273,154	\$6,988,112	\$166,491,448

APPENDIX C

Exhibit 1		
Horizon BCBS New Jersey		
	Plan C 80/70%, \$2500	Plan C 100/70%
Deductible in-network	\$2500	\$0
Deductible out-of-network	\$5000	\$7500
Coinsurance in-network (carrier's obligation)	80%* 50% for Rx	100%* 50% for Rx
Coinsurance out-of-network (carrier's obligation)	70%	70%
Copayments	\$30/PCP; \$50/Specialist*	\$30/PCP; \$50/Specialist*
Maximum out-of-pocket in-network	\$5000	\$5000
Maximum out-of-pocket out-of-network	\$10,000	\$22,500
Covered services	<ul style="list-style-type: none"> ➤ office visits ➤ hospital care including emergency room ➤ care and treatment of injury and illness by surgical and non-surgical means ➤ transplant benefits ➤ prenatal and maternity care ➤ immunizations and well-child care ➤ screenings, including mammograms, pap smears and prostate examinations ➤ x-ray and laboratory services ➤ blood and blood products ➤ anesthesia ➤ ambulance service ➤ durable medical equipment ➤ prosthetics and orthotic appliances ➤ biologically based mental illness and alcoholism services ➤ certain non-biologically based mental illness and substance abuse services ➤ home health care ➤ hospice care ➤ rehabilitation services ➤ therapy services (physical, occupational, speech etc.) ➤ prescription drugs ➤ certain infant formulas 	

*Coinsurance and copayments do not apply to the same services.

Exhibit 2	
AmeriHealth Insurance Company	
	Plan C 90/70%
Deductible in-network	\$2500
Deductible out-of-network	\$5000
Coinsurance in-network (carrier's obligation)	90%* 50% for Rx
Coinsurance out-of-network (carrier's obligation)	70%
Copayments	\$30/physician office visit*
Maximum out-of-pocket in-network	\$5000
Maximum out-of-pocket out-of-network	\$10,000
Covered services	<ul style="list-style-type: none"> ➤ office visits ➤ hospital care including emergency room ➤ care and treatment of injury and illness by surgical and non-surgical means ➤ transplant benefits ➤ prenatal and maternity care ➤ immunizations and well-child care ➤ screenings, including mammograms, pap smears and prostate examinations ➤ x-ray and laboratory services ➤ blood and blood products ➤ anesthesia ➤ ambulance service ➤ durable medical equipment ➤ prosthetics and orthotic appliances ➤ biologically based mental illness and alcoholism services ➤ certain non-biologically based mental illness and substance abuse services ➤ home health care ➤ hospice care ➤ rehabilitation services ➤ therapy services (physical, occupational, speech etc.) ➤ prescription drugs ➤ certain infant formulas

*Coinsurance and copayments do not apply to the same services.

CONTRACT TO OPERATE A QUALIFIED HIGH RISK POOL

CONTRACT AGREEMENT: Between the Department of Health and Human Services (HHS) and New Jersey Individual Health Coverage Program Board

PROJECT TITLE: Temporary High Risk Insurance Pool Program

CONTRACT NUMBER: 2010NJHRPC

CONTRACTOR: New Jersey Individual Health Coverage Program Board

Contract Overview:

The statutory authority for this contract agreement is set out at section 1101(b) of the Patient Protection and Affordable Care Act ("Affordable Care Act," Public Law 111-148), which authorizes the Secretary of the Department of Health and Human Services (HHS) to enter into contracts with States to establish and operate temporary high risk health insurance pool programs to provide coverage for eligible individuals beginning in 2010 and ending on December 31, 2013.

The Office of Consumer Information and Insurance Oversight in HHS awards this contract to New Jersey Individual Health Coverage Program Board (hereinafter "Contractor") to establish and operate a temporary high risk health insurance pool and serve eligible individuals according to the terms and conditions set forth below and agreed upon by both HHS and the Contractor.

This contract between HHS and the Contractor is not subject to the Federal Acquisition Regulation (FAR) except where referenced herein.

SECTION A: SUPPLIES OR SERVICES AND PRICES/COSTS

A.1 BRIEF DESCRIPTION OF SUPPLIES OR SERVICES

The purpose of the contract is to establish and operate a temporary high risk health insurance pool program in New Jersey to provide coverage for eligible individuals.

A.2 PRICES/COSTS

In consideration of performance of the work described in SECTION B, HHS agrees to compensate the Contractor the amount that is the difference between premiums collected and claims plus allowable administrative costs incurred, for the work described in SECTION B, unless the contract is otherwise modified, for which estimated amounts are shown below:

Base Period

Estimated Amount \$17,171,624

Option Year 1

Estimated Amount \$37,434,945

Option Year 2

Estimated Amount \$41,152,344

Option Year 3

Estimated Amount \$45,240,843

Close-Out Period

Estimated Amount \$0 _____

All Periods (Base + Options)

Total Estimated Amount \$140,999,756

Note that HHS reserves the right to reallocate unobligated funds based on actual cost experience of the state's administration of the temporary high risk health insurance pool program.

A.3 EXERCISE OF OPTIONS UNDER A.2

HHS shall exercise each of the option years described in paragraph A.2 of this Contract by giving a preliminary notice of its intent at least 90 days prior to the end of each performance period and a written notice of exercise at least 60 days prior to the end of each performance period to the Contractor. The 90-day notice will state HHS's intent to exercise the option, but does not commit HHS to exercising the option. The Contractor's right to terminate is governed by paragraph G.6. of this Contract.

A.4 EXTENDING THE TERM OF THE CONTRACT

HHS may extend the term of this contract for an additional period of performance beyond December 31, 2013, by written notice to the Contractor no later than 120 days prior to that date. The close out period will be extended by the length of any additional period of performance. If the Contractor does not agree to extend the period of performance, the Contractor must provide written notice to HHS of its intention not to do so within 60 days of the notice from HHS.

SECTION B: DESCRIPTIONS/SPECIFICATIONS/WORK STATEMENT

B.1 DEFINITIONS

Administrative costs refer to reasonable costs incurred by the Contractor to administer the pool.

Contracting Officer refers to the Government Official delegated responsibility to sign the contract and negotiate and issue changes.

Creditable coverage has the meaning given such term under both section 2701(c)(1) of the Public Health Service Act before enactment of the Affordable Care Act and 45 CFR 146.113(a)(1).

Enrollee refers to an individual receiving coverage from the federal high risk pool established under this section.

High risk pool or Pool refers to a program which provides coverage in accordance with the requirements of section 1101 of the Affordable Care Act, as determined by HHS.

Nonprofit entity refers to a nonprofit insurer or other organization capable of operating a high risk pool.

Pre-existing condition exclusion has the meaning given such term in 45 CFR 144.103.

Resident means an individual who is legally domiciled in the Contractor's State.

Service Area refers to the geographic area encompassing an entire State or States in which a high risk pool furnishes benefits.

State refers to any one of the 50 States or the District of Columbia.

Subcontractor refers to any person or entity from whom the Contractor obtains goods or services for the performance of this Contract Agreement.

B.2 BACKGROUND

On March 23, 2010, the President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (Public Law 111-148), hereafter referred to as the Affordable Care

Act, as amended by the Health Care and Education Recovery Act of 2010 (Public Law 111-152). Section 1101 of the Affordable Care Act establishes a "temporary high risk health insurance pool program" to provide health insurance coverage to currently uninsured individuals with pre-existing conditions. The Affordable Care Act authorizes HHS to carry out the program directly or through contracts with States or private, nonprofit entities.

B.3 SPECIFIC SERVICE AND DELIVERY TASKS OF CONTRACTED STATE HIGH RISK POOL PROGRAMS

B.3.1 General Requirements: The Contractor agrees to perform all functions necessary to design, implement, and operate a high risk pool program, as set forth in Section A.4 of the HHS "Solicitation for State Proposals to Operate Qualified High Risk Pools," (hereafter, "the Solicitation") and consistent with the Contractor's proposal submitted in response to the solicitation (as amended, if applicable). Such solicitation, proposal and amendments are hereby incorporated into this contract by reference unless otherwise inconsistent with the terms of this contract.

Contractor also agrees to comply with the implementation plan and progress report requirements set forth in section A.7 of the Solicitation. If the Contractor operates another high risk pool, the Contractor shall segregate funding and expenditures for the two programs and track all benefits and services separately for enrollees in each program, consistent with section C.4.1 of its proposal and the general rules regarding Non-Commingling of Funds set forth in section H.4 of this contract. The basic requirements of the temporary high risk pool program are set forth below, beginning at section B.3.2.

B.3.2 Basic Requirements: The Contractor shall develop and implement a high risk pool program that meets the basic requirements to operate the program, as described in section A.4.2 of the Solicitation, and consistent with sections C.4.1 and C.4.2 of the Contractor's approved proposal.

B.4 PROGRAM REQUIREMENTS

B.4.1 Eligibility Criteria: The Contractor shall develop eligibility criteria, consistent with section C.4.2.1 of its proposal. Thus, the criteria will require that an individual:

1. Is a citizen or national of the United States or lawfully present in the United States and resides in the high risk pool's service area;
2. Has not been covered under creditable coverage for a continuous 6-month period of time prior to the date on which such individual is applying for coverage in the high risk pool program; and
3. Meets the preexisting condition requirements specified in the Contractor's proposal and approved by HHS.

B.4.2 Benefits: Consistent with section C.4.2.2 of its proposal, the Contractor shall offer one or more benefit plans that are actuarially consistent with the statutory requirement that the issuer's share of the costs is not less than 65 percent (65%) of the total costs of the benefit.

B.4.3 Pre-Existing Conditions: Consistent with section C.4.2.3 of its proposal, the contractor shall provide to all eligible individuals that it enrolls in a high risk pool health coverage that does not impose any pre-existing condition exclusions with respect to such coverage, and may not deny enrollment based on a pre-existing condition.

B.4.4 Premiums: Consistent with section C.4.2.4 of its proposal, the contractor shall establish premiums designed not to exceed 100 percent (100%) of the premium for the applicable standard risk rate that would apply to the coverage offered in the State. The Contractor shall determine a standard risk rate by considering the premium rates charged for similar benefits and cost-sharing by other insurers offering health insurance coverage to individuals in the applicable State or States. The standard risk rate shall be established using reasonable actuarial techniques. A high risk pool may not use other methods of determining the standard rate, except with the approval of the Secretary. Premiums charged to enrollees in the high risk pool may vary on the basis of age, by a factor not greater than 4 to 1.

B.4.5 Cost-Sharing Structure: Consistent with section C.4.2.5 of its proposal, the Contractor shall establish a cost-sharing structure designed so that the high risk pool's average share of the total allowed costs of the required benefits is at least 65 percent (65%) of such costs, and that the out-of-pocket limit of coverage for cost-sharing for the required benefits is not greater than the applicable amount described in section 223(c)(2) of the Internal Revenue Code of 1986 for the year involved.

B.4.6 Provider Access: Consistent with section C.4.2.6 of its proposal, the Contractor shall use best efforts to ensure that the high risk pool program includes a sufficient number and range of providers to ensure that all covered services are reasonably available and accessible to its enrollees.

B.4.7 Appeals: Consistent with section C.4.2.7 of its proposal, the Contractor shall establish and maintain procedures for individuals to appeal eligibility and coverage determinations. Minimally, the appeals procedures must provide enrollees and potential enrollees the right to a timely redetermination by the high risk pool or its designee of a determination concerning eligibility or coverage, and the right to a timely reconsideration of a coverage redetermination by an entity independent of the high risk pool or the entity designated to make that redetermination.

B.4.8 Eligibility Determinations and Enrollment Procedures: Consistent with section C.4.3 of its proposal, the Contractor shall perform all eligibility determination and enrollment functions, including but not limited to the following:

1. The Contractor shall develop and utilize an eligibility determination process and will use best efforts to assure that only individuals eligible for coverage receive benefits from the program.

2. As part of the enrollment application process, the Contractor will obtain the name, address, date of birth and Social Security number of a person applying for coverage.
3. The Contractor shall implement a process to determine that the enrollee is a citizen or national of the United States or an alien lawfully present in the United States.
4. The Contractor shall develop and operate an enrollment process and will use best efforts to ensure eligible individuals timely access to benefits under the high risk pool.
5. The Contractor shall develop and operate a disenrollment process, including a process for disenrolling an individual if the monthly or other periodic premium is not paid on a timely basis; when an individual no longer resides in the high risk pool's service area; when an individual obtains other creditable coverage; and, in the case of a death of the individual.
6. To the extent that HHS or the Contractor determine that maximum enrollment capacity for the State has been reached, the Contractor shall develop and implement procedures approved by HHS to discontinue new enrollments, establish an eligible enrollee waiting list, and / or take other actions to limit program costs.

B.4.9 Customer Service: Consistent with section C.4.4 of its proposal, the Contractor shall provide all necessary customer service functions on behalf of high risk pool enrollees, including but not limited to:

1. Application forms, information brochures, and related enrollee communication materials (subject to review by HHS at its discretion). Contractor shall provide or modify its Certificate of Coverage or equivalent (subject to review by HHS at its discretion), which is to be issued to each enrollee at the time of enrollment, and annually thereafter at renewal if high risk pool program benefits are modified, and/or as otherwise directed by HHS.
2. Contractor shall also develop and distribute to each enrollee a membership card that is consistent with industry standards.
3. Contractor shall respond to all enrollee correspondence within 20 calendar days.

B.4.10 Technical Support: Consistent with C.4.5 of its proposal, the Contractor shall operate a technical support center to respond to health care and pharmacy providers seeking information related to an enrollee's benefits, coverage determinations (including exceptions and prior authorizations) and enrollee appeals.

B.4.11 Premium Administration: Consistent with C.4.6 of its proposal, the Contractor shall operate a system to bill, collect and account for enrollee premiums, including:

1. The Contractor shall calculate the appropriate premium amount, bill, and collect premiums from high risk pool program enrollees or enrollee's designee.
2. The Contractor shall use premiums collected and any interest earned on premiums held by the high risk pool program solely to offset the approved administrative expenses

and high risk pool program enrollee claims for health services as included in this Contract.

B.4.12 Utilization Management (if applicable): Consistent with C.4.7 of its proposal, the Contractor shall implement disease and utilization management that will assure high risk pool program enrollees have access to necessary health care services and prescription drugs in a cost-effective manner.

B.4.13 Claims Payment: Consistent with C.4.6(2) of its proposal, the Contractor shall develop and implement a system for processing and paying covered health claims on behalf of the high risk pool program.

1. This system shall encompass claims receipt through final payment, or denial, through a fully automated claim adjudication system that is consistent with industry standards for comparable commercial health insurance carriers or health plan administrators, such that claims are adjudicated in a timely and accurate manner, and all necessary functions are performed to assure timely and accurate claims adjudication, and timely and accurate claims payment. Claims handling and claims payment processes and policies in all respects shall comply with State and federal law. The system shall have at a minimum the following capabilities:

- a) automated eligibility verification that coverage has not terminated on the date of loss;
- b) benefit plan information stored on the system;
- c) automatic calculation of deductibles, co-insurance, co-pays, out-of-pocket limits, and lifetime maximum accumulations;
- d) individual claim history stored on the system and automatically updated;
- e) ability to distinguish claims by diagnosis code;
- f) automated calculation of cost containment provisions;
- g) identification and collection of claim overpayments;
- h) procedures for review of "medically necessary" determinations;
- i) automated production of an Explanation of Benefits; and
- j) automated tracking of individual deductible limits, annual individual out of pocket limits, and any other internal limits such as limits on days, sessions, visits, etc., consistent with industry standards.

2. 97 percent (97%) of all eligible claims, which contain all information necessary for an accurate adjudication ("Clean Claims"), shall be paid within 30 calendar days of receipt for electronically submitted claims and within 40 days of receipt for paper claims.

3. 99 percent (99%) of individual Clean Claim payments for a month shall be accurate.

4. During or after the claim adjudication process, if a claim overpayment occurs or is discovered by the Contractor, the Federal government or its designee, a provider, the participant or any other party, the Contractor will make all reasonable efforts to recover the overpayment on behalf of the high risk pool program.

5. The Contractor shall also be responsible for making available information relating to the proper manner of submitting a claim for benefits to the high risk pool program and distributing forms upon which claim submissions shall be made, or making provision for the acceptance and processing of electronically-filed claims.

6. Contractor shall provide pharmacy benefit management services for the high risk pool program, including:

- a) Administration of a benefit structure consistent with C.4.8 of its proposal.
- b) Perform pharmacy claim processing and payment functions on behalf of the high risk pool program from receipt of both paper and electronic claims, through final payment or denial on a fully automated claim adjudication system in a timely and accurate manner and all other necessary functions to assure timely adjudication of claims and payment of benefits to eligible persons under the high risk pool program;
- c) A formulary that promotes therapeutic and economic value for enrollees and the high risk pool program and covers all therapeutic diagnostic categories;
- d) Drug utilization review designed to effectively and efficiently identify and address instances of potential fraud and abuse, as well as key prescribing and utilization patterns;
- e) Administration of pharmacy benefits shall at all times comply with all standards required under state and federal laws and regulations, in a manner consistent with industry standards for comparable commercial health insurance carriers, or health plan administrators; and
- f) Procedures to ensure that manufacturer rebates earned from prescriptions covered by the federal high risk pool shall accrue to the benefit of the federal program, and shall be separately tracked and credited.

7. Claims Database--Contractor will use best efforts to ensure that adequate information is captured during the claim payment process to allow HHS to evaluate individual and overall high risk pool program health care utilization. Contractor shall provide HHS reports upon request concerning utilization that are in a mutually agreeable electronic format, to include the ability to routinely update claims files as necessary, report individual claims histories as well as claims experience by category of condition or treatment, and fully document the claims adjudication process. The Claims database shall contain for each claimant an identification number, claim number, date(s) of service, treatment by descriptor and treatment code, provider name and provider number, date and type of service, amount billed, amount allowed, and amount paid, enrollee responsibility. In all respects, claims and utilization data shall be maintained,

and available for reporting to and analysis by HHS or any designee, in a manner consistent with industry standards for comparable commercial health insurance carriers, or health plan administrators.

B.4.14 Marketing and Outreach: Consistent with C.4.9 of its proposal, the Contractor shall implement marketing and outreach procedures for the high risk pool program to make potentially eligible individuals and organizations and providers that interact with potentially eligible individuals aware of the high risk pool program and the coverage offered by the high risk pool.

B.4.15 Anti-Dumping Procedures: Consistent with C.4.10 of its proposal, the Contractor shall establish procedures to identify and report to HHS instances where health insurance issuers or group health plans are discouraging high-risk individuals from remaining enrolled in their current coverage (or discouraging enrollment in available coverage) in instances in which such individuals subsequently are eligible to enroll in the high risk pool.

B.4.16 Fraud, Waste, and Abuse: Consistent with C.4.11 of its proposal, the Contractor shall develop operating procedures to prevent, detect, recover (when applicable or allowable), and promptly report to HHS incidences of waste, fraud, and abuse and shall cooperate with Federal law enforcement authorities in cases involving waste, fraud, and abuse.

B.4.17 Compliance Risks: Consistent with C.4.12 of its proposal, the Contractor shall establish and implement an effective system for routine monitoring and identification of compliance risks, including internal monitoring and audits. Compliance risks must be reported to the HHS Contracting Officer Technical Representative ("COTR").

B.4.18. Coordination of Benefits: Consistent with C.4.13 of its proposal, the Contractor shall develop and implement a system for coordinating benefits for health and prescription drug claims with other payers as needed. Claims shall be payable under the high risk pool program on a secondary basis to all other coverage.

B.4.19 Maintenance of Effort: Consistent with section 1101(b)(3) of the Affordable Care Act, a state must agree not to reduce the annual amount the State expended for the operation of one or more State high risk pools during the year preceding the year in which such contract is entered into, as described in section C.5 of the Contractor's approved proposal. The Contractor shall notify HHS of any change in the state spending that would impact the description provided in section C.5 of its proposal.

B.5. GOVERNMENT CONTRACTOR

In undertaking the responsibility for operating the federal risk pool program under this contract in the state identified in A.1, above, as a contractor of HHS, Contractor and its officers, employees, agents and subcontractors are carrying out uniquely federal interests and, to the fullest extent allowed by federal law, are entitled to the protection of the government contractor defense to liability arising from operation of the high risk pool program.

SECTION C: PAYMENT TO CONTRACTOR

C.1 PAYMENT TO CONTRACTOR

The Contractor shall receive actual cost payments from HHS for allowable and allocable administrative costs and claims costs incurred in the development and operation of the high risk pool. Administrative costs for the life of the program may not exceed 10 percent (10%) of total program expenses (including program expenses paid through premiums), absent advance approval from HHS.

C.2 CONTRACTOR/HHS RESPONSIBILITY

1. The Contractor will not be responsible for the costs of covered health insurance claims filed by enrollees in the high risk pool program or for the administrative expenses of operating those programs to the extent that those claims and administrative expenses are in excess of the premiums collected by the high risk pool program. The Contractor will be responsible for operating the high risk pool program in accordance with the terms of the contract. HHS will pay or reimburse the Contractor for claims for covered services and for administrative expenses that are in excess of the premiums collected by the Contractor. Contractor agrees to use its best efforts, in consultation with HHS, to limit the amount of anticipated expenses to the amounts identified in this contract or any modification thereto, for Contractor's operation of the high risk pool program.

2. The Contractor acknowledges that HHS, as are all Government agencies, is bound by certain laws limiting the available funds for programs and, in particular the appropriation set out in section 1101 of the Affordable Care Act, as may be amended from time to time. For this reason the Contractor has the following responsibilities:

(a) The Contractor shall notify HHS within 5 business days of reaching a number of active high risk pool enrollees that equals or exceeds 75% of the enrollment projected for the current time period in Table 2 of the Cost Proposal.

(b) As part of each monthly report, the Contractor will notify HHS if its available claims data indicate that the projected claims for the year to date would result in the Contractor exceeding the per member per month claims amounts projected in Table 2 of the Cost Proposal.

(c) The Contractor shall notify HHS within 5 business days of learning of any potential future development or event that is likely to cause the Contractor to exceed 75% of the projected enrollment, or is likely to cause the Contractor to project that Total Claims Against the Federal Fund Allotment would exceed the amounts as projected in Table 2 of the Cost Proposal.

3. In the event an action is brought against the Contractor and/or its Subcontractor in any court or administrative forum regarding the operation or performance of this Contract, the Contractor shall immediately, as described in paragraph G.18 of this Contract, notify HHS and provide a copy of the complaint and summons or other

documentation to HHS. HHS will, upon notification and after consultation with the U.S. Department of Justice, determine whether it will intervene in, or otherwise defend, the action brought against the Contractor and promptly notify the Contractor and/or its Subcontractor of this decision in writing.

4. The Contractor and/or its Subcontractor will not be responsible for the defense of, or the cost to defend any action brought against HHS, the Contractor, or Subcontractor, separately or together relating to (1) the constitutionality or legality of the Affordable Care Act or this contract; (2) any policies, procedures or operational requirements implemented by HHS or by Contractor at HHS's direction, or actions undertaken or omissions made by HHS, in relation to this contract; (3) inability to cover individuals or pay claims because of the unavailability of federal funding; or (4) the Contractor's operation of the high risk pool program, whether directly or through the Subcontractor, in accordance with the terms of this Contract.

5. The Contractor will provide information and support to assist HHS in defending any such action as requested by HHS.

6. The Contractor's and/or its Subcontractor's costs associated with any law suit, including monetary judgment, will be an allowable expense insofar as permitted under OMB Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments, and will not be subject to the 10 percent limitation under C.3, below.

7. Nothing in this Contract shall be deemed a waiver of HHS's right to prosecute any claim under the False Claims Act, any Federal criminal violation, or any violation of the Internal Revenue Code.

8. This provision shall survive termination of this Contract for any reason, so long as the action stems from, or is the result of, the operation of the program or the performance of this Contract.

C.3 ALLOWABLE ADMINISTRATIVE COSTS

As is noted in C.1 above, administrative costs cannot exceed a total of 10 percent (10%) of total program expenses (including program expenses paid through premiums) over the life of the contract and no more than the amount set forth in its cost proposal over the first performance period, absent advance approval of HHS. The allowable administrative costs include those associated with implementing the high risk pool program, including expenses directly related to the tasks outlined in B.3 as well as other expenses including, but not limited to the use of actuarial services, accounting and auditor fees, agent referral fees, assessment operations, bank charges, board of director expenses, staff salary and expenses, legal expenses, marketing and outreach, office rent, equipment and supplies, postage, and printing and other administrative costs as approved by HHS consistent with OMB Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments." This includes administrative costs incurred before the effective date of the contract directly pursuant to negotiation with HHS and in anticipation of contract award, when such incurrence is necessary to comply with the proposed contract delivery schedule. These costs are allowable to the extent that they

would have been allowable if incurred after the date of the contract (see FAR 31.205-32).

On at least a monthly basis, the Contractor shall submit a Statement of costs indicating:

1. The contract line item number;
2. The administrative expenses of the Contractor;
3. The number of high risk pool program enrollees and the claims paid on behalf of high risk pool enrollees;
4. The amount of premiums billed and the amount of premiums collected; and
5. A summary of amount of Federal funds drawn down during that month.

The Contractor's Statement shall not contain personally identifiable information describing the enrollees in the high risk pool.

C.4 RECEIPT OF PAYMENT

Funds to pay the difference between premiums and the total of allowable administrative costs and claims will be placed in an account established with the Payment Management System (PMS). PMS is administered by the Division of Payment Management (DPM), an office of U.S. Department of Health & Human Services' (HHS) Program Support Center, Financial Management Service (<http://www.dpm.psc.gov>). The Contractor may submit a request for payment for the claims and allowable administrative costs for review and approval, as often as daily, on a Standard Form 270.

The Contractor's request may not contain personally identifiable information describing the enrollees in the high risk pool.

Upon approval, funds will be disbursed to the Contractor via electronic funds transfer. HHS will reimburse costs incurred under the terms of this contract up to the amount allotted to the state, but shall not pay the Contractor a fee or profit for performing this contract.

C.5 MONITORING OF AVAILABLE FUNDS

The Contractor shall monitor the total expenses submitted to HHS, as well as the anticipated expenses of the high risk pool. The Contractor shall work with HHS to develop mitigation strategies should the actual or projected expenses reimbursable under this contract be projected to exceed the amounts established in this contract or modifications to this contract. If HHS determines that the amounts available in this contract for expenses of the high risk pool may be less than the projected amount of Contractor expenses, the Contractor shall recommend adjustments sufficient to eliminate such deficit, and implement such adjustments after approval by the contracting officer. If the contractor has exercised reasonable efforts to eliminate the deficit, HHS will reimburse the Contractor for all claims and administrative expense in excess of the amounts established in the contract or modification to the contract insofar

as permitted under Section 1101 of the Affordable Care Act. HHS reserves the right to adjust the aggregate amounts available for payment of expenses in the high risk pool as are necessary to eliminate an aggregate deficit as provided in 1101(g)(2) of the Affordable Care Act and to direct the Contractor to cease taking applications for participation in the program as provided in 1101(g)(4) of the Affordable Care Act.

SECTION D IMPLEMENTATION

D.1 PROMPT IMPLEMENTATION REQUIREMENT

The Contractor shall begin to accept enrollments into the qualified high risk pool and provide coverage to enrollees within the timeframe specified in the Contractor's proposal and approved by HHS.

D.2 IMPLEMENTATION PLAN AND PROGRESS REPORTS

1. Within calendar 10 days of award of this contract, the Contractor shall submit to the (COTR) a project implementation plan that highlights each step of implementation of this contract and that is consistent with the Contractors' proposal. The implementation plan, at a minimum, shall include a copy of the Contractor's draft enrollment application as well as the specific dates on which the Contractor will:

- a) Announce the availability of the high risk pool program to the public;
- b) Begin accepting high risk pool program enrollments; and
- c) Begin to cover the claims submitted by or on behalf of high risk pool program enrollees.

2. The Contractor shall submit progress reports to HHS on the status of implementing and carrying out the high risk pool program. Reports should be submitted in a format to be provided by HHS. The first progress report will be due on the last business day of the month following the calendar quarter being reported. At a minimum, progress reports shall include:

- a) Evidence that the major milestones of the implementation plan have been met and clear identification of milestones yet to be met;
- b) An updated timeline for implementing the program and meeting other identified milestones;
- c) Risks and problems identified or encountered by the Contractor and mitigation strategies implemented to address those risks and problems;
- d) A description of the enrollment into the high risk pool program, at least broken down geographically and demographically to describe whether the enrollees in the program are representative of the eligible individuals in the State
- e) The number of new enrollees into the program;

- f) The number of individuals who have disenrolled from the program since the previous progress report, including the reason for the disenrollments, if known;
- g) The average length of enrollment in the program;
- h) A breakdown of how enrollees satisfied the pre-existing condition requirement; and
- i) In the first progress report of each year, updated annual cost projections, based on actual expenditures and enrollment. If a shortfall is projected, a plan with specific cost-containment strategies will be submitted to HHS that assures high risk pool expenditures stay within allotment levels.

The quarterly reports shall not contain personally identifiable information about the enrollees in the high risk pool program.

3. The Contractor shall submit monthly reports to HHS, beginning on the last business day of the month following the month of the effective date of the contract and continuing on the last business day of the month after the month being reported until the expiration of the contract. The monthly reports shall provide information on the previous calendar month of operations and contain a complete accounting of temporary high risk pool expenditures and revenue, as follows:

- a) Medical claims paid on behalf of high risk pool enrollees;
- b) Prescription drug claims paid on behalf of high risk pool enrollees;
- c) Estimated claims incurred but not reported;
- d) The total number of high risk pool program enrollees;
- e) The amount of premiums billed and the amount of premiums collected;
- f) The amount of administrative costs;
- g) The number of new enrollments and disenrollments,
- h) Average out-of-pocket costs for enrollees.

The Contractor must certify that all information submitted to HHS in these reports is true, accurate, and complete. The monthly reports shall not contain personally identifiable information about the enrollees in the high risk pool program.

4. No later than March 15 of the year following each period of performance, as described in Section E.1, Contractor shall provide an annual reconciliation of the difference between premiums collected plus federal payments under this Contract and claims plus allowable administrative expenses. After such reconciliation, Contractor shall report to HHS with necessary changes. To the extent the Contractor has received an excess of payments, the payments will be credited or returned to HHS. To the extent the Contractor identifies any underpayment for administrative costs, it will bill to and receive from HHS such underpayments subject to the limitations of the

appropriation in Section 1101 of the Affordable Care Act and the estimated cost provisions of this Contract.

5. By June 30, 2011, and each June 30 thereafter, the Contractor shall submit an independently audited financial report detailing the finances of the high risk pool program operated by the Contractor.

D.3 MEETINGS

The Contractor shall participate in monthly meetings or teleconferences with HHS to be scheduled by HHS through January 2011 and as may be necessary thereafter to provide for the exchange of information relative to the implementation of high risk pool programs.

D.4 DATA USE AGREEMENTS

The Contractor shall enter into and comply with provisions of data use agreements with HHS and other Federal agencies as may be required for the implementation of the high risk pool program.

D.5 TRANSITION TO HEALTH BENEFIT EXCHANGES

The Contractor shall use all reasonable efforts to cooperate with and assist HHS in providing for the transition of eligible enrollees in high risk pool programs into qualified health plans offered through Health Benefit Exchanges as provided in section 1311 of the Affordable Care Act so that there is no lapse in coverage for the individual involved. All costs of such cooperation and assistance are allowable administrative costs to the extent permitted under Section C.3 above.

D.6 NON-DISCRIMINATION

The Contractor shall not discriminate based on race, ethnicity, religion, gender, age, or disability.

SECTION E: DELIVERIES OF PERFORMANCE/TERM OF AGREEMENT

E.1 PERIOD OF PERFORMANCE

This contract includes a start-up period of performance that will run until December 31, 2010, which will be referred to as the contract Base Period. There will be three additional one-year option periods which will run January 1, 2011, through December 31, 2011, January 1, 2012, through December 31, 2012, and January 1, 2013, through December 31, 2013. There will be a final option, which will be referred to as the contract closeout period which will run from January 1, 2014 through June 30, 2015. All terms and conditions applicable to the base period shall extend to the option periods unless otherwise mutually agreed upon by HHS and the Contractor.

E. 2 DELIVERABLE SCHEDULE

The Contractor shall comply with the following delivery schedule:

Deliverable	ITEM (Task #)	DUE DATE
Project Implementation Plan	A.7 of Solicitation	Within 10 days of Date of Contract Award
Quarterly Progress Reports	A.7 of Solicitation	Due on the last business day of the month following the calendar quarter being reported on starting with the first calendar quarter after contract inception.
Monthly Reports	A.7 of Solicitation	The first two months of reports will be due the last business day of the 3rd month after the contract start date. The remaining monthly reports are due the last business day of the month following the month being reported on.
Audited Financial Report	A.7 of Solicitation	Annually, beginning on June 30, 2011

E.3 PLACE OF DELIVERY

All deliverables and correspondence shall be delivered electronically to the COTR and the Contracting Officer concurrently. Paper mail and email addresses shall be set forth in any contract resulting from this solicitation.

SECTION F CONTRACT ADMINISTRATION DATA

F.1 INSPECTION AND ACCEPTANCE

The Contractor's performance and the quality of services provided hereunder shall be subject to final inspection and acceptance by the Contracting Officer in conjunction with the Contracting Officer's Technical Representative (COTR).

F.2 ELECTRONIC FUNDS TRANSFER

The Contractor shall forward electronic funds transfer information in writing to the COTR Program Support Center, Financial Management Branch (PSC/FMB).

SECTION G – STANDARD TERMS AND CONDITIONS

G.1 DESIGNATION OF CONTRACTING OFFICER TECHNICAL REPRESENTATIVE (COTR)

HHS will designate in writing a COTR who will be responsible for monitoring the Contractor's progress in the implementation of the high risk pool program, interpret the Statement of Work and any other technical performance requirement, perform technical evaluation as required, and assist in the resolution of technical problems encountered during performance. HHS may change its COTR designation in writing and will provide such notice in advance, if reasonably possible.

G.2 REGULATORY GUIDANCE

HHS will provide guidance on regulations that it may promulgate that will govern requirements and operations of high risk pool programs. The Contractor must follow such guidance for the duration of the contract, as well as other applicable laws and regulations. HHS agrees that it will provide written notification of regulations or other guidance that may impact this contract. If the regulations or guidance have a material impact on the costs of this contract, the Contractor has the right to notify HHS within 10 working days of receipt of such regulations or guidelines. HHS will reasonably negotiate any additional costs related to implementation of necessary changes to the contract.

G.3 HHS RIGHT TO AUDIT

The Contractor agrees that, with prior written notice and during normal business hours, HHS, other Federal agencies in the citizenship verification process, the Comptroller General, any Federal law enforcement agency, or their designee may evaluate, through inspection, audit or other means:

1. The quality, appropriateness and timeliness of services furnished to high risk pool enrollees under the Contract;
2. Enrollment records and claims data;
3. Compliance with HHS and other Federal requirements for maintaining the privacy and security of protected health information and other personally identifiable information of high risk pool enrollees, including, but not limited to the Federal Information Security Management Act of 2002 (44 U.S.C. §3541, et seq.), Computer Matching and Privacy Protection Act of 1988, and The Privacy Act of 1974 (5 U.S.C. §552a);
4. The facilities of high risk pool programs to include computer and other electronic systems;
5. Any books, contracts, computer or other electronic systems, including medical records and documentation of sub-contractors related to the HHS Contract with the high risk pool program. The financial accounting system and/or methods employed by the Contractor must establish and leave a clear audit trail of all financial transactions and records executed and maintained by the Contractor on behalf of the high risk pool program. The Contractor shall maintain all financial records consistent with sound business practices and based upon accounting principles consistent with industry standards for comparable commercial health insurance carriers or health plan administrators, and shall clearly identify all business revenue and disbursements by

type of transaction. Contractor shall maintain all federal funds, premium payments, interest, reimbursements, credits and prescription drug rebates in a separate bank account. The Contractor at a minimum will be responsible for determining net written and earned premiums, the expense of administration, the paid and incurred losses, interest paid to providers, and any other business conducted on behalf of the temporary high risk health insurance pool program. Such information shall be reported to HHS in a form and manner prescribed by HHS, and in full good-faith cooperation with HHS or its designee.

6. Contractor will maintain a general ledger and supporting accounting records and systems for the temporary high risk pool that are adequate to meet the needs of an insurance carrier of comparable size. This will include, at a minimum, the ability to separately report the temporary federal high risk pool financial statements, as specified in E.2, in accordance with the financial reporting requirements mandated by the State's Insurance Commissioner, including:

- a) Summarized annual income and expense statement;
- b) Unassigned surplus roll forward;
- c) Journal entries;
- d) Interest paid on claims;
- e) Balance sheet showing the balances at the end of the previous year, the transactions for the year, and the balances at the end of the year;
- f) Detailed backup for each of the assets and liabilities;
- g) Entire bank statement for the year; and
- h) A statement as to how bad debt expense was calculated.

Nothing in this Agreement shall be interpreted as a requirement for prior written notice of inspection in the event inspection is executed by any Federal law enforcement agency in the investigation of suspected fraud, false claims, violations of the Internal Revenue Code, or any criminal activity.

G.4 NON-COMMINGLING OF FUNDS

1. The Contractor shall keep all funds for this contract physically separate from funds obtained from other sources. Accounting for such funds shall not be based on allocations or other sharing mechanisms and shall agree with the Contractor's accounting records.

2. In certain instances the physical separation of funds may not be practical or desirable. In such cases, the Contractor may request a waiver from this requirement from the Contracting Officer. The waiver shall be requested in advance and the

Contractor shall demonstrate that accounting techniques have been established that will clearly measure cash and investment income (i.e., subsidiary ledgers). Reconciliations between amounts reported and actual amounts shown in accounting records shall be provided as supporting schedules to the Annual Accounting Statements.

3. The Contractor shall incorporate this clause in all subcontracts that exceed \$25,000.

G.5 RECORD RETENTION

The Contractor is required to retain records that the Contractor or sub-contractors create, collect or maintain while participating in the high risk pool program for at least six years following termination. This retention period may be extended by the Secretary if a high risk pool's records relate to an ongoing investigation, litigation or negotiation by the Secretary, the Office of the Inspector General, the Department of Justice or a State, or such documents otherwise relate to suspicions of fraud and abuse or violations of Federal or State law. The Contractor shall return or destroy protected health information created or received in the Contractor's capacity in operating a high risk pool program under this contract.

G.6 TERMINATION OF CONTRACT

1. Termination for HHS's convenience. HHS reserves the right to terminate this contract, or any part hereof, for its sole convenience. In the event of such termination, the Contractor shall immediately stop all work hereunder and shall immediately cause any and all of its suppliers, service providers and subcontractors to cease work. The Contractor shall be paid a percentage of the contract price reflecting the percentage of the work performed prior to the notice of termination, consistent with paragraph G.6.4 below, plus reasonable charges the Contractor can demonstrate to the satisfaction of HHS using its standard record keeping system, have resulted from the termination. The Contractor shall not be required to comply with the cost accounting standards or contract cost principles for this purpose. This paragraph does not give HHS any right to audit the Contractor's records. The Contractor shall not be paid for any work performed or costs incurred which reasonably could have been avoided.

2. Termination for Default. HHS may terminate this contract, or any part hereof, for cause in the event of any default by the Contractor, or if the Contractor fails to comply with any contract terms and conditions, provisions of law pertaining to contract performance (including, but not limited to, applicable provisions of the Social Security Act), or fails to provide HHS, upon request, with adequate assurances of future performance. In the event of termination for default, HHS shall not be liable to the Contractor for any amount for supplies or services not authorized by this contract, and the Contractor shall be liable to HHS for any and all rights and remedies provided by law. If it is determined that HHS improperly terminated this contract for default, such termination shall be deemed a termination for convenience.

3. Termination by Contractor. The Contractor may not terminate this Agreement except at the end of an option period. If the Contractor chooses to terminate this Agreement at the end of an option period, it must notify HHS 120 calendar days before the planned

day of termination. It also must notify the enrolled beneficiaries 60 calendar days before the planned day of termination.

4. Unpaid Claims and Expenses at Termination. In the event of any termination, HHS shall pay the Contractor for all in-process and incurred but not reported claims that would otherwise be eligible for payment under the contract and for reasonable costs of administration as provided in this Contract.

5. Corrections. Should a Contractor receive notice from HHS that HHS intends to terminate the contract under the terms of this contract, the high risk pool will have 30 days to cure its failure(s) that were the basis for the termination and to notify HHS in writing at the address specified in the notification letter. HHS will review the correction and notify the entity in writing of its decision to either find the contractor has cured its failure(s) or to proceed with the termination.

G.7 DISPUTES

(a) This contract is subject to the Contract Disputes Act of 1978, as amended (41 U.S.C. 601-613).

(b) Except as provided in the Act, all disputes arising under or relating to this contract shall be resolved under this clause.

(c) "Claim," as used in this clause, means a written demand or written assertion by one of the contracting parties seeking, as a matter of right, the payment of money in a sum certain, the adjustment or interpretation of contract terms, or other relief arising under or relating to this contract. However, a written demand or written assertion by the Contractor seeking the payment of money exceeding \$100,000 is not a claim under the Act until certified. A voucher, invoice, or other routine request for payment that is not in dispute when submitted is not a claim under the Act. The submission may be converted to a claim under the Act, by complying with the submission and certification requirements of this clause, if it is disputed either as to liability or amount or is not acted upon in a reasonable time.

(d)(1) A claim by the Contractor shall be made in writing and, unless otherwise stated in this contract, submitted within 6 years after accrual of the claim to the Contracting Officer for a written decision. A claim by HHS against the Contractor shall be subject to a written decision by the Contracting Officer.

(2)(i) The Contractor shall provide the certification specified in paragraph (d)(2)(iii) of this clause when submitting any claim exceeding \$100,000.

(ii) The certification requirement does not apply to issues in controversy that have not been submitted as all or part of a claim.

(iii) The certification shall state as follows: "I certify that the claim is made in good faith; that the supporting data are accurate and complete to the best of my knowledge and belief; that the amount requested accurately reflects the contract adjustment for

which the Contractor believes HHS is liable; and that I am duly authorized to certify the claim on behalf of the Contractor.”

(3) The certification may be executed by any person duly authorized to bind the Contractor with respect to the claim.

(e) For Contractor claims of \$100,000 or less, the Contracting Officer must, if requested in writing by the Contractor, render a decision within 60 days of the request. For Contractor-certified claims over \$100,000, the Contracting Officer must, within 60 days, decide the claim or notify the Contractor of the date by which the decision will be made.

(f) The Contracting Officer's decision shall be final unless the Contractor appeals or files a suit as provided in the Act.

(g) If the claim by the Contractor is submitted to the Contracting Officer or a claim by HHS is presented to the Contractor, the parties, by mutual consent, may agree to use alternative dispute resolution (ADR). If the Contractor refuses an offer for ADR, the Contractor shall inform the Contracting Officer, in writing, of the Contractor's specific reasons for rejecting the offer.

(h) HHS shall pay interest on the amount found due and unpaid from: (1) the date that the Contracting Officer receives the claim (certified, if required); or (2) the date that payment otherwise would be due, if that date is later, until the date of payment. With regard to claims having defective certifications, as defined in FAR 33.201, interest shall be paid from the date that the Contracting Officer initially receives the claim. Simple interest on claims shall be paid at the rate, fixed by the Secretary of the Treasury as provided in the Act, which is applicable to the period during which the Contracting Officer receives the claim and then at the rate applicable for each 6-month period as fixed by the Treasury Secretary during the pendency of the claim.

(i) The Contractor shall proceed diligently with performance of this contract, pending final resolution of any request for relief, claim, appeal, or action arising under the contract, and comply with any decision of the Contracting Officer.

G.8 RIGHTS IN DATA

The Contractor agrees to the extent that it receives or is given access to data necessary for the performance of this contract which contains restrictive markings, the Contractor shall treat the data in accordance with such markings unless otherwise specifically authorized in writing by the Contracting Officer

G.9 SECURITY

The Contractor shall comply with any security requirements established by HHS to ensure proper and confidential handling of data and information. The Contractor shall refer to 'Secure ONE HHS', which is HHS' Information Security Program Policy, dated December 15, 2004. Data obtained for this contract shall not be used to create databases or any other product not intended for use specifically in this project. All data containing personal identifiers shall be handled in accordance with the Privacy Act of 1974 (Public Law 93-579). No data is to be released to anyone without the specific approval of the Contracting Officer's Technical Representative and the Contracting Officer.

G.10 PRIVACY ACT

Performance of this effort may require the Contractor to access and use data and information proprietary to a Government agency or Government contractor which is of such a nature that its dissemination or use, other than in performance of this effort would be adverse to the interests of HHS and/or others.

Neither the Contractor nor contractor personnel shall divulge or release data or information developed or obtained in performance of this effort, until made public by HHS, except to authorized Government personnel or upon written approval of the Contracting Officer (CO). The Contractor shall not use, disclose, or reproduce proprietary data that bears a restrictive legend, other than as required in the performance of this effort. Nothing herein shall preclude the use of any data independently acquired by the Contractor without such limitations or prohibit an agreement at no cost to HHS between the Contractor and the data owner which provides for greater rights to the Contractor.

G.11 ANTI-KICKBACK REQUIREMENTS

(a) Definitions.

"Kickback," as used in this clause, means any money, fee, commission, credit, gift, gratuity, thing of value, or compensation of any kind which is provided, directly or indirectly, to any prime Contractor, prime Contractor employee, subcontractor, or subcontractor employee for the purpose of improperly obtaining or rewarding favorable treatment in connection with a prime contract or in connection with a subcontract relating to a prime contract.

"Person," as used in this clause, means a corporation, partnership, business association of any kind, trust, joint-stock company, or individual.

"Prime contract," as used in this clause, means a contract or contractual action entered into by the United States for the purpose of obtaining supplies, materials, equipment, or services of any kind.

"Prime Contractor" as used in this clause, means a person who has entered into a prime contract with the United States.

"Prime Contractor employee," as used in this clause, means any officer, partner, employee, or agent of a prime Contractor.

"Subcontract," as used in this clause, means a contract or contractual action entered into by a prime Contractor or subcontractor for the purpose of obtaining supplies, materials, equipment, or services of any kind under a prime contract.

"Subcontractor," as used in this clause, (1) means any person, other than the prime Contractor, who offers to furnish or furnishes any supplies, materials, equipment, or services of any kind under a prime contract or a subcontract entered into in connection with such prime contract, and (2) includes any person who offers to furnish or furnishes general supplies to the prime Contractor or a higher tier subcontractor.

"Subcontractor employee," as used in this clause, means any officer, partner, employee, or agent of a subcontractor.

(b) The Anti-Kickback Act of 1986 (41 U.S.C. 51-58) (the Act), prohibits any person from—

(1) Providing or attempting to provide or offering to provide any kickback;

(2) Soliciting, accepting, or attempting to accept any kickback; or

(3) Including, directly or indirectly, the amount of any kickback in the contract price charged by a prime Contractor to the United States or in the contract price charged by a subcontractor to a prime Contractor or higher tier subcontractor.

(c)(1) The Contractor shall have in place and follow reasonable procedures designed to prevent and detect possible violations described in paragraph (b) of this clause in its own operations and direct business relationships.

(2) When the Contractor has reasonable grounds to believe that a violation described in paragraph (b) of this clause may have occurred, the Contractor shall promptly report in writing the possible violation. Such reports shall be made to the inspector general of the contracting agency, the head of the contracting agency if the agency does not have an inspector general, or the Department of Justice.

(3) The Contractor shall cooperate fully with any Federal agency investigating a possible violation described in paragraph (b) of this clause.

(4) The Contracting Officer may (i) offset the amount of the kickback against any monies owed by the United States under the prime contract and/or (ii) direct that the Prime Contractor withhold from sums owed a subcontractor under the prime contract the amount of the kickback. The Contracting Officer may order that monies withheld under subdivision (c)(4)(ii) of this clause be paid over to HHS unless HHS has already offset those monies under subdivision (c)(4)(i) of this clause. In either case, the Prime Contractor shall notify the Contracting Officer when the monies are withheld.

(5) The Contractor agrees to incorporate the substance of this clause, including paragraph (c)(5) but excepting paragraph (c)(1), in all subcontracts under this contract which exceed \$100,000.

G.12 COVENANT AGAINST CONTINGENT FEES

(a) The Contractor warrants that no person or agency has been employed or retained to solicit or obtain this contract upon an agreement or understanding for a contingent fee, except a bona fide employee or agency. For breach or violation of this warranty, HHS shall have the right to annul this contract without liability or, in its discretion, to deduct from the contract price or consideration, or otherwise recover, the full amount of the contingent fee.

(b) "Bona fide agency," as used in this clause, means an established commercial or selling agency, maintained by a contractor for the purpose of securing business, that neither exerts nor proposes to exert improper influence to solicit or obtain Government contracts nor holds itself out as being able to obtain any Government contract or contracts through improper influence.

"Bona fide employee," as used in this clause, means a person, employed by a contractor and subject to the contractor's supervision and control as to time, place, and manner of performance, who neither exerts nor proposes to exert improper influence to solicit or obtain Government contracts nor holds out as being able to obtain any Government contract or contracts through improper influence.

"Contingent fee," as used in this clause, means any commission, percentage, brokerage, or other fee that is contingent upon the success that a person or concern has in securing a Government contract.

"Improper influence," as used in this clause, means any influence that induces or tends to induce a Government employee or officer to give consideration or to act regarding a Government contract on any basis other than the merits of the matter.

G.13 SUBCONTRACTS

The Contractor shall notify the Contracting Officer reasonably in advance of placing any subcontract or modification to the subcontracting plan contained in its response to the solicitation.

G.14 CHANGES

a) Changes in the terms and conditions of this contract may be made only by written agreement of the parties. HHS may request changes to the work to be done by providing Contractor a written request for change(s) which specifies the change(s) and the timeframe within which the federal government desires the change(s) to be implemented. Contractor shall provide a written response within no more than twenty (20) calendar days indicating the timeframe required for implementing the change.

b) Changes, which shall be issued by the contracting officer and bilaterally agreed to by both parties, are deemed a "Change Order." The Contractor will implement the change within the agreed timeframe. An appropriate amendment to this Agreement will be executed if the Change Order does not otherwise constitute a valid amendment under the terms of this Agreement.

c) Contractor may also assert that a material change in cost will result from implementing a Change Order, in which case Contractor's written response shall also include a description of the basis for the claimed change in cost, and indicate whether the change in cost should be recovered by Contractor as a one-time fee, an installment-type fee, or a change to the ongoing administrative cost.

d) Any such additional or increased payment(s) shall be an Equitable Adjustment. In all cases, the Parties agree that any Equitable Adjustment is intended to, and shall be calculated to, cover the increased cost that results from a Change Order, and to restore Contractor to its financial position prior to the Change Order. Any change in the cost pursuant to this section shall be billed and payable on succeeding invoice(s), as appropriate.

G.15 ORDER OF PRECEDENCE

Any inconsistency in this contract shall be resolved by giving precedence in the following order:

- a) This contract, or amendments to the contract;
- b) Contractor's Proposal; and
- c) The solicitation.

G.16 ACCEPTANCE OF CONTRACT

An individual with legal authority to bind the organization shall sign this Agreement below indicating acceptance of all provisions contained within this contract.

G.17 HIPAA PROVISIONS

In carrying out its HIPAA responsibilities, the Contractor shall comply with all of the following:

- a) Use of Protected Health Information. Contractor shall not use, and shall ensure that its directors, officers, employees, sub-contractors and agents and representatives do not use Protected Health Information (PHI), within the meaning of 45 CFR § 160.103, in any manner that would constitute a violation of the Health Insurance Portability and Accountability Act ("HIPAA"), or Title 45 Code of Federal Regulations, parts 160 and 164 ("Privacy Regulations" or "Privacy Rule") if that use were made by HHS directly. Contractor (and others on its behalf) may only use PHI for the purpose of fulfilling its obligations under this Agreement with respect to treatment, payment, or health care

operations for a plan or its enrollees; as required by law or as needed for proper management and administration and for the Contractor to carry out its legal responsibilities; or, as otherwise permitted by HIPAA.

b) Disclosure of PHI. Contractor shall not disclose, and shall ensure that its directors, officers, employees, sub-contractors and agents and representatives do not disclose PHI in any manner that would constitute a violation of HIPAA or the Privacy Regulations if that disclosure were made by HHS directly. This provision applies to any third party, subcontractor, agent or employee of Contractor. Contractor (and others on its behalf) may only disclose PHI for the purpose of fulfilling its obligation under this Agreement with respect to treatment, payment, or health care operations for a plan or its enrollees; as required by law or as needed for proper management and administration and for the Contractor to carry out its legal responsibilities.

c) Reporting of Uses or Disclosures of PHI. Contractor shall, within ten (10) working days of becoming aware of a use or disclosure of PHI in violation of this Agreement by Contractor, its directors, officers, employees, sub-contractors and agents or representatives, or by a third party to which Contractor disclosed PHI pursuant to G.17(d) of this Agreement, report any such disclosure to HHS and the relevant health plan. Contractor shall also, following the discovery of a breach of unsecured PHI, notify HHS of such breach as provided in 45 CFR 164.410.

d) Agreements with Third Parties. Contractor shall enter into an agreement with any agent, subcontractor or representative that will have access to PHI to be bound by the same restrictions and conditions that apply to Contractor pursuant to this Agreement with respect to PHI.

e) Access to Information. In the event an individual requests access to PHI in a designated record set directly from Contractor (or where HHS forwards a request it receives to the Contractor), the Contractor shall provide the individual with access to the extent required under 45 CFR 164.524. Contractor shall meet all other access requirements in 45 CFR 164.524.

f) Availability of PHI for Amendment. Within ten (10) working days of receipt of a request for the amendment of an individual's PHI in a designated record set, Contractor shall incorporate any such amendments in the PHI if required by 45 CFR section 164.526, and shall otherwise meet the requirements of 164.526.

g) Accounting for Disclosures. Within ten (10) working days of receipt of a notice by HHS (or an HHS contractor acting as HHS' agent) that HHS has received a request for an accounting of disclosures of PHI regarding an individual, Contractor shall make such information available to HHS (or its agent) so as to allow HHS or its agent to make the accounting required by 45 CFR section 164.528. At a minimum, Contractor shall provide HHS or its agent with the following information: (a) the date of the disclosure; (b) the name of the entity or person who received the PHI, and if known, the address of such entity or person; (c) a brief description of the PHI disclosed; and (d) a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure. In the event the request for an accounting is delivered directly to Contractor,

Contractor shall, within two (2) days of receipt of such request by Contractor, forward such request to HHS and the relevant health plan. It shall be the responsibility of HHS or its agent to prepare and deliver any such accounting requested. Contractor hereby agrees to implement an appropriate record keeping process to enable it to comply with this requirement.

h) Administrative Standards. Contractor shall implement the following administrative standards to ensure its compliance with the requirements of this Agreement to protect PHI in accordance with HIPAA and the Privacy Regulations:

- 1) Contractor shall designate a privacy official who is responsible for the development and implementation of the policies and procedures through which Contractor carries out its responsibilities to protect PHI under this Agreement.
- 2) Contractor shall train all members of its workforce engaged in work under this Agreement on the policies and procedures with respect to PHI as necessary and appropriate for them to carry out their functions. Such training shall be documented.
- 3) Contractor shall use appropriate administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of protected health information to prevent use or disclosure of PHI in violation of the requirements of this Agreement, or federal or State law.
- 4) With respect to any protected health information that is transmitted by electronic media, or maintained in electronic media, Contractor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of such electronic protected health information that it creates, receives, maintains, or transmits on behalf of the covered entity, and ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect such electronic protected health information, and report to HHS any security incident concerning such electronic protected health information of which it becomes aware at any time.
- 5) Contractor shall provide a process for individuals to make complaints concerning Contractor's compliance with the requirements of HIPAA and the Privacy Regulations. Contractor shall document all complaints received. Contractor shall not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against an individual for the filing of a complaint.
- 6) Contractor shall have and apply appropriate sanctions against members of its workforce who fail to comply with the privacy policies and procedures of Contractor related to the protection of PHI and shall document the sanctions that are applied.
- 7) Contractor shall mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of PHI in violation of its policies and procedures or the requirements of HIPAA and the Privacy Regulations.

- i) Availability of Books and Records. Contractor hereby agrees to make its internal practices, books and records, including such practices, books, and records received from any source, relating to the use and disclosure of PHI, available to HHS for purposes of determining the compliance with HIPAA.
- j) Definitions. The terms used in this Provision shall be defined as in 45 CFR parts 160 and 164.
- k) Amendment. Upon the enactment of any law or regulation affecting the use and/or disclosure of PHI, or the publication of any court decision relating to any such law, or the publication of any interpretive policy, opinion or guidance of any governmental agency charged with the enforcement of any such law or regulation, HHS may, by written notice to Contractor, amend this Agreement to comply with such law or regulation, court decision or opinion. If Contractor agrees with any such amendment, it shall so notify HHS in writing within thirty (30) calendar days of the written notice. If the parties are unable to agree on an amendment within thirty (30) days thereafter, HHS may terminate this Agreement as provided herein.
- l) Breach. Without limiting the rights of the parties pursuant to this Agreement, if Contractor breaches its obligations under this provision, HHS may, at its option: (a) exercise any of its rights of access and inspection under paragraph (i) of this Provision; (b) require Contractor to submit to a plan of monitoring and reporting, as HHS may determine necessary to maintain compliance with this Agreement, and such plan shall be made part of this Agreement; or (c) terminate this Agreement, with or without opportunity to cure the breach. HHS' remedies under this Section and any other part of this Agreement or provision of law shall be cumulative, and the exercise any remedy shall not preclude the exercise of any other.
- m) Procedure Upon Termination. Upon termination of this Agreement, or partial termination, Contractor shall return or destroy all PHI that it maintains in any form and shall retain no copies of such information, if so directed by HHS. If the parties agree that return or destruction is not feasible, Contractor shall continue to extend the protections of this Agreement to such information and limit further use of the information to those purposes that make the return or destruction of the information not feasible. The respective rights and obligations of Contractor concerning the HIPAA Privacy Rule and its implementing regulations shall survive the termination of this Agreement.
- n) Interpretation. Any ambiguity in this Agreement shall be resolved to permit HHS to comply with the Privacy Rule.

G.18 RECOVERED FUNDS AND NOTICE OF CLAIM OR SUIT

As stated in B.4.13.4, above, Contractor will make reasonable efforts to recover any claim overpayment made on behalf of the high risk pool program, and further shall use reasonable efforts to recover other overpayments known to Contractor. Such overpayments may include, but are not limited to, duplicative claims payments, payments to an administrator or other subcontractor for services not actually performed or similar circumstances. To the extent such funds are recovered, Contractor will credit

such funds to HHS. At the end of all contract performance periods, and after any necessary reconciliation, any recovered funds will be returned to HHS.

Contractor shall immediately notify HHS of any claim or suit made or filed against Contractor or its subcontractors regarding any matter resulting from or relating to Contractor's obligations under the Agreement, and will cooperate, assist, and consult with HHS in the defense or investigation of any claim, suit, or action made or filed against HHS as a result of or relating to Contractor's performance under this Agreement.

G.19 CENTRAL CONTRACTOR REGISTRATION

The Contractor shall be registered in the CCR database, which requires that:

- (1) The Contractor has entered all mandatory information, including the DUNS number or the DUNS+4 number, into the CCR database; and
- (2) HHS has validated all mandatory data fields, to include validation of the Taxpayer Identification Number (TIN) with the Internal Revenue Service (IRS), and has marked the record "Active". The Contractor will be required to provide consent for TIN validation to HHS as a part of the CCR registration process.
- (3) Although the term "Contractor" is used herein to designate the state high risk pool that is a party to this Agreement for the purpose of implementing Section 1101 of the Affordable Care Act in its home state(s), it is understood that this Agreement is in the nature of an intergovernmental agreement, and that this contract is not subject to the Federal Acquisition Regulation (FAR), except as otherwise specifically referenced herein. Furthermore, as a state entity, or as a state contractor acting pursuant to state law which establishes a high risk pool, it is understood that Contractor handles membership and claims operations pursuant to a contract with a third party administrator (as referenced more particularly in the proposal incorporated herein by reference), which imposes comprehensive requirements pertaining to the third party administrator's qualification to engage in business based on compliance with all applicable state and federal laws, rules, and regulations, including those concerning minority business enterprises, small business utilization, wage and hour laws, workplace safety, and other similar requirements.

G.20 ORGANIZATIONAL CONFLICT OF INTEREST

The contractor shall notify the HHS of all situations involving organizational conflicts of interest. Such conflicts mean that because of other activities or relationships with other persons, a person is unable or potentially unable to render impartial assistance or advice to HHS or the person's objectivity in performing the contract work is or might be impaired, or a person has an unfair competitive advantage.

G.21 WHOLE AGREEMENT

This contract and documents incorporated by reference in whole or in part, constitute the whole agreement of the parties. If any portion of the Agreement is found by a court or administrative forum of competent jurisdiction to be unenforceable, the remainder of the contract remains in full force and effect.

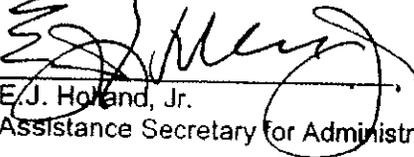
SECTION H – CONTRACT APPROVAL

The following officials are authorized to sign this contract and hereby mutually agree to the Whole Agreement:

For the Contractor:

 July 30, 2010
Date
Ellen F. DeRosa
Executive Director,
New Jersey Individual Health Coverage Program Board

For the Department of Health and Human Services:

 7/30/10
Date
E.J. Holland, Jr.
Assistance Secretary for Administration

CONTRACT TO PARTICIPATE IN NJ PROTECT

This contract is made by and between the New Jersey Individual Health Coverage (IHC) Program Board of Directors (Board) and Horizon Healthcare Services, Inc., dba Horizon Blue Cross Blue Shield of New Jersey (Carrier) on this 30th day of July, 2010 to implement NJ Protect, New Jersey's Pre-Existing Conditions Insurance Coverage, established pursuant to section 1101 of the Federal Patient Protection and Affordable Care Act, Public Law 111-148.

1. The purposes of this contract is to effectuate the provisions of the *Contract to Operate a Qualified High Risk Pool* entered into between the IHC Board and the United States Department of Health and Human Services (HHS), set forth in Appendix 1 of this contract and incorporated herein by reference and made a part of this contract.

2. The terms of the *Contract to Operate a Qualified High Risk Pool* (hereafter, the HHS Contract), refer to the HHS' *Solicitation to States to Operate a Qualified High Risk Pool* (hereafter, the HHS Solicitation), and to the IHC Board's *Response to the Solicitation to States to Operate a Qualified High Risk Pool* (hereafter, IHC Proposal). Accordingly, the HHS Solicitation is included in Appendix 2 to this contract, and the IHC Proposal is included in Appendix 3 of this contract, and both are incorporated herein by reference and are made a part of this contract. Any inconsistency in this contract shall be resolved by giving precedence in the following order:

- a) this contract, or amendments to this contract;
- b) the HHS Contract;
- c) IHC Proposal
- d) HHS Solicitation

3. To effectuate the terms of the HHS Contract, Carrier shall be considered a subcontractor of the HHS Contract, and shall perform the duties delegated to it by this contract consistent with the terms of the HHS contract, except as this contract specifically may state otherwise. In all instances, Carrier shall comply with all applicable laws of the State of New Jersey that govern the Carrier's provision of health coverage in the State of New Jersey generally, and individual health benefits plans specifically, as well as all applicable Federal laws.

4. To effectuate the terms of the HHS Contract, the following duties are delegated to the Carrier for performance by the Carrier in the normal course of its licensed business in New Jersey:

a) Provider access (as set forth in HHS Contract B.4.6). The carrier shall use the same network for the NJ Protect option as is used for the standard IHC plans the NJ Protect Rider amends.

b) Appeals (as set forth in HHS Contract B.4.7). The carrier shall provide the IHC Board with all documentation the applicant provided to carrier when seeking coverage to enable the IHC Board to make an appeal determination regarding eligibility of the applicant. The Carrier shall provide access to its appeals processes consistent with the appeals processes provided for its commercial business.

c) Eligibility determinations and enrollment (as set forth in HHS Contract B.4.8).

i. If the IHC Board enters into an agreement with a vendor that has the capacity to verify one or more of the NJ Protect eligibility criteria (for instance, when prior creditable coverage terminated), the IHC Board and Carrier shall, in consultation with the vendor, develop written procedures for determining eligibility of applicants using the vendor's verification capabilities, and such procedures shall

be incorporated into and become a part of this contract.

ii. If the IHC Board enters into an arrangement with another government program for the purpose of verifying one or more of the NJ Protect eligibility criteria (for instance, citizenship, national or legal alien status), the IHC Board and the Carrier shall develop written protocols for use of the government verification program consistent with the government program's terms of use, and such protocols shall be incorporated into and become a part of this contract.

iii. Carrier shall not be responsible for determining enrollment capacity for the State of New Jersey, nor shall Carrier be responsible for obtaining approval from HHS for procedures to discontinue enrollment, establish a waiting list or other actions necessary to avoid over-enrollment in NJ Protect, because this function shall remain that of the IHC Board. Nevertheless, the IHC Board will consult with the Carrier in the evaluation of enrollment capacity and the development of procedures to limit enrollment and Carrier shall cooperate in implementing enrollment limitation procedures that may be established by the IHC Board and approved by HHS.

d) Customer service (as set forth in HHS Contract B.4.9). The Carrier shall provide customer service consistent with the customer service provided for its commercial business. The Carrier shall specifically issue its IHC standard policy forms for the plan option(s) identified in the IHC Proposal with the NJ Protect Rider developed by the IHC Board as included in the IHC Proposal.

e) Technical support (as set forth in HHS Contract B.4.10).

f) Premium administration (as set forth in HHS Contract B.4.11).

- g) Utilization management (as set forth in HHS Contract B.4.12). The Carrier shall provide utilization management services consistent with the utilization management services provided for its commercial business.
- h) Claims payment (as set forth in HHS Contract B.4.13 and G.18). With respect to B.4.13.2 and B.4.13.3, Carrier shall comply with the existing internal standards it has established for its commercial business, so long as such standards are consistent with New Jersey law. With respect to claims not paid within the 30 or 40 day period referenced in item 2 of HHS Contract B.4.13, any interest payable shall not be eligible for reimbursement as a claim or as an administrative cost. Carrier shall follow its current recovery procedures that carrier follows with respect to its commercial business.
- i) Anti-dumping procedures (as set forth in HHS Contract B.4.15). However, Carrier shall track and report the responses to employment and prior coverage questions set forth on the Supplemental NJ Protect Application Form to the IHC Board, which shall otherwise be responsible for communicating with HHS on this matter.
- j) Detection and avoidance of fraud, waste and abuse (as set forth in HHS Contract B.4.16). The Carrier shall utilize the Special Investigation Unit and its fraud programs consistent with its commercial business.
- k) Compliance Program (as set forth in HHS Contract B.4.17). Carrier will include NJ Protect under Carrier's Compliance Program and the applicability of that Program shall be consistent with its applicability to Carrier's commercial business.
- l) Coordination of benefits (as set forth in HHS Contract B.4.18), to wit: the Carrier shall not coordinate benefits for NJ Protect.
- m) Retention of records that the Carrier or its subcontractors create, collect or maintain while participating in NJ Protect for at least six years following termination. This retention

period may be extended by HHS if the records relate to an ongoing investigation, litigation or negotiation by the Secretary of HHS, the Office of the Inspector General, the Department of Justice or a State, or such documents otherwise relate to suspicions of fraud and abuse or violations of Federal or State law.

n) HIPAA Provisions (as set forth in HHS Contract G. 17)

5. In addition, the Carrier shall provide the reports and/or data listed below to the IHC Board in the timeframes specified. The Carrier shall submit reports electronically in a format mutually agreed upon between the IHC Board and the Carrier.

a) As frequently as weekly, but not less than monthly (by the 15th of the month, or the immediately following business day, if the 15th occurs on the weekend or a government holiday), the Carrier shall submit a Statement of Costs indicating:

- 1) The contract line item number;
- 2) The administrative expenses of the Carrier;
- 3) The number of high risk pool program enrollees and the claims paid on behalf of high risk pool enrollees;
- 4) The amount of premiums billed and the amount of premiums collected.

b) The Carrier shall submit the following information on a monthly basis, no later than the 15th of the month (or the immediately following business day if the 15th occurs on the weekend or a government holiday), with the report encompassing information for the immediately preceding month:

- 1) Medical claims paid on behalf of high risk pool enrollees;
- 2) Prescription drug claims paid on behalf of high risk pool enrollees;
- 3) Estimated claims incurred but not reported;
- 4) The number of high risk pool program enrollees;

- 5) the number of new enrollments and disenrollments;
 - 6) average out-of-pocket costs for enrollees.
- c) The Carrier shall include the following information in the third monthly report of each quarter:
- 1) A description of the enrollment into the high risk pool program, at least broken down geographically and demographically to describe whether the enrollees in the program are representative of the eligible individuals in the State;
 - 2) The reasons for disenrollments, if known;
 - 3) The average length of enrollment in the program;
 - 4) A breakdown of how enrollees satisfied the pre-existing condition requirement;
- and
- 5) In the first quarter of each year, updated annual cost projections, based on actual expenditures and enrollment.
- d) No later than March 1 of the year following each completed calendar year, the Carrier shall provide an annual reconciliation to the IHC Board setting forth the difference between premiums the Carrier has collected plus Federal payments it has received under this contract and claims plus allowable administrative expenses. To the extent the Carrier has received an excess of payments, the payments will be credited or returned to HHS through the IHC Board. To the extent the Carrier identifies any underpayment for administrative costs, it will indicate such amount to the IHC Board, which will bill to, and receive from HHS such underpayments subject to the limitations of the appropriation in Section 1101 of the Affordable Care Act and the estimated cost provisions of this Contract, and remit such underpayment to the Carrier.

6. The IHC Board shall be responsible for submitting requests for funds to HHS to reimburse Carrier for claims for covered services and for administrative expenses that are in excess of the premiums collected by the Carrier.

a) The Carrier agrees to use its best efforts, in consultation with the IHC Board, to limit the amount of anticipated expenses to the amounts identified in the IHC Proposal or this contract or any modification thereto, for the Carrier's operation of NJ Protect. Carrier shall not be entitled to payment of a fee or profit for performing this contract.

b) Remittance of payment to the Carrier by the IHC Board shall be through a mutually agreeable process. The IHC Board shall remit payment to the Carrier within no more than three business days following the date that the IHC Board receives funds from HHS for claims and/or administrative expenses submitted to HHS by the IHC Board on behalf of the Carrier.

c) The Carrier agrees to specifically account for all funds associated with NJ Protect using established processes to capture the information in its general ledger, consistent with item 2 of G.4 of the HHS Contract.

7. The Carrier shall make its books and records relating to NJ Protect available to the IHC Board for an annual audit as required by HHS Contract provision D.2.5 and G.3.

8. In the event an action is brought against the Carrier with respect to its participation in NJ Protect in any court or administrative forum regarding the operation or performance of this contract, the Carrier shall immediately notify the IHC Board and provide a copy of the complaint and summons or other documentation to the IHC Board, if the IHC Board is not also named in the action. The IHC Board shall communicate the information to HHS. The terms of C.2(c)3 and 4 of the HHS Contract shall then apply. The IHC Board shall promptly

notify the Carrier in writing of HHS' decision whether to intervene or otherwise defend the action brought against NJ Protect. The Carrier shall provide information and support to assist HHS in defending any such action as requested by HHS.

9. The term of this contract shall be from the date of execution through the expiration of the HHS Contract with the IHC Board.

10. Termination of this contract shall be controlled by G.6 of the HHS Contract. References therein to Contractor (which is the IHC Board) may be read to apply equally to the Contractor's subcontractor, which is the Carrier, except that Carrier shall not have the right to terminate the HHS Contract. In addition, should HHS cease to perform its obligations under the HHS contract, including if it ceases to provide funding for any reason, or if the IHC Board fails to perform its obligations under this Contract, including remittance of funding from HHS, the Carrier shall have no further obligations under this contract. It is agreed that procedures to be followed in connection with any such cessation of performance or funding or with a termination shall be developed by the carrier and the IHC Board.

11. Definitions of terms used in this contract shall be the same as the definitions used in the HHS Contract. In addition, references in the HHS Contract to qualified high risk pool or high risk pool shall mean NJ Protect.

12. Carrier agrees to the Standard Terms and Conditions as set forth below.

A. Source Disclosure Certification

Execution of this contract will confirm that carrier agrees, in accordance with Executive Order 129 (McGreevey) and N.J.S.A. 52:34-13.2 (P.L. 2005, c. 92), that all services performed for the contract shall be performed within the United States. In the event that all services performed for the contract shall NOT be

performed within the United States, the Carrier shall send the IHC Board a letter that states with specificity the reasons why the services cannot be so performed. The letter shall require review and approval pursuant to N.J.S.A. 52:34-14.2 prior to execution of this contract.

B. New Jersey Business Registration

Pursuant to N.J.S.A. 52:32-44(b), Carrier has copy of a valid New Jersey Business Registration as of the time of execution of this contract.

C. Notice of Set-off for State Taxes

Pursuant to P.L. 1995, c159, effective January 1, 1996, (codified at N.J.S.A. 54:49-19 et seq.), and notwithstanding the provision of any other law to the contrary, whenever any taxpayer, partnership or S corporation under contract to provide goods or services or construction projects to the State of New Jersey or its agencies or instrumentalities, including the legislative and judicial branches of State government, is entitled to payment for those goods or services at the same time a taxpayer, partner or shareholder of that entity is indebted for any State tax, the Director of the Division of Taxation shall seek to set off so much of that payment as shall be necessary to satisfy the indebtedness. The amount set-off shall not allow for the deduction of any expense or other deduction which might be attributable to the taxpayer, partner, or shareholder subject to set-off under this Act.

The Director of the Division of Taxation shall give notice of the set-off to the taxpayer, partner or shareholder and provide an opportunity for a hearing within thirty (30) days of such notice under the procedures for protests established under

N.J.S.A. 54:49-19. No request for conference, protest, or subsequent appeal to the Tax Court from any protest shall stay the collection of the indebtedness.

D. New Jersey Conflict of Interest Law

The New Jersey Conflict of Interest Law, N.J.S.A. 52:13D-12 et seq. and Executive Order 189 (Kean), prohibit certain actions by persons or entities which provide goods or services to any State Agency. Specifically:

- I. The Carrier shall not pay, offer to pay, or agree to pay, either directly or indirectly, any fee, commission, compensation, gift, gratuity, or other thing of value of any kind to any State officer or employee or special State officer or employee, as defined by N.J.S.A. 52:13D-13b. and e., in the Department of the Treasury or any other agency with which the Carrier transacts or offers or proposes to transact business, or to any member of the immediate family, as defined by N.J.S.A. 52:13D-13i., of any such officer or employee, or any partnership, firm, or corporation with which they are employed or associated, or in which such officer or employee has an interest within the meaning of N.J.S.A. 52:13D-13g.
- II. The solicitation of any fee, commission, compensation, gift, gratuity or other thing of value by any State officer or employee or special State officer or employee from the carrier shall be reported in writing forthwith to the Ethics Liaison of the Department of Banking and Insurance and the State Ethics Commission.
- III. The Carrier may not, directly or indirectly, undertake any private business, commercial or entrepreneurial relationship with, whether or not pursuant

to employment, contract or other agreement, express or implied, or sell any interest in the carrier to, any State officer or employee or special State officer or employee having any duties or responsibilities in connection with the purchase, acquisition or sale of any property or services by or to any State agency or any instrumentality thereof, or with any person, firm or entity with which he is employed or associated or in which he has an interest within the meaning of N.J.S.A. 52:13D-13g. Any relationships subject to this provision shall be reported in writing forthwith to the State Ethics Commission, which may grant a waiver of this restriction upon application of the State officer or employee or special State officer or employee upon a finding that the present or proposed relationship does not present the potential, actuality or appearance of a conflict of interest.

- IV. The Carrier shall not influence, or attempt to influence or cause to be influenced, any State officer or employee or special State officer or employee in his official capacity in any manner which might tend to impair the objectivity or independence of judgment of said officer or employee.
- V. The Carrier shall not cause or influence, or attempt to cause or influence, any State officer or employee or special State officer or employee to use, or attempt to use, his official position to secure unwarranted privileges or advantages for the carrier or any other person.
- VI. The provisions cited above in paragraph D(I) through D(V) shall not be construed to prohibit a State officer or employee or special State officer or

employee from receiving gifts from or contracting with the carrier under the same terms and conditions as are offered or made available to members of the general public subject to any guidelines the State Ethics Commission may promulgate.

13. Correspondence between the Carrier and the IHC Board shall be deemed valid if made as in accordance with the instructions below. It is the responsibility of each party to promptly notify the other of any changes in the process or personnel to whom correspondence should be sent.

a) For submission of electronic reports to the IHC Board, including Statements of Cost:

Rosaria Lenox at Rosaria.Lenox@dobi.state.nj.us

b) For remittance of payments or return of overpayments:

1) To the Carrier:

To be determined

2) To the IHC Board:

Rosaria Lenox, Program Accountant

c) All other correspondence:

1) To the Carrier:

To be determined.

2) To the IHC Board:

Ellen DeRosa, Executive Director

14. This contract and documents incorporated by reference in whole or in part, constitute the whole agreement of the parties. If any portion of this whole agreement is found by

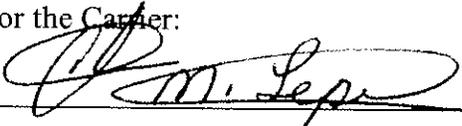
a court or administrative forum of competent jurisdiction to be unenforceable, the remainder of the contract remains in full force and effect.

15. Neither party shall be responsible for any delay or failure in performance caused by flood, riot, insurrection, fire, earthquake, explosion, or act of God, or any other force or unanticipated cause similarly beyond the control of the party claiming the protection of this clause.

16. The signatories to this contract, being employed by and having the titles as specified herein, are authorized to act on behalf of their respective employers to bind the parties to the terms of this whole agreement.

For the Carrier:





Christopher M. Lepre
Senior Vice President MBU
Horizon Healthcare Services, Inc.

7-30-2010
Date

For the IHC Board:



Ellen DeRosa
Executive Director
Individual Health Coverage Program

July 30, 2010
Date

CONTRACT TO PARTICIPATE IN NJ PROTECT

This contract is made by and between the New Jersey Individual Health Coverage (IHC) Program Board of Directors (Board) and Horizon Healthcare Services, Inc., dba Horizon Blue Cross Blue Shield of New Jersey (Carrier) on this 30th day of July, 2010 to implement NJ Protect, New Jersey's Pre-Existing Conditions Insurance Coverage, established pursuant to section 1101 of the Federal Patient Protection and Affordable Care Act, Public Law 111-148.

1. The purposes of this contract is to effectuate the provisions of the *Contract to Operate a Qualified High Risk Pool* entered into between the IHC Board and the United States Department of Health and Human Services (HHS), set forth in Appendix 1 of this contract and incorporated herein by reference and made a part of this contract.

2. The terms of the *Contract to Operate a Qualified High Risk Pool* (hereafter, the HHS Contract), refer to the HHS' *Solicitation to States to Operate a Qualified High Risk Pool* (hereafter, the HHS Solicitation), and to the IHC Board's *Response to the Solicitation to States to Operate a Qualified High Risk Pool* (hereafter, IHC Proposal). Accordingly, the HHS Solicitation is included in Appendix 2 to this contract, and the IHC Proposal is included in Appendix 3 of this contract, and both are incorporated herein by reference and are made a part of this contract. Any inconsistency in this contract shall be resolved by giving precedence in the following order:

- a) this contract, or amendments to this contract;
- b) the HHS Contract;
- c) IHC Proposal
- d) HHS Solicitation

3. To effectuate the terms of the HHS Contract, Carrier shall be considered a subcontractor of the HHS Contract, and shall perform the duties delegated to it by this contract consistent with the terms of the HHS contract, except as this contract specifically may state otherwise. In all instances, Carrier shall comply with all applicable laws of the State of New Jersey that govern the Carrier's provision of health coverage in the State of New Jersey generally, and individual health benefits plans specifically, as well as all applicable Federal laws.

4. To effectuate the terms of the HHS Contract, the following duties are delegated to the Carrier for performance by the Carrier in the normal course of its licensed business in New Jersey:

- a) Provider access (as set forth in HHS Contract B.4.6). The carrier shall use the same network for the NJ Protect option as is used for the standard IHC plans the NJ Protect Rider amends.
- b) Appeals (as set forth in HHS Contract B.4.7). The carrier shall provide the IHC Board with all documentation the applicant provided to carrier when seeking coverage to enable the IHC Board to make an appeal determination regarding eligibility of the applicant. The Carrier shall provide access to its appeals processes consistent with the appeals processes provided for its commercial business.
- c) Eligibility determinations and enrollment (as set forth in HHS Contract B.4.8).
 - i. If the IHC Board enters into an agreement with a vendor that has the capacity to verify one or more of the NJ Protect eligibility criteria (for instance, when prior creditable coverage terminated), the IHC Board and Carrier shall, in consultation with the vendor, develop written procedures for determining eligibility of applicants using the vendor's verification capabilities, and such procedures shall

be incorporated into and become a part of this contract.

ii. If the IHC Board enters into an arrangement with another government program for the purpose of verifying one or more of the NJ Protect eligibility criteria (for instance, citizenship, national or legal alien status), the IHC Board and the Carrier shall develop written protocols for use of the government verification program consistent with the government program's terms of use, and such protocols shall be incorporated into and become a part of this contract.

iii. Carrier shall not be responsible for determining enrollment capacity for the State of New Jersey, nor shall Carrier be responsible for obtaining approval from HHS for procedures to discontinue enrollment, establish a waiting list or other actions necessary to avoid over-enrollment in NJ Protect, because this function shall remain that of the IHC Board. Nevertheless, the IHC Board will consult with the Carrier in the evaluation of enrollment capacity and the development of procedures to limit enrollment and Carrier shall cooperate in implementing enrollment limitation procedures that may be established by the IHC Board and approved by HHS.

d) Customer service (as set forth in HHS Contract B.4.9). The Carrier shall provide customer service consistent with the customer service provided for its commercial business. The Carrier shall specifically issue its IHC standard policy forms for the plan option(s) identified in the IHC Proposal with the NJ Protect Rider developed by the IHC Board as included in the IHC Proposal.

e) Technical support (as set forth in HHS Contract B.4.10).

f) Premium administration (as set forth in HHS Contract B.4.11).

- g) Utilization management (as set forth in HHS Contract B.4.12). The Carrier shall provide utilization management services consistent with the utilization management services provided for its commercial business.
- h) Claims payment (as set forth in HHS Contract B.4.13 and G.18). With respect to B.4.13.2 and B.4.13.3, Carrier shall comply with the existing internal standards it has established for its commercial business, so long as such standards are consistent with New Jersey law. With respect to claims not paid within the 30 or 40 day period referenced in item 2 of HHS Contract B.4.13, any interest payable shall not be eligible for reimbursement as a claim or as an administrative cost. Carrier shall follow its current recovery procedures that carrier follows with respect to its commercial business.
- i) Anti-dumping procedures (as set forth in HHS Contract B.4.15). However, Carrier shall track and report the responses to employment and prior coverage questions set forth on the Supplemental NJ Protect Application Form to the IHC Board, which shall otherwise be responsible for communicating with HHS on this matter.
- j) Detection and avoidance of fraud, waste and abuse (as set forth in HHS Contract B.4.16). The Carrier shall utilize the Special Investigation Unit and its fraud programs consistent with its commercial business.
- k) Compliance Program (as set forth in HHS Contract B.4.17). Carrier will include NJ Protect under Carrier's Compliance Program and the applicability of that Program shall be consistent with its applicability to Carrier's commercial business.
- l) Coordination of benefits (as set forth in HHS Contract B.4.18), to wit: the Carrier shall not coordinate benefits for NJ Protect.
- m) Retention of records that the Carrier or its subcontractors create, collect or maintain while participating in NJ Protect for at least six years following termination. This retention

period may be extended by HHS if the records relate to an ongoing investigation, litigation or negotiation by the Secretary of HHS, the Office of the Inspector General, the Department of Justice or a State, or such documents otherwise relate to suspicions of fraud and abuse or violations of Federal or State law.

n) HIPAA Provisions (as set forth in HHS Contract G. 17)

5. In addition, the Carrier shall provide the reports and/or data listed below to the IHC Board in the timeframes specified. The Carrier shall submit reports electronically in a format mutually agreed upon between the IHC Board and the Carrier.

a) As frequently as weekly, but not less than monthly (by the 15th of the month, or the immediately following business day, if the 15th occurs on the weekend or a government holiday), the Carrier shall submit a Statement of Costs indicating:

- 1) The contract line item number;
- 2) The administrative expenses of the Carrier;
- 3) The number of high risk pool program enrollees and the claims paid on behalf of high risk pool enrollees;
- 4) The amount of premiums billed and the amount of premiums collected.

b) The Carrier shall submit the following information on a monthly basis, no later than the 15th of the month (or the immediately following business day if the 15th occurs on the weekend or a government holiday), with the report encompassing information for the immediately preceding month:

- 1) Medical claims paid on behalf of high risk pool enrollees;
- 2) Prescription drug claims paid on behalf of high risk pool enrollees;
- 3) Estimated claims incurred but not reported;
- 4) The number of high risk pool program enrollees;

- 5) the number of new enrollments and disenrollments;
 - 6) average out-of-pocket costs for enrollees.
- c) The Carrier shall include the following information in the third monthly report of each quarter:
- 1) A description of the enrollment into the high risk pool program, at least broken down geographically and demographically to describe whether the enrollees in the program are representative of the eligible individuals in the State;
 - 2) The reasons for disenrollments, if known;
 - 3) The average length of enrollment in the program;
 - 4) A breakdown of how enrollees satisfied the pre-existing condition requirement;
and
 - 5) In the first quarter of each year, updated annual cost projections, based on actual expenditures and enrollment.
- d) No later than March 1 of the year following each completed calendar year, the Carrier shall provide an annual reconciliation to the IHC Board setting forth the difference between premiums the Carrier has collected plus Federal payments it has received under this contract and claims plus allowable administrative expenses. To the extent the Carrier has received an excess of payments, the payments will be credited or returned to HHS through the IHC Board. To the extent the Carrier identifies any underpayment for administrative costs, it will indicate such amount to the IHC Board, which will bill to, and receive from HHS such underpayments subject to the limitations of the appropriation in Section 1101 of the Affordable Care Act and the estimated cost provisions of this Contract, and remit such underpayment to the Carrier.

6. The IHC Board shall be responsible for submitting requests for funds to HHS to reimburse Carrier for claims for covered services and for administrative expenses that are in excess of the premiums collected by the Carrier.

a) The Carrier agrees to use its best efforts, in consultation with the IHC Board, to limit the amount of anticipated expenses to the amounts identified in the IHC Proposal or this contract or any modification thereto, for the Carrier's operation of NJ Protect. Carrier shall not be entitled to payment of a fee or profit for performing this contract.

b) Remittance of payment to the Carrier by the IHC Board shall be through a mutually agreeable process. The IHC Board shall remit payment to the Carrier within no more than three business days following the date that the IHC Board receives funds from HHS for claims and/or administrative expenses submitted to HHS by the IHC Board on behalf of the Carrier.

c) The Carrier agrees to specifically account for all funds associated with NJ Protect using established processes to capture the information in its general ledger, consistent with item 2 of G.4 of the HHS Contract.

7. The Carrier shall make its books and records relating to NJ Protect available to the IHC Board for an annual audit as required by HHS Contract provision D.2.5 and G.3.

8. In the event an action is brought against the Carrier with respect to its participation in NJ Protect in any court or administrative forum regarding the operation or performance of this contract, the Carrier shall immediately notify the IHC Board and provide a copy of the complaint and summons or other documentation to the IHC Board, if the IHC Board is not also named in the action. The IHC Board shall communicate the information to HHS. The terms of C.2(c)3 and 4 of the HHS Contract shall then apply. The IHC Board shall promptly

notify the Carrier in writing of HHS' decision whether to intervene or otherwise defend the action brought against NJ Protect. The Carrier shall provide information and support to assist HHS in defending any such action as requested by HHS.

9. The term of this contract shall be from the date of execution through the expiration of the HHS Contract with the IHC Board.

10. Termination of this contract shall be controlled by G.6 of the HHS Contract. References therein to Contractor (which is the IHC Board) may be read to apply equally to the Contractor's subcontractor, which is the Carrier, except that Carrier shall not have the right to terminate the HHS Contract. In addition, should HHS cease to perform its obligations under the HHS contract, including if it ceases to provide funding for any reason, or if the IHC Board fails to perform its obligations under this Contract, including remittance of funding from HHS, the Carrier shall have no further obligations under this contract. It is agreed that procedures to be followed in connection with any such cessation of performance or funding or with a termination shall be developed by the carrier and the IHC Board.

11. Definitions of terms used in this contract shall be the same as the definitions used in the HHS Contract. In addition, references in the HHS Contract to qualified high risk pool or high risk pool shall mean NJ Protect.

12. Carrier agrees to the Standard Terms and Conditions as set forth below.

A. Source Disclosure Certification

Execution of this contract will confirm that carrier agrees, in accordance with Executive Order 129 (McGreevey) and N.J.S.A. 52:34-13.2 (P.L. 2005, c. 92), that all services performed for the contract shall be performed within the United States. In the event that all services performed for the contract shall NOT be

performed within the United States, the Carrier shall send the IHC Board a letter that states with specificity the reasons why the services cannot be so performed. The letter shall require review and approval pursuant to N.J.S.A. 52:34-14.2 prior to execution of this contract.

B. New Jersey Business Registration

Pursuant to N.J.S.A. 52:32-44(b), Carrier has copy of a valid New Jersey Business Registration as of the time of execution of this contract.

C. Notice of Set-off for State Taxes

Pursuant to P.L. 1995, c159, effective January 1, 1996, (codified at N.J.S.A. 54:49-19 et seq.), and notwithstanding the provision of any other law to the contrary, whenever any taxpayer, partnership or S corporation under contract to provide goods or services or construction projects to the State of New Jersey or its agencies or instrumentalities, including the legislative and judicial branches of State government, is entitled to payment for those goods or services at the same time a taxpayer, partner or shareholder of that entity is indebted for any State tax, the Director of the Division of Taxation shall seek to set off so much of that payment as shall be necessary to satisfy the indebtedness. The amount set-off shall not allow for the deduction of any expense or other deduction which might be attributable to the taxpayer, partner, or shareholder subject to set-off under this Act.

The Director of the Division of Taxation shall give notice of the set-off to the taxpayer, partner or shareholder and provide an opportunity for a hearing within thirty (30) days of such notice under the procedures for protests established under

N.J.S.A. 54:49-19. No request for conference, protest, or subsequent appeal to the Tax Court from any protest shall stay the collection of the indebtedness.

D. New Jersey Conflict of Interest Law

The New Jersey Conflict of Interest Law, N.J.S.A. 52:13D-12 et seq. and Executive Order 189 (Kean), prohibit certain actions by persons or entities which provide goods or services to any State Agency. Specifically:

- I. The Carrier shall not pay, offer to pay, or agree to pay, either directly or indirectly, any fee, commission, compensation, gift, gratuity, or other thing of value of any kind to any State officer or employee or special State officer or employee, as defined by N.J.S.A. 52:13D-13b. and e., in the Department of the Treasury or any other agency with which the Carrier transacts or offers or proposes to transact business, or to any member of the immediate family, as defined by N.J.S.A. 52:13D-13i., of any such officer or employee, or any partnership, firm, or corporation with which they are employed or associated, or in which such officer or employee has an interest within the meaning of N.J.S.A. 52:13D-13g.
- II. The solicitation of any fee, commission, compensation, gift, gratuity or other thing of value by any State officer or employee or special State officer or employee from the carrier shall be reported in writing forthwith to the Ethics Liaison of the Department of Banking and Insurance and the State Ethics Commission.
- III. The Carrier may not, directly or indirectly, undertake any private business, commercial or entrepreneurial relationship with, whether or not pursuant

to employment, contract or other agreement, express or implied, or sell any interest in the carrier to, any State officer or employee or special State officer or employee having any duties or responsibilities in connection with the purchase, acquisition or sale of any property or services by or to any State agency or any instrumentality thereof, or with any person, firm or entity with which he is employed or associated or in which he has an interest within the meaning of N.J.S.A. 52:13D-13g. Any relationships subject to this provision shall be reported in writing forthwith to the State Ethics Commission, which may grant a waiver of this restriction upon application of the State officer or employee or special State officer or employee upon a finding that the present or proposed relationship does not present the potential, actuality or appearance of a conflict of interest.

- IV. The Carrier shall not influence, or attempt to influence or cause to be influenced, any State officer or employee or special State officer or employee in his official capacity in any manner which might tend to impair the objectivity or independence of judgment of said officer or employee.
- V. The Carrier shall not cause or influence, or attempt to cause or influence, any State officer or employee or special State officer or employee to use, or attempt to use, his official position to secure unwarranted privileges or advantages for the carrier or any other person.
- VI. The provisions cited above in paragraph D(I) through D(V) shall not be construed to prohibit a State officer or employee or special State officer or

employee from receiving gifts from or contracting with the carrier under the same terms and conditions as are offered or made available to members of the general public subject to any guidelines the State Ethics Commission may promulgate.

13. Correspondence between the Carrier and the IHC Board shall be deemed valid if made as in accordance with the instructions below. It is the responsibility of each party to promptly notify the other of any changes in the process or personnel to whom correspondence should be sent.

a) For submission of electronic reports to the IHC Board, including Statements of Cost:

Rosaria Lenox at Rosaria.Lenox@dobi.state.nj.us

b) For remittance of payments or return of overpayments:

1) To the Carrier:

To be determined

2) To the IHC Board:

Rosaria Lenox, Program Accountant

c) All other correspondence:

1) To the Carrier:

To be determined.

2) To the IHC Board:

Ellen DeRosa, Executive Director

14. This contract and documents incorporated by reference in whole or in part, constitute the whole agreement of the parties. If any portion of this whole agreement is found by

a court or administrative forum of competent jurisdiction to be unenforceable, the remainder of the contract remains in full force and effect.

15. Neither party shall be responsible for any delay or failure in performance caused by flood, riot, insurrection, fire, earthquake, explosion, or act of God, or any other force or unanticipated cause similarly beyond the control of the party claiming the protection of this clause.

16. The signatories to this contract, being employed by and having the titles as specified herein, are authorized to act on behalf of their respective employers to bind the parties to the terms of this whole agreement.

For the Carrier:



Christopher M. Lepre

7-30-2010
Date

Christopher M. Lepre
Senior Vice President MBU
Horizon Healthcare Services, Inc.

For the IHC Board:

Ellen DeRosa

July 30, 2010
Date

Ellen DeRosa
Executive Director
Individual Health Coverage Program



Guide to States for Reporting Pre-Existing Condition Insurance Plan Data to Health and Human Services

OMB Control: 0938-1100

This guide references the excel spreadsheet template (file name: State PCIP Monthly Report.xls) that states will be asked to complete each month as required by sections C.3, D.2 and E2 of the PCIP contracts. Please e-mail completed forms to your HHS state account manager and direct questions regarding completion instructions to shana.montrose@hhs.gov.

General Instructions	Please use N/A rather than 0 to indicate that a certain measure does not apply to the program in your particular state. Use 0 only to indicate the numerical count for the applicable field. For example, if your state does not use a condition list for meeting the pre-existing condition requirement enter "N/A". If your state does use a condition list but no one was determined eligible on the basis of such list, enter "0" on sheet 2 in column U, enrollment eligibility code 4.	
Deadlines	As stipulated by the contract, monthly reports are due on the last business day of the month (see column D) following the reporting period (see column C). The first report is due 3 months after the contract was signed (that is, by the end of October for a contract signed in July.)	
Sheet 1: Applications		
Column	Name	Instruction
E	Total applications received since inception	Please include all applications received, since your program started accepting applications, regardless of whether these were accepted, denied or pending. If an individual supplies additional information while the application is pending, do not double count that person. However, if an individual is disenrolled, waits the period required by your state to reapply and submits a new application then count that person twice.
F	Total applications	Please report here only new applications received during the reporting period identified in column C, regardless of

	received this period	the prospective enrollment date.
G/H	Denial totals	Self-explanatory
I	Denial code 1	Indicate the number of individuals who were found ineligible on the basis of not meeting the citizenship, national status, or lawful presence requirement.
J	Denial code 2	Indicate the number of individuals who were found ineligible on the basis of not meeting the residency requirement.
K	Denial code 3	Indicate the number of individuals who were found ineligible on the basis of not meeting the pre-existing condition requirement. See sheet 2, columns R, S, T and U for eligibility codes.
L	Denial code 4	Indicate the number of individuals who were found ineligible on the basis of not meeting the six-month period without creditable coverage requirement.
M	Denial code 5	Indicate the number of individuals for which fraud was suspected and the individual was denied as a result. If fraud is suspected please provide a paragraph explaining reasons for suspicion and actions taken in the e-mail to which the excel form is attached.
N	Denial code 6	Indicate the number of applications that were incomplete and were eventually denied or cancelled as a result of failure to complete. In the case where more information was requested, count these applications as pending in sheet 1 column U or V, as appropriate.
O	Denial code 7	Indicate other applications that were denied for reasons not listed above here.
P/Q	Eligibility appeals submitted	Indicate the number of individuals who submit an appeal of an eligibility determination. Do not double count more than one appeal submitted by the same individual.
R	Eligibility appeals adjudicated in favor of applicant accepted this period	Indicate the number of appeals related to denials of eligibility that were adjudicated in favor of the applicant. Count appeals that are denied as "denials" with the corresponding denial code in sheet 1 columns I-O.
S	Total appeals denied this period	Self-explanatory
T	Total pending appeals this period	Self-explanatory
U/V	Pending	Include in these column the number of applications that are pending for the following reasons: a) applications are on

		hold until more information is submitted and verified and b) applications are approved but not yet activated because initial premium payment has yet to be received (not to be confused with column W).
W	Total approved applications not activated due to non-payment of initial premium	Include in this column the number of applications that were approved but were never activated based on non-receipt of initial premium payment. The amount of time allowed to provide payment will vary by state. If your state enrolls individuals before payment is received enter N/A in this column and use column AD on sheet 2 (disenrollment code 3) to report the number of individuals who were disenrolled due to non-payment of premium.

Sheet 2: Enrollment

Column	Name	Instruction
C	Reporting Period	The month in column C indicates the reporting period, such that numbers entered in subsequent columns reflect individuals who are newly enrolled for coverage effective during the month indicated by this column . Individuals are defined as enrolled provided that they have applied and been determined eligible for PCIP coverage and will have a coverage in effect for that period. Similarly, individuals are defined as newly disenrolled if their coverage is no longer effective.
E	Total ever enrolled since inception	This is the total number of unique individuals who have ever been enrolled at any point (see definition of enrollment above as described for column C) since the inception of the PCIP program. Do not subtract disenrollment from this number.
F	Total newly enrolled this period	See instruction for column C.
G	Total enrolled this period	This is the number of total enrolled since inception, minus the number of people who were disenrolled, to reflect the number of people covered with PCIP in your state.
H/I	Male/Female	The numbers in column H + I should equal the number in column F.
J, K, L, M, N	Age	Please enter the age of the newly enrolled individual at the time of application. The numbers in column J, K, L, M, N should equal the number in column F.
O,P,Q	Plan 1, 2, 3	If your state only offers one plan, write N/A in cell O4. If your state offers multiple plans, write the name of the plans in O3, O4 and O5. Include the deductible for each plan in parenthesis after the name. The numbers in columns O, P and Q should equal the number in column F.

R	Enrollment eligibility code 1	The number of individuals who are enrolled on the basis of having provided a letter from an insurance company, agent or broker that shows evidence of a refusal of coverage (such as a denial letter from an insurance company) .
S	Enrollment eligibility code 2	The number of individuals who are enrolled on the basis of having provided evidence of an offer of coverage with a rider .
T	Enrollment eligibility code 3	The number of individuals who are enrolled on the basis of having provided evidence of an excessive premium (as determined by your PCIP).
U	Enrollment eligibility code 4	The number of individuals who are enrolled on the basis of having provided evidence of a diagnosis of a condition that is on your state's condition list . If your state does not use a condition list, simply enter N/A in column U.
NOTE	R+S+T+U=F	Please make sure that no individual is counted more than once. Where more than one reason code applies, count the individual in the first relevant code. For example, if someone is eligible under reason codes 2 and 4, count that person only under reason 2.
V, W, X, Y, Z, AA	Enrollment duration	In these columns enter the number of individuals who have been enrolled in the program for the duration specified in row 3. Note that the enrollment duration numbers should add up to the total number of enrollments reported under column E .
AB	Disenrollment code 1	In this column enter the number of individuals who were newly disenrolled on the basis of having voluntarily disenrolled from the program for reasons other than those listed below.
AC	Disenrollment code 2	In this column enter the number of individuals who were newly disenrolled due to death .
AD	Disenrollment code 3	In this column enter the number of individuals who were newly disenrolled due to nonpayment of premium . Do not include individuals who have yet to exhaust their grace period, as determined by your state. Use sheet 1, column W (non-activation) to indicate the number of individuals who were eligible, but were never enrolled due to failure to submit the first premium payment.
AE	Disenrollment code 4	In this column enter the number of individuals who were newly disenrolled due to obtaining other creditable coverage .
AF	Disenrollment code 5	In this column enter the number of individuals who were newly disenrolled because he/she moved out of the service area (no longer a resident in your state).
AG	Disenrollment code 6	In this column enter the number of individuals who were newly disenrolled due to material misrepresentation or fraud . If fraud is suspected please provide a paragraph

		explaining reasons for suspicion and actions taken in the e-mail to which the excel form is attached.
AH	Disenrollment code 7	In this column enter the number of individuals who were newly disenrolled for reasons not listed above . One example might include loss of legal residency due to visa expiration.
AI	Disenrollment code 8	In this column enter the number of individuals who were newly disenrolled because they did not respond to a request for information such as change of address, enrollment renewal, or updates to legal status to remain in the U.S. For example, a student who's visa has expired may need to submit new information.
NOTE	AB + AC + AD + AE + AF + AG + AH + AI = F	Please make sure that no individual is counted more than once. Where more than one reason code applies, count the individual in the first relevant code. For example, if someone is disenrolled under reason codes 3 and 4, count that person under reason 3.
Sheet 3: Zip codes		
Column	Name	Instruction
Sheet 3	Zip codes	Please use the columns in this worksheet to reflect all zip codes in which an enrollee resides. in row 3 of the second tab in the excel workbook. Under each zip code column, report the number of enrollees whose enrollment takes effect for the applicable month.