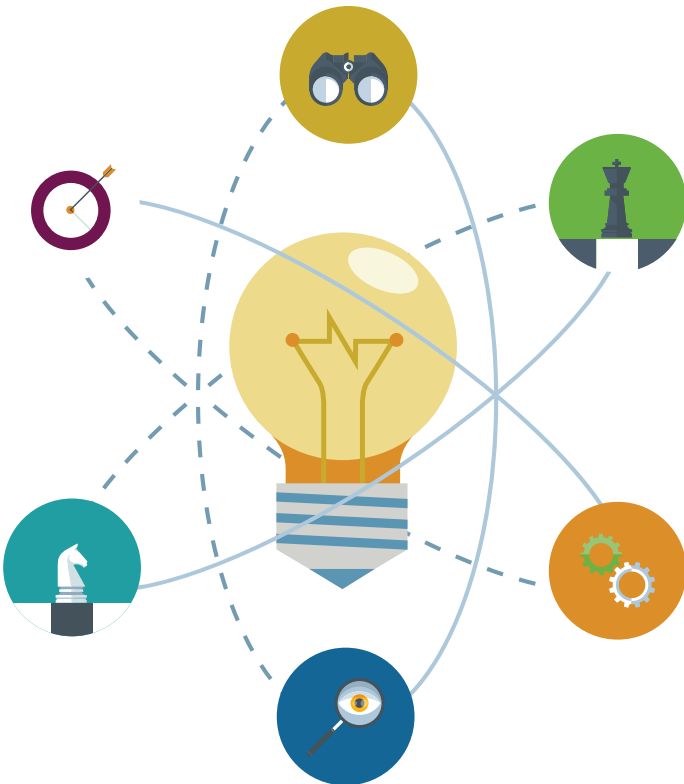


Commonwealth
Health Connector
Insurance Authority

**Strategic Plan
2020-2022**



Contents

Executive Summary 2

Introduction 3

Chapter 1. Context Setting..... 3

Assessing Present Day Health Connector’s Strengths and Challenges 4

Chapter 2. Strategic Planning Process 8

Chapter 3: Strategic Goals for ConnectorCare 9

Strengths and Areas for Improvement10

Goals and Action Steps.....10

Key Progress Indicators.....12

*Chapter 4: Strategic Goals for Unsubsidized and APTC Only Nongroup Membership*13

Strengths and Areas for Improvement13

Goals and Action Steps.....14

Key Progress Indicators.....16

Chapter 5: Strategic Goals for Small Group Membership16

Strengths and Areas for Improvement17

Goals and Action Steps.....18

Key Progress Indicators.....20

Chapter 6: Strategic Goals for Customer Experience and Operations20

Strengths and Areas for Improvement21

Goals and Action Steps.....22

Key Progress Indicators.....24

Chapter 7: Strategic Goals for the Remaining Uninsured24

Strengths and Areas for Improvement24

Goals and Action Steps.....25

Key Progress Indicators.....27

Chapter 8. How we will use this strategic plan.....27

Executive Summary

The Health Connector's Strategic Plan for the upcoming period between 2020-2022 covers five key areas of focus:

1. Strengthen the ConnectorCare program
2. Improve coverage and experience for our unsubsidized and APTC-only members
3. Improve our overall member experience
4. Better serve the small group market in Massachusetts
5. Cover the remaining uninsured

How do we best ensure a strong ConnectorCare program?

- Provide members with affordable premiums and choice of carriers across the state
- Ensure members can easily access the health care they need
- Maximize stability and predictability in the design and financing of the program
- Simplify the member journey as much as possible

How do we improve the experience of our unsubsidized non-group members?

- Ensure access to the full Massachusetts health insurance market and ensure availability of affordable plan options
- Expand and leverage scale of Health Connector unsubsidized non-group membership in the broader insurance market
- Offer tools that help members make informed choices about their coverage

How will we better serve the small group market in Massachusetts?

- Make it easier for groups to shop and enroll through Health Connector for Business
- Drive down average premium costs for small businesses through on-Exchange competition and choice models
- Work with other agencies and small business community on policies and efforts to ensure stability and affordability of small group insurance market
- Bring new groups into the merged market that have not offered group coverage before

How will we improve the overall member experience?

- Conduct a stable transition to new customer service vendors
- Design our web experience to be on par with other Marketplaces and e-commerce sites
- Look for ways to change policies, systems, and operations in ways that can improve the user experience for our diverse membership
- Explore ways to provide more in-person access in our communities
- Take a holistic approach to making notice improvements

How will we cover more of the uninsured population?

- Explore new opportunities for outreach with the uninsured
- Find ways to avoid unnecessary disruptions to our members' coverage
- Identify ways to better use the individual mandate for increasing coverage levels
- Navigate federal policy changes with an eye on maintaining coverage levels

The Commonwealth Health Insurance Connector Authority Strategic Plan 2020-2022 includes details and analysis of both our current state and planned approach for meeting the objectives within these five key areas of focus.

Introduction

Six years after implementation of major changes brought by the Affordable Care Act (ACA), the Massachusetts Health Connector has identified its goals for the next several years. This document outlines the current state of the Health Connector, the process used to gather feedback for strategic planning, the goals identified by the organization as being strategic areas of focus for the next several years, the high-level action steps the organization will take to achieve those goals, and key progress indicators.

The Health Connector intends this document to articulate core focus areas, but also for it to be a “living document” that will reflect and incorporate progress, as well as new priorities and challenges that emerge over the coming years. The document has been reviewed and confirmed by the Health Connector Board of Directors.

Chapter 1. Context Setting

The Massachusetts Health Connector is the country’s first and longest running state-based marketplace, having been created in 2006 to provide high-value coverage to individuals and small businesses in the Commonwealth and to serve as a policy and outreach hub for both state and federal health reforms designed to expand and improve coverage. The Health Connector’s 13-year history allows it to draw from a rich set of experiences and lessons acquired in the several ‘chapters’ of its existence, first as a state-designed independent public entity at the forefront of the state’s pioneering health reform law, Chapter 58 of the Acts of 2006, and later as an ACA-compliant state-based marketplace (SBM) when the federal reform law that was heavily influenced by Massachusetts’s approach to coverage expansion and insurance market reform was implemented. Even within those two key chapters of marketplace experience lays a multitude of program and policy experiences and lessons that have shaped the present-day Health Connector, including the coverage it provides to over a quarter million Massachusetts residents and the role it plays in the wider health care landscape in the Commonwealth.

The below strategic plan for calendar years 2020-2022 outlines specific goals and activities related to key program areas, but all goals are informed on a fundamental level by the Health Connector’s long-standing mission and values:

Mission statement:

Advance access to high-quality health care by serving as a transparent and transformative marketplace for Massachusetts residents and small businesses to come together and easily find, compare, and enroll in affordable health insurance.

Values:

- Structure a health insurance eligibility and shopping experience that makes it easy for individuals and small businesses to understand their health insurance options and choose, enroll in and maintain coverage that best meets their needs.
- Promote affordability in the health insurance market and health care system through the power of transparent competition.
- Capably assess and execute health care reform policymaking and other regulatory responsibilities to promote health insurance coverage and shared responsibility for sustaining health care reform.
- Fully embody the high standards inherent to serving as the Commonwealth's official public Health Insurance Exchange.
- Promote robust public engagement.

Assessing Present Day Health Connector's Strengths and Challenges

What's working well

- After Open Enrollment 2019, the Health Connector is experiencing its highest-yet Health Connector enrollment, with roughly 280,000 individuals covered in nongroup coverage, and approximately 6,000 enrolled in its small group coverage. An additional 20,000 individuals have dental coverage through the Health Connector without health coverage.
- The Commonwealth has the highest rate of insurance coverage in the nation (97%).
- The Health Connector had the lowest average premiums of any Exchange in 2017, 2018, and 2019.
- The Health Connector is expanding into the small group market in earnest with promising early trends, seeking to grow its value as an Exchange and ability to assist a wider swath of the Massachusetts merged market.
- At 13 years old, the Health Connector has navigated and learned from multiple iterations of health reform, and throughout each chapter has preserved affordability programs that help low- and lower-middle-income residents stay covered with high-value plans.
- The Health Connector and MassHealth's shared HIX system has stabilized after a problematic roll-out of ACA functionality.
- The Health Connector has stayed true to the purposes and principles of Massachusetts health reform efforts, despite turbulent federal policy direction in recent years.
- Other states are looking to replicate features of the Commonwealth's approach to exchange and individual market stability (e.g., state individual mandates, "state wrap" subsidy programs to augment federal subsidies, etc.).

Opportunities for improvement

- Customer satisfaction is plateauing among Health Connector members.

- The online consumer experience remains difficult to navigate and needs improvements to make it more consumer-friendly. Processes that currently have to be handled manually by staff, like dental enrollment for individuals without health plans, are also burdensome and in need of streamlining.
- ConnectorCare is programmatically complex and has become more so in recent years due to federal factors.
- There are areas within the state that risk lack of coverage or lack of choice from carriers in the ConnectorCare program (e.g., Cape and Islands, and portions of the northwestern part of the state).
- While the Health Connector offers all carriers selling merged market coverage, increasing concentration of membership with one specific carrier may pose challenges in the future.
- Increasing reliance on narrower network products may pose access challenges for some members needing some services.
- The uninsured population has remained roughly static as a percent of state population in recent years.
- Premium impacts due to federal actions (Cost Sharing Reduction non-payment by federal government, and subsequent “Silver Loading” to make up for lost CSR) have been borne by the unsubsidized population.
- The Health Connector is seeking to make substantive inroads in assisting the small group market, which will require increasing small group participation in Health Connector for Business and addressing the currently low levels of awareness among Massachusetts small employers of the Health Connector’s value proposition.

Key challenges & barriers to improvement and continued success

- Unpredictable federal interventions impacting Massachusetts’s approach to health coverage continue to make long-range planning difficult and also requires the Health Connector to devote substantial resources to navigating an unsettled federal policy landscape.
- Opportunities for systems improvements are often limited due to HIX program and vendor constraints.
- Continued growth in medical cost trends that outpace wages and other economic activity will continue to place burdens on unsubsidized individuals and small employers (as they also affect large employers and the Commonwealth generally).
- At any given point, the Commonwealth has between 200,000 and 250,000 uninsured residents (composed of long-term and short-term uninsured), and population outreach utilized to date has not yet succeeded in closing this coverage gap.
- Pending federal actions on issues including immigration may have a deterrent effect on enrollment.

The Health Connector is establishing a strategic plan for 2020-2022 based on its commitment to not only continuing to deliver the coverage it has sought to provide to the residents of the Commonwealth since its inception, but to ensure it has a clear and

measurable pathway to future improvements. The last several years of Health Connector activity has focused chiefly on stability, both as it has related to (1) stabilizing the shared Health Connector/MassHealth HIX system that was upended in 2014 and (2) navigating federal policy changes and challenges (e.g., attempted congressional actions to repeal significant portions of the ACA, federal regulations that could undermine state-based marketplaces and ACA-compliant health insurance markets). While system and market stability continue to be baseline priorities and guiding principles for Health Connector program and policy decision making, the Health Connector seeks to ensure that ample organizational energies can be devoted to improvement and forward-movement. To that end, the agency has identified five key areas of particular interest related to those forward-moving energies: strengthening ConnectorCare, improving experience and coverage options for our unsubsidized members, serving the small group market in Massachusetts, improving member experience, and covering the remaining uninsured.

These areas of focus have been implicit areas of work for the Health Connector for thirteen years, but this plan makes them explicit. This will allow the Health Connector to serve its members and the Massachusetts public at large in a way that can be measured against goals.

In all of the Health Connector's work, it seeks to honor the public trust and operate in a manner characterized by integrity, precision, transparency, cost effectiveness and care for its members and for the public it serves. Such goals permeate all work the Health Connector conducts— in matters big and small—and irrespective of the work's explicit inclusion in this strategic plan document. Core functions of the agency, ranging from appropriate stewardship of public monies, ensuring both members and staff are well treated and supported, clear and honest accounting of information, are assumed and expected. A strategic plan is not an enumeration of ongoing obligations and accountabilities. While some areas of Health Connector work, like ensuring privacy of member information, or ensuring compliance with state and federal audit requirements, will not be called out in the strategic plan, the Health Connector recognizes the entirety of its obligations under state and federal law and regulation.

An important aspect of setting and executing organizational priorities is acknowledging the variety of roles the Health Connector plays, especially when those roles may result in competing (even conflicting) demands on the same organizational resources. The complex interplay of these roles make goal-setting for long-range planning challenging.

Areas where the Health Connector's organizational identity and operating environment intersect and diverge include:

Feature(s) of Health Connector's Role	Duality of Characteristic	Practical Implication
Governance: Public and Private	Independent public agency (both public and independent)	Faithful to Executive and Legislative priorities while independently governed by a multi-stakeholder board
Governance: State and Federal	Created by state law (Chapter 58 of the Acts of 2006) Subject to the ACA and federal requirements for SBMs.	Mandates and requirements of state and federal law dictate action State law contemplates a further-reaching policy role for the Health Connector compared to other SBMs (e.g., regarding its role in the state individual mandate, etc.) Federal law applies more comprehensive requirements on SBMs than state law
Serving Two Market Segments: Individuals and Businesses	Operates in both the nongroup market and small group market.	The nongroup and small group markets in Massachusetts, though merged, represent different populations Require different policy and program considerations Have different stakeholders
Serving Two Kinds of Nongroup Members: Subsidized and Unsubsidized Enrollees	Covers both subsidized and unsubsidized nongroup enrollees	Different life situations of subsidized and unsubsidized influence how enrollees approach nongroup coverage Have different application and enrollment experiences Have different affordability challenges

Feature(s) of Health Connector’s Role	Duality of Characteristic	Practical Implication
Offering: Public and Private Coverage	<p>Health Connector exists entirely in the commercial market</p> <p>Coverage is regulated by the Division of Insurance and ACA commercial market requirements</p> <p>Although all coverage offered by the Health Connector is private, the Health Connector administers a public subsidy program (ConnectorCare), and shares an eligibility system with MassHealth</p>	<p>The Health Connector serves households transitioning between MassHealth and Heath Connector programs and “mixed” households with members in both programs</p> <p>Maintain compliance and policy congruence with DOI and ACA-regulated commercial merged market, while ensuring ConnectorCare and MassHealth are programmatically compatible</p>
Role in Sale of Insurance and also as Policymakers & Regulators	<p>Responsible for policy making and regulation on key coverage issues, yet also selling insurance</p> <p>Must translate policies into action and program design/business processes, creating a member experience embodying its policy goals</p>	<p>Skills and organizational capacity for business functions (e.g., plan management, IT supports, customer service) are distinct from those required of the Health Connector’s policy and public education functions</p>

The Health Connector’s role is to serve at a crossroads between these different types of consumers, market segments, regulatory frameworks, organizational responsibilities, market actors and to innovate and implement policy to help facilitate a fair market environment around that crossroads. The Health Connector certainly learns from other SBMs and enjoys peer support from them, but the Health Connector’s more expansive set of policy responsibilities in its home state plus eight additional years of experience has led to some design differences that distinguish its identity.

Chapter 2. Strategic Planning Process

As the Health Connector approached the development of this strategic plan, it sought inputs from a broad array of voices and perspectives.

The Health Connector Board of Directors devoted its December 2018 Board meeting to a discussion of strategic priorities for 2020-2022. Board members provided thoughtful perspectives on areas they hope to see the agency focus on in the coming years, as well as thoughtful questions that helped illuminate where the Health Connector should place

enhanced emphasis, as well as areas that should *not* receive immense focus. Slides used by Health Connector leadership to facilitate the Board discussion can be found at https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2018/12-13-18/Strategic-PlanningKick-Off-Presentation-121318.pdf, and meeting minutes can be found at https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2019/03-14-19/Minutes-121318.pdf.

Health Connector member perspectives were incorporated and front-of-mind in the development of the strategic plan through the most recent annual member experience survey that was conducted in summer 2018. Areas of member satisfaction and concern identified by the survey and other data helped drive careful staff and Board thinking and planning to ensure that the Health Connector’s future efforts are responsive to the needs articulated by Health Connector members themselves.

Stakeholder feedback was solicited in February 2019 through an open-ended survey that was shared with an array of stakeholders, including carriers, sister agencies, consumer advocacy groups, employer associations, brokers, legislative staff, and others. Stakeholders were asked to share reflections and feedback on what the Health Connector is excelling at and what should be improved. The survey also asked for feedback on the Health Connector’s approach to engaging with stakeholders so that the strategic plan can address both process and policy goals. The survey was anonymous in order to maximize candor, although stakeholders were invited to reach out directly if they wished to provide more detailed feedback in person or telephonically.

Internal Health Connector staff were engaged in a variety of settings throughout fall 2018 and winter 2019, with staff perspectives engaged on specific topics of strategic importance to them and also on how they thought the agency could most effectively organize itself to pursue new goals that are longer-horizon in nature.

Chapter 3: Strategic Goals for ConnectorCare

As of September 2019, the Health Connector serves approximately 217,000 members as part of its ConnectorCare program, which provides “state wrap” subsidies on top of ACA subsidies for individuals up to 300% of the federal poverty level. ConnectorCare enrollment makes up nearly three-quarters of overall nongroup health membership of the Health Connector. Depending on the region they live in, ConnectorCare members have access to affordable plans from up to four carriers, with no deductibles and limited cost-sharing that increases based on income. The consumer-facing elements of this program were modeled after the Health Connector’s pre-ACA subsidy program from low and moderate income individuals, Commonwealth Care.

Strengths and Areas for Improvement

Strengths

ConnectorCare’s affordable options help make Massachusetts a national leader in health insurance coverage by:

- (1) making coverage more accessible to a population that would otherwise be at higher risk of uninsurance; and
- (2) making it affordable to obtain services through low point-of-service cost sharing.

Carrier competition for ConnectorCare membership contributes to lower Silver tier premiums, which are also available to non-ConnectorCare members throughout the merged market (unsubsidized individuals and small businesses alike).

Areas for Improvement

- The program financing is vulnerable to federal changes.
- The program and its enrollment has become increasingly focused in narrow networks—which are both a strength (cost) and a possible vulnerability (access).
- Members often experience changes in eligibility that leave them without coverage or churning between Health Connector and MassHealth coverage.
- Three ConnectorCare regions in 2020 only have one carrier available, limiting member choice and creating risk of a “bare” region in program.

Goals and Action Steps

1. Preserve or grow carrier participation to ensure adequate ConnectorCare carrier choice statewide

- Explore ways of maintaining and/or increasing carrier participation and increasing in areas where only one carrier serves ConnectorCare members.
- Work with non-participating carriers to determine whether there are ways that their concerns about participating in the program can be overcome (e.g., concerns about federal financing, membership risk profiles, and commercial brand considerations).
- Take steps to mitigate the risks of increasing reliance on one or small number of carriers.

2. Carefully manage ConnectorCare's reliance on lower-cost, narrow network carriers against possible side effects

- Create stronger internal controls for monitoring trends in network and provider access trends that are specific to ConnectorCare (not market-wide network adequacy, which is the purview of DOI), medical advances access, risk adjustment dynamics, broader market dynamics such as tension between Medicaid contracts for ConnectorCare vs. other lines of business.
- Stand up system for early monitoring of forthcoming medical advances that may be clinically significant and valuable but not widely available in ConnectorCare networks to determine whether any policy and program adjustments are needed to address.

3. Stabilize approach to ConnectorCare program and financing year over year to make program participation experience more predictable (for carriers, members, and Commonwealth)

- Where possible, evaluate and adopt multi-year policy approaches to the Seal of Approval process and state premium subsidization that provides ample time for implementation and maturation of policies over time.
- Advocate for stability and predictability in state and federal insurance market related policy making so ConnectorCare program operates on a solid, durable market playing field.

4. Preserve affordability principles that have proven effective over time

- Maintain state approach to premiums (e.g., affordability schedule) and cost sharing that are currently working well.
- Pursue preservation (if not expansion) of federal subsidies (APTC and CSR) that undergird ConnectorCare and subsidies through the Health Connector.

5. Ensure ConnectorCare Program is highly member-focused and administratively designed to efficiently execute ConnectorCare specific initiatives

- Develop member profiles that highlight the range of ConnectorCare member experiences, to better understand the perspective and journey of our members. Member profiles should include a range of examples related to: previous type of coverage; length of time in Health Connector coverage; demographic characteristics; families with a mix of Health Connector and MassHealth eligibility. Profiles will be used to examine the amount of interaction members have with the Health Connector (i.e., explore high number of Requests for Information, confusing noticing, chronic terminations, and payment issues).
- Pursue greater collaboration with MassHealth in order to better serve members who move between MassHealth and ConnectorCare, including exploring ways to address confusing/conflicting information and notices received by such members and better understanding and supporting challenges that may result from member movement between ACOs and MCOs.

Key Progress Indicators

- Continue to increase ConnectorCare membership, among all eligible but uninsured state residents
- Premiums of ConnectorCare plans grow at modest and sustainable rates and enrollee contributions to coverage through participating carriers are affordable and within-reach.
- Improved member satisfaction results on monthly call center operation reports and through member survey (increase from 74% in 2018 to 80% by 2022).
- Hold steady or reduce in member experience survey data the percentage of ConnectorCare members reporting challenges accessing care.
- Hold steady or reduce in member experience survey data the percentage of ConnectorCare members reporting that they forewent care due to cost.
- Same number of or more carriers participating in the ConnectorCare program.
- Reduction in number of state regions with only one carrier in ConnectorCare.
- Reduction in churn out of program due to avoidable factors (e.g., non-payment, non-response to RFIs – as opposed to appropriate changes to eligibility due to income change, etc.).
- Reduction in escalated cases and/or member feedback resulting from confusing noticing or unexpected issues with Health Connector coverage maintenance.

Chapter 4: Strategic Goals for Unsubsidized and APTC Only Nongroup Membership

As of September 2019, the Health Connector provides coverage to roughly 54,000 individuals who pay the full cost of their health insurance premiums. Members may have over 50 plans available to choose from, depending on their location, and the majority of them choose Bronze and Silver tier plans, citing premiums as the driving factor in their plan choice. As of March 2019, the Health Connector served 45 percent of unsubsidized nongroup enrollees, with the remainder purchasing directly through a carrier.¹

Additionally, over 17,000 members receive federal premium subsidies, but do not qualify for ConnectorCare. (These are sometimes referred to as the “APTC only” members.) While these members do not pay the full cost of their premium, subsidies vary based on household composition and are considerably less generous than ConnectorCare, resulting in a variety of experiences of affordability within this population. Members receiving only advance premium tax credits have the same plan set to choose from as their unsubsidized peers and exhibit similar shopping and enrollment behavior. Challenges and goals identified below reflect organizational intentions for both unsubsidized and “APTC only” members since their challenges are similar.

Strengths and Areas for Improvement

Strengths

- The Health Connector’s approach to standardizing the cost sharing requirements for most benefits helps consumers choose a plan that varies on their two most important factors: premiums and providers.
- The Health Connector has 45% of unsubsidized nongroup market share in Massachusetts as of March 2019, indicating its ability to compete effectively for covered lives beyond those who can only obtain a subsidy by purchasing coverage through the Health Connector.
- The Health Connector offers plans from every major nongroup market carrier in Massachusetts, providing consumers with all their options in one place for comparison.

¹ Center for Health Information and Analysis. (2019.) Enrollment Trends: August 2019 Report. Available at <http://www.chiamass.gov/enrollment-in-health-insurance/>.

Areas for Improvement

- Unsubsidized members face significant challenges in affording their premiums and out of pocket costs, despite Massachusetts having the lowest average marketplace premiums in the nation.
- Members overwhelmingly report needing additional guidance to help weigh and narrow down plan options. Additional decision support could provide better information on providers and formulary coverage, as well as estimates of out-of-pocket costs based on expected health needs, as well better in-person supports for unsubsidized shoppers.

Goals and Action Steps

1. Continue to ensure member access to full range of Massachusetts merged market carriers

- Continue to enforce and ensure market understanding of requirement that all carriers in merged market with 5,000 or more covered lives participate in the Health Connector, if selected to do so.
- Determine whether there are opportunities to streamline internal processes in plan management process to ensure carriers have smooth plan management and business relationship (thereby preserving strong continued carrier participation).
- Highlight the value of market-wide carrier access and participation in consumer-facing and policy discussions, in recognition of the policy benefit that has been generated by full and enthusiastic market participation.

2. Offer plans that provide meaningfully affordable coverage options and access to services

- Design plans with cost sharing that is not prohibitive, taking into consideration constraints such as the federal Actuarial Value calculator and the impact on member premiums.
- Collaborate with other stakeholders to work on measures that address root causes of high health care costs and give voice to the circumstances and affordability needs of Health Connector members and unsubsidized nongroup market generally.
- Explore desirability, feasibility, and cost of making subsidies or other cost relief measures (e.g., preferential state tax treatment of unsubsidized nongroup coverage) available to individuals at higher incomes (above 300% for state subsidies, or higher than 400% where federal subsidies end), similar to efforts underway in other states (e.g., California).
- Establish set of affordability and customer experience goals for vulnerable/unique “APTC only” population (300-400% FPL population).

3. Expand advocacy and purchasing power capacity for broader nongroup market

- Study reasons why some nongroup consumers choose to shop off-Exchange, understanding that they may be a bell-weather for the Health Connector’s value proposition to the unsubsidized nongroup market.
- Consider policy, technical, or operational modifications that could make the Health Connector a more attractive option for off-Exchange purchasers to the extent the Health Connector would otherwise appeal to this population.
- Ensure that policy activity the Health Connector leads or to which it contributes keeps the circumstances and policy needs of all nongroup market enrollees (even those off-Exchange) in central focus.

4. Offer robust tools to support consumers in choosing the right plan for their needs and all facets of member experience

- Implement new anonymous browsing tool to help consumers better “window shop,” allowing a greater number of potential enrollees to fully understand their coverage options and the affordability of the coverage for which they may be eligible.
- Implement robust, integrated decision support tools into the online shopping experience that will help consumers consider all aspects of a plan, including providers, formularies, and out of pocket costs for expected health needs.
- Evaluate the feasibility and desirability of specialized comparison shopping and enrollment support (including in-person) for the unsubsidized population, whether through customer service/call center representatives or a special variant of Navigator or Navigator-like program.
- Implement a new member portal with enhanced ability to interact with customer service and receive, view, and print paperless notices.

Key Progress Indicators

- Steady growth year-over-year in the portion of total unsubsidized nongroup enrollees who enroll through the Health Connector, as published by CHIA in their Enrollment Trends series.
- Study market share by income category and ensure Health Connector enrollment is healthy across income-bands (including for 300%-400% category which is eligible for APTC) and eligible market segments.
- Health Connector engagement in substantial discussions with peer state agencies on how to address issues that can meaningfully affect premium cost drivers (e.g., prescription drug costs, provider prices, etc.), and able to reflect circumstances of its members in those discussions.
- At least one improvement to user experience and/or user interface in each HIX release. (One release will contain a decision support tool that includes an out-of-pocket cost calculator.).
- Increase member satisfaction among unsubsidized membership in annual member experience survey over the 2018 satisfaction rate of 48% up to at least 60%.

Chapter 5: Strategic Goals for Small Group Membership

When the Health Connector was created in 2006, it was conceived to serve both individuals and small businesses (those with 50 or fewer workers). While the small group market in Massachusetts was mature and fairly well-saturated (e.g., experienced market reforms in the 1990s, longstanding purchasing channels, fairly broad levels of employer-based coverage), many small employers reported struggling with the group coverage landscape, unsatisfied with premiums and unclear about their options. However, the Health Connector has not made significant inroads into the small group market, in contrast to its strength in

the nongroup market. Although the Health Connector began offering small group coverage after it was created, its model and offerings at the time were not widely perceived as a significant value-add to the broader small group marketplace, resulting in low enrollment and almost non-existent awareness in the small business community that it offered small group coverage.

In 2017, the Health Connector began to consider how it could add new value to the small group market in Massachusetts, where levels of employer-sponsored coverage were declining and small employers continued to report that the small group market as they knew it was not meeting their needs. After conducting goal setting for the effort to re-vamp its small group program and conducting a competitive procurement process, the Health Connector partnered with DC Health Link, the state-based marketplace for the District of Columbia, to launch Health Connector for Business (HCB). At the same time, the Health Connector also refreshed its approach to broker commissions, making them on par with off-Exchange market practice. In the year since its launch, the program's growth has been modest, but early data indicates that new groups shopping through the platform are pleased with their options and experience, are benefitting from the platform's newfound flexibility for businesses and employees and are—on average—saving money compared to groups who shop off-Exchange.

Strengths and Areas for Improvement

Strengths

- Unique “choice” options that allow small employers to easily offer a variety of coverage options to their employees, including the ability to shop from different carriers while the employer’s contribution stays constant.
- Savings opportunities for businesses: (1) Shopping on Exchange saves money via comparison shopping compared to off-Exchange (~20% on average based on different shopping decisions when shopping through Exchange), and (2) the Health Connector for Business’s wellness-based rebate program, “ConnectWell,” that can help small businesses save up to 15% on their premiums.

Areas for Improvement

- Small businesses in Massachusetts and their employees are struggling with affordability (on premiums and cost sharing), and existing resources directed toward this challenge may not be sufficient to meet the needs. (Note that the wellness rebate is time-limited to 3 years, which may dilute its attractiveness to small businesses that do not want to offer a benefit that will be taken away.
- Although platform is functional, technical enhancements are needed to allow small groups to “window shop” before creating an application.
- Low awareness among small businesses of Health Connector for Business and—for some employers—a sense of skepticism about partnering with a public agency for employee coverage.

Goals and Action Steps

1. Continue to make it easier and simpler for small groups to shop from full Massachusetts carrier market without barriers to entry

- Continue to work closely with carrier partners to ensure continued productive engagement and participation in HCB.
- Enhance the HCB platform to include the ability to preview rates before applying (“window shopping” or “anonymous browsing”) so potential HCB groups can understand the value of full market access and comparison shopping.
- Develop and enable decision support tools for shopping employers and employees (e.g., direct comparison tools, etc.) and tools to help retain members more easily (e.g., auto-pay).
- Develop creative awareness raising campaigns and outreach strategies to better support small businesses that need help navigating their coverage options (e.g., evaluate the desirability and feasibility of the concept of ‘small business Navigators,’ partnerships with other state agencies and entities that work with small employers looking for assistance – all with a focus on removing market entrance barriers).

2. Increase and retain HCB enrollment among groups that have not offered coverage previously or are at risk of dropping coverage

- Expand partnerships with trusted business organizations and chambers of commerce to raise awareness of HCB among small employers not offering coverage.
- Evaluate ways to diminish any ‘government feel’ of Health Connector for Business to the extent it can help draw new opportunities to partner with outside employer associations.
- Highlight existing wellness subsidy as a tool to help employers find affordable coverage and identify opportunities to make it maximally easy for employers entering the group market for the first time to use and obtain savings.
- Launch a regular annual HCB member survey to better understand our own members’ experience and preferences and implement data-driven improvements to retain existing members and attract new groups.

3. Drive down average premiums for small employers in Massachusetts – both by encouraging shopping through HCB, but also acting as advocate for wider small group market stability generally

- Educate employers, brokers, and other small group opinion leaders about the benefits of comparison shopping and the “choice models” that early data suggests result in savings
- Build on “ConnectWell” 15% premium rebates and explore additional ways of helping businesses reduce premiums through Health Connector for Business
- Effectively monitor the broader merged market to identify policy and program tools to protect market stability, and react to market risks (e.g., continue to work with DOI and AGO and others to ensure that non-compliant plans for employer groups do not take hold in the Massachusetts market. In addition to the state’s vigorous enforcement of market rules to keep such plans from proliferating, HCB should hold itself out as an alternative for employers that could otherwise be vulnerable to such offers.)

4. Grow awareness and utilization of “choice model” shopping options that expand choice and flexibility for both employers and employees

- Revisit HCB marketing budget starting in FY20 to improve messaging content and reach regarding the unique value and flexibility/savings benefits of the choice models offered by Health Connector for Business.
- Establish new ways to educate brokers, employers, and employees about choice models.

5. Explore learnings from other states that have been successful in small group market

- Study other state exchanges’ small group markets, including those with structural supports/advantages, as input to what further reforms would make sense in the Massachusetts market.

Key Progress Indicators

- Growth of over 10% each year, with a membership goal of roughly 10,000 by 2023.
- Increased awareness among Massachusetts small employers about the availability and benefits of Health Connector for Business, based on CHIA employer survey or another measurement tool to monitor outside market awareness.
- Internal quarterly reviews of key HCB metrics, to ensure the Health Connector is meeting or moving closer to its threshold goals (e.g., at least 5% of new groups are newly offering employer-sponsored coverage, at least one-third of groups are using one of the two “choice models”, etc.). If the Health Connector is not meeting goals yet, or moving in opposite direction, HCB team and Health Connector leadership will assess possible course corrections.
- New employer associations establish partnerships with the Health Connector (in addition to existing partnerships such as the Greater Boston Chamber of Commerce).
- Carriers continuing to work closely and collaboratively with the Health Connector in service of HCB’s success, both from an operational and plan management perspective, but also with respect to marketing and outreach to small employers not yet offering group coverage.
- Increased understanding among opinion leaders in employer community, local officials and legislators, brokers, and state health policy field of HCB and its value.

Chapter 6: Strategic Goals for Customer Experience and Operations

The Health Connector has made significant progress achieving a place of relative stability following the upending of the integrated Health Connector-MassHealth health insurance

exchange (“HIX”) system in 2014. The HIX system enables an individual (from the nongroup market) to complete an application for health insurance coverage, receive an eligibility determination with respect to possible subsidies, shop for and enroll in a plan of their choice and maintain their account as needed; however, member satisfaction has declined since 2016. Members describe the online application process as “clunky” and “unfriendly” to use. Health Connector members have diverse experiences with health insurance that lead to a variety of expectations and customer support needs as it relates to their time as our members – some may be obtaining coverage for their first time ever, others may only have the experience of group coverage coordinated by a large employer. The single Health Connector website and call center serves individuals and families who may not be eligible for subsidies, those who receive varying amounts of subsidies and members who may have a family member that is covered by MassHealth. From the moment that Health Connector members apply for coverage they are presented with very different experiences, with unsubsidized members facing different cost challenges, having access to a larger number of plans and carriers, and the need to understand the benefit designs of a plan. These many factors contribute to the unique and diverse needs of a constantly evolving membership base; how to best serve those members and train call center staff appropriately and design Health Connector customer experience elements generally remains a challenge. The Health Connector’s contract with its current vendor handling call center and premium billing services expires in 2020. During 2019, the Health Connector will be conducting several procurements to solicit bids from vendors to conduct these member support services, seeking high value outcomes that maximize member satisfaction for the best cost possible.

Strengths and Areas for Improvement

Strengths

- Stable customer support experience has been achieved in call center
- Discrete adjustments to better support members and avoid escalations have been successfully pursued by staff and had desired results (e.g., reinstatement policy changes).

Areas for Improvement

- Understand and adapt Health Connector member services to better meet the needs of our unique member profiles—unsubsidized, subsidized, mixed household (e.g., someone receiving benefits through ConnectorCare and Health Safety Net)
- Need to meet market standards for customer service and website tools to enhance the member experience

Goals and Action Steps

1. Create a web-based customer service experience comparable to other online marketplaces (in health coverage and other e-commerce settings)

- Prioritize user interface and user experience (UI/UX) improvements to the existing shopping experience by designating an agency lead and cross-functional workgroup with an executive sponsor.
- Collaborate with other agencies on the re-procurement of technology vendors that will result in a website of which the Health Connector will have better control over and therefore able to more nimbly iterate with over time.

2. Provide a tailored member services experience taking into consideration the unique needs of identified subgroups of our membership (e.g., ConnectorCare versus HCB, etc.)

- Establish evidence-based goals for service delivery model for each type of member (i.e., understanding what the specific service expectations/needs are of the unsubsidized population, etc., and delivering those service elements).
- Explore closer cross-training with MassHealth to help customer service representatives more easily identify scenarios better served by MassHealth and educate members on next steps.
- Establish ‘captains’ or ‘champions’ within the agency for each corollary of market segment that can be responsible for proposing and monitoring goals specific to member experience of each category, using data and input from other staff.

3. Navigate a stable transition of customer experience vendors and/or approaches, and ensure the next phase of customer service offers members a high quality experience at a competitive price to the Health Connector

- Complete required procurements and vendor transitions before expiration of current contract for customer service vendor.
- All Health Connector teams work diligently, and, as highest priority for 2019-2020, ensure members experience no disruptions or inconvenience owing to this transition.

4. Focus on system, policy, and operational improvements to make the user experience easier to navigate and less intimidating for members with a focus on preventing coverage disruptions or hassle

- Determine whether disconnects in the member experience are caused by legal, policy, or operational constraints and consider alignment where flexibility exists, and establish action plans to address fixable issues.
- Establish internal work group to explore how the Health Connector can facilitate greater self-service in today's technology environment by continuing to keep pace with advances in mobile technology and how people are using web-based, phone, and other member services tools today.
- Study member "churn" between programs to discover root causes of movement and help members find the right coverage type quickly and consistently.
- Apply a person-centered design approach to all aspects of the Health Connector's work, using diverse member profiles and consideration of the wide range of circumstances reflected in its membership to conduct program and customer service decision making.
- Study whether the number of plans being offered by the Health Connector is too few or too many to support the experience that members want/expect.

5. Explore greater community-based access for members to maintain coverage

- Determine pros and cons of establishing additional channels for in-person member business needs to be met, such as making payments or dropping off documents.
- If determined feasible to pursue, work to make new channels available for members, with a particular focus on high-need and high-volume regions.

6. Refresh noticing and communications with consumers to be clearer and easier, and establish unified customer communication strategy

- Conduct top to bottom review of Health Connector noticing to understand where conflicting and/or confusing messages occur and root out causes of undue sources of frustration and lack of clarity.
- Establish unified customer communication strategy to ensure we are providing or are on pathway to providing supports and messages in the communication channels our members (across member profiles) expect and prefer. This could include exploration of support chat, etc.

Key Progress Indicators

- Successful execution of new vendor contracts prior to expiration of existing ones.
- Health Connector has greater control of its own IT/customer service destiny and is able to move more nimbly in response to member needs.
- Implementation of meaningful progress on at least five member experience improvement initiatives, one of which will be a decision support tool.
- Increase in customer service satisfaction to 80% by 2022
- Increase in staff expertise and data-driven understanding in the economic, social, and experiential characteristics of different types of Health Connector members in order to ensure decision making reflects a current and nuanced understanding of membership needs.

Chapter 7: Strategic Goals for the Remaining Uninsured

Since 2006, the Health Connector has played a leading role in educating Massachusetts residents about the importance of and requirement to carry health coverage, and the Health Connector serves as the “front door” through which residents can find the coverage they need. The Commonwealth has the lowest uninsured rate in the US at 3.7%, according to the Center for Health Information and Analysis, and this percentage of uninsured has stayed level for the last several years. Despite ongoing outreach activity and a state-level individual mandate, a population of 200,000 to 250,000 state residents remain uninsured. A 2016 report examining state tax filings related to health insurance coverage found that roughly half of the uninsured are persistently uninsured, while the other half experience temporary gaps in coverage. New obstacles to maintaining and further expanding coverage have emerged due to federal policy making, such as the potential impact of the proposed federal “public charge” rule that would penalize lawfully present immigrants for utilizing certain public health benefits, like Medicaid.

Strengths and Areas for Improvement

Strengths

- Commonwealth has achieved highest in nation insurance coverage rate, which has persisted through economic ups and downs, implementation of the ACA, and changes in federal policy dynamics.
- The Commonwealth’s approach to coverage expansion through activities of the Health Connector (specifically, state subsidies augmenting ACA subsidies and the state’s continued individual mandate) have been preserved and have been proven effective in helping the Commonwealth reach near-universal coverage.
- The Health Connector has high-quality data available to understand the demographics of the uninsured in Massachusetts, which inform a tailored outreach strategy.

Areas for Improvement

- ~3% of population remains uninsured (roughly 200-250,000 residents at any given time). Outreach and marketing (however well-tailored and targeted) may have limits in effectively enrolling all of the Massachusetts residents eligible for coverage. Stronger policy/mechanical approaches to enrolling uninsured (e.g., autoenrollment) should be evaluated.
- A majority of the uninsured are eligible for free or low-cost coverage through MassHealth or ConnectorCare. (And many of the uninsured are individuals who were formerly in MassHealth and/or ConnectorCare and ‘fell out’).

Goals and Action Steps

1. Increase the rate of insurance in Commonwealth

- Enhance and update Health Connector primary research on the uninsured to support clear information campaigns about the Health Connector’s plans and prices to remove any perceived barriers to coverage (e.g., analysis of DOR data, conducting focus groups with uninsured or recently uninsured, collaborating with other researchers on the uninsured).
- Explore enhanced capacity for outreach and marketing to the uninsured to be more consistent with agency’s goals and its central role as the state’s commercial coverage and outreach hub. Ensure and expand free consumer assistance available online, by phone, and in person to support individuals seeking to gain coverage. Ensure such supports are supported by the latest understanding of uninsured population’s needs and which populations are at highest risk of uninsurance.
- Conduct more direct outreach to uninsured if the Health Connector is able to utilize DOR data on uninsured residents for coverage assistance purposes.
- Identify and engage other state agencies likely to encounter the uninsured as part of their work, knowingly or unknowingly, such as MassHealth, Dept. of Revenue, Registry of Motor Vehicles, Health Policy Commission’s Office of Patient Protection, Division of Unemployment Assistance, Dept. of Transitional Assistance, etc.

2. Increase continuity in Health Connector programs to avoid coverage gaps and increase evaluation of Health Connector-based policy tools designed to reduce uninsurance

- Determine most frequent avoidable causes of termination for Health Connector members and develop educational outreach materials or policy changes to help prevent them.
- Explore creation of specific resources/pathways for former members to most seamlessly re-enter coverage.

3. Increase evaluation of Health Connector-based policy tools designed to reduce uninsurance

- Monitor and quantitatively evaluate effectiveness of policy tools designed to increase enrollment in health insurance, such as ConnectorCare subsidies and the state's individual mandate, as well as other tools that could help the state further reduce uninsurance.

4. Enhance ability to use individual mandate processes and data to help residents to obtain and maintain coverage

- Utilize to the fullest extent possible the individual mandate data available to the Commonwealth on remaining uninsured to conduct more tailored outreach and enrollment assistance (e.g., explore how the Health Connector could more directly/frequently use DOR data on uninsured to provide direct outreach to the uninsured and/or more tailored policy interventions, such as auto-enrolling individuals eligible for free coverage).
- Monitor, evaluate, and, if appropriate, recommend strategies to enrolling the uninsured that are underway in other states (e.g., Maryland's new auto-enrollment policy whereby the state automatically enrolls people eligible for Medicaid, and conducts direct outreach to individuals eligible for subsidies through their Exchange).
- Explore with the Department of Revenue the opportunity to modify state tax forms/processes to allow individuals reporting uninsurance to be directly outreached.

5. Successfully work to mitigate negative impacts of potential federal policy changes (e.g., public charge or others) that results in erosion of coverage levels in the Commonwealth

- Identify strategies for mitigation of coverage losses among residents likely to be subject to coverage disruptions as a result of proposed federal public charge rules or other ‘chilling effect’ risks likely to disrupt coverage for segments of the Massachusetts population.
- Collaborate with sister agencies and stakeholders against federal policy proposals likely to result in coverage losses.
- With sister agencies, provide clear, reliable information about eligibility for coverage, public charge implications, and appropriate supports to remain in coverage to Massachusetts immigrant communities.

Key Progress Indicators

- An increase in the rate of insured individuals in the Commonwealth, as measured by CHIA in its Massachusetts Household Insurance Survey or national surveys such as the National Health Insurance Survey or American Community Survey.
- Advancement of Massachusetts individual mandate policies and outreach using individual mandate data (e.g., successful launch of an “individual mandate policy 2.0” in Massachusetts by linking the tax filing process with enhanced pathways to coverage and/or to outreach).
- Lower attrition rates of Health Connector coverage.
- Increase in Health Connector-driven personalized outreach touchpoints with the uninsured using administrative data on Massachusetts residents without coverage.
- Increased utilization of qualitative feedback from Navigators, enrollment assisters, and other ‘front line’ organizations that can report on emerging trends or shifts in enrolling the uninsured or maintaining coverage among target populations.

Chapter 8. How we will use this strategic plan

The purpose of this strategic plan is to establish clear goals and directional priorities for the agency’s focus in the coming years. These goals are ones to which we seek to hold ourselves accountable. We will regularly measure how we use our finite resources to both execute our baseline operating functions with a standard of excellence, as well as to advance the goals outlined in this plan.

Using this document’s articulated goals as a set of organizational guideposts for forward-looking work will take on many forms: it will be used for budget development for Fiscal Year 2021 and future Fiscal Years (in the context of ongoing commitment to financial sustainability), individual staff and team performance goal setting and project planning, using team and/or all staff meetings to review and evaluate ourselves and each other based on how our work contributes to and advances the strategic goals. If new challenges emerge

that require us to revisit these goals, the organization will re-examine its landscape and do so in a way that is transparent and involves its Board, its members, and other stakeholders in understanding its rationale.

In addition to the Health Connector using this plan to guide its proactive and affirmative work in the coming years, it will also be equally operative for organizational decisions with respect to what work falls outside of these goals and what initiatives or areas of staff focus or resourcing may make sense to reconsider, re-sequence in order of priority, or decommission.

The Health Connector is committed to ensuring that its Board, its members, and its stakeholders have a clear line of sight into not just its goals, but into its progress (or challenges) in advancing towards these goals. To ensure regular reporting and dialogue on such advancement, the Health Connector plans to report out each year to its Board of Directors as part of the Board's annual strategic planning meeting, which is open to all, and by creating and using a dashboard for updates to the Board on progress achieving these goals. Further, the Health Connector will include its progress in meeting these goals to the General Court in its annual report to the legislature, which is submitted after the close of each Fiscal Year.