



2014 Seal of Approval Introduction (IV): Exchange Product Platform

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Updated Timeline of 2014 SoA RFP Release

- We had previously contemplated a potential release date of the 2014 Seal of Approval (SoA) RFR in January 2013
- We now propose to revise the timetable and target the RFR release in February 2013
 - Ensure that the RFR is appropriately informed by the Administration’s FY2014 Budget proposal, to be released in late January
 - Necessary given the involvement of state funding in a key component of Qualified Health Plan (QHP) offering – “wrap” plans for the up-to-300% FPL population shopping through the Exchange
 - MassHealth is still in the process of seeking Federal Financial Participation (FFP) for the state wrap, the outcome of which may affect the level of state wrap provided through the Budget development process
 - Certain elements of the RFR are influenced by federal regulations that are still in proposed form and expected to be finalized in early 2013. Though it is possible to move forward without these being finalized, releasing the RFR in February provides a greater chance of leveraging more definitive federal guidance (e.g., federal AV calculator)



Updated Timeline of 2014 SoA RFP Release (cont'd)

- We continue to target the award date of “conditional SoA” by mid-to-late spring of 2013, with final SoA subject to carriers’ completion of the applicable DOI filing process
 - Ensure adequate time for implementation of the 2014 program for both the Health Connector and carriers
- We intend to seek Board approval of the final RFP at the February Board meeting



2014 Exchange Product Platform



Strategic Goals

- Having a vibrant Exchange product portfolio is among the most critical components of our 2014 vision
- We believe that a strong Exchange product shelf should have these characteristics:
 - Able to **meet the needs of a diverse customer base**
 - Offers products that have market appeal. Specifically, the Exchange should have **solid representation of “best-selling” products**
 - Serves as the place to find **cost-effective product options**, by maximizing competition and being the best platform for new entrants
 - Attracts **innovative, leading-edge products**, offering unique purchasing programs, and leveraging an innovative website to facilitate comparison shopping
 - Achieves all of the above goals and still maintains a **reasonably-sized, easy-to-navigate portfolio**



Overarching Framework

- We have previously presented to the Health Connector Board:
 - The intention to maintain a “base” of standardized plans for both the non-group and small-group product offering
 - The requirement that carriers offer at least one plan for each of the standardized benefit packages on their broadest commercial network
 - The proposal to retain the option to supplement with a select number of “high-value” non-standardized plans for both shelves (*e.g.*, tiered cost-sharing products)
 - The recommendation to include additional non-standardized plans for the small-group shelf only, to further enhance the breadth of the SHOP portfolio



Today's Focus

- Since that time we have taken a series of steps to conduct research and develop detailed recommendations regarding the 2014 product platform
 - Performed a “market scan” analysis of popular plans in the Massachusetts small and non-group market
 - Engaged Gorman Actuarial for a review of “popular” plans in the merged market
 - Utilized the federal AV calculator released on November 20, 2012
 - Developed proposed parameters for standardized plan designs that align with the ACA metallic-tier requirements
 - Reviewed multiple iterations of proposed standardized plan designs with carriers
 - Developed proposals pertaining to other aspects of the requirements (*e.g.*, non-standardized products)
- Consistent with the previously proposed framework, today's presentation focuses on our detailed recommendations



Key Decisions

One Integrated Exchange; Serving Distinct Population Segments



- ***Incorporate a significant amount of learning from the market to make our standardized product suite as strong as possible***
- ***Supplement the standardized shelf with high-quality non-standardized products***
- ***Leverage "wrap" plans to promote competition***



“Market Scan” Findings

Deductibles are the “norm” for the market, with more than half of the market purchasing deductible plans.

- Merged-market enrollment in plans with deductibles of at least \$1,000 (individual)/\$2,000 (family) increased from approximately 3% in 2006 to approximately 55% in 2012 (Gorman Actuarial)
- Deductibles typically apply to hospital services (*e.g.*, inpatient admission, outpatient surgery, lab and radiology, etc.)
 - Popular plans often have minimal cost-sharing after the deductible is met, except for “discretionary” services (*e.g.*, ER visits, high-cost imaging)
 - Deductibles rarely apply to office visits except for HSA-qualified plans
 - Separate Rx deductibles do not appear to be popular – out of the plans reviewed, less than 15% have Rx deductibles, covering ~7% of membership



“Market Scan” Findings (cont’d)

Co-insurance plans and HSA-compatible plans continue to have very slow take up by the market.

- Of the “popular” plans reviewed, less than 5% had any form of co-insurance (Medical or Rx)
 - Carriers reflect that members are often hesitant to purchase products relying on co-insurance because they have very limited knowledge of what services typically cost
- Federally-qualified high-deductible plans (HSA-compatible) have very low traction in the market
 - None of the “popular” plans included in the analysis represented this type of plan
 - This design has yet to demonstrate strong preference among consumers
 - Compared with HSAs, HRAs are more prevalent among employers – HRAs can be set up for most plans, while HSAs can only be applied to HDHPs



“Market Scan” Findings (cont’d)

Narrower-network and tiered-network plans represent a growing trend in the market.

Narrower-network plans cover a subset of (often lower cost) providers in the market, but feature uniform member cost-sharing across covered providers

- Enrollment is still low. However, carriers that offer these plans remain positive that they offer attractive price points and are positioned to grow
- There is a wide continuum of narrower networks, including some that are fairly broad and exclude a few high-cost providers

Tiered-network plans typically come with a carrier’s full network of providers, but feature differential member cost-sharing depending on the provider that delivers care

- Have grown considerably in the past several years
- These plan designs target savings by providing member incentives to choose better-value providers, without “blocking” access to other providers
- An operational lift for carriers – to date only the larger commercial carriers have the operational readiness to support tiered-network plans



“Market Scan” Findings (cont’d)

The merged market continues to be dominated by HMO plans, with no indication of migration towards PPO plans.

- It is estimated that well over 80% of the merged market population is covered by HMO plans (Gorman Actuarial)
- This is in part due to the robust availability of broad-network HMO plans in the state, which mitigates the need for (non-emergency) access to out-of-network providers
- PPO plans are often offered in tandem with HMO plans to small groups so as to accommodate the needs of accounts with out-of-state employees



Current Commonwealth Choice Standardized Plans

While providing a simplified shopping experience, the current standardized product shelf has insufficient market appeal.

	Gold	Silver High	Silver Low	Bronze High	Bronze Medium	Bronze Low (HDHP)
Medical Deductible			\$1,000/\$2,000	\$250/\$500	\$2,000/\$4,000	\$2,000/\$4,000
Rx Deductible				\$250/\$500	\$250/\$500	
Out-of-Pocket Max.		\$2,000/\$4,000	\$2,000/\$4,000	\$5,000/\$10,000	\$5,000/\$10,000	\$5,000/\$10,000
PCP visits	\$20	\$25	\$20	\$25	\$30	\$20 <i>Ded.</i>
Diagnostic x-ray/lab	\$25	\$0	\$0 <i>Ded.</i>	35% <i>Ded.</i>	\$0 <i>Ded.</i>	20% <i>Ded.</i>
Inpatient Admission	\$150	\$500	\$0 <i>Ded.</i>	35% <i>Ded.</i>	\$500 <i>Ded.</i>	20% <i>Ded.</i>
Outpatient Surgery	\$150	\$500	\$0 <i>Ded.</i>	35% <i>Ded.</i>	\$250 <i>Ded.</i>	20% <i>Ded.</i>
ER visit	\$75	\$100	\$100 <i>Ded.</i>	\$150	\$150 <i>Ded.</i>	\$100 <i>Ded.</i>
Rx						
Tier 1	\$15	\$15	\$15	\$15	\$10	\$15 <i>Ded.</i>
Tier 2	\$30	50%	\$30	50% <i>Ded.</i>	\$30 <i>Ded.</i>	50% <i>Ded.</i>
Tier 3	\$50	50%	\$50	50% <i>Ded.</i>	\$50 <i>Ded.</i>	50% <i>Ded.</i>
Approx. AV	~91%	~90%	~85%	~80%	~78%	~70%
Metallic Tier	Platinum	Platinum	Gold	Gold	Gold	Silver

* AV estimate is not exact because we have to make certain assumptions on non-standardized cost-sharing categories.

- Certain “popular” features and plan configurations are missing or insufficiently represented:
 - A progressive range of deductibles
 - High AV plan with low generic Rx cost-sharing
- There are also certain plan design features that are prevalent on our shelf but proven to be unappealing to the market
 - Copayment for lab/x-ray; Rx deductible; co-insurance



2014 Standard Products – Key Considerations

- **We believe there are meaningful opportunities to improve, or revamp, our current standardized product shelf**
- The ACA transition provides a unique and important opportunity for us to strengthen our product shelf and establish market appeal
 - The market as a whole is expected to experience a host of required changes designed for a more transparent and consumer-friendly market (EHB, metallic tier, etc.)
- Based on findings from our market analysis, there are certain “low-hanging fruits” that we can pursue to make our product portfolio more attractive
 - The market has been evolving, but we have not had a mechanism to continuously update our products
- Our goal is to 1) make each plan sufficiently strong on a standalone basis, and 2) construct a package that collectively offers robust coverage of popular options



Scope of Standardization

- **We propose to substantially maintain the current level of standardization in terms of the categories of defined cost-sharing**
- We currently prescribe cost-sharing in eight categories, selected to represent: 1) material impact on spending; and 2) the items that typically influence consumers' purchasing decisions
- There is no indication from our Commonwealth Choice experience that the current standardization is not sufficient
- The new requirements for AV ranges by metallic tier will institute a degree of limitation on the magnitude of variations within a given metallic tier, which will meaningfully mitigate the risk of insufficient standardization
- Carriers generally favor more flexibility in plan design
- We will continue to leverage the QHP certification process to ensure that no discriminatory plan designs are applied



Scope of Standardization (cont'd)

We propose two areas of potential modifications to the current standardization categories:

1. Replace Lab/X-ray with high-cost imaging

- Lab/X-ray is neither a significant cost driver nor a utilization concern (in contrast with high-cost imaging)
- Co-pays on Lab/X-ray not well received by consumers
- Carriers often do not charge them even if they are part of the plan design

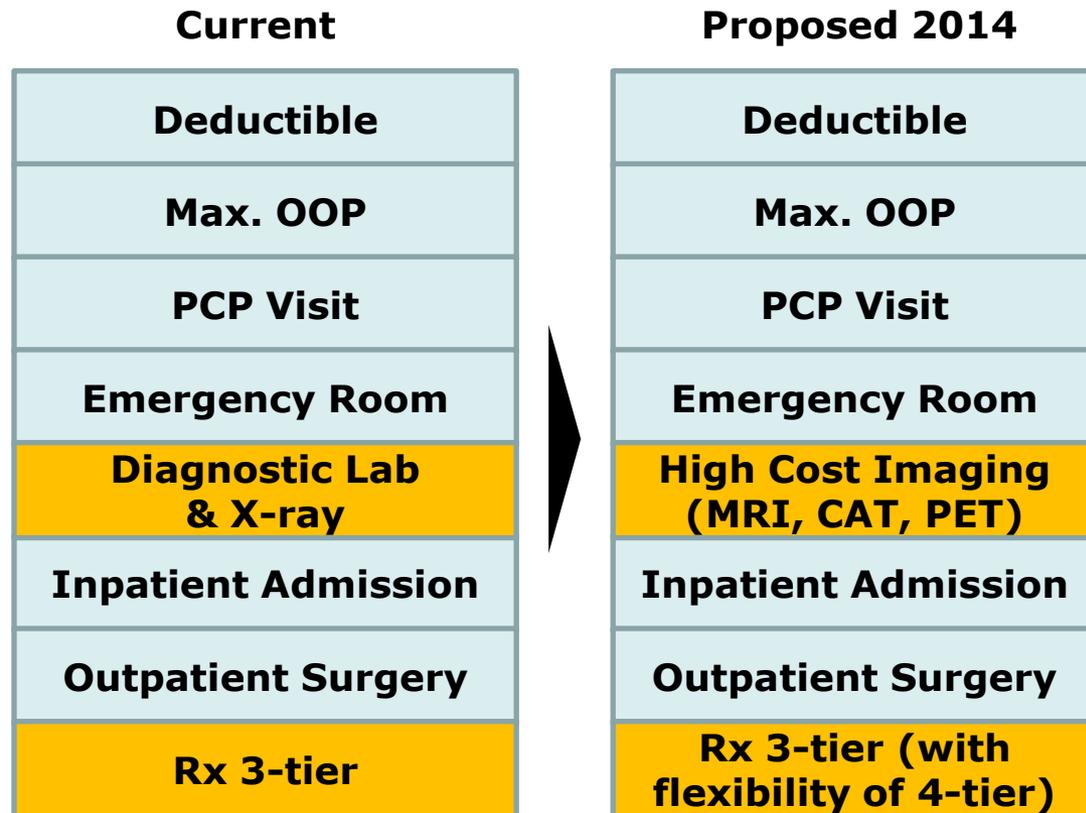
Current	Proposed 2014
Deductible	Deductible
Max. OOP	Max. OOP
PCP Visit	PCP Visit
Emergency Room	Emergency Room
Diagnostic Lab & X-ray	High Cost Imaging (MRI, CAT, PET)
Inpatient Admission	Inpatient Admission
Outpatient Surgery	Outpatient Surgery
Rx 3-tier	Rx 3-tier (with flexibility of 4-tier)



Scope of Standardization (cont'd)

We propose two areas of potential modifications to the current standardization categories (cont'd):

2. Accommodate the “preferred generic” tier as a variation within the standardized structure
 - Our standardized design currently allows the traditional 3-tiered Rx co-pay structure: generics, preferred brand, non-preferred brand
 - There is indication that the market is attracted to more tiers (e.g., splitting generics into preferred and non-preferred) – a form of Valued-Based Insurance Design (VBID)
 - Can be incorporated as part of the shopping experience design: “flag” certain standardized plans as having the added feature of extra-low co-pay on certain generics
 - Failing to incorporate this feature will preclude us from offering a consumer-friendly concept that is gaining market traction





Alignment with ACA Metallic Tiers

- The ACA metallic tier structure is based on statutorily-prescribed actuarial value ranges (90%±2%, 80%±2%, etc.), which must be determined with the federal AV calculator
- The proposed federal AV calculator, released on November 20, 2012, was developed by HHS based on a standard commercial population not specific to any region
- Measured with the proposed federal AV calculator, the AVs of current Commonwealth Choice plans suggest that most of them would likely fall under the the Platinum or Gold tiers defined by the ACA

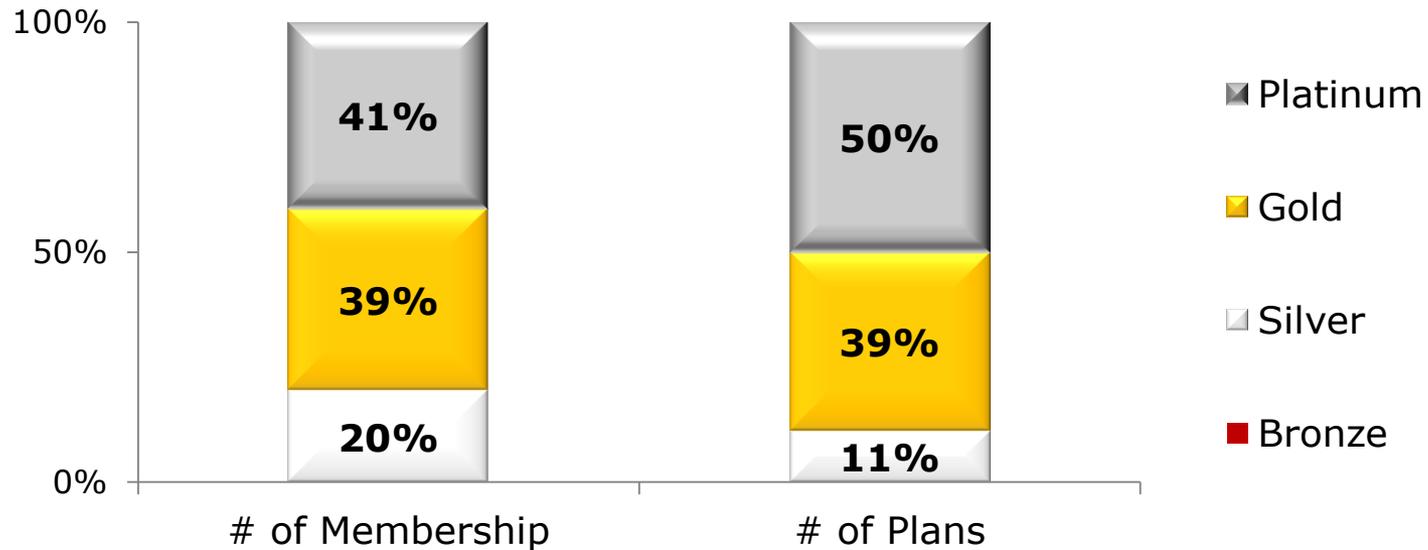
Commonwealth Choice Standardized Plan	Gold	Silver High	Silver Low	Bronze High	Bronze Medium	Bronze Low
Most likely ACA Tier	Platinum	Platinum	Gold	Gold	Gold	Silver

- The proposed federal AV calculator is expected to be finalized by HHS in early 2013



Alignment with ACA Metallic Tiers (cont'd)

- Similarly, products in the Massachusetts merged market as a whole appear to be highly concentrated in the Platinum and Gold tiers



Note:

- Analysis provided by Gorman Actuarial. Statistics based on a sample of 57 plans sold in the merged market in 2012 with the highest volume, representing the 4 largest commercial carriers and 71% of membership
- Metallic tier assignment determined with the federal AV calculator and based on the closest AV target (e.g., an 84% AV plan is classified as Gold)



Alignment to ACA Metallic Tiers (cont'd)

- While federal tax credit is tied to the Silver tier, it should be noted that the high concentration of Gold and Platinum plans in our market does not necessarily imply adverse impact on members from an affordability perspective

**Up-to-300%
FPL
Population**

- The State intends to make a “wrap” available to enrollees through a subset of QHPs on the Silver tier, which is intended to bring both premium and cost-sharing to affordable levels defined by the State

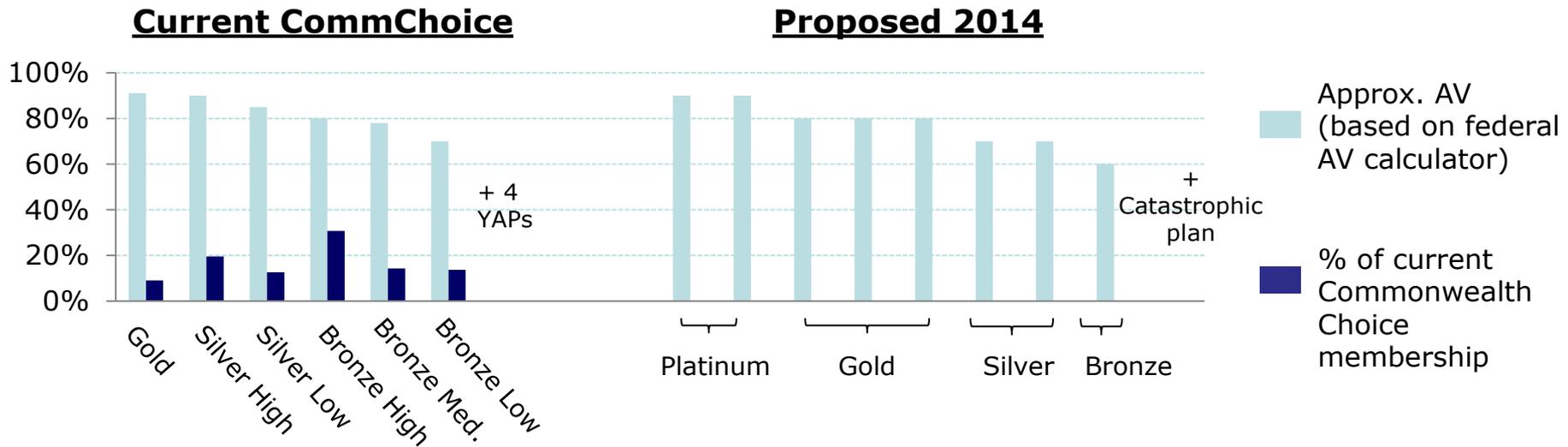
**300–400%
FPL
Population**

- This population will be NEWLY eligible for premium subsidies in the form of advance premium tax credits (APTCs)
- The subsidy is tied to the Silver level, but may be used to “buy up” or “buy down” across the metallic tiers



Size of Standardized Portfolio

We propose to largely retain the same number of standardized plans to provide adequate choice while maintaining a reasonable overall size.



- We continue to recommend that all carriers be required to offer the full set of standardized plans
 - Consistent with 2013, each carrier is required to offer at least one plan on its broadest commercial network for each of the 8 standardized plan designs
 - Additional narrower network plans on the standardized platform are allowed



Proposed Standardized Plan Designs

- The proposed standardized plan designs highlighted here reflect our efforts to date to construct a portfolio of plans leveraging our learning from the market
- We expect continued refinement of the plan parameters before our recommendation is finalized for the RFR. Key outstanding questions that influence our considerations include:
 - Are the proposed plans within each metallic tier and across tiers sufficiently different such that they represent meaningful choices for consumers?
 - Will this package of plans enable easy transition for the majority of current Commonwealth Choice members?
 - Does this package adequately capture plan design elements that are likely to emerge as market trends in 2014 and beyond?
- Our final recommendation may also be affected by the final federal AV calculator if modified from its proposed form



Potential 2014 Standardized Plans

Platinum (AV: 88% ~ 92%)			
	A	B	
Medical deductible	n/a	\$250/500	
Rx deductible	n/a	n/a	
Out-of-pocket Maximum	\$2,000/\$4,000	\$2,000/\$4,000	
	<i>Subj. to Ded.</i>	<i>Subj. to Ded.</i>	
PCP visits	\$25	\$20	
High-cost imaging	\$150	\$100	✓
Inpatient hospitalization	\$750	\$0	✓
Outpatient surgery	\$500	\$0	✓
Emergency room visit	\$150	\$100	✓
Rx			
Tier 1	\$15	\$15	
Tier 2	\$30	\$25	
Tier 3	\$50	\$45	

Do these two plans offer meaningful differences for consumers?



Potential 2014 Standardized Plans (cont'd)

Gold (AV: 78% ~ 82%)						
	A		B		C	
Medical deductible	\$500/\$1,000		\$1,250/\$2,500		\$2,000/\$4,000	
Rx deductible	n/a		n/a		n/a	
Out-of-pocket Maximum	\$5,000/\$10,000		\$5,000/\$10,000		\$5,000/\$10,000	
	<i>Subj. to Ded.</i>		<i>Subj. to Ded.</i>		<i>Subj. to Ded.</i>	
PCP visits	\$35		\$25		\$25	
High-cost imaging	\$250	✓	\$150	✓	\$100	✓
Inpatient hospitalization	\$750	✓	\$250	✓	\$0	✓
Outpatient surgery	\$500	✓	\$250	✓	\$0	✓
Emergency room visit	\$250	✓	\$150	✓	\$100	✓
Rx						
Tier 1	\$20		\$15		\$10	
Tier 2	\$30		\$25		\$25	
Tier 3	\$60		\$50		\$50	

Should we consider replacing one of these options with a plan analogous to the current Bronze High (with 35% co-insurance), given that it has the greatest proportion of current Commonwealth Choice membership?



Potential 2014 Standardized Plans (cont'd)

Silver (AV: 68% ~ 72%)				
	A		B	
Medical deductible	\$2,000/\$4,000		\$2,000/\$4,000	
Rx deductible	n/a		n/a	
Out-of-pocket Maximum	\$6,250/\$12,500		\$6,250/\$12,500	
	<i>Subj. to Ded.</i>		<i>Subj. to Ded.</i>	
PCP visits	\$30		\$35	
High-cost imaging	\$250	✓	35%	✓
Inpatient hospitalization	\$1,000	✓	35%	✓
Outpatient surgery	\$750	✓	35%	✓
Emergency room visit	\$250	✓	35%	✓
Rx				
Tier 1	\$15		\$15	
Tier 2	\$35		40%	
Tier 3	\$70		40%	

In light of the market analysis that suggests low take-up of co-insurance plans, should we consider excluding Silver B or replacing it with another co-pay plan (especially if we add our current Bronze High to Gold)?



Potential 2014 Standardized Plans (cont'd)

Bronze (AV: 58% ~ 62%)		
	A	
Medical deductible	\$2,000/\$4,000	
Rx deductible	n/a	
Out-of-pocket Maximum	\$6,250/\$12,500	
	<i>Subj. to Ded.</i>	
PCP visits	\$35	
High-cost imaging	\$400	✓
Inpatient hospitalization	\$1,000	✓
Outpatient surgery	\$1,000	✓
Emergency room visit	\$500	✓
Rx		
Tier 1	\$20	✓
Tier 2	\$40	✓
Tier 3	\$80	✓

If we believe the market has interest in "catastrophic-like" plans, is this option sufficient in meeting that demand? Are there alternative designs we ought to consider within the confines of ACA insurance market rules and our state MCC regulations?



Catastrophic Plans

ACA Requirements on Catastrophic Plans

- Must cover EHB
 - No coverage applied until deductible hits Maximum Out-of-Pocket limit on HDHP for a given year, with the exception that preventive care must be covered without cost-sharing, and that the deductible excludes at least three primary care visits
 - Available to specific populations only: up to age 30 or exempt from individual mandate on affordability grounds
 - Catastrophic plans are only available to individuals (not small group) and only through the Exchange
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- Premium price is expected to be attractive and therefore the product will likely have demand
 - Carriers are generally interested in offering catastrophic plans



Catastrophic Plans (cont'd)

- It is hard to predict, however, whether there will be significant enrollment in catastrophic plans in Massachusetts
 - Low un-insurance rate in the state
 - With the exception of YAP (~2,300 members), there are no comparable plans (~57% AV) in the current merged market
 - Alternative options through extended dependent coverage and student health insurance
- **Proposed Approach:**
 - Minimal additional standardization besides what is required by statute
 - Cost-sharing for primary care visits (at least 3 per year) must not exceed 50% in co-insurance or \$35 in co-pay, whichever is lower
 - Carriers that participate in the Exchange are permitted, but not mandated to offer catastrophic plans
 - However, if the Exchange does not receive an adequate number of catastrophic plans (e.g., 2 options), it reserves the right to require that each carrier offer one such plan



Non-Standardized Plans – Key Objectives

- Introduce meaningful diversification that adds positive value to the Exchange
 - Include plans that cannot easily fit into a standardized platform (*e.g.*, tiered network)
- Expand choice offered by our small-group product portfolio
 - Small businesses (often through brokers) are accustomed to comparing a wide range of options when making purchasing decisions
 - Some carriers have noted that for larger groups (25+) and certain industry “clusters”, they often market certain unique plan designs
- A select set of non-standardized products sold along with the standardized shelf also provides us with a perspective on how the market evolves, which will help us continuously improve our standardized plans
- Provide opportunity to work with carriers who have embraced the Exchange as a strong platform for offering products and have particular plan designs they wish to feature



Tiered Network

- **We recommend that the offering of tiered-network plans be included as a requirement that applies to certain carriers, as part of their non-standardized product portfolio on the Exchange**
- Specifically, carriers with greater than 1,000 commercial members on tiered-network products as of 2013 will be required to offer at least one tiered-network plan in either the Platinum or Gold tier
- Considerations:
 - We believe that tiered-network plans represent an important area of market demand and that including these plans adds meaningful value to the Exchange
 - Fitting tiered-network plans into the standardized framework would be very challenging for both consumers and carriers
 - Carriers that are not already offering tiered-network plans should not be mandated to do so
 - Incorporating tiered-network plans into our shopping experience design is a key ongoing effort



Maximum Number of Non-Standardized Plans

- **We recommend applying a “cap” on the number of non-standardized plans that each carrier is permitted to offer**
- Besides meeting the minimum requirement of offering standardized plans, each carrier may offer a maximum of 10 non-standardized plans
 - The cap is inclusive of the required tiered-network plans that apply to certain carriers
 - The cap does not apply to additional standardized plans (*e.g.*, on narrower networks) beyond the minimum requirement
- Rationale:
 - Maintain a reasonably-sized portfolio that is easy to navigate
 - Create incentives for carriers to offer attractive plans to maximize the value of their “shelf space”
 - Offer diverse product offerings to meet market preferences, while maintaining the core value of standardization
- The cap serves as a maximum, but the Health Connector is not obligated to accept all plans. All plans will continue to be subject to review by the Health Connector Board for determination of approval/inclusion



Non-Group vs. Small-Group Product Offerings

- **As previously proposed, we plan to offer a “base” of standardized plans that apply to both the small and non-group shelves**
- The standardized shelf will be supplemented by a small number of “high-value” non-standardized plans (e.g., tiered-network plans that are included in the requirement)
- For additional plans proposed beyond the minimum requirement, we recommend that carriers have the flexibility to choose whether a plan is to be offered through SHOP only or both shelves
 - Subject to Health Connector approval, all plans offered to non-group members will automatically be available to small groups through the Exchange
 - To comply with merged market rules, all plans must be made available to all eligible members at a market-wide level





Transition from Current Commonwealth Choice Plans

- **Incorporated into the scope of our 2014 product strategy is the planning for transition of current Commonwealth Choice members to new Exchange products**
- Like the rest of the small and non-group market, we anticipate that many Commonwealth Choice members will need to transition from their current plans to new, ACA-compliant plans during the course of 2014
- We envision a process in which the Health Connector will work with carriers to facilitate a “plan mapping” effort that helps members identify the Exchange plan option that most closely matches their existing plan parameters, while informing them of other alternatives that are available to them
 - Members will be provided advance notice of the proposed plan to which they would be automatically transitioned unless they choose otherwise, highlighting any plan design or premium differences
 - Members will have ample time to review alternative options, if interested
- The Health Connector has worked with members and carriers in the past to successfully perform these types of transitions (*e.g.*, plan closures due to low membership)



Subsidized QHPs with State Wrap



Proposed *High-Level* Approach

(As discussed at the Dec 2012 Board meeting)

- The wrap will be available to enrollees through a subset of QHPs offered on the Health Connector's Silver shelf
- Only certain carriers will qualify to offer wrap plans – those that offer the lowest-priced QHPs and potentially other requirements developed and specified by the Health Connector
- As in Commonwealth Care today, enrollees who choose the least expensive wrap plan will pay a base enrollee premium tied to their income level; enrollees who choose more expensive plans will pay higher premiums
- Also similar to Commonwealth Care today, cost-sharing will vary by “plan type” and enrollees within a given income level will have access to the same co-pays, regardless of which wrap plan they choose



Key Pending Decisions

- Our final recommendation on the specific parameters (base enrollee premium and cost-sharing) of the wrap plans will be informed by the release of the Administration's FY2014 Budget proposal
 - Our goal is to preserve coverage affordability for the up-to-300% FPL population as much as possible within available fiscal means
- Besides product-related issues, there are a host of additional decisions that need to be specified as part of the 2014 Seal of Approval design
 - What, if any, additional requirements will be applied to wrap plans and their issuers beyond what are required for all QHPs?
 - Operational details of wrap QHP certification, *e.g.*, coordination with the DOI form review and rate review processes
- We are currently working with MassHealth, ANF and DOI, as well as engaging stakeholder inputs to develop proposal details



Transition from Commonwealth Care

- Another critical element of the 2014 planning process is the transition of members from current subsidized programs to their ACA coverage configuration
 - The current Commonwealth Care program will bifurcate, with a portion of members moving to Medicaid, and the remainder accessing wrap QHPs through the Exchange
- Subject to permissibility under State funding, we are contemplating the pursuit of a contract renewal strategy for the final 6-month period of Commonwealth Care, instead of a re-procurement
 - Reduces disruption in the market in advance of a major transition process at the end of 2013
 - Allows health plans to focus on preparing for the 2014 Seal of Approval responses
- We plan to present our specific renewal proposal to the Board in February