

Health Connector Board of Directors Meeting

February 12, 2026



Agenda

1. Approval of Minutes
2. Executive Director's Report
3. Open Enrollment 2026 Recap
4. Topics Related to the Individual Mandate for 2027 (VOTE)
 - a) Affordability Schedule
 - b) Minimum Creditable Coverage Deductibles
5. Proposed Amendments to Minimum Creditable Coverage Regulations (VOTE)
6. Seal of Approval 2027 Preview

Approval of the Annual and November 13, 2025 Meeting Minutes (VOTE)

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Executive Director's Report

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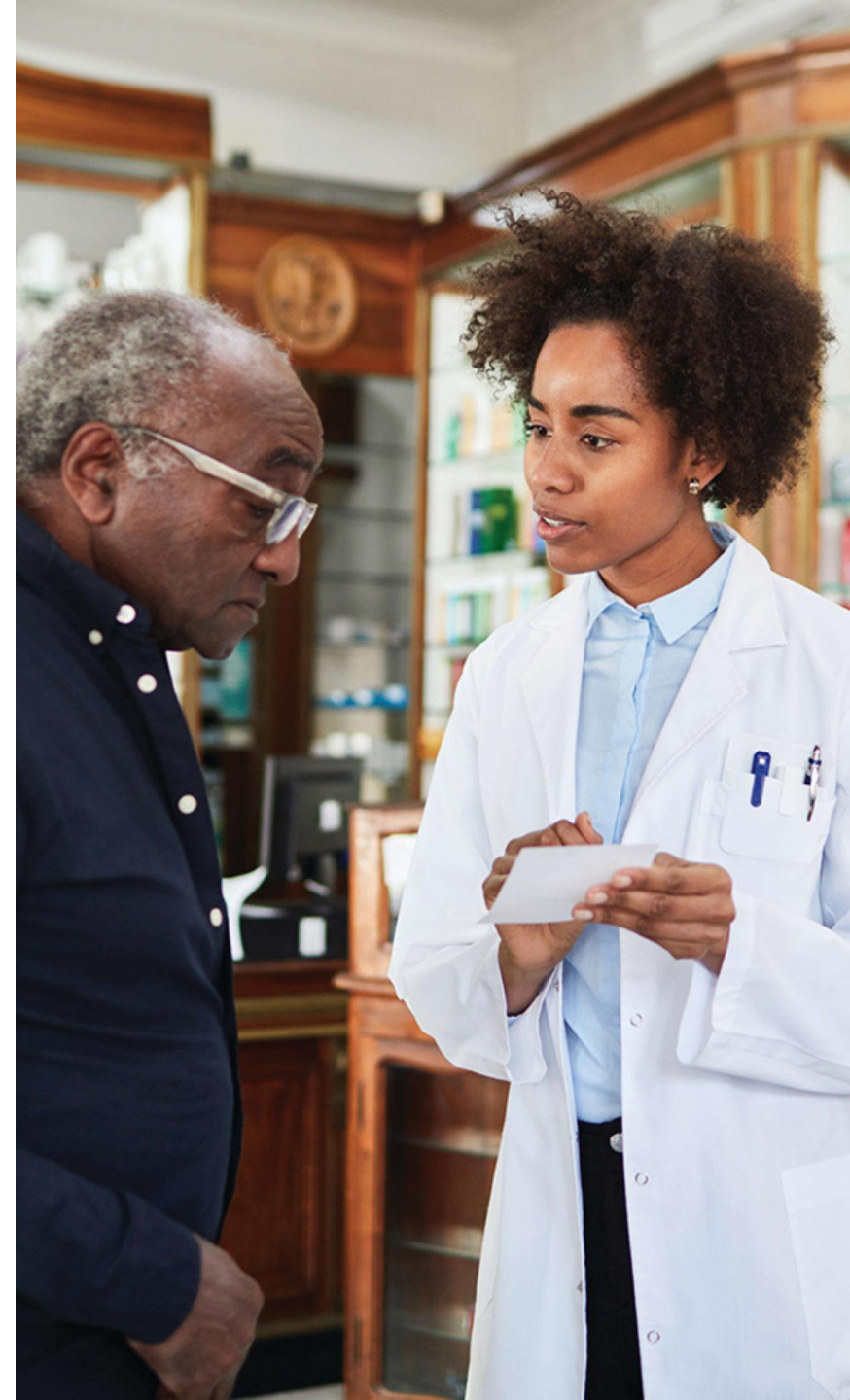
Open Enrollment 2026 Recap

Jason Lefferts, Senior Director of External Affairs

Patricia Grant, Deputy Executive Director and Chief
Operating Officer

Signe Flieger, Director of Policy

Board of Directors Meeting, February 12, 2026



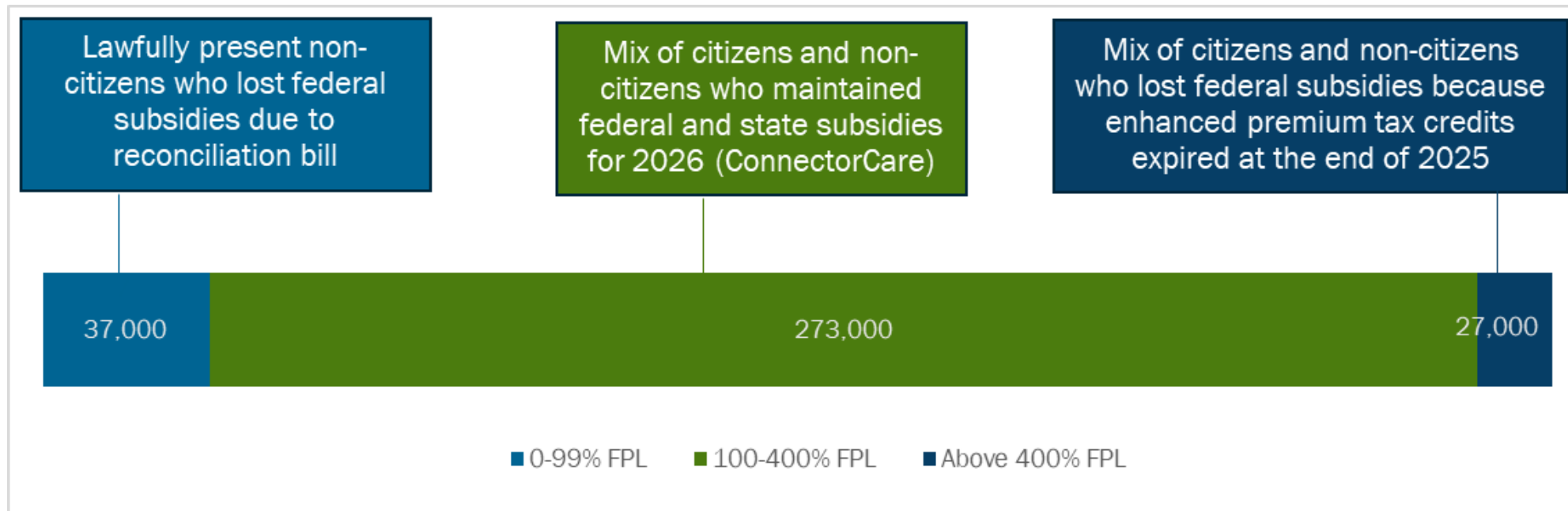
Overview

The 2026 Open Enrollment period was characterized by unprecedented eligibility changes, policy uncertainty, and enhanced outreach to promote retention and prevent coverage losses where possible. Today, staff will review:

- Changes heading into 2026 Open Enrollment (OE)
- Outreach and engagement
- Member and applicant supports
- Enrollment results

Federal Changes That Affected 2026 OE

Open Enrollment 2026 was challenging due to federal policy changes that eliminated or reduced federal subsidies for thousands of Massachusetts residents.

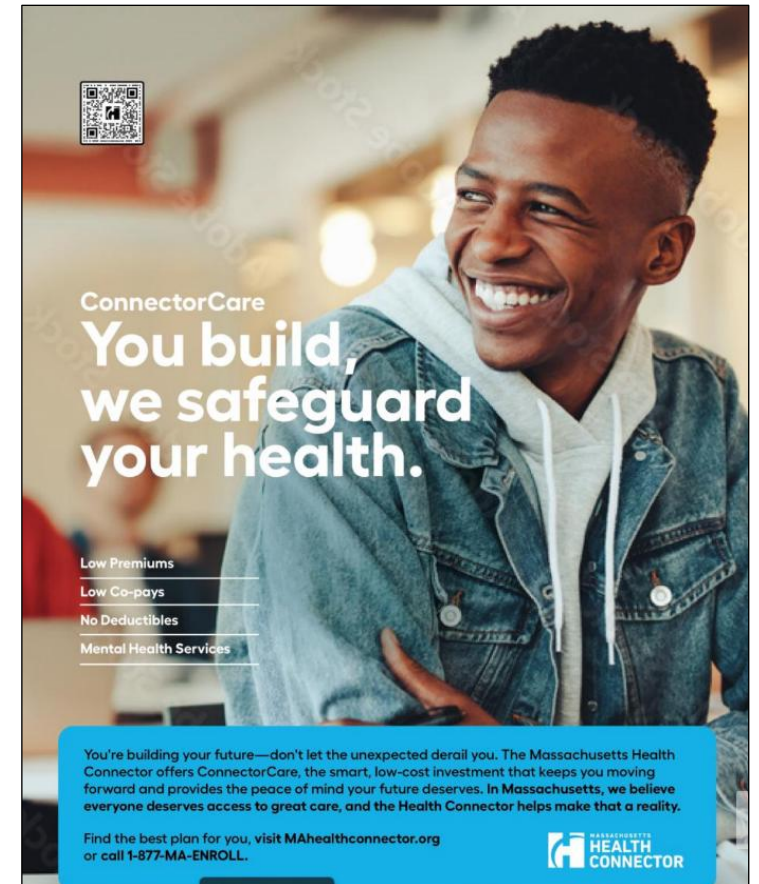


Outreach and Engagement

Outreach and Engagement

Federal changes carried distinct implications for outreach strategies:

- Members needed information about their status and options
- Enrollment messaging was adapted to meet the moment
- Media interest in the Health Connector and Marketplaces was at a peak



QR code

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MASSACHUSETTS HEALTH CONNECTOR

Outreach and Engagement (Cont'd)

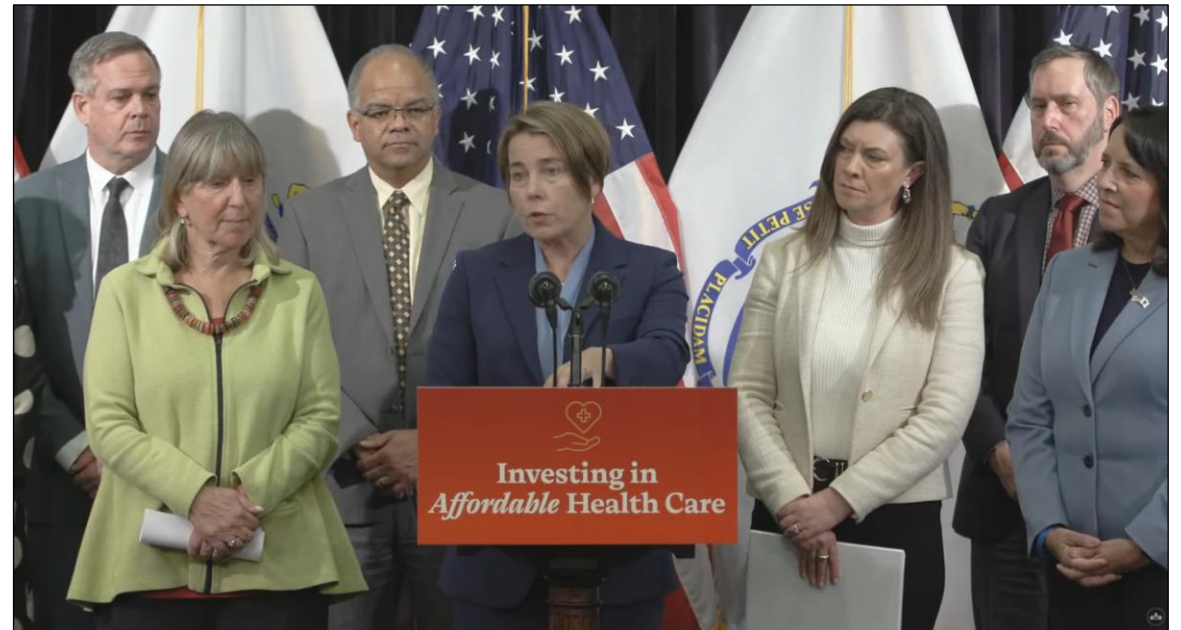
Direct messaging to members provided information and access to support.

- Communications began in mid-August, focusing on federal changes
- More than 50 different pieces of messaging were distributed during Open Enrollment
- Members were provided general information and detail specific to their status due to eligibility and premium changes
- [Mahealthconnector.org/updates](https://mahealthconnector.org/updates) has been a home for information

Outreach and Engagement (Cont'd)

Federal change dynamics fueled more than 140 press stories.

- Enrollment press events were held in Framingham and Springfield
- Gov. Maura Healey conducted three Health Connector-related press conferences
- State Marketplaces worked together nationally on messaging



Outreach and Engagement (Cont'd)

In-community activities continued to focus on encouraging enrollment.

- Material was distributed in 40 communities
- Mall visibilities timed for peak holiday season shopping
- 17,000 flyers in food orders in 10 communities leading up to the Jan. 23 deadline



Outreach and Engagement (Cont'd)

Marketing included a mix of platforms, with new emphasis on ways to meet changing media consumption.

- Additional focus placed on digital/streaming, and out-of-home methods
- PSAs on local television and radio stations were new for this year
- MassDOT billboards offered space on 70 locations



Outreach and Engagement (Cont'd)

Navigators provided critical community-based education and enrollment support during Open Enrollment 2026.

- 24 organizations provided support in 47 locations
- 158 certified Navigators assisted members in 29 languages
- From November-December, Navigators:
 - Helped consumers submit over 3,500 applications
 - Helped 9,700 individuals select and enroll in a plan
 - Assisted consumers to maintain coverage over 27,000 times

"So many people needed so much more assistance in choosing a plan that they could afford which also let them continue seeing their long-time providers as they tried to avoid the difficult decision of changes to a less-expensive plan and change physicians, or even drop coverage. We spent a lot of time with these members, helping them try to figure out the numbers so they could stay covered."

-Navigator Tina Alu

Member and Applicant Supports

Contact Center Performance During Open Enrollment

Contact Center volume increased this OE compared to last year.

OE 25-26	November '25	December '25	January '26*	TOTAL
Calls Offered	108,895	151,690	113,551	374,136
Calls Handled	105,971	143,615	107,087	356,673
Average Handle Time	15:54	15:02	15:04	Avg: 15:20

OE 24-25	November '24	December '24	January '25*	TOTAL
Calls Offered	101,112	126,431	114,620	342,163
Calls Handled	99,266	120,850	98,855	318,971
Average Handle Time	15:07	14:51	14:08	Avg: 14:55

*Through January 23, 2026

Service Levels Were Consistently High

Increased staffing levels led to more consistently high service levels for customers.

OE 25-26	30 seconds	60 seconds	120 seconds	240 seconds (callback threshold)
November	91%	95%	96%	98%
December	68%	74%	79%	85%
January*	69%	78%	85%	91%

NOVEMBER: Average speed to answer = 52 seconds, abandonment rate = 2.69%

DECEMBER: Average speed to answer = 2 minutes 24 seconds, abandonment rate = 5.32%

JANUARY: Average speed to answer = 2 minutes 22 seconds, abandonment rate = 5.69%

**Through January 23, 2026*

Contact Center Performance Review

Outside of a few days where the contact center struggled, overall performance was strong.

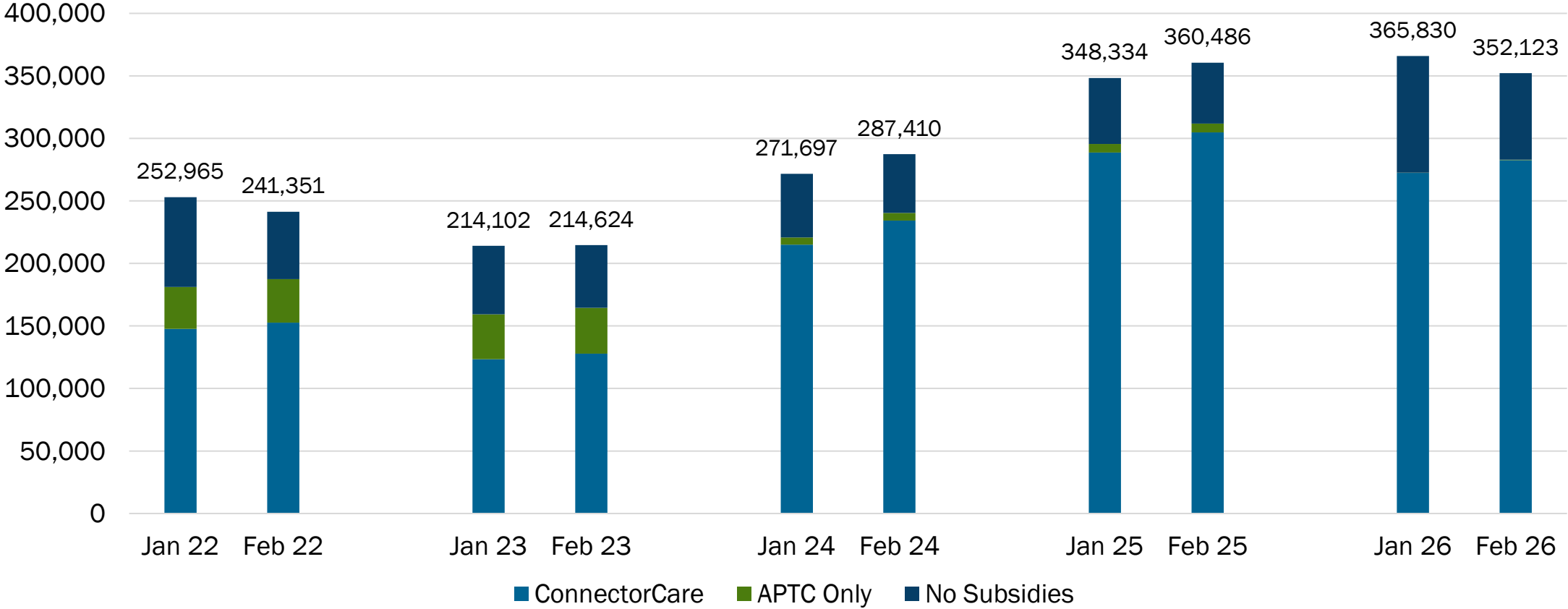
- With the exception of the first two days of Open Enrollment, the contact center maintained an average daily service level of 94 percent in November
- Despite a 40 percent increase in call volume in December, AHS successfully answered 85 percent of calls before a callback was offered
- In January, service level increased over December, and both average speed to answer and callbacks decreased
- Customer satisfaction score based on an after-call survey remained consistent throughout OE at 93 percent

Enrollment Results

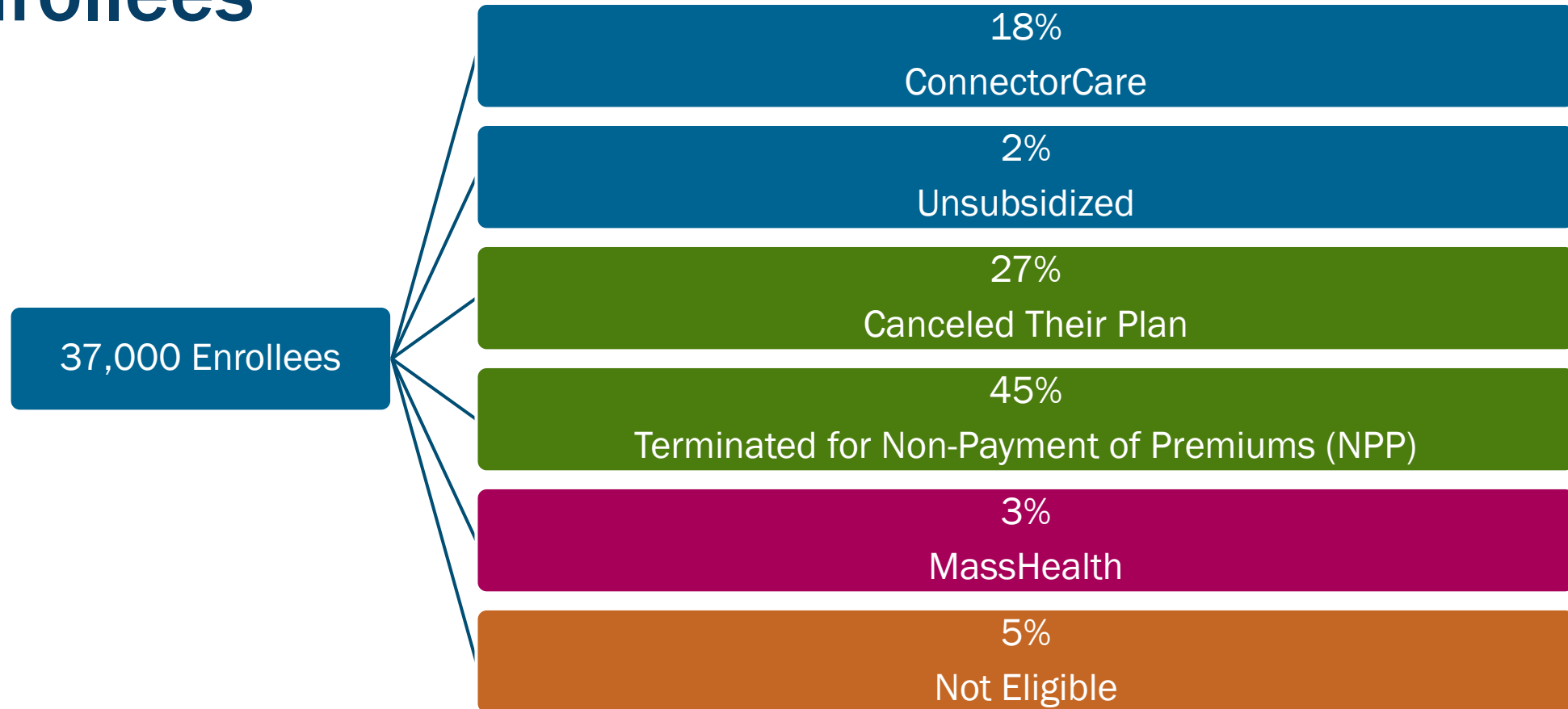
Key Takeaways

- Enrollment snapshots captured at the end of Open Enrollment do not tell the whole story this year
- Total enrollment is about 27,500 lower, a decrease of 7.2 percent
- Those who lost eligibility for subsidies were more likely to cancel their 2026 coverage, and more likely to have their plan terminated for non-payment of premium, relative to those who maintained subsidy eligibility
- Enrollment in ConnectorCare with income eligibility between 100 and 400 percent FPL remained strong

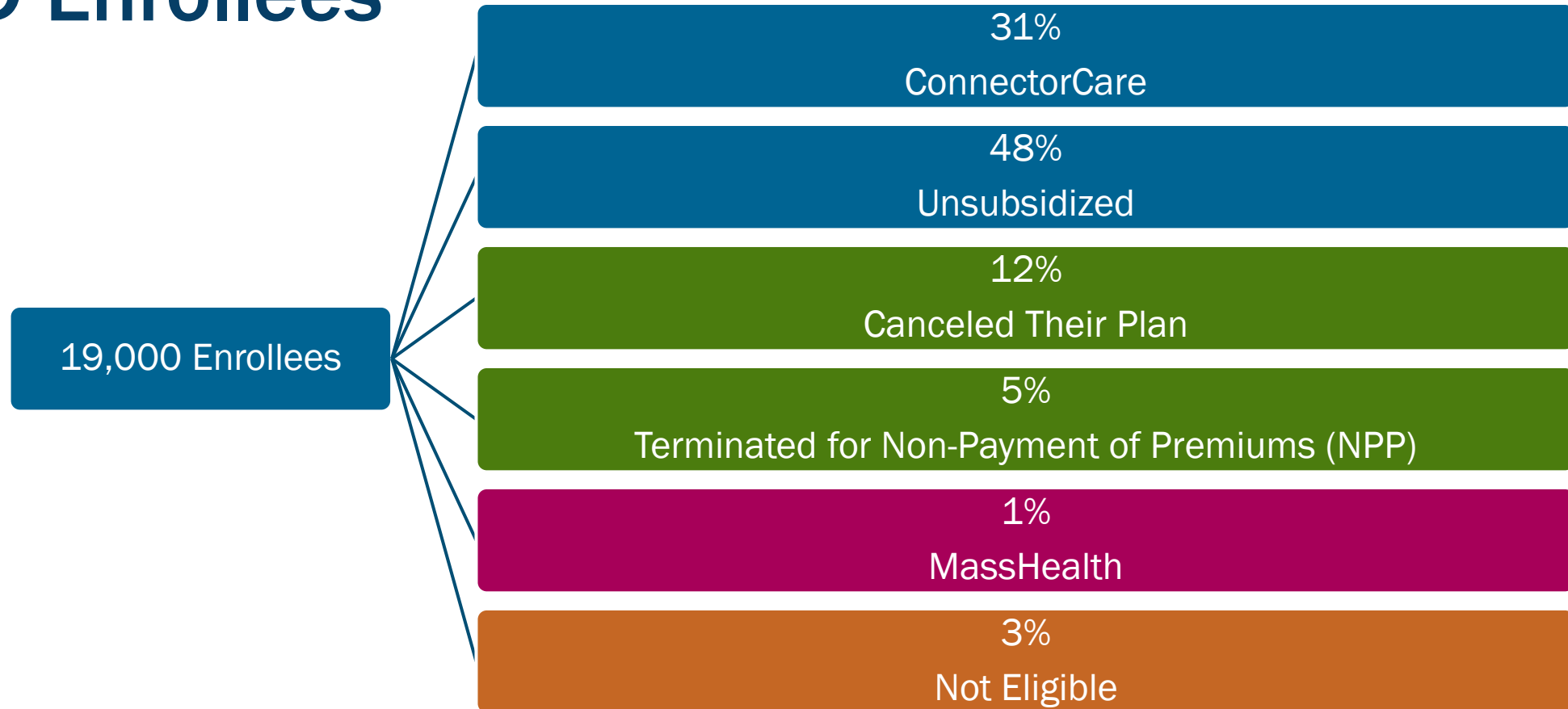
January and February Enrollment, 2022 to 2026



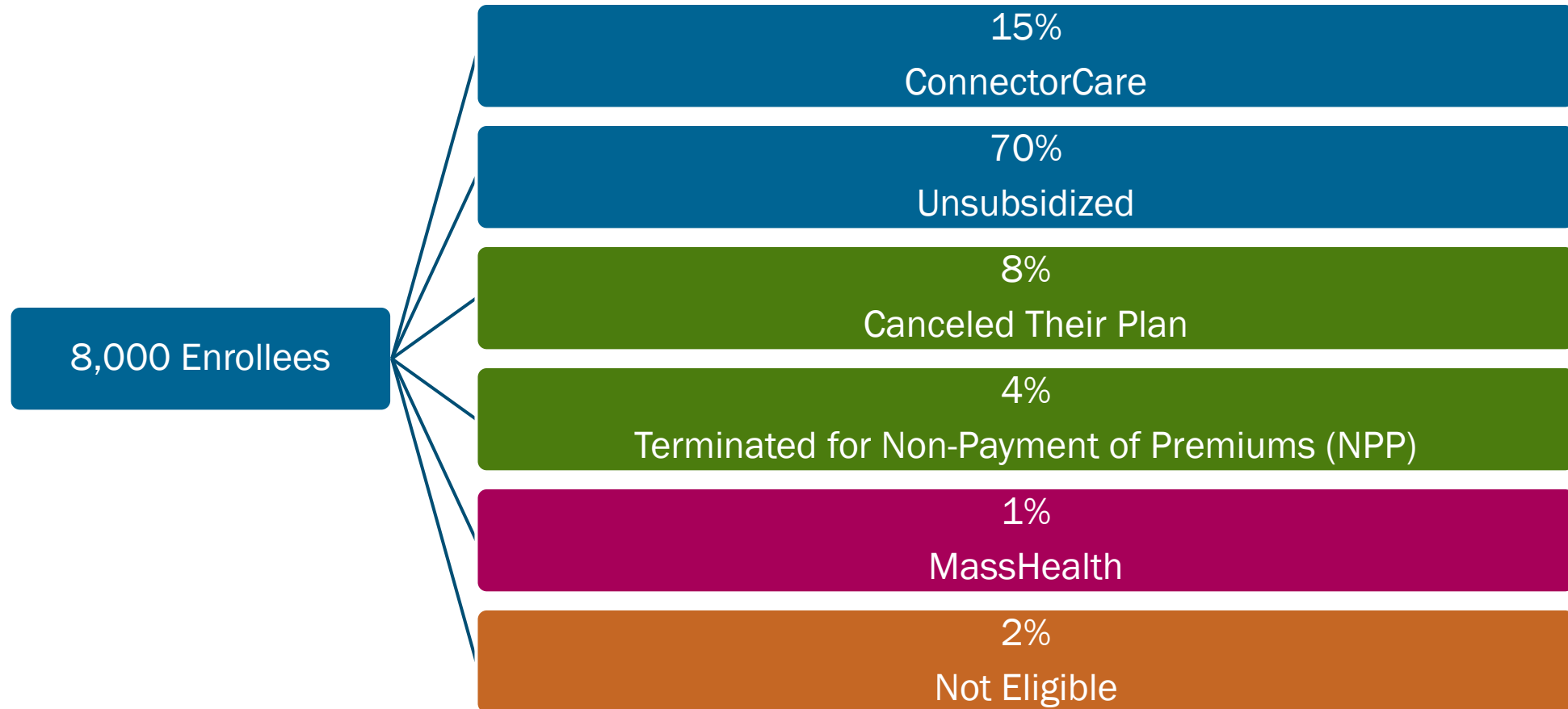
What Happened to ConnectorCare Plan Type 1 Enrollees



What Happened to ConnectorCare Plan Type 3D Enrollees



What Happened to APTC-Only Enrollees



ConnectorCare Enrollment (All OE)

While total ConnectorCare enrollment is down for 2026 compared to 2025, ConnectorCare enrollment within the 2026 eligibility criteria (between 100 and 400 percent FPL) is higher in 2026 relative to 2025.

ConnectorCare Plan Type	2026 Enrollment (All OE)	2025 Enrollment (All OE)
2A (100 – 150% FPL)	51,710	42,065
2B (150.1 – 200% FPL)	78,416	73,858
3A (200.1 – 250% FPL)	64,221	64,207
3B (250.1 – 300% FPL)	45,329	42,904
3C (300.1 – 400% FPL)	50,927	44,340
Totals	290,603	267,374

More People Fell Out of Coverage

- More than 22,000 actively canceled their 2026 enrollments, more than twice the rate of 2025 plan cancelations
- Nearly 35,000 Health Connector enrollees were terminated at the end of January due to non-payment, more than twice the number in 2025

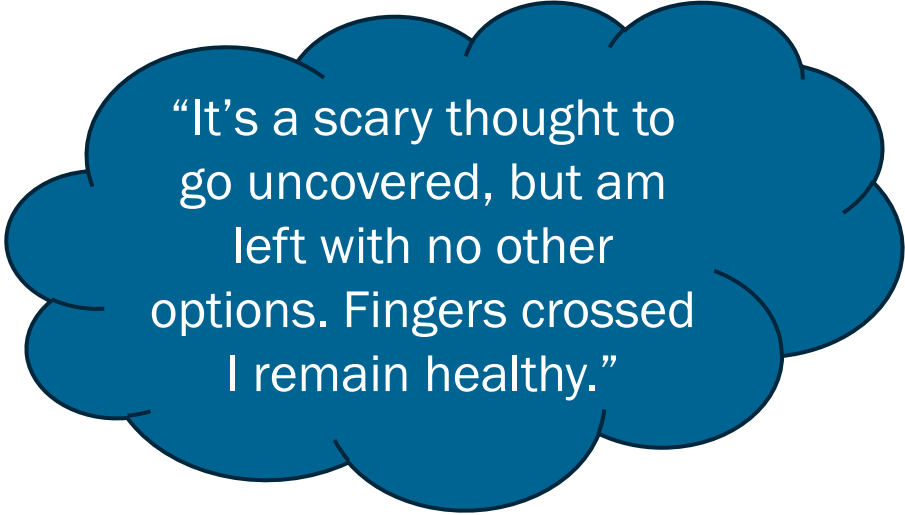
“I am very upset that I had to leave. But it was impossible to pay 890 dollars every month.”

“Premiums became astronomical, and I still had thousands of dollars of out-of-pocket costs. Not manageable, especially with everything else rising in cost.”

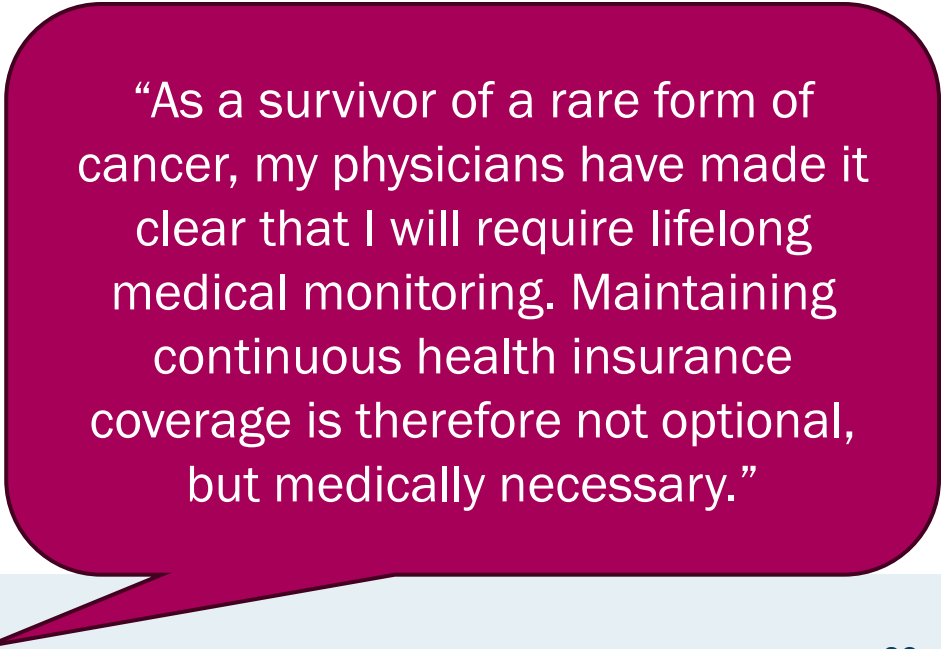
“The premiums were more than double what it was in 2025, and it had a \$4,000 deductible. That equals really no insurance and I just couldn’t afford the premiums being a single Mom.”

Coverage Matters

- People without coverage are:
 - More likely to delay or go without care due to cost
 - Less likely to access preventive care and chronic condition management
 - More like to accumulate medical debt



“It’s a scary thought to go uncovered, but am left with no other options. Fingers crossed I remain healthy.”



“As a survivor of a rare form of cancer, my physicians have made it clear that I will require lifelong medical monitoring. Maintaining continuous health insurance coverage is therefore not optional, but medically necessary.”

Moving Forward

- Continued support for individuals eligible for a special enrollment period
- Preparation for 2027 Open Enrollment
 - End no later than December 31, 2026, per federal rules
 - Changes to subsidy eligibility for certain immigrant populations
 - Impacts of MassHealth changes, including work requirements and 6-month eligibility checks
- Continued engagement with stakeholders and monitoring of the coverage landscape

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Topics Related to the Individual Mandate for Calendar Year 2027 (VOTE)

Kayla Scire, Associate Director of Policy

Board of Directors Meeting, February 12, 2026



Overview

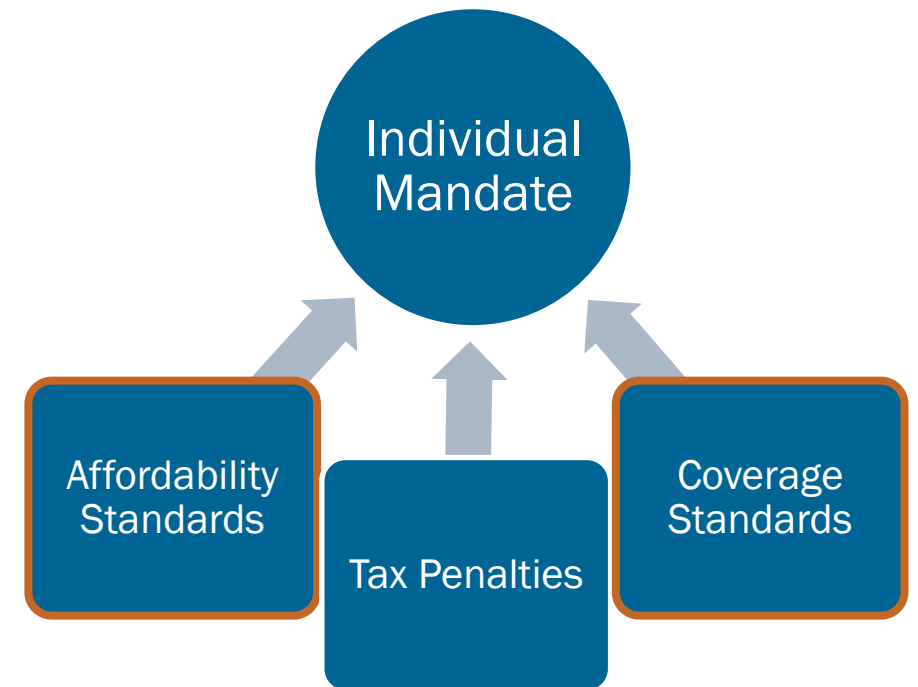
Today's presentation will propose for the Board's consideration annual updates for 2027 related to two components of the Commonwealth's individual mandate:

- **2027 Affordability Schedule**
 - Affordability schedule refresher
 - Proposed approach for 2027
 - Vote to release recommended 2027 schedule for public comment
- **2027 Deductible Limits within Minimum Creditable Coverage (MCC)**
 - Minimum Creditable Coverage deductible limit refresher
 - Proposed approach for 2027
 - Vote to finalize proposed 2027 MCC deductible limits

Background

Since 2007, Massachusetts has required adults to maintain health insurance, and the “individual mandate” remains an important tool in promoting market stability today.

- The Commonwealth’s individual mandate has a wide reach and is applicable to approximately 5 million Massachusetts residents
- The Health Connector Board is responsible for several policy aspects of the individual mandate, including affordability standards, Minimum Creditable Coverage (MCC) standards, and hardship exemption criteria
- Today’s discussion will focus on annual updates to the **affordability** and **coverage standards** for 2027



Affordability Schedule for Calendar Year 2027

How the Affordability Schedule Applies to the Market

The affordability schedule does determine whether an uninsured individual must pay a penalty for forgoing coverage.

- If an individual has access to coverage considered affordable but does not enroll, they will be assessed a tax penalty
- ConnectorCare contributions are always considered affordable according to the schedule and eligible individuals must enroll or pay a penalty

The affordability schedule does not require employers or carriers to offer affordable coverage.

- The affordability schedule does not penalize employers or issuers if individuals fail to enroll in affordable coverage they offered
- The affordability schedule is independent of federal policies related to affordable coverage standards and is separate from the determination of federal premium tax credit amounts

2027 Schedule: Proposed Approach

The proposed 2027 affordability schedule is consistent with the standards used in prior years (aside from when staff adjusted the schedule for high inflation for 2023 and 2024).

- Until 2023, the Board maintained steady percentages of income considered affordable but incorporated updated federal poverty guidelines each year that drove changes in terms of the dollar values of premiums considered affordable
- For 2023 and 2024, due to high inflation, staff proposed, and the Board finalized, reductions in the percentage of income considered affordable
- For 2025, the Board approved going back to the pre-2023 affordability percentages to account for easing of inflation in 2025
- If the Board votes to approve the proposed schedule for 2027, Health Connector staff will release the schedule for public comment as required by our statute. We will then return to the May Board meeting to summarize public comments received within a 30-day comment period and request a vote on the final 2027 affordability schedule
- For 2027, staff are proposing to stay consistent with last year's approach and continue with the original standards

2027 Schedule: Proposed Approach (Cont'd)

% of FPL	2025 Individuals' Affordability Standards	2026 Individuals' Affordability Standards	2027 Individual's Affordability Standards (Proposed)
0 – 150%	0%	0%	0%
150.1 – 200%	2.90%	2.90%	2.90%
200.1 – 250%	4.20%	4.20%	4.20%
250.1 – 300%	5.00%	5.00%	5.00%
300.1% – 350%	7.45%	7.45%	7.45%
350.1% – 400%	7.60%	7.60%	7.60%
Above 400%	8.00%	8.00%	8.00%

Proposed 2027 Schedule: Individuals

% of FPL	Bottom of Income Range	Top of Income Range	Affordability Standard	Bottom of Affordable Monthly Premium Range	Top of Affordability Monthly Premium Range
0 - 150%	\$0	\$23,475	0%		
150.1 - 200%	\$23,476	\$31,300	2.90%	\$58	\$77
200.1 - 250%	\$31,301	\$39,125	4.20%	\$112	\$140
250.1 - 300%	\$39,126	\$46,950	5.00%	\$166	\$200
300.1 - 350%	\$46,951	\$54,775	7.45%	\$297	\$347
350.1 - 400%	\$54,776	\$62,600	7.60%	\$354	\$404
Above 400%	\$62,601		8.00%	\$426	

Proposed 2027 Schedule: Couples

% of FPL	Bottom of Income Range	Top of Income Range	Affordability Standard	Bottom of Affordable Monthly Premium Range	Top of Affordability Monthly Premium Range
0 - 150%	\$0	\$31,725	0%		
150.1 - 200%	\$31,726	\$42,300	4.30%	\$116	\$155
200.1 - 250%	\$42,301	\$52,875	6.20%	\$224	\$280
250.1 - 300%	\$52,876	\$63,450	7.40%	\$334	\$400
300.1 - 350%	\$63,451	\$74,025	7.45%	\$403	\$470
350.1 - 400%	\$74,026	\$84,600	7.60%	\$480	\$548
Above 400%	\$84,601		8.00%	\$577	

Proposed 2027 Schedule: Families

% of FPL	Bottom of Income Range	Top of Income Range	Affordability Standard	Bottom of Affordable Monthly Premium Range	Top of Affordability Monthly Premium Range
0 - 150%	\$0	\$39,975	0%		
150.1 - 200%	\$39,976	\$53,300	3.45%	\$118	\$157
200.1 - 250%	\$53,301	\$66,625	4.95%	\$225	\$282
250.1 - 300%	\$66,626	\$79,950	5.85%	\$333	\$400
300.1 - 350%	\$79,951	\$93,275	7.45%	\$509	\$594
350.1 - 400%	\$93,276	\$106,600	7.60%	\$606	\$692
Above 400%	\$106,601		8.00%	\$729	



Board Vote

Vote

Health Connector staff recommend that the Board of Directors vote to issue for public comment the draft Affordability Schedules for Individuals, Couples, and Families for Calendar Year 2027, as set forth in the staff proposal.

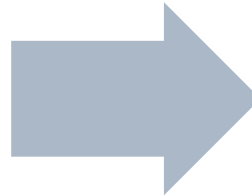
Minimum Creditable Coverage (MCC) Deductible Limits for Calendar Year 2027

Background on MCC's Deductible Limits

MCC standards both reflect and shape market “norms” for coverage in determining what kind of coverage is sufficient to avoid a penalty under state health coverage requirements.

2007-2019

- Regulations set MCC deductible limits at \$2,000 for an individual and \$4,000 for a family
- A 2013 update to the regulations called for annual indexing of deductible limits, but the methodology relied on a federal provision that was later repealed prior to becoming effective, so the regulatory update was ineffectual (resulting in no indexing)



2020-Current

- Updated Health Connector regulations allow for yearly updates to the limits, consistent with indexing on Maximum Out of Pocket limits under the ACA
- Adjustments were needed to allow individuals with “market standard” coverage to avoid tax penalties
- Further, the adjustments provide needed flexibility in designing plans that meet Federal Actuarial Value constraints

How MCC Deductible Limits Apply to the Market

MCC deductible limits do determine what kind of coverage an individual can have and “check the box” when they file their taxes.

- Indexing of deductibles allows flexibility in plan design that helps plan sponsors create high-value, MCC-compliant plans that residents can use to comply with individual mandate requirements
- Without periodic indexing, state residents may be unfairly penalized through the individual mandate despite having coverage that meets reasonable minimum standards

MCC deductible limit changes do not require deductible changes for consumers.

- The deductible limits proposed today also do not impact high-deductible health plans (HDHPs) as defined by the IRS
 - The IRS will publish 2027 cost sharing requirements for HDHPs later this year
 - HDHPs that are compatible with Health Savings Accounts (HSAs) or Health Reimbursement Arrangements (HRAs) qualify as MCC under Health Connector regulations

2027 MCC Deductible Limits – Indexing Background

The Health Connector's MCC regulations state that MCC deductible limits are indexed annually using the premium adjustment percentage published by the U.S. Dept. of Health and Human Services or may be another amount determined by the Board.

- The premium adjustment percentage is used by CMS to index the maximum annual limitation on cost sharing and other parameters in the ACA
- The premium adjustment percentage is a measure of premium growth and represents the percentage (if any) by which the average premium for health insurance coverage for the preceding calendar year exceeds the average premiums for health insurance for 2013
- The 2027 premium adjustment percentage is 1.8916224814 (\$8,919/\$4,715) which represents an increase in private health insurance premiums (excluding Medigap and property and casualty insurance) of approximately 89.2 percent over the period from 2013 to 2026

Adjustment of MCC Deductibles

- Using the premium adjustment percentage, the MCC deductible limits for 2027 would be \$3,750 for individuals and \$7,500 for families
- This would represent a \$550 and \$1,110 increase for the MCC individual and family deductible limits, respectively
 - \$3,200 ➡ \$3,750
 - \$6,400 ➡ \$7,500
- This is a 17.2 percent increase, which is significantly higher than ever before
- This comes after an already steep increase from 2025 to 2026 (10.8 percent) compared to past year over year increases (3.6 percent on average)
- Based on this, Health Connector staff recommend freezing 2027 deductible limits at the 2026 levels

2027 MCC Deductible Limits

Staff recommend freezing MCC deductible limits at the 2026 levels for 2027.

Deductible Limit	2025 Final deductible limits (frozen from 2024)	2026 Final deductible limits (indexed)	2027 Proposed deductible limits
Individual Medical	\$2,950	\$3,200	\$3,200
Individual Separate Prescription	\$360	\$400	\$400
Family Medical	\$5,900	\$6,400	\$6,400
Family Separate Prescription	\$720	\$800	\$800



Board Vote

Vote

Health Connector staff recommend that the Board of Directors vote to approve the deductible limits for Plan Year 2027, as set forth in the staff proposal.

Agenda

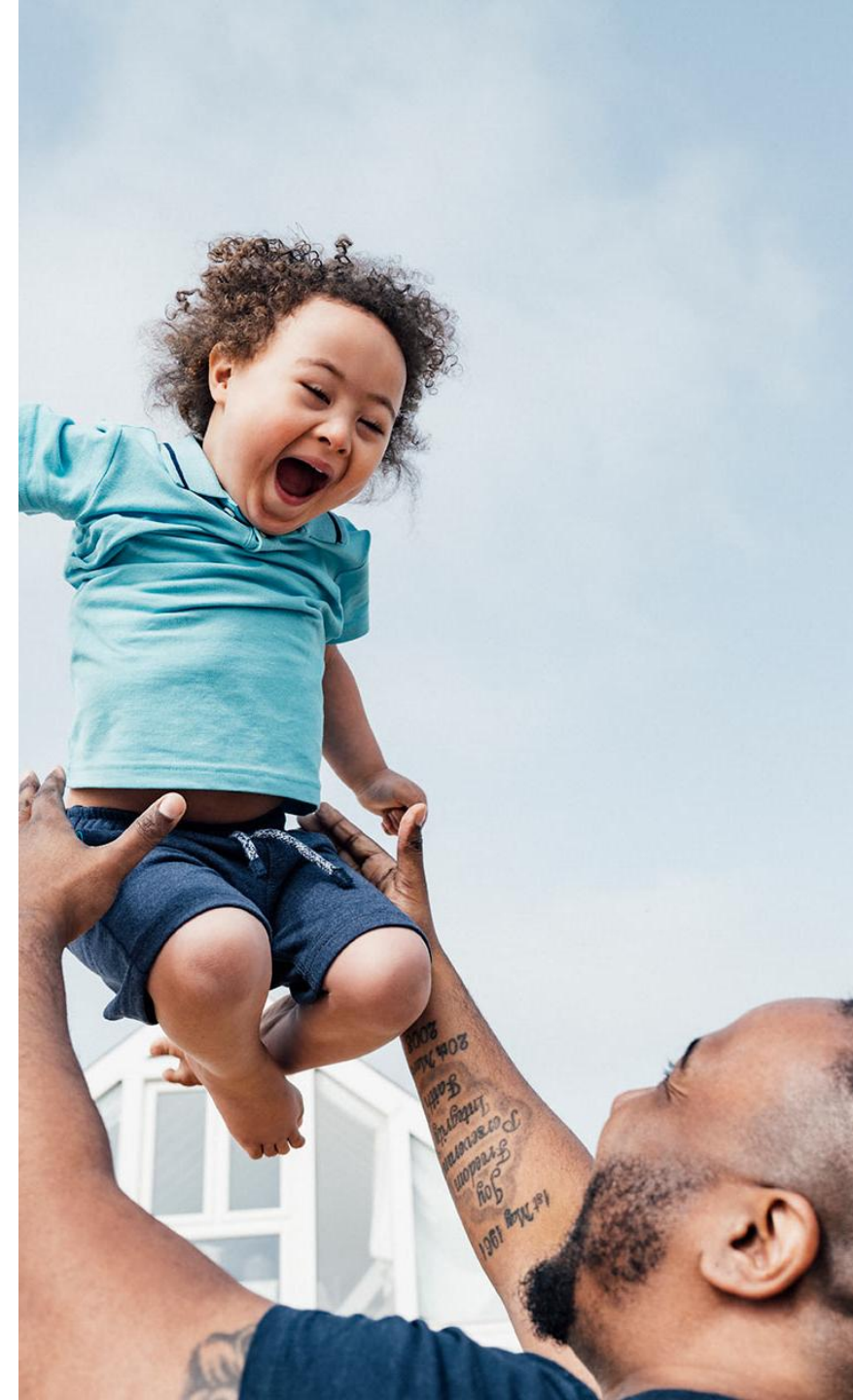
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Proposed Amendments to the Minimum Creditable Coverage Regulations (VOTE)

Emily Sroczyński, Senior Policy and Applied
Research Analyst

Michael Cannella, Assistant General Counsel

Board of Directors Meeting, February 12, 2026



Overview

Staff seek a Board vote today on an amendment to Minimum Creditable Coverage (MCC) regulations to preserve evidence-based no cost preventive services by requiring that coverage can only meet MCC standards if it includes, at minimum, those services that were identified as recommended services pursuant to federal law as of July 1, 2025. This amendment will prevent the erosion of existing benefits in the Massachusetts market today if current preventive services lose their “recommended” status.

- Minimum Creditable Coverage (MCC) and Preventive Services
- Federal policy landscape and Preventive Services
- Proposed amendments
- Board vote

Minimum Creditable Coverage (MCC) and Preventive Services

Minimum Creditable Coverage (MCC)

As part of Chapter 58 of the Acts of 2006, Massachusetts law requires adult residents to have health insurance that meets the state's Minimum Creditable Coverage (MCC) standards or potentially face an individual mandate penalty.

- State law defines MCC at a high level and authorizes the Health Connector Board to set minimum standards for plans that individual residents are required to have (via MCC regulations)
- The Health Connector's MCC regulations govern what constitutes MCC for approximately 5.6 million state residents
- MCC outlines the type of coverage a person needs to avoid facing a tax penalty under the state's individual mandate, establishing a "floor" of benefits required to "check the box" as having been covered

Preventive Services

Currently, MCC regulations rely on the federal definition for Preventive Health Services (42 U.S.C. § 300gg-13) to identify the no-cost preventive services that a Massachusetts resident needs in their coverage to satisfy the individual mandate.

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved;
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- With respect to women, such additional preventive care and screenings not described in 42 U.S.C. § 300gg-13 as provided for in comprehensive guidelines supported by HRSA

Federal Policy Landscape and Preventive Services

Braidwood Management Inc. v. Becerra

- *Braidwood Management Inc. v. Becerra* challenged the provision that required coverage of preventive services without cost sharing
- The U.S. Supreme Court ruled that the Affordable Care Act's (ACA) mechanism for requiring that health plans cover a broad range of preventive services, and without cost-sharing, was constitutional
- However, the Court gave the Secretary of Health and Human Services broad authority to change makeup of the recommending bodies

Recent Modifications to Federal Preventive Services

- In June 2025, the HHS Secretary changed the membership of ACIP
- In the fall of 2025, the newly constituted ACIP issued recommendations that are inconsistent with evidence, as documented by the Massachusetts Department of Public Health*
- Risk of future erosion of the scope of evidence-based preventive services recommended by those bodies (USPSTF, ACIP, and HRSA)

Proposed Regulation Amendments

Proposed Amendment to 956 CMR 5.00

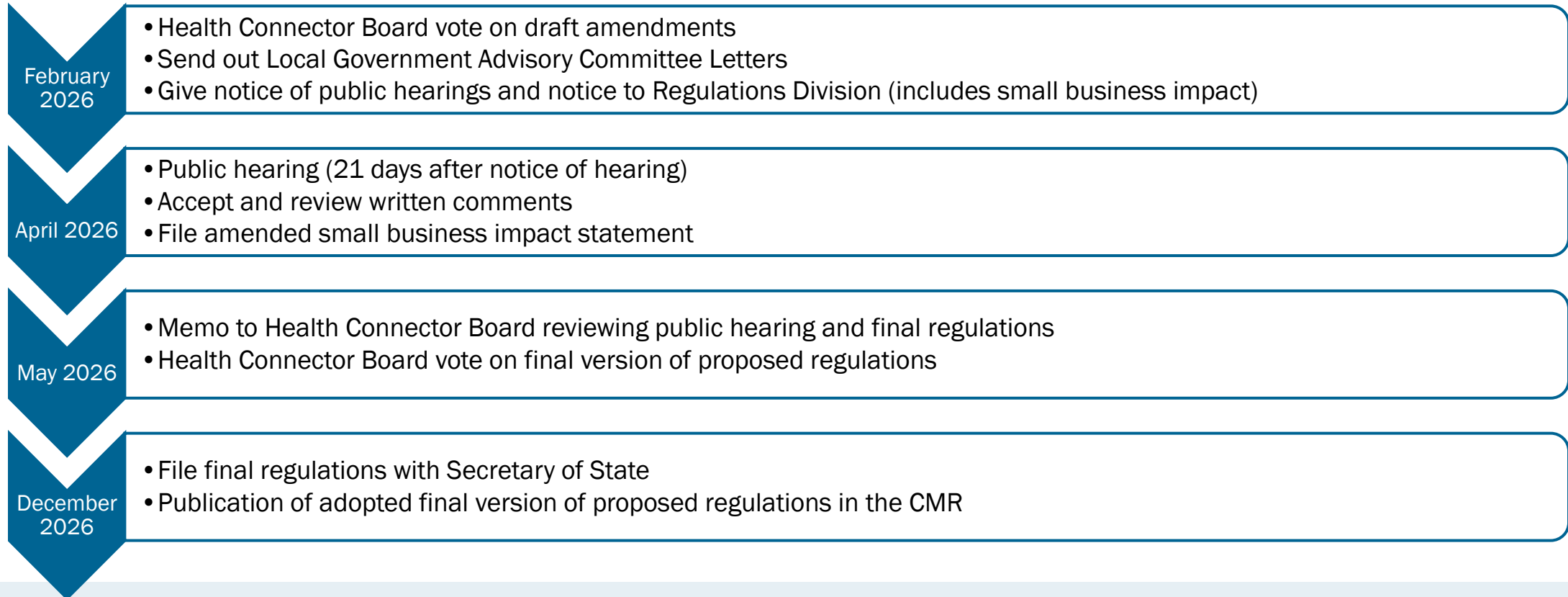
Current regulations at 956 CMR 5.00 define Preventive Health Services by referring to the definition in federal law, therefore Health Connector staff propose draft amendments to lock in federally defined preventive services in effect as of July 1, 2025, to ensure those entities cannot weaken access to existing robust coverage of preventive services in Massachusetts or change residents' ability to afford and access these services.

- The regulatory change would be to the definition of "Preventive Health Services" as appearing at 956 CMR 5.02 by adding the qualifying phrase: "provided, however, that these services shall, at minimum, include all such preventive health services required by established federal regulatory and sub-regulatory guidance pursuant to 42 U.S.C. § 300gg-13 as of July 1, 2025"
- Health Connector staff also propose aligning the publication of this regulatory change with the 2027 tax year to ensure that Massachusetts residents have consistent guidance about whether their coverage met MCC standards

Regulation Process

Timeline and Next Steps

The process to amend regulations would officially begin with today's Board vote.





Board Vote

Vote

Health Connector staff recommend that the Board of Directors vote to approve the draft regulation amendments at 956 CMR 5.00, as proposed.

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Seal of Approval 2027 Preview

Monica Smolinski, Program and Product Specialist

Marissa Woltmann, Chief of Policy and Plan Management

Board of Directors Meeting, February 12, 2026

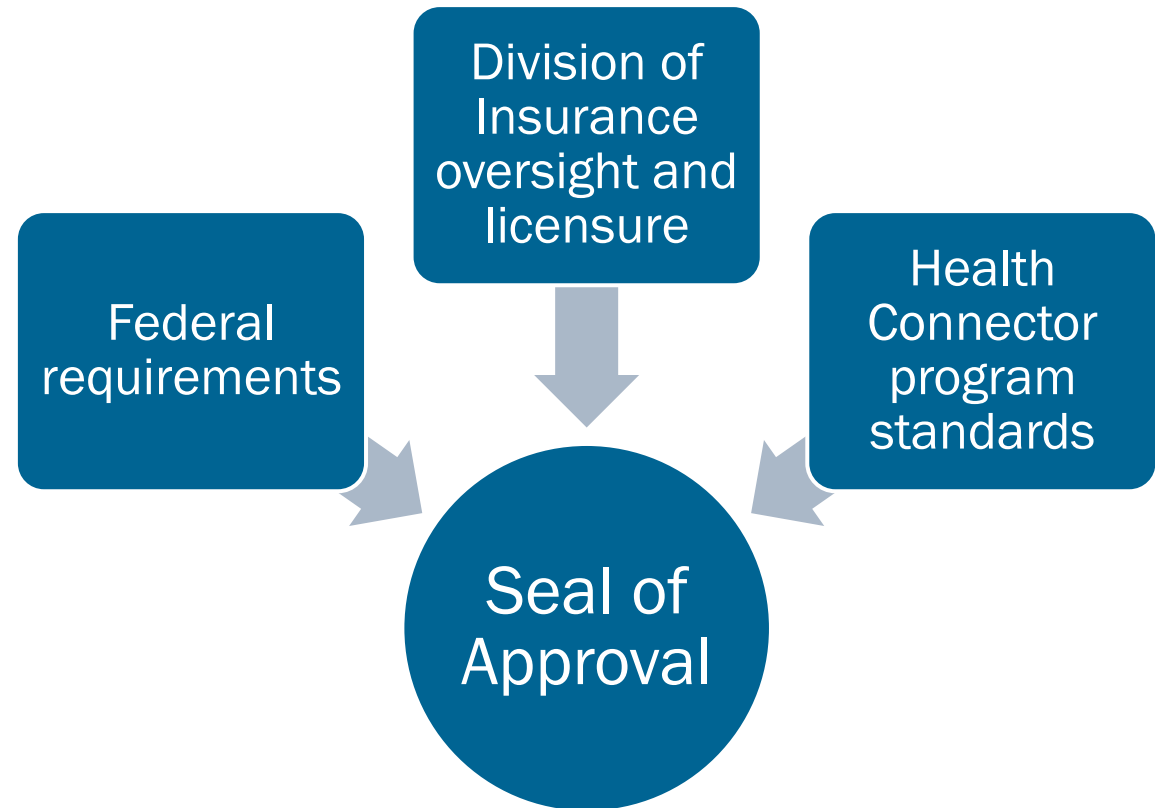


Overview

- Background and Goals for 2027
- Product Shelf
- ConnectorCare
- Additional Proposed 2027 Adjustments
- Next Steps

Seal of Approval (SOA) Background and Goals

- SOA supports the certification of Qualified Health Plans for Health Connector members
- State law empowers the Board to confer the Seal of Approval



2027 Strategic Objectives



Deliver high value coverage to the residents of Massachusetts

- Offer a robust suite of individual and small business products at different price points to maintain high levels of insurance given changes in subsidies and rates



Improve equitable access to affordable health insurance coverage

- Address affordability, access and member health equity through product innovation and pilots



Improve and modernize the applicant and enrollee experience

- Simplify and improve plan comparison and shopping experience for enrollees
- Gain greater efficiency through improved internal processes

Stakeholder Input

- Staff conducted a stakeholder survey and received feedback from Board members
 - Received thoughtful feedback on proposals included for today's discussion
 - Collected information on alternative supports for weight loss after discontinued GLP-1 coverage—an area the Health Connector continues to monitor



Product Shelf

Current Product Shelf



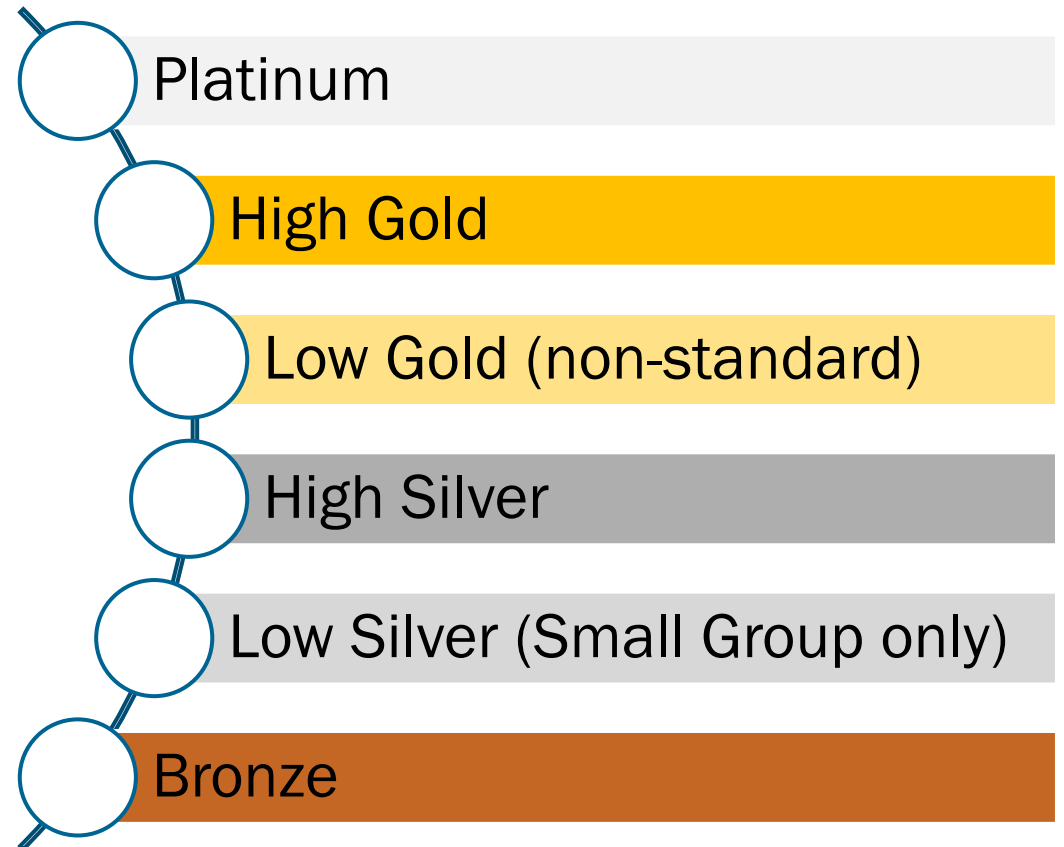
48 Individual plans



56 Small Group plans



12 Individual and Small Group Dental plans



Overview of Proposed Changes

- To offer plans that support members in getting needed care at an affordable price point, staff propose several plan design changes for 2027:
 - Opportunity to offer plans with cost sharing based on site of service
 - Provide for up to three pre-deductible (i.e., copay only) PCP/BH visits in Bronze plans

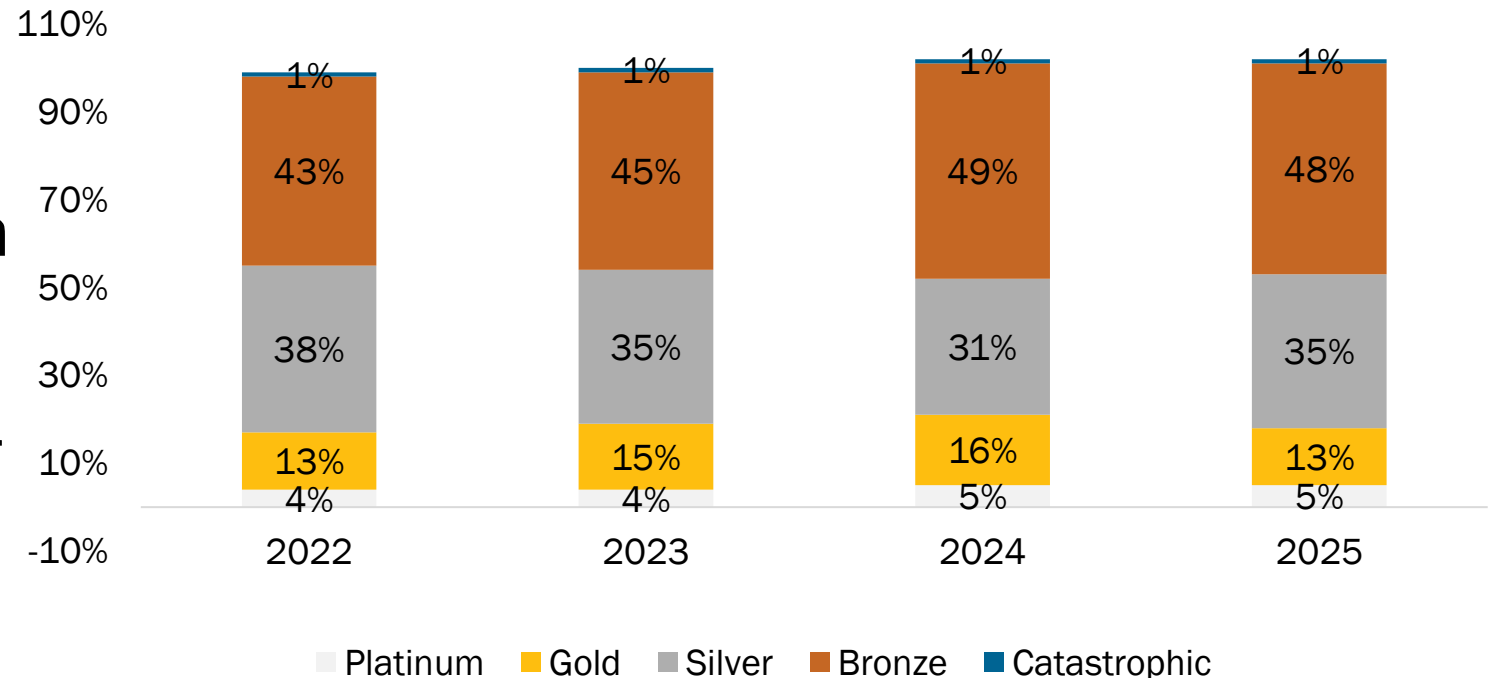
Site of Service (SOS) Plan Option

- Prices for services vary significantly depending on where they are provided, with hospital-based services more expensive than non-hospital-based services
- Allow plans to innovate with SOS benefits, lowering overall premium
 - To avoid crowding the product shelf, carriers could offer plans with SOS *in lieu of* standard non-silver metal level plans, rather than in addition to standard designs
 - Provide specific services they may apply to (e.g., Lab, High-Cost Imaging, Outpatient Surgery), with standard plan design required for other services
 - Provide parameters for how far AV can deviate from standard plan AV
 - Ensure network adequacy of low-cost sites
- Due to low-cost sharing and complexity, this variation will not be available in ConnectorCare plans (including base silver plan)

Pre-Deductible PCP/BH Visits

- To avoid forgone care, staff propose adding three pre-deductible PCP/outpatient behavioral health visits in Bronze plans
- Members would pay their PCP copay, but not the full cost of the office visit

Non-group, Non-ConnectorCare Metal Tier Choice, as a Percent of Total Non-ConnectorCare Enrollment, 2017-2025



ConnectorCare

Proposed ConnectorCare Contributions

- Modest increases in enrollee contributions are consistent with prior years and would remain affordable under the proposed individual mandate affordability schedule

	Plan Type 2		Plan Type 3		Pilot Population, if extended
Subgroups	2A	2B	3A	3B	3C
Income range (% FPL)	100.01-150%	150.01-200%	200.01-250%	250.01-300%	300.01-400%
2026 Minimum enrollee contribution	\$0	\$53	\$103	\$152	\$235
2027 Proposed minimum enrollee contribution	\$0	\$55	\$107	\$158	\$242

Premium “Smoothing”

- “Smoothing” subsidies are provided to some plans to mitigate premium differences between options for ConnectorCare members
- Staff recommend continued narrowing of the availability of smoothing, with exceptions in regions where no plan is within \$200 of the lowest cost plan considered to ensure stability for members

Change to cap on smoothing	Percent of the ConnectorCare Plan rate difference that may be subsidized				
	Plan Type 2A	Plan Type 2B	Plan Type 3A	Plan Type 3B	Plan Type 3C
Cap on lower-cost plans would drop from \$60 to \$45	100%	65%	20%	15%	0%
Cap on higher-cost plans would drop from \$250 to \$200	50%	32.5%	10%	7.5%	0%

Additional Proposed 2027 Adjustments

Administrative Simplicity

- Aim to streamline submissions and provide clear expectations around
 - Addressing forgone care
 - Ongoing doula coverage discussions
 - AI use in plan administration
 - Language access services
 - \$0 copay drugs



Next Steps

Next Steps

- Request for Responses (RFR) will be released to carriers later this month
- Staff will share updates on the plan certification process as it moves forward, including:
 - Any changes needed based on federal regulatory guidance or actuarial value calculator
 - July memo on responses received
 - September Board vote to award the Seal of Approval certification

Thank You and Adjournment

Appendix

2026 Affordability Schedule for Reference

2026 Affordability Schedule

% of FPL	2024 Individuals' Affordability Standards	2025 Individuals' Affordability Standards	2026 Individuals' Affordability Standards
0 – 150%	0%	0%	0%
150.1 – 200%	2.70%	2.90%	2.90%
200.1 – 250%	3.95%	4.20%	4.20%
250.1 – 300%	4.68%	5.00%	5.00%
300.1% – 350%	7.45%	7.45%	7.45%
350.1% – 400%	7.60%	7.60%	7.60%
Above 400%	8.00%	8.00%	8.00%

2026 Schedule: Individuals

% of FPL	Bottom of Income Range	Top of Income Range	Affordability Standard	Bottom of Affordable Monthly Premium Range	Top of Affordability Monthly Premium Range
0 - 150%	\$0	\$23,475	0%		
150.1 - 200%	\$23,476	\$31,300	2.90%	\$57	\$76
200.1 - 250%	\$31,301	\$39,125	4.20%	\$110	\$137
250.1 - 300%	\$39,126	\$46,950	5.00%	\$163	\$196
300.1 - 350%	\$46,951	\$54,775	7.45%	\$291	\$340
350.1 - 400%	\$54,776	\$62,600	7.60%	\$347	\$396
Above 400%	\$62,601		8.00%	\$417	

2026 Schedule: Couples

% of FPL	Bottom of Income Range	Top of Income Range	Affordability Standard	Bottom of Affordable Monthly Premium Range	Top of Affordability Monthly Premium Range
0 - 150%	\$0	\$31,725	0%		
150.1 - 200%	\$31,726	\$42,300	4.30%	\$114	\$152
200.1 - 250%	\$42,301	\$52,875	6.20%	\$219	\$273
250.1 - 300%	\$52,876	\$63,450	7.40%	\$326	\$391
300.1 - 350%	\$63,451	\$74,025	7.45%	\$394	\$460
350.1 - 400%	\$74,026	\$84,600	7.60%	\$469	\$536
Above 400%	\$84,601		8.00%	\$564	

2026 Schedule: Families

% of FPL	Bottom of Income Range	Top of Income Range	Affordability Standard	Bottom of Affordable Monthly Premium Range	Top of Affordability Monthly Premium Range
0 - 150%	\$0	\$39,975	0%		
150.1 - 200%	\$39,976	\$53,300	3.45%	\$115	\$153
200.1 - 250%	\$53,301	\$66,625	4.95%	\$220	\$275
250.1 - 300%	\$66,626	\$79,950	5.85%	\$325	\$390
300.1 - 350%	\$79,951	\$93,275	7.45%	\$496	\$579
350.1 - 400%	\$93,276	\$106,600	7.60%	\$591	\$675
Above 400%	\$106,601		8.00%	\$711	

2027 Proposed Plan Options

Proposed Platinum Design

- No changes unless required by forthcoming actuarial value calculator

Plan Feature/ Service		2026 Platinum	DRAFT 2027 Platinum
Note: "Deductible then..." means the member must first meet the plan's deductible; then, the member pays only the copay as listed for in-network services.			
Annual Deductible – Combined		\$0	\$0
Annual Deductible – Medical		\$0	\$0
Annual Deductible – Prescription Drugs		N/A	N/A
		N/A	N/A
Annual Out-of-Pocket Maximum		N/A	N/A
		N/A	N/A
Primary Care Provider (PCP) Office Visits and Mental/Behavioral Health Outpatient Services		\$3,000	\$3,000
		\$6,000	\$6,000
Specialist Office Visits		\$20	\$20
Urgent Care		\$40	\$40
Emergency Room		\$40	\$40
Emergency Transportation		\$150	\$150
Inpatient Hospitalization		\$0	\$0
Skilled Nursing Facility		\$500	\$500
Durable Medical Equipment		\$500	\$500
Rehabilitative Occupational and Rehabilitative Physical Therapy		20 percent	20 percent
Laboratory Outpatient and Professional Services		\$40	\$40
X-rays and Diagnostic Imaging		\$0	\$0
High-Cost Imaging		\$0	\$0
Outpatient Surgery: Ambulatory Surgery Center		\$150	\$150
Outpatient Surgery: Physician/Surgical Services		\$250	\$250
Prescription Drug	Retail Tier 1	\$0	\$0
	Retail Tier 2	\$10	\$10
	Retail Tier 3	\$25	\$25
	Mail Tier 1	\$50	\$50
	Mail Tier 2	\$20	\$20
	Mail Tier 3	\$50	\$50
Federal Actuarial Value Calculator		\$150	\$150
		90.51 percent	[TBD]

Proposed Gold Design

- No changes unless required by forthcoming actuarial value calculator

Plan Feature/ Service		2026 High Gold	DRAFT 2027 High Gold
Note: "Deductible then..." means the member must first meet the plan's deductible; then, the member pays only the copay as listed for in-network services.			
Annual Deductible – Combined		\$1,000	\$1,000
		\$2,000	\$2,000
Annual Deductible – Medical		N/A	N/A
		N/A	N/A
Annual Deductible – Prescription Drugs		N/A	N/A
		N/A	N/A
Annual Out-of-Pocket Maximum		\$7,000	\$7,000
		\$14,000	\$14,000
Primary Care Provider (PCP) Office Visits and Mental/Behavioral Health Outpatient Services		\$20	\$20
Specialist Office Visits		\$40	\$40
Urgent Care		\$40	\$40
Emergency Room		\$250	\$250
Emergency Transportation		\$0	\$0
Inpatient Hospitalization		Deductible then \$300	Deductible then \$300
Skilled Nursing Facility		Deductible then \$300	Deductible then \$300
Durable Medical Equipment		20 percent	20 percent
Rehabilitative Occupational and Rehabilitative Physical Therapy		\$40	\$40
Laboratory Outpatient and Professional Services		Deductible then \$25	Deductible then \$25
X-rays and Diagnostic Imaging		Deductible then \$35	Deductible then \$35
High-Cost Imaging		Deductible then \$150	Deductible then \$150
Outpatient Surgery: Ambulatory Surgery Center		Deductible then \$150	Deductible then \$150
Outpatient Surgery: Physician/Surgical Services		Deductible then \$0	Deductible then \$0
Prescription Drug	Retail Tier 1	\$25	\$25
	Retail Tier 2	\$45	\$45
	Retail Tier 3	Deductible then \$75	Deductible then \$75
	Mail Tier 1	\$50	\$50
	Mail Tier 2	\$90	\$90
	Mail Tier 3	\$225	\$225
Federal Actuarial Value Calculator		81.69 percent	[TBD]

Proposed High Silver Design

- No changes unless required by forthcoming actuarial value calculator

Plan Feature/ Service		2026 High Silver	DRAFT 2027 High Silver
Note: "Deductible then..." means the member must first meet the plan's deductible; then, the member pays only the copay as listed for in-network services.			
Annual Deductible – Combined		\$2,000 \$4,000	\$2,000 \$4,000
Annual Deductible – Medical		N/A N/A	N/A N/A
Annual Deductible – Prescription Drugs		N/A N/A	N/A N/A
Annual Out-of-Pocket Maximum		\$10,150 \$20,300	\$10,150 \$20,300
Primary Care Provider (PCP) Office Visits and Mental/Behavioral Health Outpatient Services		\$25	\$25
Specialist Office Visits		\$60	\$60
Urgent Care		\$60	\$60
Emergency Room		Deductible then \$350	Deductible then \$350
Emergency Transportation		Deductible then \$0	Deductible then \$0
Inpatient Hospitalization		Deductible then \$1,000	Deductible then \$1,000
Skilled Nursing Facility		Deductible then \$1,000	Deductible then \$1,000
Durable Medical Equipment		Deductible then 20 percent	Deductible then 20 percent
Rehabilitative Occupational and Rehabilitative Physical Therapy		\$60	\$60
Laboratory Outpatient and Professional Services		Deductible then \$30	Deductible then \$30
X-rays and Diagnostic Imaging		Deductible then \$60	Deductible then \$60
High-Cost Imaging		Deductible then \$350	Deductible then \$350
Outpatient Surgery: Ambulatory Surgery Center		Deductible then \$500	Deductible then \$500
Outpatient Surgery: Physician/Surgical Services		Deductible then \$0	Deductible then \$0
Prescription Drug	Retail Tier 1	\$30	\$30
	Retail Tier 2	\$55	\$55
	Retail Tier 3	Deductible then \$75	Deductible then \$75
	Mail Tier 1	\$60	\$60
	Mail Tier 2	\$110	\$110
	Mail Tier 3	Deductible then \$225	Deductible then \$225
Federal Actuarial Value Calculator		71.74 percent	[TBD]

Proposed Silver HSA-Compatible Design (Small Group)

- No changes unless required by forthcoming actuarial value calculator

Plan Feature/ Service Note: "Deductible then..." means the member must first meet the plan's deductible; then, the member pays only the copay as listed for in-network services.		2026 HSA-compatible Low Silver (Small Group Only)	DRAFT 2027 HSA-compatible Low Silver (Small Group Only)
Annual Deductible – Combined		\$2,500	\$2,500
		\$5,000	\$5,000
Annual Deductible – Medical		N/A	N/A
		N/A	N/A
Annual Deductible – Prescription Drugs		N/A	N/A
		N/A	N/A
Annual Out-of-Pocket Maximum		\$8,450	\$8,450
		\$16,900	\$16,900
Primary Care Provider (PCP) Office Visits and Mental/Behavioral Health Outpatient Services		Deductible then \$30	Deductible then \$30
Specialist Office Visits		Deductible then \$60	Deductible then \$60
Urgent Care		Deductible then \$60	Deductible then \$60
Emergency Room		Deductible then \$300	Deductible then \$300
Emergency Transportation		Deductible then \$0	Deductible then \$0
Inpatient Hospitalization		Deductible then \$750	Deductible then \$750
Skilled Nursing Facility		Deductible then \$750	Deductible then \$750
Durable Medical Equipment		Deductible then 20 percent	Deductible then 20 percent
Rehabilitative Occupational and Rehabilitative Physical Therapy		Deductible then \$60	Deductible then \$60
Laboratory Outpatient and Professional Services		Deductible then \$60	Deductible then \$60
X-rays and Diagnostic Imaging		Deductible then \$75	Deductible then \$75
High-Cost Imaging		Deductible then \$500	Deductible then \$500
Outpatient Surgery: Ambulatory Surgery Center		Deductible then \$500	Deductible then \$500
Outpatient Surgery: Physician/Surgical Services		Deductible then \$0	Deductible then \$0
Prescription Drug	Retail Tier 1	Deductible then \$30	Deductible then \$30
	Retail Tier 2	Deductible then \$60	Deductible then \$60
	Retail Tier 3	Deductible then \$105	Deductible then \$105
	Mail Tier 1	Deductible then \$60	Deductible then \$60
	Mail Tier 2	Deductible then \$120	Deductible then \$120
	Mail Tier 3	Deductible then \$315	Deductible then \$315
Federal Actuarial Value Calculator		70.19 percent	[TBD]

Proposed Bronze #1 Design

- Proposed increases to Annual Out-of-Pocket Maximum
- Proposed 3 PCP office visits before deductible
- Additional changes if required by forthcoming federal actuarial value calculator

Plan Feature/ Service		2026 Bronze #1	DRAFT 2027 Bronze #1
Note: "Deductible then..." means the member must first meet the plan's deductible; then, the member pays only the copay as listed for in-network services.			
Annual Deductible – Combined		\$2,900	\$2,900
Annual Deductible – Medical		\$5,800	\$5,800
Annual Deductible – Prescription Drugs		N/A	N/A
Annual Out-of-Pocket Maximum		N/A	N/A
Primary Care Provider (PCP) Office Visits and Mental/Behavioral Health Outpatient Services		N/A	N/A
Specialist Office Visits		\$10,150	\$12,000
Urgent Care		\$20,300	\$24,000
Emergency Room		Deductible then \$30	\$30; first 3 office visits before deductible
Emergency Transportation		Deductible then \$65	Deductible then \$65
Inpatient Hospitalization		Deductible then \$65	Deductible then \$65
Skilled Nursing Facility		Deductible then \$400	Deductible then \$400
Durable Medical Equipment		Deductible then \$0	Deductible then \$0
Rehabilitative Occupational and Rehabilitative Physical Therapy		Deductible then \$1,000	Deductible then \$1,000
Laboratory Outpatient and Professional Services		Deductible then \$1,000	Deductible then \$1,000
X-rays and Diagnostic Imaging		Deductible then 20 percent	Deductible then 20 percent
High-Cost Imaging		Deductible then \$65	Deductible then \$65
Outpatient Surgery: Ambulatory Surgery Center		Deductible then \$50	Deductible then \$50
Outpatient Surgery: Physician/Surgical Services		Deductible then \$100	Deductible then \$100
Prescription Drug	Retail Tier 1	Deductible then \$350	Deductible then \$350
	Retail Tier 2	Deductible then \$500	Deductible then \$500
	Retail Tier 3	Deductible then \$0	Deductible then \$0
	Mail Tier 1	\$30	\$30
	Mail Tier 2	Deductible then \$65	Deductible then \$65
	Mail Tier 3	Deductible then \$100	Deductible then \$100
Federal Actuarial Value Calculator		64.82 percent	[TBD]

Proposed Bronze #2 Design

- Proposed increases to Annual Out-of-Pocket Maximum
- Proposed 3 PCP office visits before deductible
- Additional changes if required by forthcoming federal actuarial value calculator

Plan Feature/ Service		2026 Bronze #2 (HSA compatible)	DRAFT 2027 Bronze #2 (HSA compatible)
Note: "Deductible then..." means the member must first meet the plan's deductible; then, the member pays only the copay as listed for in-network services.			
Annual Deductible – Combined		\$3,800	\$3,800
		\$7,600	\$7,600
Annual Deductible – Medical		N/A	N/A
		N/A	N/A
Annual Deductible – Prescription Drugs		N/A	N/A
		N/A	N/A
Annual Out-of-Pocket Maximum		\$8,450	\$8,500
		\$16,900	\$17,000
Primary Care Provider (PCP) Office Visits and Mental/Behavioral Health Outpatient Services		Deductible then \$60	\$60 first 3 office visits before deductible
Specialist Office Visits		Deductible then \$90	Deductible then \$90
Urgent Care		Deductible then \$90	Deductible then \$90
Emergency Room		Deductible then \$875	Deductible then \$875
Emergency Transportation		Deductible then \$0	Deductible then \$0
Inpatient Hospitalization		Deductible then \$1,500	Deductible then \$1,500
Skilled Nursing Facility		Deductible then \$1,500	Deductible then \$1,500
Durable Medical Equipment		Deductible then 20 percent	Deductible then 20 percent
Rehabilitative Occupational and Rehabilitative Physical Therapy		Deductible then \$90	Deductible then \$90
Laboratory Outpatient and Professional Services		Deductible then \$55	Deductible then \$55
X-rays and Diagnostic Imaging		Deductible then \$135	Deductible then \$135
High-Cost Imaging		Deductible then \$750	Deductible then \$750
Outpatient Surgery: Ambulatory Surgery Center		Deductible then \$500	Deductible then \$500
Outpatient Surgery: Physician/Surgical Services		Deductible then \$0	Deductible then \$0
Prescription Drug	Retail Tier 1	Deductible then \$30	Deductible then \$30
	Retail Tier 2	Deductible then \$120	Deductible then \$120
	Retail Tier 3	Deductible then \$200	Deductible then \$200
	Mail Tier 1	Deductible then \$60	Deductible then \$60
	Mail Tier 2	Deductible then \$240	Deductible then \$240
	Mail Tier 3	Deductible then \$600	Deductible then \$600
Federal Actuarial Value Calculator		64.81 percent	[TBD]

Proposed Dental Plan Designs

- No changes to the 2026 designs

Plan Feature/ Service	Family Plus	Family High	Family Low	Pediatric-only
Plan Year Deductible	\$50/\$150	\$50/\$150	\$50/\$150	\$50
Deductible Applies to	Major and Minor Restorative	Major and Minor Restorative	Major and Minor Restorative	Major and Minor Restorative
Plan Year Max (>=19 only)	\$1,750	\$1,250	\$750	N/A
Plan Year MOOP <19 Only	\$350 (1 child) \$700 (2+ children)	\$350 (1 child) \$700 (2+ children)	\$350 (1 child) \$700 (2+ children)	\$350 (1 child)
Preventive & Diagnostic Co-Insurance (In/out-of-Network)	0 percent/20 percent	0 percent/20 percent	0 percent/20 percent	0 percent/20 percent
Minor Restorative Co-Insurance (In/out-of-Network)	20 percent/40 percent	25 percent/45 percent	25 percent/45 percent	25 percent/45 percent
Major Restorative Co-Insurance (In/out-of-Network)	50 percent/70 percent	50 percent/70 percent	50 percent/70 percent No Major Restorative >=19	50 percent/70 percent
Medically Necessary Orthodontia, <19 only (In/out-of-Network)	50 percent/70 percent	50 percent/70 percent	50 percent/70 percent	50 percent/70 percent
Non-Medically Necessary Orthodontia, <19 only (In/out-of-Network)	N/A	N/A	N/A	N/A