



*The Commonwealth of Massachusetts
Commonwealth Health Insurance Connector Authority
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Boston, MA 02108*

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Board Chair

KARYN POLITO
Lieutenant Governor

LOUIS GUTIERREZ
Executive Director

Board of the Commonwealth Health Insurance Connector Authority

Minutes

Thursday, December 8, 2016
9:00 AM to 11:00 AM

One Ashburton Place
Boston, MA 02108
21st Floor Conference Room

Attendees: Celia Wcislo, Daniel Judson, Rina Vertes, Roberta Herman, Mark Gaunya, Michael Chernew, Dimitry Petion, Louis Malzone, Marylou Sudders, Kristen Lepore, Louis Gutierrez, Nancy Turnbull.

The meeting was called to order at 9:04 AM.

I. Minutes: The minutes of the November 10, 2016 meeting were unanimously approved.

II. Executive Director's Report: Mr. Gutierrez began the meeting with an update on Open Enrollment. He noted it was 38 days into Open Enrollment and that shopping activity was somewhat high. He stated that this was expected considering the strong encouragement for members to shop as there are some high premium increases for this year. He remarked that he expected to see more member activity near the payment deadline of December 23. He added that the Health Connector needs to keep in contact with those re-determined into programs with less subsidy to ensure their information is updated for 2017. He stated that in comparison to last year's Open Enrollment period, more applications and plan selections are being made during this Open Enrollment, though we are seeing a similar number of enrollments to date. He added that call center and walk-in site traffic are both up roughly 30 percent, and that enrollment events with Navigators are also garnering significant customer visits. Next, Mr. Gutierrez stated that the second part of the meeting's agenda would be a look ahead to the 2018 Seal of Approval (SOA). He stated that while many questions about potential changes at the federal level are unanswerable at this point, conclusions can be based on what is known, while also understanding the need to be nimble. Mr.

Gutierrez concluded by providing an update on risk adjustment noting that Blue Cross Blue Shield requested a reconsideration that was approved, yielding a settlement of \$41 million dollars.

III. Open Enrollment 2017 Status Update: The PowerPoint Presentation “Open Enrollment 2017 Status Update” was presented by Rebekah Diamond, Audrey Gasteier, Jen Bullock, Rory Connell and Michael Piantanida. Ms. Diamond provided a summary of activity during Open Enrollment to date, stating that the Health Connector has seen increased engagement this Open Enrollment period as compared to last year. She added that while there are many individuals who have yet to act, the Health Connector often sees that the premium bill and additional communications leading up to the December 23 payment deadline will encourage additional activity. She reviewed a timeline of key Open Enrollment activities. Ms. Gasteier then provided an update on enrollment and application activity. In response to a question from Ms. Wcislo, Ms. Gasteier explained the need to keep an eye on individuals who may have yet to shop during Open Enrollment to ensure that they are in an affordable plan that is right for them. Ms. Gasteier clarified that “enrolled” indicates that the member has paid for coverage. Ms. Gasteier continued to describe the movement of members who apply, plan select and then pay, and said that often members remain in plan selected status while they take time to ensure they pick the plan that is right for them. In response to a question from Ms. Turnbull, Ms. Diamond indicated that the change in enrollment of ConnectorCare members from 2016 and 2017 is largely due to eligibility changes, especially in light of new federally required program integrity measures. Ms. Gasteier noted that the Health Connector sends an array of communications to members affected by downgrade during renewals.

Ms. Diamond then gave an overview on renewing members and shopping activity trends within Open Enrollment. She stated there is a higher percentage of active shoppers among this year’s renewing population than last year. She added that just under 10 percent have checked out or paid for a new plan, and another 9 percent have a plan in their cart but not yet paid. She stated 81 percent of remaining members have not yet shopped but many may take action before the December 23 deadline, or before the end of Open Enrollment. In response to a question asked by Ms. Wcislo, Mr. Gutierrez explained that the ‘Status by New and Renewing Individuals’ visual included renewing member enrollments, and even if they have not yet paid for January coverage, because a binder payment is not required, those members are included in enrollment. Ms. Turnbull noted that many of the members undergoing auto enrollments are receiving bills for large premium increases and are concerned about how to act in response. In response to several comments from Board members, Mr. Gutierrez explained that in response to the higher premiums that many members are facing, the Health Connector implemented special communications, a dedicated shopping queue with customer service, and heavy collaboration with all stakeholders. He noted that by January, once the plan selection and payment deadline has passed, it will be possible to understand how deep the issues are for this population.

Ms. Diamond proceeded to discuss shopping activity for renewing members, noting that many have taken action to shop for 2017 plans instead of passively renewing old plans. She stated that the data shows that members from higher premium plans who do shop tend to pick different carriers in comparison to lower-cost plan shoppers who more often remain in the same carrier. She also added that, as compared to other 2017 program types, there are higher shopping rates among Plan Type 1 members. In response to a question made by Ms. Wcislo, Ms. Diamond clarified that the total renewals population being evaluated is just over 223,000 members. Ms. Turnbull noted the concern about the 55,028 members facing a premium increase of 15 percent or more for 2017, especially the lowest income members, and asked what the Health Connector is doing to respond proactively. In response to Ms. Turnbull, Ms. Diamond referred to the chart at the bottom of slide 11, stating

that the Health Connector will continue to focus not just on all members affected by high premiums, but on low income members in particular. She noted that Neighborhood Health Plan (NHP) Plan Type 1 members have the highest rate of switching plans but many have yet to take action. Ms. Diamond remarked that, of members who actively shop and pick a new plan, the majority of shoppers, both subsidized and unsubsidized, are choosing Tufts Direct, one of the Health Connector's lowest cost options. She added that Boston Medical Center Health Net Plan and NHP continue to be attractive choices, consisting of 18 percent and 20 percent of unsubsidized plans and 34 percent and nine percent of subsidized plans, respectively.

Ms. Diamond continued with an eligibility update. She explained that as of December 1, 2016, 22,363 ConnectorCare members have downgraded to unsubsidized coverage. In response to a question asked by Mr. Gaunya, Ms. Diamond explained that the term "downgraded" is a term the Health Connector shares with MassHealth and indicates a decrease in benefits. Ms. Turnbull emphasized that there are 3,800 persons still in NHP that have taken no further action and are therefore liable for the bill payment. Ms. Diamond explained that subsidized members who do not pay their full premium for January will get a notice and one month grace period if they do not pay, and will have until January 31, 2016 to switch plans. Mr. Petion questioned if there is a debt issue for carriers regarding the number of people who do not pay attention to increases in their premiums and cannot pay their outstanding balances. Mr. Petion additionally inquired if this action would put members into debt and what the Health Connector is doing to remediate the issue. In response to terminology used regarding individuals who had not yet shopped, Ms. Turnbull requested that the term 'sleeping' not be used as there may be a variety of reasons that individuals do not take action in these circumstances. Mr. Gutierrez agreed that these members are a serious concern, and concurred that the terminology was incorrectly applied. In response to Ms. Wcislo's suggestion to contact such members, Ms. Diamond stated that outreach efforts included robo calls as well as direct mailing that contained other pricing options available to them, and additional messaging about shopping during Open Enrollment for members who receive a past due notice. She stated that, of 55,000 members, 23 percent have shopped and enrolled, representing twice the rate of shopping for the overall population. She added that the Health Connector hopes to see more movement of Plan Type 1 members in the coming weeks of Open Enrollment. Ms. Turnbull asked Ms. Diamond what the Health Connector has heard concerning the elimination of premium smoothing and the number of indigent individuals in debt. Ms. Diamond indicated that many members have expressed the need to be in lower cost plans, and often have difficulty in parting with providers. She noted that some may choose to pay what is a very high premium for them in order to remain with their current providers, as well. Ms. Connell then proceeded to provide an overview of 2017 membership trends including program determinations as well as shopping trends.

Mr. Piantanida then gave an update on the auto renewal business process. He stated that 210,128 members who had not actively shopped for a new plan had been passively enrolled and 197,128 had been processed. He noted that this represented 23 percent more auto enrollments than last year's Open Enrollment. He added that the transactions were processed more expediently this year than last, and with fewer errors. He stated that so far, web traffic and performance based metrics are being met as seen through increased member usage of the provider search tool and other shopping support tools. He added that, despite the high level of web activity, there continues to be satisfactory performance from the website.

Ms. Bullock then provided an update on customer service. She stated that the Health Connector Customer Service Center has shown a strong performance with quick answering rates and low rates of abandonment during the first month of Open Enrollment. She added that the Customer Service Center has received approximately 30 percent more calls in November of 2016 compared with

November 2015 and the shopping queue fielded approximately 21 percent of incoming call volume, noting that much volume has been related to enrollment as opposed to eligibility. In response to Ms. Turnbull's question, Ms. Bullock stated that it is the call center's duty to be unbiased when advising consumers, and to convey to the member that if the provider is important to them, they could remain with their current carrier, but that if cost is of more importance, they should look at alternative options. Ms. Bullock continued to provide an update on customer service operations, stating that the Health Connector's walk in centers have supported over 5,000 customers in November 2016, which represents a 34 percent increase over last year's numbers.

Ms. Diamond provided an update on Navigator activity, stating that there has been an increase in volume at nearly all sites, most substantially in Boston and Springfield, and that Navigators have assisted over 4,000 individuals. She added that premium increases and shopping are the primary drivers of volume.

Ms. Diamond then provided an overview of upcoming outreach initiatives of note. She stated that the Health Connector was working with the Massachusetts Department of Transportation to have electronic signage along highways, has started a partnership with Union Capital for members to gain points and other incentives for partaking in healthy activities, as well as a partnership with the Registry of Motor Vehicles on a messaging campaign. She added that there will be call-in programs featured on Telemundo and Univision to reach Spanish-speaking populations, ethnic media press events highlighting multi-lingual outreach and weekly office hours at the State House to better support Legislative staff on constituent matters. In response to Ms. Diamond's update on outreach plans, Mr. Gaunya stated that gamifying is a great way to incentivize people to engage with the Health Connector's outreach efforts. In response to Ms. Turnbull's suggestion, Mr. Gutierrez mentioned that a billing error earlier in the month that was remediated within two business days. Ms. Diamond then concluded the presentation discussing next steps. Secretary Sudders left the meeting at 9:30am and Mr. Chernew took over as Vice Chair.

- IV. Seal of Approval Discussion:** The PowerPoint presentation "Seal of Approval Discussion" was presented by Brian Schuetz, Maria Joy and Emily Brice. Mr. Schuetz began by noting that the presentation's purpose was to engage the Board early on, prior to the 2018 Seal of Approval (SOA) process, as the Request for Responses (RFR) is sent out in March. Mr. Schuetz noted the high-level goals for SOA 2018: incorporating value elements, strengthening the Health Connector's partnerships with carriers, promoting consistency and driving competition within the ConnectorCare program. He noted that these goals are all intended to provide stability and to improve the customer experience. Mr. Schuetz reviewed the 2018 SOA timeline. Mr. Schuetz then discussed dental products, stating that there will be no changes to the current product shelf requirements. He then introduced the policy proposal to shift non-group dental plans from a plan year to a calendar year basis to reduce consumer confusion and operational complexity issues that have arisen from "mid-year" dental renewals. He added that this opportunity better aligns non-group dental offerings with the non-group medical shelf, as well as other public exchanges, at a low risk. He also noted the business process review underway for dental product operational activities, stating that this analysis will lead to the improvement of operational stability. In response to a question posed by Mr. Petion about accelerating the process to develop calendar year dental plans, Mr. Schuetz explained that the timeline must begin for 2018 given that 2017 contracts have been signed. Ms. Turnbull noted that whenever a plan year is changed, it could be a difficult transition for consumers because of deductible and benefit sensitivities. Mr. Schuetz noted that because dental tends to work in the opposite way from medical, this is less of a concern.

Next, Mr. Schuetz reviewed health plan product shelf, stating that the goals for the unsubsidized and tax-credit-only product shelf are to promote competition and choice for members. He stated

that a focus will be on maintaining the current health plan product shelf as approximately three quarters of members are satisfied with their choice of plans and just over half felt the Health Connector offers “the right number of plans.” He added that the comparison shopping experience increases competition among carriers, illustrating this by showing enrollment by carrier in non-group products on the Exchange versus off of the Exchange. Ms. Wcislo inquired whether the graph on slide ten depicting non-group off exchange enrollment rates included large employer coverage. In response to Ms. Wcislo’s question, Mr. Schuetz explained that the figures only showed non-group enrollment.

Ms. Joy then provided an overview of quality initiatives implemented for the 2017 plan year, such as carrier-submitted Quality Improvement Strategies (QIS). She noted that there were a variety of responses, and the strongest had clear performance benchmarks and targets based on nationally-endorsed quality measures. She added that carriers mentioned global budget-based incentives, bonus payments for providers meeting certain Healthcare Effectiveness Data and Information Set (HEDIS) measure targets and financial incentives to members for using high-value services. In response to a question asked by Ms. Turnbull, Mr. Schuetz explained that high-value services include wellness visits, visits for medication therapies and things that are agreed upon as promoting and maintaining wellness. Ms. Joy added that the Health Connector will be asking for detailed updates from carriers on their progress towards their QIS goals in addition to individualized questions concerning their public health initiatives, such as addressing the opioid crisis and reducing health disparities in target populations.

Next, Ms. Brice discussed the Health Connector’s goals for the 2018 SOA related to value. She stated that the Health Connector continues to promote increased customer access and utilization of decision-support tools. She added that transparent information can be enhanced through highlighting standardized plans and alternative network types as well as improving the provider search tool to include community health centers, nurse practitioners, physician assistants and mental health professionals. She stated that the Health Connector has launched an exploration to add new tools to support customer decisions by expanding offerings not yet integrated, such as formulary searches and total cost calculation tools. Ms. Wcislo asked for further clarification of the integration of a decision support tool. In response to Ms. Wcislo, Ms. Brice elaborated that the experience in the future would ideally be better integrated into the existing shopping experience whereas now members are brought to a separate website. Ms. Herman remarked on the sophistication of the system as is, and asked how many products are on the product shelf compared to the number of products for sale on other State-based Marketplaces (SBMs). Mr. Schuetz replied that Massachusetts has a comparatively large number of carriers compared to other states and noted that this would be discussed in greater detail later in the presentation. He added that, given the relatively large number of carriers and plans available, the Health Connector supports consumers with a more curated experience through decision support and other tools.

Ms. Brice then discussed opportunities to incorporate elements of Value Based Insurance Design (VBID) into plans, to ensure the highest value services are maximally affordable for enrollees. She explained that VBID aligns enrollee cost sharing with the clinical value of services, encouraging the use of higher-value services while discouraging lower-value services. She noted the importance of VBID in offering an affordable option to the most critical services. She stated that the Health Connector started down the path to VBID last year through the removal of copayments and addition of opioid treatment services to address the public health crisis. She added that SOA responses indicate a willingness and capability from many carriers to implement VBID as interests in chronic illness management and incentives for wellness management are on the rise. She stated that, for this year, a collaborative approach with carriers for VBID implementation will include balancing carrier readiness, metallic tier actuarial value requirements and responsibility. She noted the

importance of coordinating with other state programs and agencies. Ms. Wcislo expressed concern if VBID elements addressing a certain disease results in adverse selection when individuals with that disease migrate to that plan. Ms. Herman noted her experience in VBID, stating that there would be a lot of assumptions going into the development of these products. She emphasized the need for baseline measurements to ensure the selected VBID approach can be measured. Mr. Petion stated that he looks forward to the final VBID policy, noting the importance of involving the provider community. Mr. Chernew applauded the effort to utilize VBID and its incentive to drive behavior to promote transparency and quality. He added that transparency does not work if incentives are not provided. Ms. Turnbull noted that it will be important to conduct research regarding evidence-based VBID strategies. Mr. Chernew noted that there are VBID models in California, for example, in which the value strategy focuses on primary care visits and chronic conditions. He stated, however, that there is a lot of difficulty implementing VBID given the need for consumer choice and balancing risk setting. He stated that, while it is difficult to know how to proceed with VBID, he warned that allowing carriers to choose different VBID approaches can be problematic and that it may be better for the Health Connector to require a standardized VBID element than allowing a great deal of carrier flexibility. Mr. Schuetz stated that the Health Connector welcomes all feedback as it works to create a VBID strategy and noted that it is a work in progress.

Next, Mr. Schuetz reviewed the design elements of subsidized programs, discussing each of the three key design pillars that define program features: carriers, members and the Commonwealth. He stated that the Health Connector's subsidized program promotes affordability and competition by helping to keep premiums down for some products, even outside of the program. He added that the selection of carriers is based on a competition model that rates the premium for the underlying Silver plan, which is also beneficial for the market. He stated that non-Connector members can purchase the base Silver plan at the competitive underlying rate, through the Health Connector or in the outside market. He elaborated on the power of the competition that incentivizes carriers to aggressively price their Silver tier products very differently as compared to the broader market. Mr. Schuetz illustrated this point by showing how competitive Massachusetts' Silver plans were compared to the rest of the country. Mr. Chernew approved of the ability of the subsidy program to promote affordability and competition, but wanted to look into the program from an economist's perspective, especially looking at scale and a competitive pricing model. Ms. Turnbull noted that there has been greater success for younger people to buy health insurance with more affordable premiums, which is a component of reform that does not get enough attention.

Mr. Schuetz stated that the annual premium changes for ConnectorCare, as well as its predecessor, Commonwealth Care, have trended lower than the merged market average. He added these ratings are something the Health Connector wants to continue moving forward. Ms. Herman commended the data findings, but asked how the overall cost difference was calculated. Mr. Schuetz noted that the changes illustrated were based on the underlying commercial product cost, which is available both on and off the Exchange. Ms. Wcislo remarked on the fact that the data showing national Silver plan average costs was based on the age of a 27-year-old. Ms. Herman responded that older individuals may be more willing to absorb higher costs, so it likely does not detract from the point of affordability overall. Mr. Schuetz then reviewed the next steps for the 2018 SOA process. Ms. Wcislo asked for more information on regarding what tools could be used going forward to promote competition and keep consumers insured. Ms. Turnbull requested a briefing on the recently approved MassHealth 1115 waiver. Mr. Gutierrez responded that the request will be approached.

The meeting was adjourned at 10:43 AM.

Respectfully submitted,

Beth Riportella & Joanna L. McDonough