



2014 Seal of Approval Launch

The Health Connector Team

Board of Directors Meeting
February 14, 2013



Introduction

- The Health Connector will issue its 2014 Seal of Approval (SoA) to solicit health plans to be offered through the Exchange beginning in 2014
- The SoA serves as the Qualified Health Plan certification mechanism, which is a required function for an ACA-compliant Exchange
- **But it is more...**



Why This Is Significant

- We have come a long way to achieve this milestone
- It signifies that the Commonwealth is ready to take its landmark health reform to new heights
- For the Health Connector, this SoA brings together everything that we have learned in the past seven years
- It is a big step forward in unveiling our vision for the future



We Have Achieved A Lot Together...

- More than 98% of Massachusetts residents are insured and nearly 100% of children are covered
- We have a vibrant Exchange that breaks down barriers to coverage and connects nearly 240,000 consumers to affordable, quality options
- We have broken new ground in proving how far competition and transparency can go to contain cost and promote innovation
- We have demonstrated that a reform model based on shared responsibility can indeed succeed



More Opportunities Are Ahead

- A historic legislation, the Affordable Care Act (ACA) brings coverage to millions of currently uninsured individuals nationwide, and makes health insurance more affordable and comprehensive for everyone
- For the Commonwealth, the ACA introduces new opportunities and a host of new tools
 - More people will receive health insurance subsidies in 2014
 - The health insurance market will become more simplified and easy-to-navigate
 - New technology will dramatically boost efficiency and enable consumer-friendly solutions (real-time eligibility determination, highly-automated Exchange platform)



The Health Connector Has A Vision

We have ambitious goals...

- Become a trusted source of value for consumers and small businesses
- Continue to serve as the platform of innovation and competition
- Achieve market-leading execution, service and operational efficiency
- Engage the market and become a major force for broader reform of the health care system

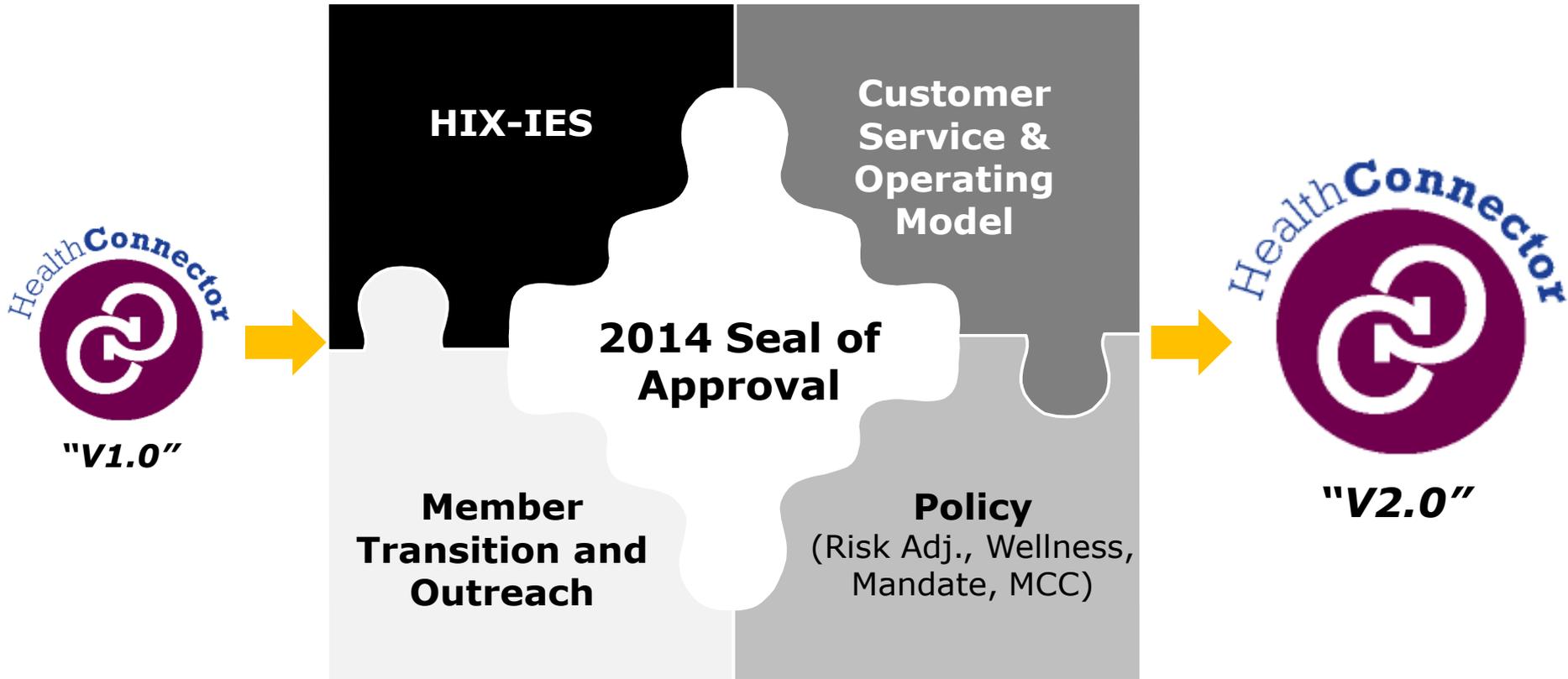


We have already gained great momentum

- Legal authorization to serve as the Commonwealth's Exchange
- \$180M in federal funding
- One of the first five states to receive conditional approval as ACA-compliant Exchange
- Major operational milestones underway
- Programmatic innovations (e.g., Wellness Track)



The SoA "Ties It All Together"





The Stakes Are High

- We are excited about this SoA
 - Many “first timers” (new product suite, tiered-network plans, expansion to dental, Employee Choice)
 - A robust solution for subsidized coverage with state and federal commitment
 - Federal backing on operations to ensure a successful launch
- It is ambitious, but has the potential to take our impact to a new level
- Massachusetts is once again in a position to lead the nation. We are ready for this challenge



Today's Focus

- Present key categories and parameters of the proposed Seal of Approval design
 - Most core elements have been discussed with the Board over several installments since Oct 2012
- Obtain Board direction to move forward with launching the 2014 Seal of Approval
- Communicate timeline and key next steps



Key Components of the 2014 Seal of Approval

2014 Seal of Approval
Request for Response
Feb 2013

QHP Certification Standards Under ACA Minimum Requirements

Exchange Product Portfolio

Dental Plan Requirements

Subsidized Coverage through the Health Connector

Operational Requirements & Administrative Fee



QHP Certification Overview

- The ACA specifies certain “minimum certification standards” that Exchanges must apply in certifying Qualified Health Plans (QHPs); Exchanges must establish procedures to ensure plans are certified through a comprehensive review process in order to become QHPs
- A majority of ACA-required categories for QHP certification are already fulfilled through the Division of Insurance’s (DOI) comprehensive plan review process, which is in place for the entire merged market
 - The ACA explicitly encourages Exchanges to leverage existing qualified processes
- The existing SoA process, which leverages broad collaboration with the DOI, is already substantially in compliance with the ACA’s requirements
 - A few categories will be refined or augmented to align with ACA standards
- The Health Connector and DOI have worked over the past several months to develop a collaborative process, with the goal of achieving compliance, ensuring robust QHP certification, while maximizing administrative simplicity for all parties



Key Categories of ACA QHP Certification Standards

- **Issuer Qualification**
 - Licensure
 - Accreditation
- **Plan benefit and cost-sharing**
 - Essential Health Benefits (EHB)
 - Cost-sharing limits
 - State-mandated benefits
 - Minimum Creditable Coverage (*state standard*)
 - Alignment with Metallic Tiers, as determined by Actuarial Value
 - Non-discrimination
- **Rating methodology & premiums**
 - Compliance with market reform rules
 - Justification for rate increases
- **Marketing**
 - Prohibition against unfair or deceptive practices
- **Network adequacy**
 - Sufficient number, type and distribution of providers, including Essential Community Providers
- **Service area**
 - Prohibits “cherry-picking” against under-served geographies
- **Quality**
 - Publication of certain defined quality data (federal guidance pending)
 - Development of a quality improvement strategy
- **Transparency in Coverage**
 - Requires reporting of certain data elements



Proposed QHP Certification Mechanism

QHP certification will be achieved through a close collaboration between the Health Connector and the DOI.

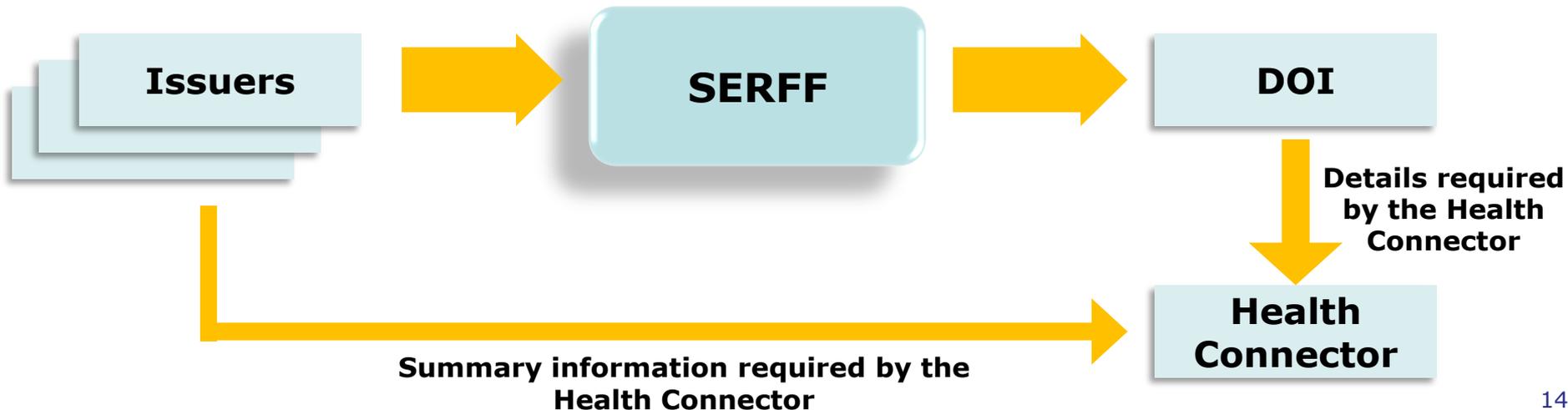
Key QHP Certification Category	Certification Approach
Issuer licensure and accreditation	<ul style="list-style-type: none">• Leverage existing DOI process
Plan design	<ul style="list-style-type: none">• DOI review as certification baseline• Subject to additional Health Connector requirements
Premium review	<ul style="list-style-type: none">• DOI quarterly rate review process• Health Connector review for competitive Issuer/plan selection
Network adequacy	<ul style="list-style-type: none">• Market-wide standard enforced by the DOI• DOI has augmented its standard to align with the ACA (adding review for Essential Community Providers)
Service Area	<ul style="list-style-type: none">• QHP-specific requirement; reviewed by Health Connector
Marketing, Quality & Transparency of coverage	<ul style="list-style-type: none">• Market-wide standards largely in place

While leveraging market-wide standards for many certification requirements, the Exchange has the right to reject plans that are not deemed to be in the best interest of Exchange shoppers.



Information/Data Collection

- In collaboration with the DOI, information collection for QHP certification will heavily leverage the System for Electronic Rate and Form Filing (SERFF)
 - Owned by the National Association of Insurance Commissioners (NAIC), SERFF is the existing platform used by many states (including Massachusetts) for insurance filings
 - NAIC is investing in a substantial expansion of SERFF to incorporate automated functionality specifically to support Exchange QHP certification
 - Leveraging SERFF will significantly simplify the administrative process, minimize duplication of effort and avoid information inconsistency





Key Components of 2014 Seal of Approval



QHP Certification Standards Under ACA
Minimum Requirements

Exchange Product Portfolio

Dental Plan Requirements

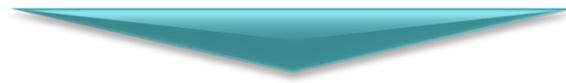
Subsidized Coverage Through
the Health Connector

Operational Requirements &
Administrative Fee



Recommended Core Principles

Strive for a vibrant product shelf that **meets market needs**, promotes **innovation, competition** and **consumer-centric** product offerings.



- Continue to promote standardization – refresh product shelf with an updated suite of standardized products that are ACA-compliant and reflective of market demand
- Introduce requirement for tiered-network plans that applies to Issuers that are already offering them
- Add catastrophic plans to the non-group Exchange
- Expand product choice, in particular for small groups, by allowing up to a defined maximum of non-standardized plans
- All plans will continue to be subject to Health Connector review and approval by the Board



Follow Up From January 2013 Board Meeting

- Several issues were raised during the last Board meeting and subject to further discussion. As a result, a number of recommendations are refined as follows:
 - Expand the categories of standardization to include specialist visits
 - Our final recommendation on standardized plans reflect careful balancing of multiple considerations
 - Reduce the total number of plans from 8 to 7 to further simplify shelf
 - Solid match of the overall “cluster” of popular plans in the market
 - Reasonable representation of certain models that have shown slow take up in the market but should be carefully monitored (co-insurance, HSA-compatible)
 - Reduce the total allowed number of non-standardized plans from 10 to 7
 - For a given Issuer, the number of non-standardized plans will not exceed that of standardized plans



Standardized Plan Parameters

PLAN FEATURE / SERVICE		COST-SHARING						
		PLAT A	PLAT B	GOLD A	GOLD B	GOLD C	SILVER	BRONZE
Annual Deductible	Individual	N/A	\$500	\$500	\$1,000	\$1,500	\$2,000	\$2,000
	Family	N/A	\$1,000	\$1,000	\$2,000	\$3,000	\$4,000	\$4,000
Annual Max. OOP	Individual	\$2,000	\$1,500	\$5,000	\$5,000	\$5,000	\$6,400	\$6,400
	Family	\$4,000	\$3,000	\$10,000	\$10,000	\$10,000	\$12,800	\$12,800
PCP Office Visits		\$25	\$20	\$20	\$30	\$25	\$30	\$50
Specialist Office Visits		\$40	\$35	\$35	\$45	\$40	\$50	\$75
Emergency Room		\$150	\$100 ✓	30% ✓	\$150 ✓	\$150 ✓	\$250 ✓	\$750 ✓
Outpatient Surgery		\$500	\$0 ✓	30% ✓	\$250 ✓	\$250 ✓	\$750 ✓	\$1,000 ✓
Inpatient Hospitalization		\$500	\$0 ✓	30% ✓	\$500 ✓	\$250 ✓	\$1,000 ✓	\$1,000 ✓
High-Cost Imaging		\$150	\$100 ✓	30% ✓	\$200 ✓	\$150 ✓	\$250 ✓	\$1,000 ✓
Rx	Retail Tier 1	\$15	\$15	\$15	\$20	\$15	\$20	\$30 ✓
	Retail Tier 2	\$30	\$25	50%	\$30	\$25	\$35	50% ✓
	Retail Tier 3	\$50	\$45	50%	\$50	\$50	\$70	50% ✓
	Mail Tier 1	\$30	\$30	\$30	\$40	\$30	\$40	\$60 ✓
	Mail Tier 2	\$60	\$50	50%	\$60	\$50	\$70	50% ✓
	Mail Tier 3	\$150	\$135	50%	\$150	\$150	\$210	50% ✓

A check mark (✓) indicates that this benefit is subject to the annual deductible



Summary of Requirements

Plan Category	Minimum Portfolio Requirement	Additional Options
Standardized Plans	1 plan on an Issuer's broadest commercial network for each of the 7 standardized plan designs	Additional standardized plan designs, such as narrower-network Plans
Non-Standardized Plans	1 tiered-network plan on either the Platinum or Gold tier by Issuers with at least 1,000 merged market members in tiered network plans as of January 2013	Issuers may propose up to 7 total Non-Standardized Plans; this includes the tiered-network plan
Catastrophic Plans	1 catastrophic plan by each Issuer must be proposed	Issuers have the option <u>not</u> to offer catastrophic plans, if the Health Connector determines that there are sufficient options



Small Group Product Options

- Small groups will have access to all QHPs offered through the Exchange (except Catastrophic plans), including both standardized plans and non-standardized plans
- Three options of plan selection are provided to small employers and employees

Business Express (Currently Offered)

Carrier/Plan

	A	B	C	D	E
Plat	<input type="checkbox"/>				
Gold	<input checked="" type="checkbox"/>				
Silver	<input type="checkbox"/>				
Bronze	<input type="checkbox"/>				

Employee Choice (Required by the ACA)

Carrier/Plan

	A	B	C	D	E
P	<input type="checkbox"/>				
G	<input checked="" type="checkbox"/>				
S	<input type="checkbox"/>				
B	<input type="checkbox"/>				

Dual-Triple (Optional for Carriers)

Carrier/Plan

	A	B	C	D	E
P	<input type="checkbox"/>				
G	<input checked="" type="checkbox"/>				
S	<input type="checkbox"/>				
B	<input type="checkbox"/>				



Key Components of 2014 Seal of Approval



QHP Certification Standards Under ACA
Minimum Requirements

Exchange Product Portfolio

Dental Plan Requirements

Subsidized Coverage Through
the Health Connector

Operational Requirements &
Administrative Fee



Background

- Providing pediatric dental coverage, which is a component of Essential Health Benefits, is a requirement for an ACA-compliant Exchange
 - The Exchange can meet the ACA requirement of offering pediatric dental coverage through standalone dental plans
- As discussed with the Board in November 2012, we believe that offering standalone dental plans is not only important from a compliance perspective, but also provides an opportunity for the Health Connector to help address unmet market needs for dental coverage
 - The MA dental market is primarily served by standalone Issuers
 - Many individuals and small business do not have dental coverage today; the Exchange can help promote access to affordable dental plans
 - Standalone dental Issuers are interested in leveraging the Exchange for streamlined distribution
- We are planning to release the standalone dental RFR concurrently with the medical RFR



Key Proposed Program Requirements

- Require the offering of standardized plan designs
 - The market as a whole is already fairly standardized
 - The Health Connector will define plan design parameters
 - As a minimum requirement, Issuers must offer at least one plan for each of the standardized packages
 - Issuers are also allowed to propose non-standardized plans above and beyond the minimum requirement
- Provide plan options that address under-served market needs
 - Child-only plans that provide EHB coverage
 - Low-cost plans that provide basic coverage at affordable price points
- To simplify transition for Issuers, the Health Connector will largely accommodate rating methodologies applied outside the Exchange
 - More permissible rating factors than for medical insurance; separate rating pools for individuals and small groups
- Similar to the approach regarding medical plans, the Health Connector will collaborate with the DOI on many aspects of the dental plan certification



Standardized Plans

Each standalone dental Issuer is required to offer at least one plan that conforms to each of the three standardized packages.

Standardized Plan Benefits	Pediatric	Low	High
Type I: Preventative & Diagnostic	100%	100%	100%
Type II: Minor Restorative	75%	75%	75%
Type III: Major Restorative	50%	Not covered	50%
Type IV: Medically necessary orthodontia	50%	Not covered	Not covered
Other	\$1000 MOOP	\$750 Annual Max	\$1250 Annual Max
Deductible for all plans: \$50 individual/\$150 family, applies to Type II & III services Scope of pediatric dental EHB defined by MA Benchmark Plan (CHIP)			

Note: Low and high plans are sold to individual adults over 19, as well as to families. When individuals under 19 are included in a family low or high plan, those individuals receive the scope of benefits and cost-sharing associated with the pediatric dental EHB



Embedded Or Bundled Dental Offering

- Issuers are permitted to offer plans that include both the medical and dental components:
 - Embedded: one integrated benefit package
 - Bundled: two separate plans offered in tandem and priced as a bundle
- Although these models may come with certain advantages (*e.g.*, coordinated management of care and/or operational efficiency), they are not prevalent in the Massachusetts market and are unlikely to represent a significant portion of our shelf
- Nevertheless, to ensure apples-to-apples product comparison by consumers, we require that:
 - Embedded/bundled dental plans also conform to the standardized dental plan designs for EHB
 - Pricing is broken down between the dental component and the medical components



Key Components of 2014 Seal of Approval

2014 Seal of Approval
Request for Response
Feb 2013

QHP Certification Standards Under ACA
Minimum Requirements

Exchange Product Portfolio

Dental Plan Requirements

**Subsidized Coverage Through
the Health Connector**

Operational Requirements &
Administrative Fee



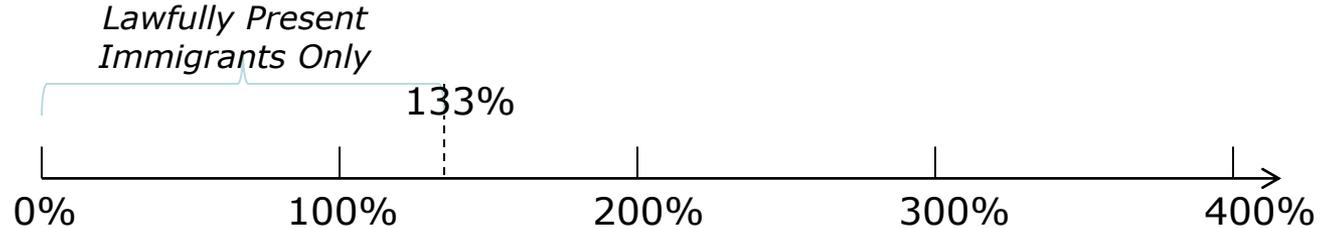
Background

- Individuals with incomes up to 400% FPL can access subsidized coverage through the Exchange
- Previously, the state had chosen to adopt and implement the Basic Health Plan (BHP) option as the coverage model for enrollees up to 200% FPL, along with a state wrap for QHP enrollees up to 300% FPL
- At the December 2012 Board meeting, we informed the Board that Federal guidance detailing the requirements for a BHP would not be released in time for states to operate a BHP in 2014
- In lieu of guidance on the BHP, we have been working closely with MassHealth to develop an alternative model, where eligible members with incomes from 0% to 300% FPL will be covered through the Exchange with federal subsidies and state wrap
- The specific parameters with regard to subsidized coverage are detailed in our 2014 Seal of Approval as we merge subsidized and non-subsidized populations together



Exchange Population Eligible for Subsidies

Subsidies available through the Health Connector starting in 2014



Federal Advance
Premium Tax Credit
(APTC)



Federal Cost-Sharing
Reductions (CSR)



State Premium &
Cost-Sharing Wrap





Newly Subsidized Populations (300-400% FPL)

- Members between 300-400% FPL are newly eligible for federal premium subsidies in the form of APTCs
- Members at this income level will pay premiums reflecting the plan they choose minus the value of the tax credit they elect and are eligible for, which will be calculated based on the price of the 2nd lowest-cost Silver plan in the Exchange
- A member can shop for any metallic QHP in the Exchange, and the APTC would be the lower of the cost of the plan chosen and the maximum APTC that the individual is eligible for and elects to apply to the cost of the premium
 - Individuals who are eligible for Catastrophic plans cannot access APTC if they choose to purchase a Catastrophic plan
- Individuals at this income level are not eligible for federal cost-sharing reduction or state wrap



State Wrap Populations (0-300% FPL)

- Individuals with incomes up to 300% FPL currently have access to coverage through Commonwealth Care or other comparable subsidized programs
- There is a material gap in premium and cost-sharing affordability between what is provided with federal subsidies alone and what is currently achieved through Commonwealth Care

	0-100%	101-133%	134-150%	151-200%	201-250%	251-300%
Premium Affordability Target (\$PMPM)						
ACA	\$18	\$18	\$48	\$82	\$151	\$219
CommCare	\$0	\$0	\$0	\$40	\$78	\$118
Cost-Sharing (AV)						
ACA	94%	94%	94%	87%	73%	70%
CommCare	99%	97%	97%	97%	95%	95%



State Wrap Populations (0-300% FPL) (cont'd)

- Preserving coverage affordability for low-income members is critical to protecting Massachusetts' nation-leading, near-universal coverage levels – the hallmark of our success under Chapter 58
- To bridge the affordability gap relative to Commonwealth Care, we must maximize the value of state and federal funding...



- Invest state dollars to inject greater competition into the Exchange marketplace, leading to lower premiums on products accessible by both subsidized and non-subsidized populations alike
- Lower premiums not only make coverage more affordable for consumers, but also for the federal government in the form of reduced APTC liability
- It is that critical piece of the puzzle – a program that **harnesses the power of competition** – that serves as the foundation for CMS's preliminary commitment to reinvest savings into the state wrap, making it possible for us to preserve affordability for this population and protect our coverage successes achieved to date



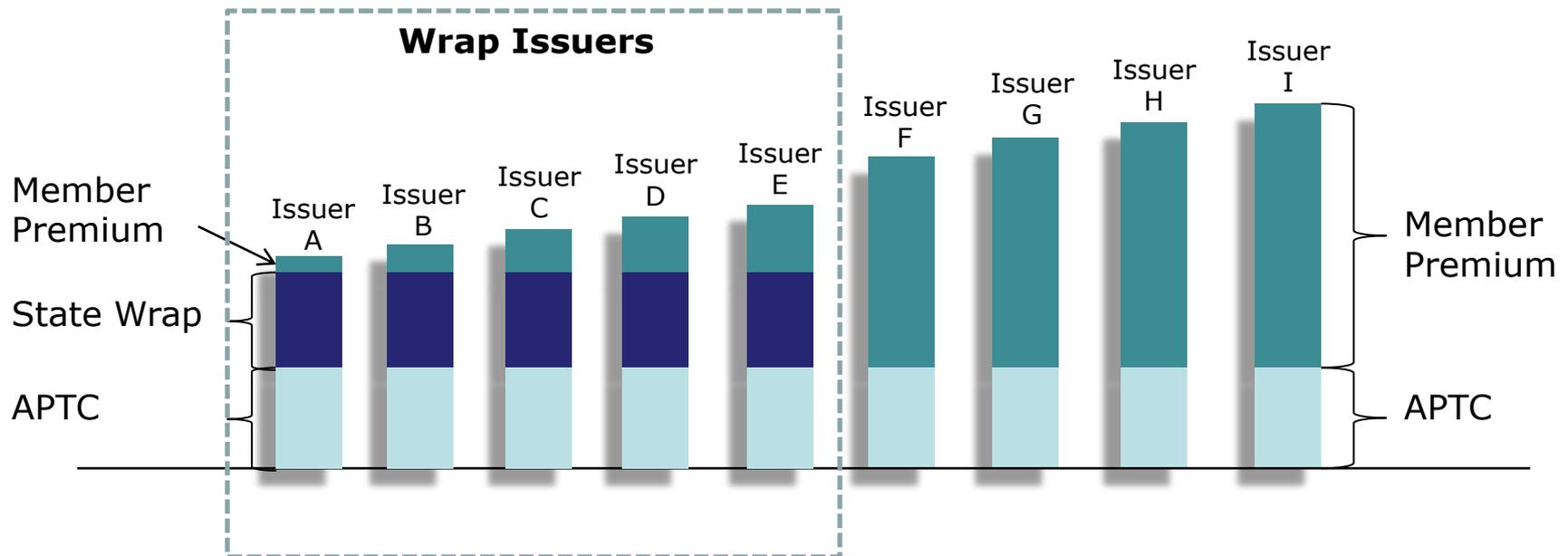
Proposed Wrap Framework

- **Our proposed “State Wrap” model borrows heavily from the Commonwealth Care program**
- The wrap will be available to enrollees through a subset of QHPs offering the most competitive premiums on the Health Connector’s Silver shelf
- 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 the wrap plan they choose



Premium Wrap

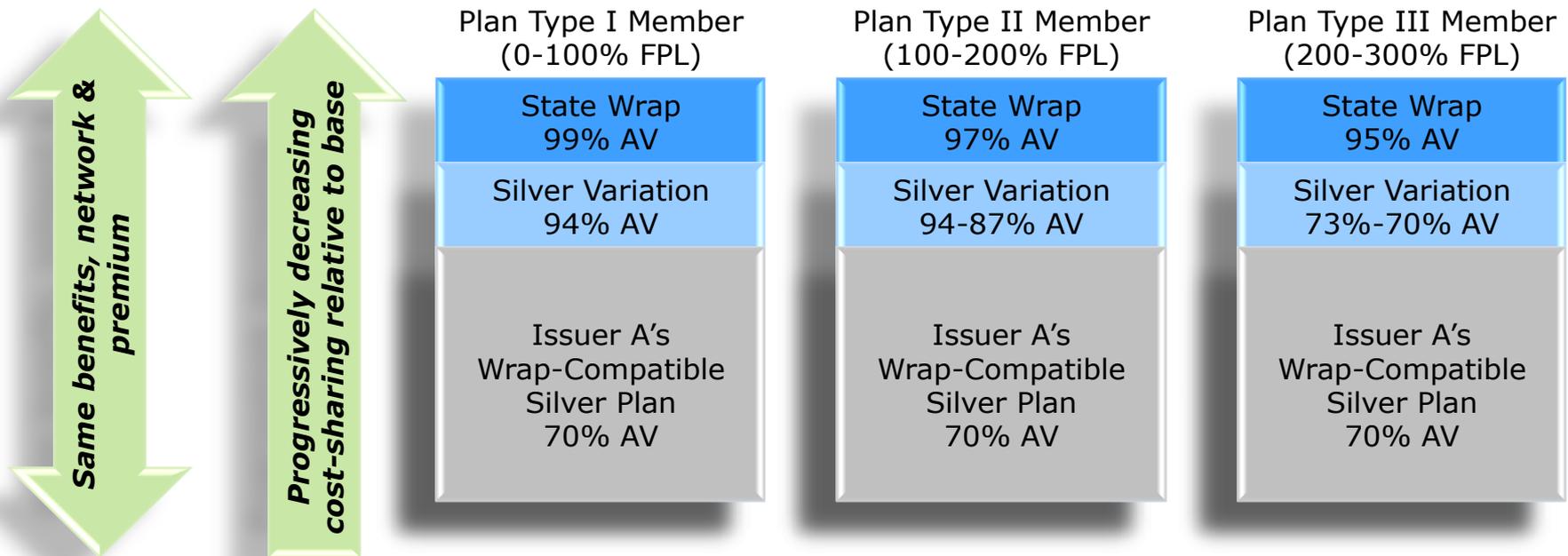
- Similar to APTCs, the state premium wrap will be a function of income
- As a result, members will be paying a differential premium when choosing a plan that is not the lowest-cost plan in their Service Area
 - For members up to 100% FPL, premium differential will be maintained at a nominal level





Cost-Sharing Wrap

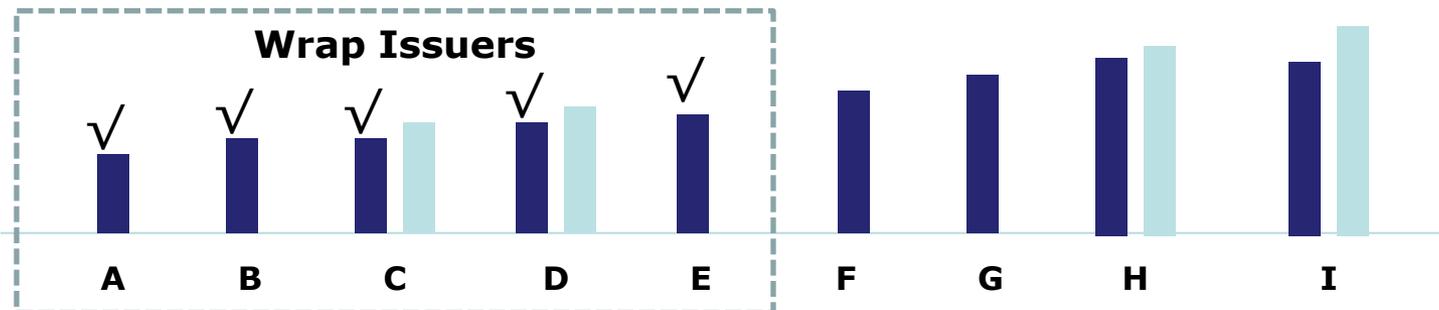
- Similar to CSRs, the state cost-sharing wrap will build up the AV of a base plan, but we will build up the AV to one of three standardized wrap plan designs, progressively richer by income
- As a result, members in the same Plan Type will be paying the same co-pays regardless of which Wrap Plan they choose





Selection of Wrap Plans

- The Health Connector will select up to five Wrap Plans for each Service Area
- Selection will be based on price comparison among the lowest-cost Silver plans offered by all Issuers
 - Pricing must comply with state and federal market rules
 - The lowest-cost Silver plan offered by an Issuer can either be a standardized plan or a non-standardized plan approved by the Health Connector
- Selection will be based on rates filed for the first quarter of 2014 – no new entrants during the year
 - Issuers can lose their status as a Wrap Plan to new membership if subsequent rate filings are deemed excessive



Relative Premium of Silver Plans Offered by Issuers



Additional Wrap Plan Requirements

- **Administration**

- All Issuers must propose Wrap-Compatible Silver Plans, ACA-compliant Silver Variation Plans and must agree to administer standardized Wrap Plans
- If an Issuer is not selected to offer state wrap, then the Issuer will not be required to administer corresponding Silver Variation Plans
 - Enrollment in these plans, without state wrap, is extremely unlikely
 - We therefore believe that this “waiver” provides significant administrative simplification value for Issuers without compromising benefits to members, and have communicated this proposal to CCIIO

- **Network**

- All Wrap-Compatible Silver Plans must meet the network adequacy standards that currently apply to Commonwealth Care
 - Has served as an important baseline threshold of ensuring network adequacy for the lower-income population without inhibiting innovative network designs
- This separate standard will only apply to Wrap-Compatible Plans; the overall QHP network adequacy review will be performed by the DOI



Additional Wrap Plan Requirements (cont'd)

- **Payment & Delivery System Reform**

- All Issuers (whether ultimately selected to offer state wrap or not) must commit to working with the Health Connector in pursuing alternative payment methodologies
 - Shared savings models
 - Shared risk models
 - Performance against global budget models
- As part of this process, Issuers must commit to transitioning towards alternative payment contracts over time



This year's Seal of Approval presents a unique opportunity to leverage the power of the Exchange to further the goals of Chapter 224



Member Transition

- Wrap Issuers must also commit to working closely with the Health Connector and MassHealth in ongoing member transition support, to minimize gaps in coverage as members move between subsidized programs
- We will also leverage Navigators, Assisters and both the Health Connector's and MassHealth's customer service vendors to conduct targeted outreach and provide enrollment support
- Finally, we are working to design systems that maximize the amount of time an individual has to complete their enrollment in a QHP while also (if funding is made available) working to extend MassHealth coverage to the end of a calendar month to minimize gaps in coverage as members transition from MassHealth to the Health Connector



Key Components of 2014 Seal of Approval

2014 Seal of Approval
Request for Response
Feb 2013

QHP Certification Standards Under ACA
Minimum Requirements

Exchange Product Portfolio

Dental Plan Requirements

Subsidized Coverage Through
the Health Connector

**Operational Requirements &
Administrative Fee**



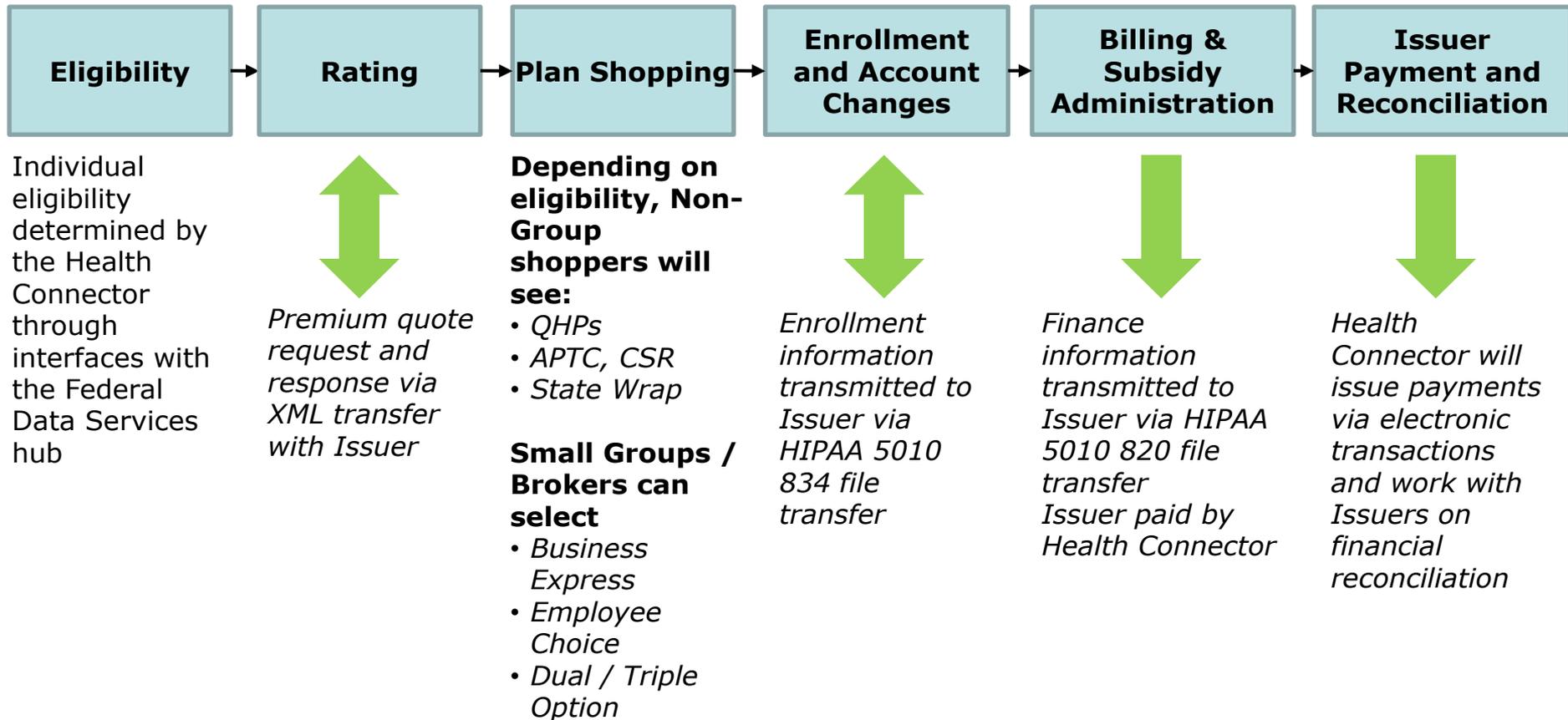
Operational Requirements – Overview

- **In order to establish an administratively efficient operating model, the Health Connector is pursuing streamlined and standardized operational interfaces with participating Issuers**
 - Reduce administrative burden of exchanging information with Issuers
 - Compliance with ACA guidance for operations and exchanging information, particularly related to enrollment and eligibility
- The Health Connector has engaged all participating Issuers to begin implementation on updated and new interfaces
- We intend to continue to work with the Issuers over the coming months to transition and integrate with the HIX-IES technology platform and Customer Service & Operations vendor



Standard Operating Model

• Standard Operating Model





Flexible Operating Model

- **Issuers can choose to establish a Flexible Operating Model for Business Express and/or Dual/Triple option for all small groups (1-50) or a segment of small groups (10-50)**
 - Some Issuers in the market currently outsource the administration of their 1-9 segment of small groups to intermediaries or other third-party administrators (TPAs)
 - Based on general market feedback, it is important for some Issuers to manage the administration of small businesses
 - The Health Connector is creating a flexible operating model option for these Issuers to allow them to offer their products to small businesses through the Health Connector's shelf, while retaining the ability to manage the administration of these accounts



Background

- Long-term financial sustainability of the Exchange is an explicit requirement of the ACA
 - Being financially self-sustaining means that the Exchange must operate without federal funding
- The Health Connector envisions significant changes that affect the organization as it transitions to an ACA-compliant Exchange
 - Membership - a significant portion of our current members will move to Medicaid in 2014, with new incoming members in both the non-group and small group segments
 - Functions - modifications/augmentations of our current operating model, some significant, will be required in order for us to become ACA-compliant
- We have begun to lay the ground work of analyzing the Health Connector's long-term financing needs and developing potential "straw man" revenue models



Health Connector 1.0 Revenue Model

Today, Health Connector 1.0 operations is supported primarily by state funding, supplemented by carrier contribution.



State Funding

- Commonwealth Care administrative fee
- Approximately 3% of capitation
- Subject to annual State Budget appropriation
- \$25.6M in FY11 and FY12;
\$22.6M in FY13

Carrier Contribution

- Commonwealth Choice administrative fee
- 3.5% of premium for non-group;
2.5% of premium for small group
- A surcharge (*i.e.*, expense) to carriers
- ~\$7M in FY13



Health Connector 2.0 Funding Needs Considerations

- **The principal influencing factor of our operating funding needs is Exchange scale**
- Compared with Health Connector 1.0, Health Connector 2.0 will have a higher proportion of fixed cost, which allows us to leverage economy of scale as enrollment grows
 - The new HIX-IES system will “absorb” certain key functions that are currently outsourced on a volume basis (*e.g.*, eligibility determination, portions of enrollment and premium billing)
- Savings from economy of scale would in turn help us fund the necessary costs associated with growing commercial membership – commissions, marketing and outreach, etc.
- We project that mid-to-long-term enrollment of the Health Connector will be 200,000~300,000
 - Besides continuing to pursue a strong presence in non-group, we will be aggressively targeting small-group membership growth



Exchange Revenue Model Considerations

- **Similar to most other states, we envision that the primary long-term funding mechanism for the Exchange will be through carrier administrative fee**
 - As an Exchange, we provide certain operational functions (*e.g.*, call center, enrollment and billing) that to varying degrees offset carriers' costs of distribution
 - We also serve as a marketing platform that helps carriers promote their product offering
- It is vitally important that the Health Connector strive to achieve market-competitive operating efficiency
 - Improve efficiency through scale
 - Shared technology/resources with MassHealth via HIX-IES
 - The Health Connector is exploring opportunities to collaborate with carriers on “flexible operating models” that have the potential to further streamline our operations



Exchange Revenue Model Considerations (cont'd)

- **A necessary enabling factor of our ability to achieve a competitive administrative fee structure is continued state support**
- As a public Exchange, we perform certain functions that are unique and essential to our mission. We do not believe that these costs should be borne entirely by carriers
 - *e.g.*, eligibility determination for subsidized coverage, Navigator program, appeals, policy development, risk adjustment
- We also believe that funding for the Exchange is aligned with the State's policy goals and generates positive "return on investment"
 - A transformative Exchange ultimately drives market-wide innovation, cost-containment and consumer-centric health care
 - As we have done in the past, the Health Connector will continue to assume many other state roles, including certain regulatory functions (*e.g.*, Student Health Program) and procurement support that contributes to State savings



Exchange Revenue Model Considerations (cont'd)

- **Our preferred long-term financing model is based on carrier contribution, supported by state funding**
- It is our goal to achieve *reduced* state funding relative to the current Commonwealth Care admin fee
 - Current state funding is \$15~17M annually net of federal matching
 - By integrating our subsidized and unsubsidized programs, we expect to have a larger pool of commercial membership than today, which reduces our reliance on state funding
- Our long-term target for carrier admin fee is to reach a meaningfully more competitive level than the current Commonwealth Choice
 - A potential goal of at or below 2.5% of premium
 - We recognize that this vision is critically dependent on the Health Connector's ability to achieve sufficient baseline scale, including the anticipated subsidized population in 2014



2014 As A Transition Year

- 2014 is a unique year as we are able to leverage federal Exchange Establishment Grant funding for the vast majority of operating costs for the 1st year of Exchange operation
 - We estimate that we will need ~\$2M (through June 2014) in alternative financing to support certain expenses that are not eligible for federal funding (e.g., Navigator grants, non-ACA-related state functions such as procurement assistance and policy development)
- **As such, we are recommending a temporary elimination of the carrier administrative fee for 2014**
 - Offers carriers the opportunity to invest in infrastructure to build streamlined and standardized interfaces with the Health Connector
- We expect to develop a proposed carrier administrative fee structure for 2015 and beyond, in part influenced by the level of operational and IT standardization that was achieved in the 2013-2014 timeframe, as well as other updated information (Exchange enrollment, costs, etc.)
 - We will discuss the 2015 administrative fee with the Board in 2014



Next Steps and 2014 Medical and Dental SoA Timeline

