MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

2018 Seal of Approval Preview

BRIAN SCHUETZ
Director of Program and Product Strategy

MARIA JOY DAWLEY
Product Manager, Health and Dental Plans

EMILY BRICE
Senior Policy Advisor

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Overview

- Today we will present our product development goals and solicit feedback in advance of the creation of the 2018 Request for Responses (RFR) to be issued in March
- Many of these goals are intended to provide stability and improve the customer experience, but we continue to push for policy innovation in key areas:
  - Value-based insurance design in our medical plans
  - Strengthening our partnerships with carriers on quality improvement
  - Learning from and promoting consistency among other public programs
  - Continuing to drive competition in the ConnectorCare program

2018 Seal of Approval Timeline

Dec 2016	Jan 2017	Feb	Mar	Apr	May	June	July	Aug	Sept
★ *Today: SOA Preview*									
			● *March: SOA Launch Board presentation*						
			★ *March: Release Medical and Dental RFRs*						
					★ *May: RFR Responses Due*				
							● *July: Conditional SOA Board presentation*		
							Sept: Final SOA Board Meeting ★		

Dental Plans

2018 Dental Plan Goals: Product Shelf Stability

For Plan Year 2018, the dental plan Seal of Approval strategy will be focused on maintaining stability of the dental product offerings and pursuing updates to the program to improve efficiency and consumer satisfaction.

- We are focused on maintaining the current dental product shelf in its roughly current configuration and scale, with no changes to the product shelf requirements
  - Three required standardized plan designs: Family High, Family Low and Pediatric-only
  - Existing limits on alternative network offerings and non-standardized plans

2017 Dental Plan Product Shelf								
Standardized Plans				Non-Standardized Plans				All Plans
High	Low	Pedi	Total	High	Low	Pedi	Total	
5	5	5	15	-	1	3	4	19

- The dental product shelf has seen significant premium stability, with enrollment adjusted rate decreases of 1.4% and 7.3% in the past two years

2018 Dental Plan Goals: Process Improvements

The major policy proposal for 2018 is to shift non-group dental plans from a plan year to a calendar year basis.

- Currently, the renewal date of a dental plan is 12 months from the effective date of coverage (*e.g.*, a consumer enrolls in a plan for May 1, the benefit year is 12 months from May 1 and the plan will renew the following May)
- The "mid-year" dental renewals that result from this model present significant operational complexity and consumer confusion – especially during Open Enrollment
- This shift better aligns the non-group dental offering with the non-group medical shelf, as well as with other public exchanges
- As a result of the design of dental plans, including the use of calendar year benefit maximums and time-based benefit exclusions, this shift does not require the proration of benefits during the transition period

	Plan Structure
Colorado	Calendar Year
Maryland	Calendar Year
Rhode Island	Calendar Year
New York	Calendar Year
Connecticut	Plan Year
California	Calendar Year
FFM	Calendar Year
Vermont	Calendar Year
D.C.	Calendar Year

2018 Dental Plan Goals: Process Improvements (cont'd)

Health Connector Staff are also undertaking a business process review for all of our dental product operational activities.

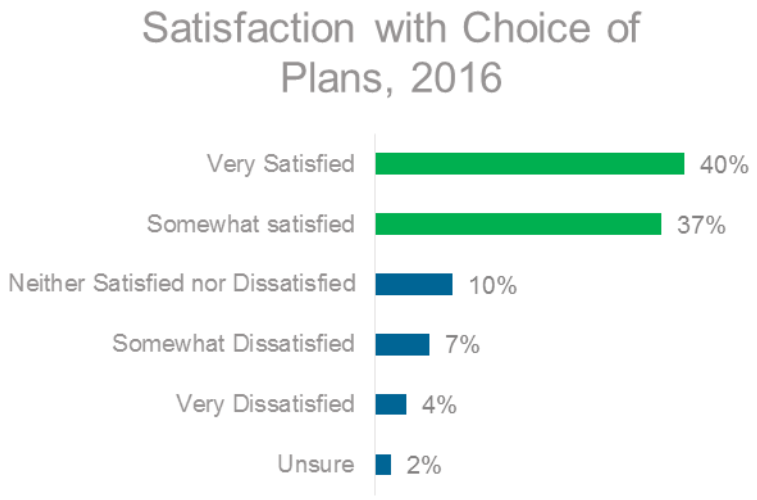
- The Health Connector's dental member experience lags behind our medical products
- The assessment will document existing system functionality including manual workarounds, and the end-to-end member experience
- Once completed, staff will develop, recommend, and implement enhancements to improve operational stability, premium accuracy, and member satisfaction

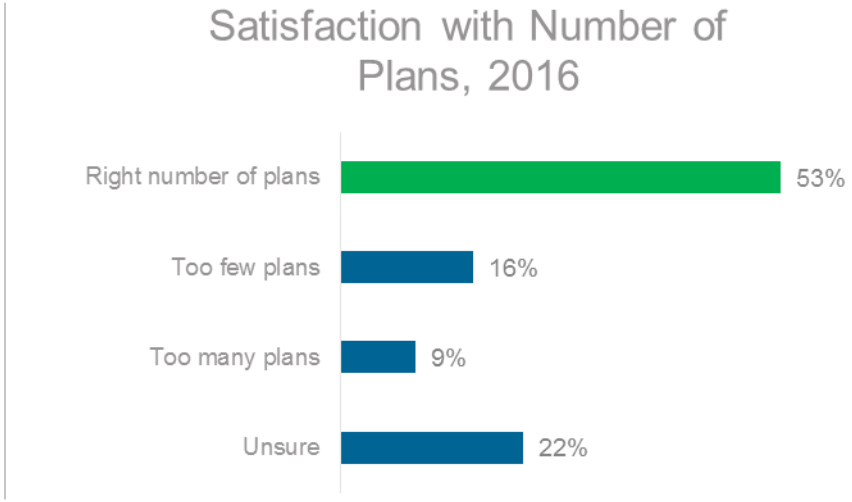
Health Plans

2018 Health Plan Goals: Product Shelf Stability

Our goals for the unsubsidized and tax credit-only product shelf are to promote competition and choice for our members.

- As with dental, we are focused on maintaining the current health plan product shelf in its roughly current configuration and scale
  - Our 2016 member experience survey indicated approximately three-quarters of members are satisfied with their choice of plans and just over half felt that the Health Connector offers "the right number of plans"

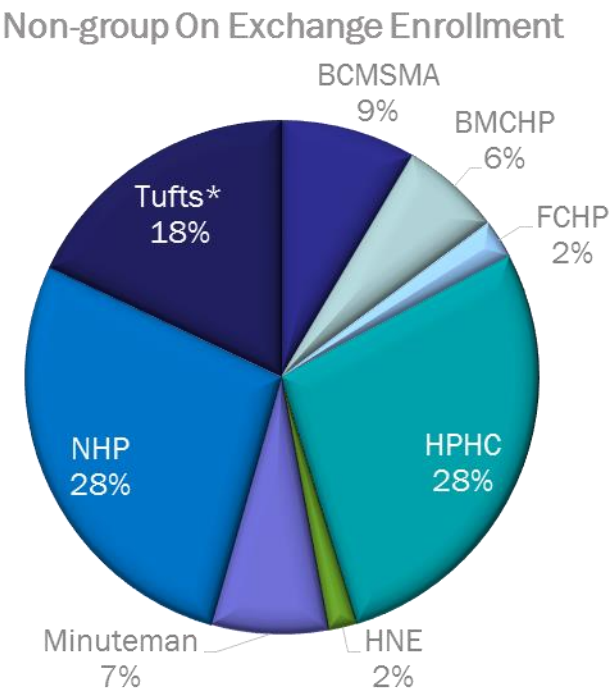


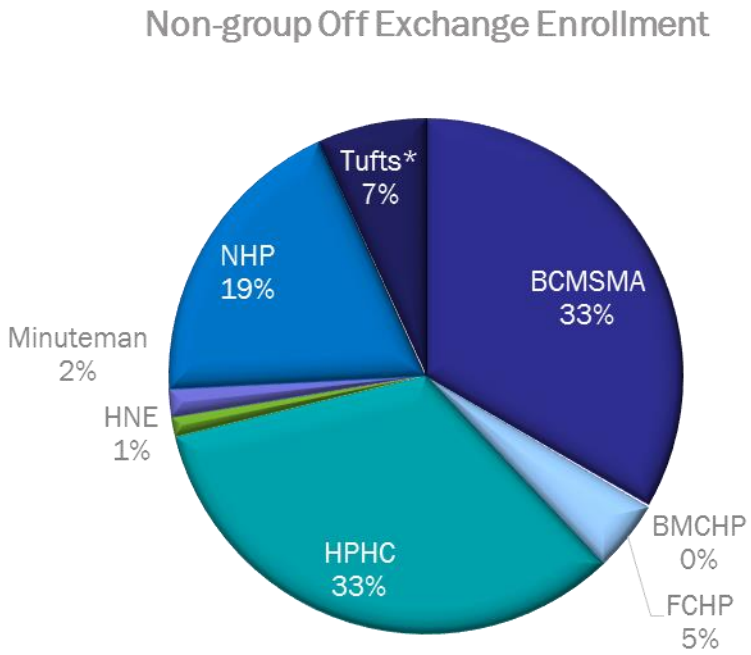


Source: Market Decisions Report, 2016 Health Connector Member Survey

2018 Health Plan Goals: Product Shelf Stability (cont'd)

- A comparison of non-group enrollment through the Health Connector and enrollment outside shows that the comparison shopping experience increases competition among carriers – consumers are more likely to shop around to discover new options that give good value for their dollar





Source: CHIA Enrollment Trends February 2016 Databook. Data from September 2015. http://www.chiamass.gov/enrollment-in-health-insurance/. Enrollment totals for On Exchange Non-Group enrollment do not include ConnectorCare enrollment. Excludes carriers with negligible enrollment.
**Tufts data includes both Tufts Health Plan – Premier and Tufts Health Plan – Direct enrollment.*

2018 Health Plan Goals: Product Shelf Stability (cont'd)

- As such, we expect to retain the existing product shelf requirements
  - At least one (1) plan for each of the four (4) standardized plan designs, with the two Bronze options, on the carrier's broadest commercial network
  - Existing limits on alternative network versions and non-standardized plans

2017 Medical Plan Product Shelf					
Platinum	Gold	Silver	Bronze	Catastrophic	Total
12	18	18	10	4	62

2018 Health Plan Goals: Quality

The Health Connector continues to work with our carrier partners to identify and implement quality improvement initiatives.

- For the 2017 plan year, all medical carriers submitted Quality Improvement Strategy (QIS) reports detailing their quality improvement efforts in the previous year
  - For this first year, the Health Connector allowed carriers significant flexibility in the format and content of the QIS submissions
- Overall, the majority of the initial QIS responses demonstrate the carriers' commitment to improving quality, and highlighted the need to continue to refine the QIS approach
  - The best responses had clear performance benchmarks/targets based on nationally endorsed quality measures and if available, baseline data for the QHP population, while some plans lacked detail around implementation plans and timelines
- In their initial QIS responses, carriers noted a number of ongoing efforts
  - Global budget-based incentive models, bonus payment for providers meeting certain HEDIS measure targets, and financial incentives to members for using high-value services

2018 Health Plan Goals: Quality (cont'd)

- We will ask carriers to provide detailed updates on progress toward their goals set in last year's QIS, with individualized questions for each carrier
- We will seek carriers' quality plans for public health and access topics, potentially including
  - In keeping with new opioid treatment benefit: Update on quality and utilization measures related to substance use disorder treatment
  - In keeping with new targeted outreach populations: Reporting on quality efforts to reduce health disparities
- We will also work with our colleagues at the Center for Health Information and Analysis (CHIA), the Group Insurance Commission (GIC), MassHealth and other state quality initiatives to ensure consistency

2018 Health Plan Goals: Value

The Health Connector continues to prioritize consumer decision-support tools, recognizing that transparent information allows consumers to select plans that offer the best value for their needs.

- For 2017, the Health Connector made key improvements to existing decision-support tools:
  - Highlighting standard plans and alternative network types
  - Enhanced the provider search tool with new provider types, including community health centers, nurse practitioners, physician assistants, and mental health professionals (dental professionals to be added soon)
- For 2018, the Health Connector is exploring adding new tools to support consumer decisions:
  - Based on literature review of effective decision-support tools and research into the tools of peer exchanges, intend to prioritize formulary search and total cost calculator tools
  - We have started the process of implementing enhanced decision support tools with the development, and anticipated release, of a procurement

2018 Health Plan Goals: Value (cont'd)

The Health Connector continues to identify opportunities to incorporate elements of value-based insurance design (VBID) into its standard plan designs, to ensure the highest-value services are maximally affordable for enrollees.

- VBID aligns enrollee cost-sharing with the clinical value of services, encouraging the use of higher-value services while discouraging lower-value services
- VBID offers an opportunity to bolster affordability for the most critical services

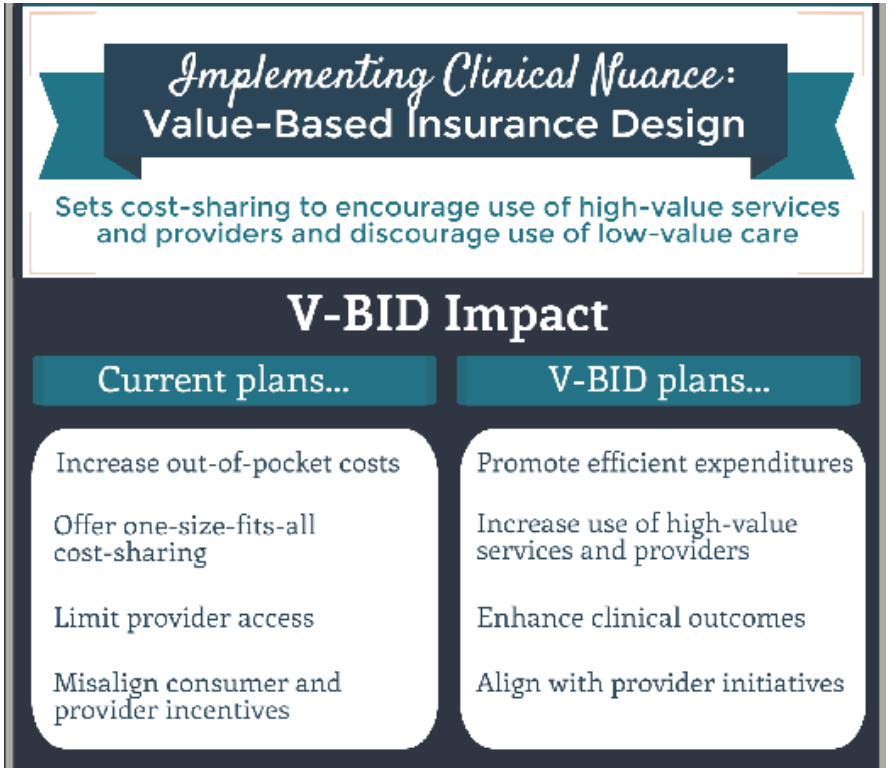


Image courtesy of U. Michigan Center for Value-Based Insurance Design, 2016, http://vbidcenter.org/

2018 Health Plan Goals: Value (cont'd)

- In 2017, SOA responses to Request for Information indicate a willingness and capability from many of our carriers to implement VBID elements
  - Interest in chronic illness management and rewarding consumers for participating in wellness/illness management care
- For 2018, examining ways to incorporate elements of VBID into products, in a collaborative approach with carriers
  - Will need to balance carrier readiness, metallic tier actuarial value requirements, and responsibility to ensure appropriate and consistent consumer access to benefits
  - Focus on coordinating and, where appropriate, leveraging value strategies used in other state programs: MassHealth, GIC
  - Potential approach – allowing carrier flexibility to offer direct financial incentives to enrollees for use of high-value services and providers
- Over the longer term, interested in collaboration with Board members, carriers, other state programs, and experts in the field to develop a comprehensive VBID approach

Subsidized Programs

Subsidized Programs: Design Elements

The Health Connector is committed to providing our 200,000 state subsidized members with high-value, affordable plan offerings.

- At the core of the this program are three key design pillars that define the program features for carriers, members and the Commonwealth.

Carrier Availability	Premium Costs	Point of Care Costs
• Service and rating area requirements and definitions • Network adequacy requirements • Geographic "region" definitions	• Underlying Silver plan premiums • Advance Premium Tax Credits • State premium subsidies	• Plan designs • Federal Cost Sharing Reduction (CSR) • State CSR

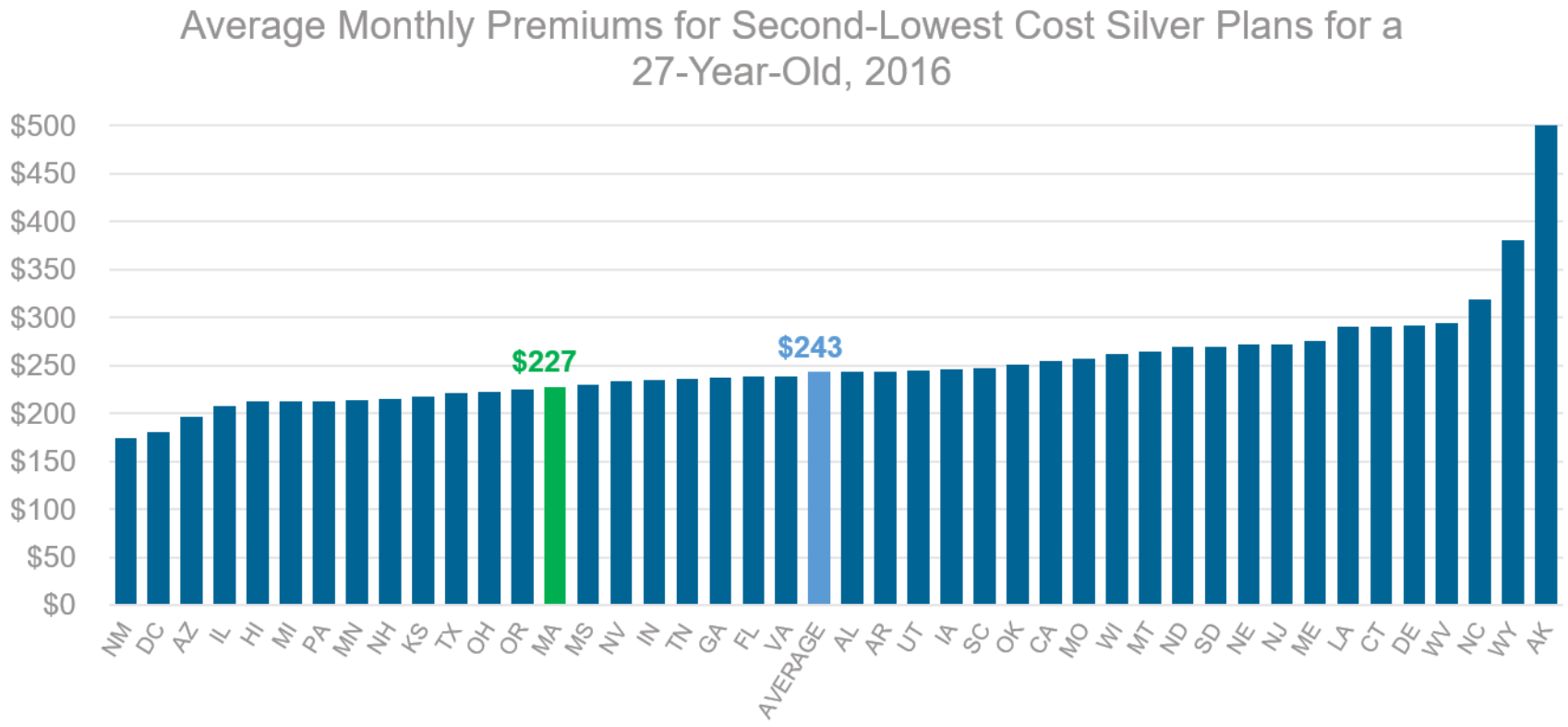
Subsidized Programs: Competition

The Health Connector's subsidized program promotes affordability and competition by helping to keep premiums down for some products, even outside of the program.

- Selection of carriers for participation in the ConnectorCare program is based in part on how competitive the premium is for the underlying Silver plan
- Non-ConnectorCare members can purchase the base Silver plan at the competitive underlying rate, through the Health Connector or outside market
- While insurance premiums in the broader market typically increase year over year based on market-wide factors, competition for membership in the ConnectorCare program, and the price sensitive shopping behavior of ConnectorCare members, incentivizes some carriers to design and aggressively price their Silver tier products very differently compared to the broader market
- For 2017, the ConnectorCare program has continued to encourage market competition by rewarding plans that came in with better premiums with a more generous level of subsidy

Subsidized Programs: Competition (cont'd)

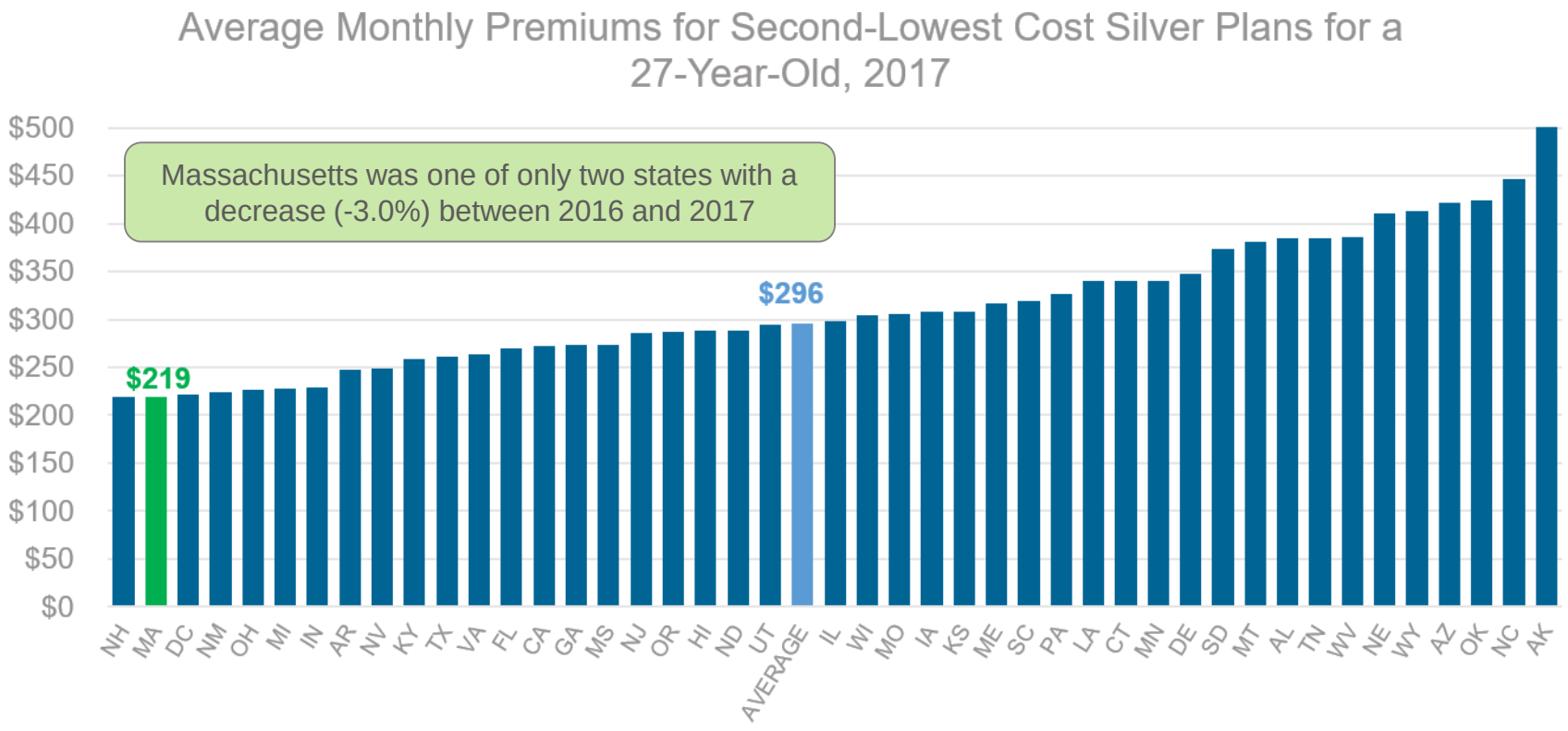
Competition among carriers in the ConnectorCare program results in lower premium costs on the Silver tier – benefits available to the entire merged market…



Source: "ASPE Research Brief: Health Plan Choice And Premiums in the 2017 Health Insurance Marketplace," Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. October 24, 2016.

Subsidized Programs: Competition (cont'd)

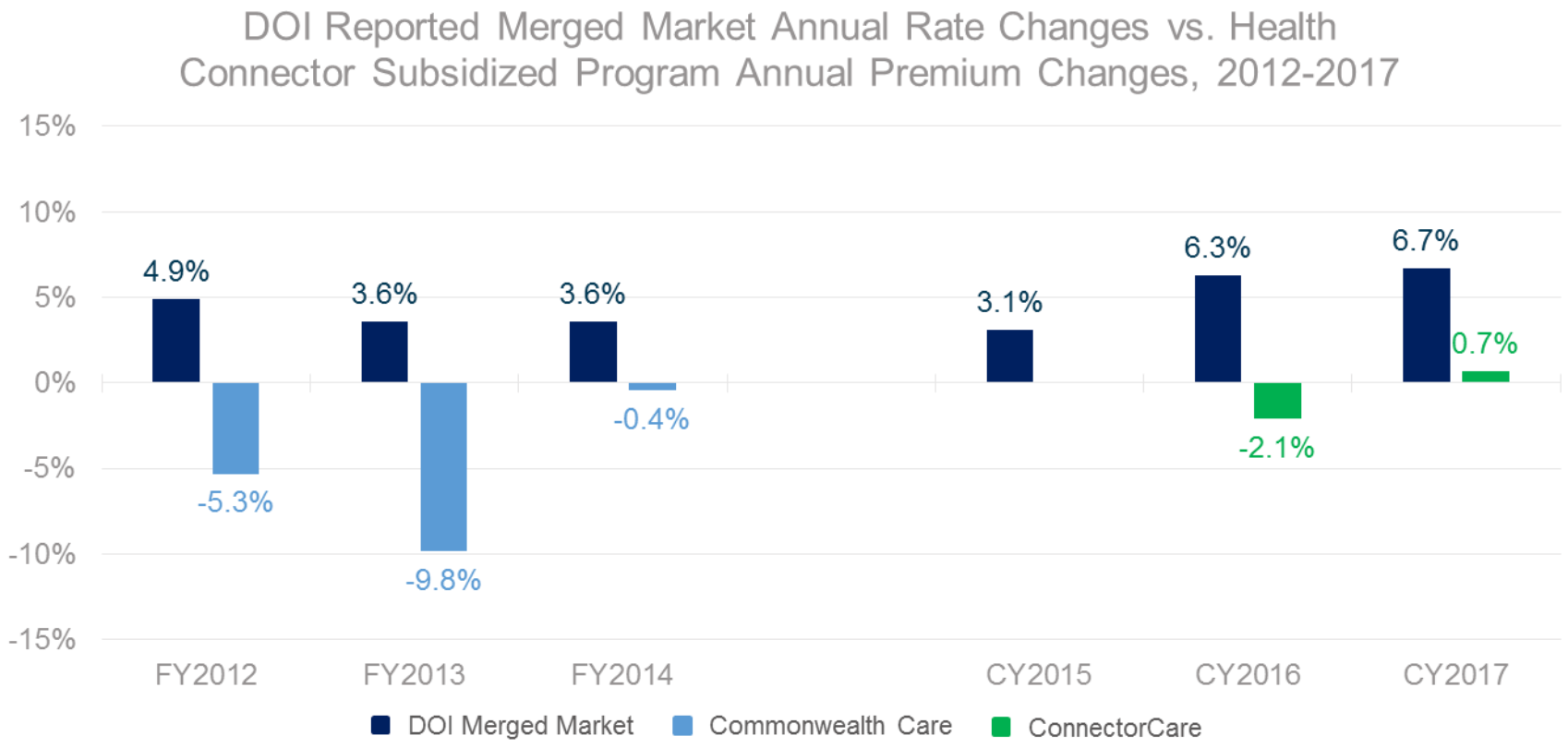
…Competition that continues year over year.



Source: "ASPE Research Brief: Health Plan Choice And Premiums in the 2017 Health Insurance Marketplace," Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. October 24, 2016.

Subsidized Programs: Competition (cont'd)

For the past five years, the annual premium increases of the ConnectorCare, and its predecessor program Commonwealth Care, have been lower than the merged market average.



Source: Massachusetts Division of Insurance reported Q1 merged market rate increases. Commonwealth Care values represent the year-over-year change in the average capitation amount. ConnectorCare values represent the year-over-year change in enrollment weighted premiums for the Silver plans that underlie the ConnectorCare plans

Next Steps

Next Steps

We will continue to explore product options and solicit Board member feedback as we draft the 2018 SOA RFR.

- 2018 RFR and product development:
  - We welcome Board member engagement in the coming months in advance of the Conditional SOA presentation to the Board in March
  - We will also make updates to standardized plan designs to continue to promote value and affordability and ensure they conform to the 2018 Actuarial Value Calculator
  - The 2018 SOA RFR will be released mid-March
- Plan Year 2017 QIS report:
  - We will work with our carrier partners to develop the content and timeline of the Plan Year 2017 QIS and expect to release the reporting form in early 2017

Appendix

Qualified Health Plans: 2017 Standardized Designs

MASSACHUSETTS HEALTH CONNECTOR

Plan Feature/ Service *A check mark (✓) indicates that this benefit is subject to the annual deductible*		Platinum	Gold	Silver	Bronze #1	Bronze #2
Annual Deductible – Combined		N/A	$1,000	$2,000	N/A	N/A
		N/A	$2,000	$4,000	N/A	N/A
Annual Deductible – Medical		N/A	N/A	N/A	$2,750	$1,500
		N/A	N/A	N/A	$5,500	$3,000
Annual Deductible – Prescription Drugs		N/A	N/A	N/A	$250	$1,500
		N/A	N/A	N/A	$500	$3,000
Annual Out-of-Pocket Maximum		$3,000	$5,000	$7,150	$7,150	$6,550
		$6,000	$10,000	$14,300	$14,300	$13,100
Primary Care Provider (PCP) Office Visits		$25	$30	$30	$25 ✓	$25 ✓
Specialist Office Visits		$40	$45	$50	$40 ✓	$50 ✓
Emergency Room		$150	$150 ✓	$700 ✓	$500 ✓	$750 ✓
Urgent Care		$40	$45	$50	$40 ✓	$50 ✓
Inpatient Hospitalization		$500	$500 ✓	$1,000 ✓	$1,000 ✓	$1,000 ✓
Skilled Nursing Facility		$500	$500 ✓	$1,000 ✓	$1,000 ✓	$1,000 ✓
Durable Medical Equipment		20%	20% ✓	20% ✓	20% ✓	20% ✓
Rehabilitative Occupational and Rehabilitative Physical Therapy		$40	$45	$50	$40 ✓	$50 ✓
Laboratory Outpatient and Professional Services		$0	$20 ✓	$25 ✓	$50 ✓	$50 ✓
X-rays and Diagnostic Imaging		$0	$20 ✓	$25 ✓	$175 ✓	$175 ✓
High-Cost Imaging		$150	$200 ✓	$500 ✓	$1,000 ✓	$1,000 ✓
Outpatient Surgery: Ambulatory Surgery Center		$500	$250 ✓	$750 ✓	$750 ✓	$1,000 ✓
Outpatient Surgery: Physician/Surgical Services		$0	$0 ✓	$0 ✓	$0 ✓	$0 ✓
Prescription Drug	Retail Tier 1	$15	$20	$20	$25 ✓	$40 ✓
	Retail Tier 2	$30	$30	$60	$75 ✓	$100 ✓
	Retail Tier 3	$50	$50	$90	$100 ✓	$150 ✓
	Mail Tier 1	$30	$40	$40	$50 ✓	$80 ✓
	Mail Tier 2	$60	$60	$120	$150 ✓	$200 ✓
	Mail Tier 3	$150	$150	$270	$300 ✓	$450 ✓
2017 Final FAVC		91.73%	81.43%	71.84%	61.86%	61.90%

ConnectorCare: 2017 Plan Designs

CONNECTORCARE BENEFITS & COPAYS				
Plan Type		**Plan Type 1**	**Plan Types 2A & 2B**	**Plan Types 3A & 3B**
Medical Maximum Out-of-Pocket (Individual/ Family)		$0	$750/$1,500	$1,500/$3,000
Prescription Drug Maximum Out-of-Pocket (Individual/ Family)		$250/$500	$500/$1,000	$750/$1,500
Preventive Care/Screening/Immunization		$0	$0	$0
Primary Care visit to treat injury or illness (exc. Well Baby, Preventive and X-rays)		$0	$10	$15
Specialist Office Visit		$0	$18	$22
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services		$0	$10	$15
Rehabilitative Speech Therapy		$0	$10	$20
Rehabilitative Occupational and Rehabilitative Physical Therapy		$0	$10	$20
Emergency Room Services		$0	$50	$100
Outpatient Surgery		$0	$50	$125
All Inpatient Hospital Services (including Mental/Behavioral Health and Substance Abuse Disorder Services)		$0	$50	$250
High Cost Imaging (CT/PET Scans, MRIs, etc.)		$0	$30	$60
Laboratory Outpatient and Professional Services		$0	$0	$0
X-Rays and Diagnostic Imaging		$0	$0	$0
Skilled Nursing Facility		$0	$0	$0
Retail Prescription Drugs:	Generics Preferred Brand Drugs Non-Preferred Brand Drugs Specialty High Cost Drugs	$1 $3.65 $3.65 $3.65	$10 $20 $40 $40	$12.50 $25 $50 $50

Qualified Dental Plans: 2017 Standardized Designs

Plan Feature/ Service	Family High	Family Low	Pediatric-only
Plan Year Deductible	$50/$150	$50/$150	$50
Deductible Applies to	Major and Minor Restorative	Major and Minor Restorative	Major and Minor Restorative
Plan Year Max (>=19 only)	$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)
Preventive & Diagnostic Co-Insurance (In/out-of-Network)	0%/20%	0%/20%	0%/20%
Minor Restorative Co-Insurance (In/out-of-Network)	25%/45%	25%/45%	25%/45%
Major Restorative Co-Insurance (In/out-of-Network)	50%/70%	50%/70% No Major Restorative >=19	50%/70%
Medically Necessary Orthodontia, <19 only (In/out-of-Network)	50%/70%	50%/70%	50%/70%
Non-Medically Necessary Orthodontia, <19 only (In/out-of-Network)	N/A	N/A	N/A