Connecticut Health Insurance Exchange

Board of Directors Meeting

November 29, 2012

Welcome and Introductions

Public Comment

Review and Approval of Minutes

CEO Report

Operations Update

Operations Update

Major Operational Efforts

- Call Center Finalist Presentations
  - November 27
- Draft SHOP RFP with CCIIO for Review.
  - Estimate Release November 30th
- Independent Verification and Validation RFP
  - In Development for December Release
- Blueprint Application Update
- Policy/Procedure Approvals
  - Investment, SHOP, QHP, Navigator
- Staffing Overall
- Operating Model
  - People and Process Coordination with DSS, HRA, etc.

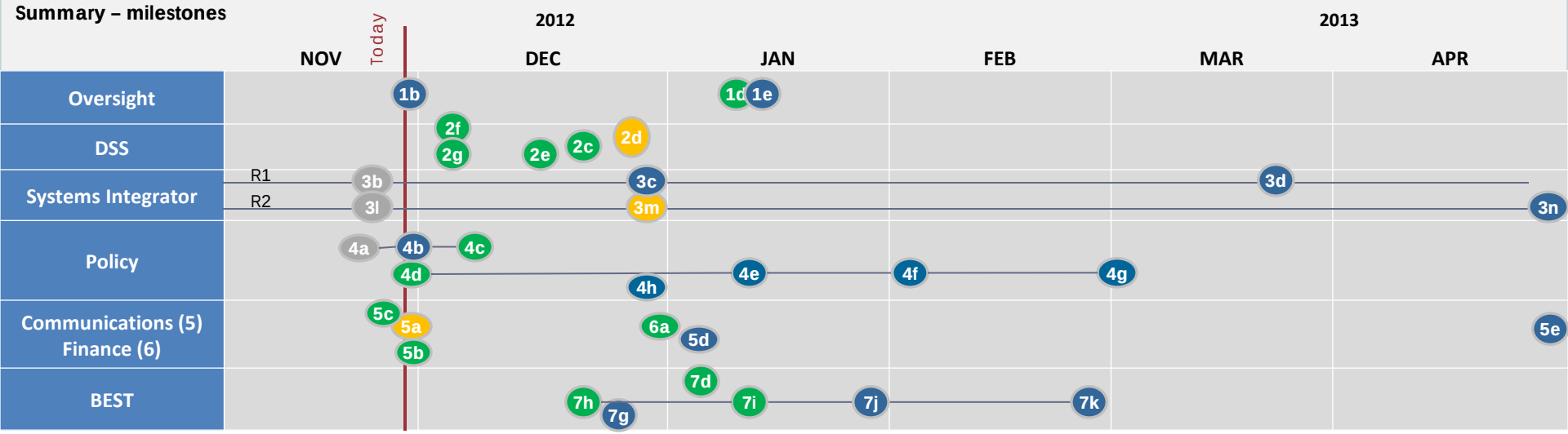
Weekly PMO Dashboard

Timeline

CT HIX / IE PMO Dashboard

11/29/12

Summary – milestones



Oversight & Support
(1b) Board Meeting (Nov 29)
(1d) Move into new HIX office (Jan 10)
(1e) Design Review with CMS (Jan 11)

DSS
Management
(2c) Preliminary High level MOU discussions with HIX (Dec 21)
Tier 1
(2d) Design Confirmations Completion (Dec 27)
(2e) Commence Development of Training and Operational Transition Plan (Dec 14)
Tiers 2, 3 & 4
(2f) Tier 2&3 Requirements and Process Flows (Dec 7)
(2g) Tier 2&3 IAPD Submission (Dec 7)

System Integrator
Release 1:
(3a) Initiation Complete (Oct 1 - Oct 9)
(3b) Planning Complete (Oct 10 – Nov 20)
(3c) Solution Fit-Gap Analysis Complete (Nov 2 – Dec 27)
(3d) Customization Complete (Dec 10 – Mar 22)
Release 2:
(3k) Initiation Complete (Oct 9)
(3l) Planning Complete (Nov 20)
(3m) Solution Fit-Gap Analysis Complete (Nov 2 – Dec 27)
(3n) Customization Complete (Dec 10 – Jun 28)

Policy
Planning for QHP (Requirements/ Solicitation)
(4a) Combined QHP/ Consumer Meeting (Nov 20)
(4b) Board Meeting (Nov 29)
(4c) Release Final QHP Solicitation (Dec 7)
Planning for SHOP (Policy, RFP)
(4d) SHOP RFP Issued (Nov 30)
(4e) SHOP Vendor Proposals Due (Jan 11)
(4f) Select SHOP Vendor (Feb 8)
(4g) SHOP Vendor Start Date (March 1)

Other Milestones
(4h) Agreement with HRA for Reinsurance (late Dec)

Communications
(5a) Define funding for Navigator Program (Nov 29)
(5b) Board approval for Broker/Navigator Program (Nov 29)
(5c) Marketing/ Outreach campaign launch (Nov 27)
(5d) Publish Navigator RFP (Jan 1)
(5e) Train & Certify Navigators (Apr 30)

Finance
(6a) Replace OPM as grantee (Dec 31)

BEST
(7g) Receive Hardware (Dec 21)
(7h) Data center infrastructure complete (Dec 21)
(7i) HIX UAT VM/OS environment built (Jan 9)
(7j) UAT vanilla software installation completed (Jan 31)
(7k) UAT software configuration completed (Feb 28)

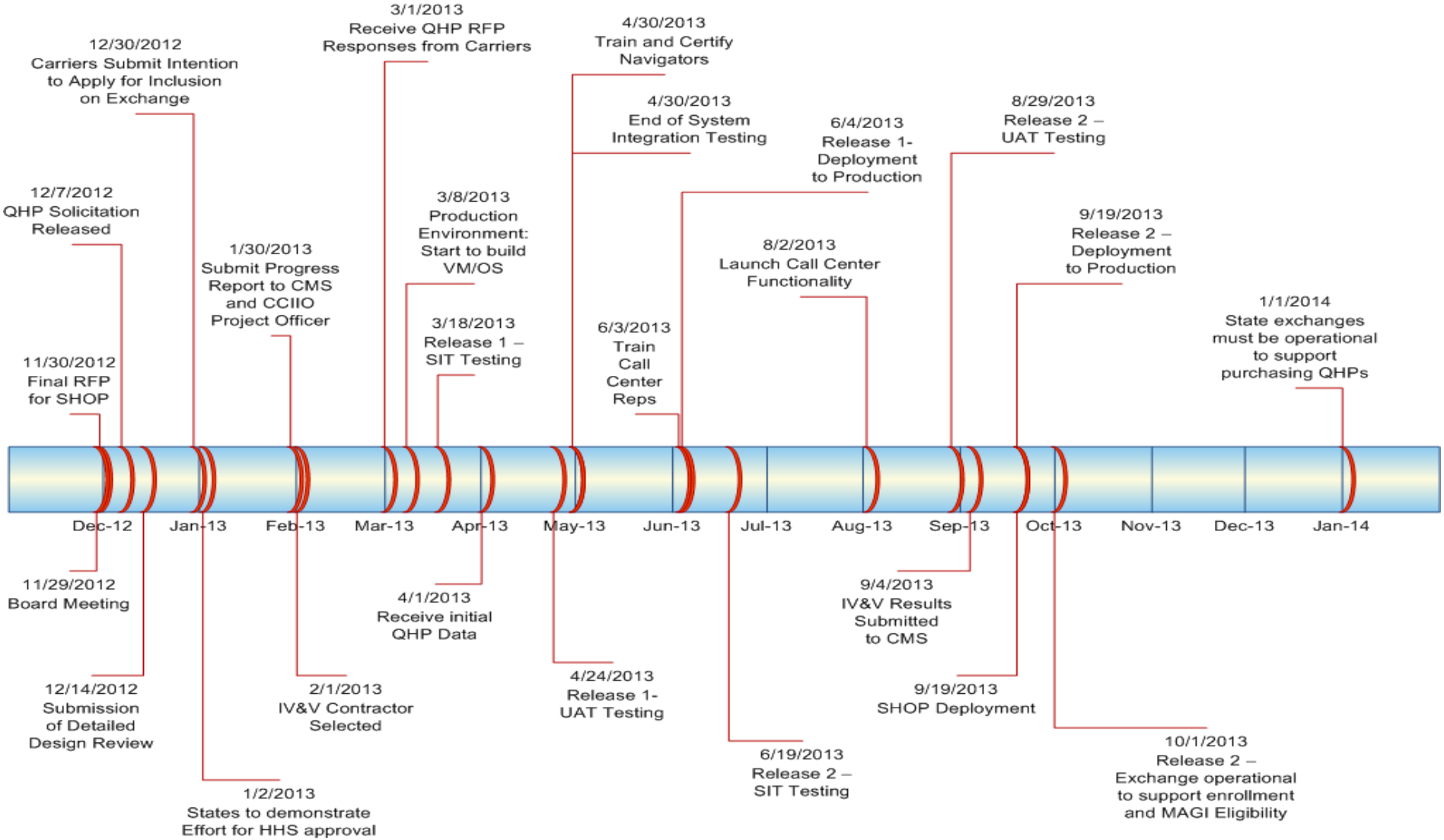
Project Risk/ Issues Summary	Schedule Risks	Resource Risks	Quality Risks	Deliverables Risks	Issues
Oversight					
DSS		(2d)			
System Integrator	(3m)				
Policy					
Communication		(5a)			
Finance					
BEST					

Schedule Risks	Resource Risks	Quality Risks	Deliverables Risks	Issues	Overall

Not started	Started and on track	Minor risk / issue	Major risk / issue	Complete

ID	Risk	Risk Level	Mitigation	Current Status
2d ,3m	Capacity of DSS staff to support HIX/IE activities while juggling business as usual activities, and other significant DSS activities. There are several risks: 1.Potential insufficient input into key design decisions early on the project could lead to expensive changes in scope, schedule delays, or poorer implementation of the proposed solutions at later stages and additional complexities in operational transitions. 2.Any catastrophic production issues (i.e. EMS unavailability, or natural disasters) will cause a disruption to the allocation of resources, and impact associated projects. 3.That DSS staff will not be able to support other commitments with DSS and the outputs from the Department will suffer.	Med	DSS Management have developed a list of policy questions and seeking to address these as soon as possible in the process. A Staffing Plan is currently in development, the initial draft of this is expected to be completed end of November. Collaborative efforts with other stakeholders when scheduling project meetings.	11/26/12: Action-Ongoing collaboration required between stakeholders to ensure effective DSS input.
5a	Uncertainty around who will pay for Navigator Program. Additionally, an in-person assistance program was recently mandated by the Feds. This program is separate and distinct from the Navigator program and requires different funding streams.	Med	This is a challenge for all the states. CT will be addressing funding issue by aggressively utilizing the new In person assister (IPA) Level 1 grant funding available (being submitted on 11/15). Funding will allow for robust IPA functionality (addressing education and enrollment), which can be further augmented and supported once Navigator funding is secured. HIX is working with OHA to aid in the administration and oversight of the IPA and Navigator programs based on their rich experience in this space. Additionally, both organizations are exploring potential Navigator funding solutions and reaching out to Connecticut Universal Healthcare as well as “Enroll America”, a national non-profit.	11/26/12: Awareness - Going to Board Nov 29. Level 1 grant will be resubmitted to fund in-person assistance program in February 5, 2013.

Timeline


3/1/2013
Receive QHP RFP
Responses from Carriers
4/30/2013
Train and Certify
Navigators
12/30/2012
Carriers Submit Intention
to Apply for Inclusion
on Exchange
4/30/2013
End of System
Integration Testing
6/4/2013
Release 1-
Deployment
to Production
8/29/2013
Release 2 –
UAT Testing
12/7/2012
QHP Solicitation
Released
3/8/2013
Production
Environment:
Start to build
VM/OS
1/30/2013
Submit Progress
Report to CMS
and CCIIO
Project Officer
8/2/2013
Launch Call Center
Functionality
9/19/2013
Release 2 –
Deployment
to Production
3/18/2013
Release 1 –
SIT Testing
6/3/2013
Train
Call
Center
Reps
1/1/2014
State exchanges
must be operational
to support
purchasing QHPs
11/30/2012
Final RFP
for SHOP
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
11/29/2012
Board Meeting
4/1/2013
Receive initial
QHP Data
9/4/2013
IV&V Results
Submitted
to CMS
12/14/2012
Submission
of Detailed
Design Review
2/1/2013
IV&V Contractor
Selected
4/24/2013
Release 1-
UAT Testing
9/19/2013
SHOP Deployment
6/19/2013
Release 2 –
SIT Testing
10/1/2013
Release 2 –
Exchange operational
to support enrollment
and MAGI Eligibility
1/2/2013
States to demonstrate
Effort for HHS approval

Policies

Policies and Procedures:

Steps in the Process

- As the Exchange looks to establish and adopt policies in key areas, there is a 3-step process which needs to be undertaken in accordance with CT State law

1 ***Craft and publish the "process" for how the policies will be created***

- The "process" states the steps that will be taken to draft the policy, who is involved, and what will be considered
- Once drafted, the policy needs to be posted for 30 days for public comment, as well as published in the CT Law Journal

2 ***Vote to adopt the "process" for how the policies will be created***

- After reviewing and incorporating any public comment, the "process" is revised, and then adopted by the Board

3 ***Vote to adopt the "actual policy" which has been created***

- Once the "process" has been approved, the Board can then review the "actual policy" recommendation developed by the Exchange staff and Advisory Committees, and vote to approve

Policies and Procedures for Adoption

The policies and procedures the Exchange is scheduled to adopt at the November 29, 2012 Board meeting:

- Investment Policy
- Small Employer Health Options Program (SHOP) Policy
- Procedure for Certification of Qualified Health Plans
- Procedure for Navigator Program

Advisory Committees Update

- Consumer Experience and Outreach / Health Plan Benefits and Qualifications
- Brokers, Agents and Navigators
- Small Employer Health Options Program (SHOP)
- Strategy Committee

Navigators and In-Person Assistance Program

Navigator Program

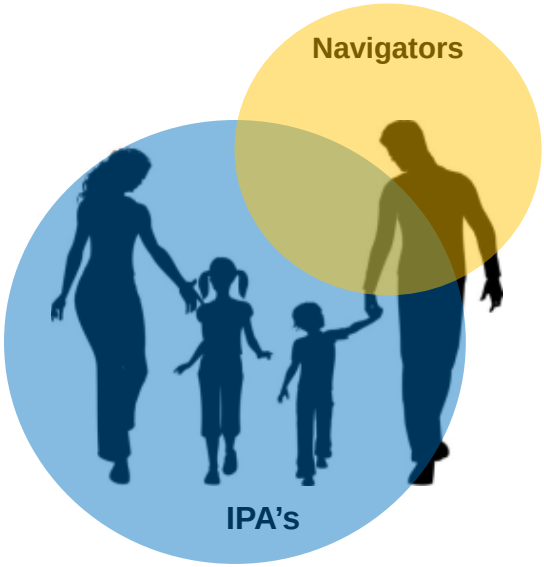
Overview of Final Recommendation

- A simplified Navigator program that combines roles of “educator” and “enroller”, with a focus on providing objective, unbiased and culturally sensitive support
  - Navigators prohibited to recommend a specific QHP or Carrier; but Navigators can give general advice on how to select a QHP
  - No SHOP-specific Navigator program; instead all Navigators will be educated about SHOP
- Training and certification will be required for all Navigators and producers enrolling individuals via the exchange
  - Draft curriculum is outlined, with additional work to be done when beginning implementation
- Simplified Navigator grant model (75% of grant issued in advance of activity, 25% issued upon successful completion)
- Navigators cannot receive direct compensation from carriers, thereby prohibiting producers from becoming Navigators unless they sever current appointments

Navigator Program:

In Person Assistor Program

- In acknowledgement of the funding challenges States are facing related to Navigator grants, a new “In-Person Assistor” program was introduced by CMS this August….. along with funding opportunities.
  - The In Person Assistor responsibilities and duties are nearly identical to Navigators, with increased flexibility to focus their efforts where most needed (education vs. enrollment)
- Our strategy is to apply for and utilize In Person Assistor funding to set up the majority of our in person infrastructure, and augment with a modest Navigator program (to meet the requirements of the law).
  - The overall program will be consistently branded and presented to the public as one program, with the Navigator IPA distinction existing behind the scenes from an operational perspective



Navigator Program:

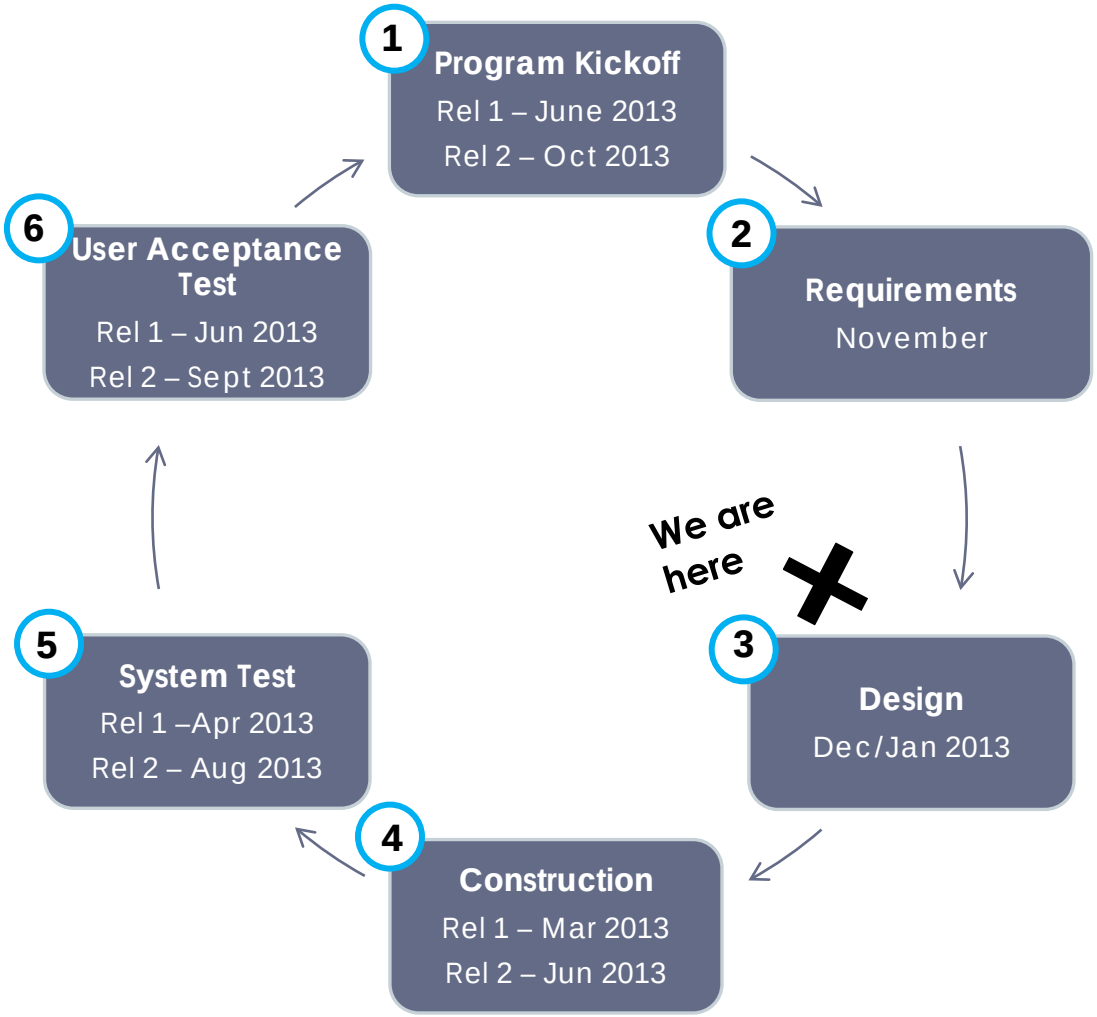
Next Steps

- Submit recommendation to the Board for approval
- Continue exploring Navigator funding options
- Re-apply for L1 In-Person-Assistor grant
- On board new Consumer Outreach Manager, who will play an active role in operationalizing the program
- Explore and formalize any partnerships with organizations who may assist in the development and deployment of the Navigator and In-Person Assistor programs

IT Update

System Integrator Update:

Established Process



- Completed Requirements review and confirmation
- Beginning Design review and Confirmation
  - Engaged Consumer Advocates
- Technical Architecture Review completed
  - Hardware/Software acquisition underway

HIX Relocation Update

- Lease signed for 15th floor of 280 Trumbull Street
- Project Manager hired to oversee logistics, office build-out and move
- Bureau of Enterprise Systems & Technology (BEST) network and telephony teams engaged to support technical infrastructure
- State furniture contract signed, leveraging state approved vendor
- Move-in date tentatively scheduled for January

Marketing and Communications Update

Marketing & Communications:

Progress Update

- Final major research initiative will conclude next month:
  - Creative concept testing
  - Quantitative Segmentation
- Naming research now complete
- Consumer outreach efforts (Healthy Chat) are underway in advance of broader campaign launch in the first quarter of 2014
- Marketing RFP process has concluded

Name Development Update

- Over the past 2 months, we have been actively exploring consumer friendly naming options for the Exchange.

- Options for names came from several different sources, with options that best aligned to needs of consumers (based on market research), and aligned with our brand positions chosen for testing.

Brand Position:

As a trusted advisor to state residents and small businesses in need of quality health insurance, the new CT Health Insurance Exchange will be a safe and objective destination for support in choosing health insurance coverage.

- In total, we will have tested a total of 12 names, and spoken with more than 300 individuals across 2 rounds of research

Name Development Update

- Names were evaluated for effectiveness across multiple categories including:

Fitting what this organization is and does?
Making you **interested** in what the organization is and does?
Making you feel this organization would provide access to name brand, **quality** health care coverage?
Making what the organization is and does **appealing** to you?
Making you feel there is something **in it for you**?
Making you feel this organization would give you **choice** in health care coverage?
Making you feel this organization is offering something **new** and different?

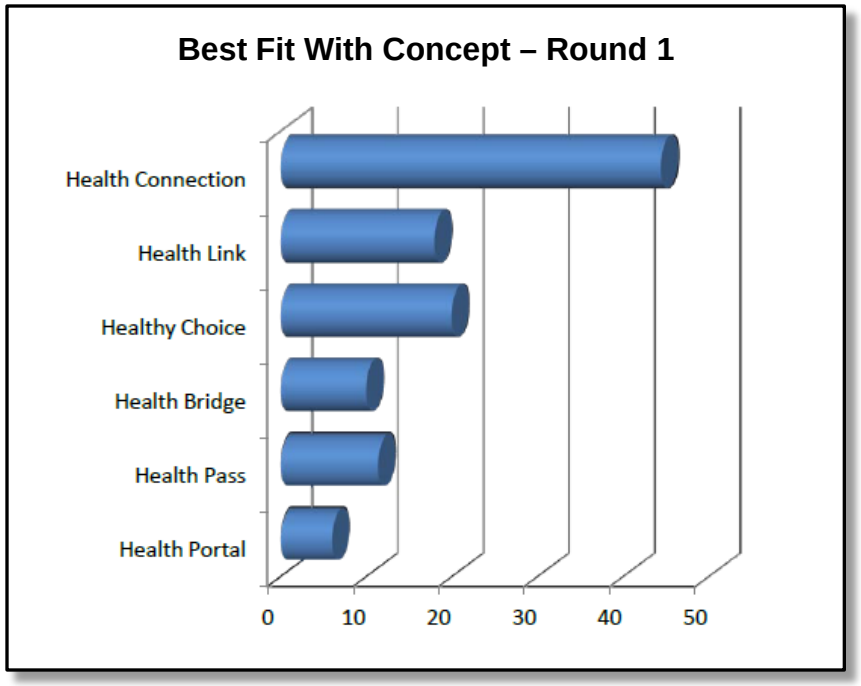
Name Development Update

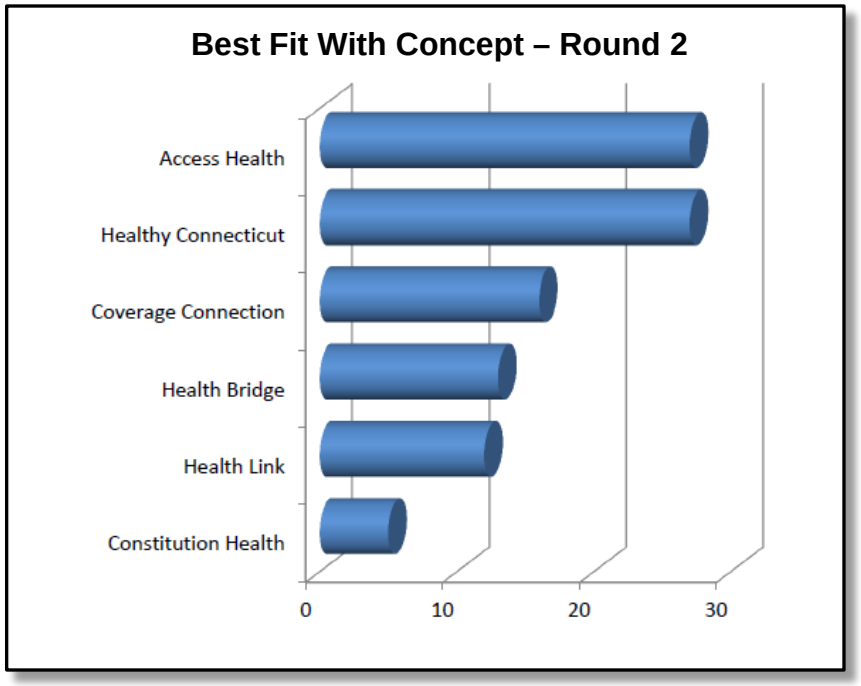
- A total of 10 unique names were tested across the two rounds of research

Health Connection	**Access Health**
Health Link	**Healthy Connecticut**
Healthy Choice	**Coverage Connection**
Health Bridge	**Constitution Health**
Health Pass	**Health Portal**

Name Development Update

- Results from both rounds provide clear winners.
- Rank order of names for all remaining questions in the study remained unchanged

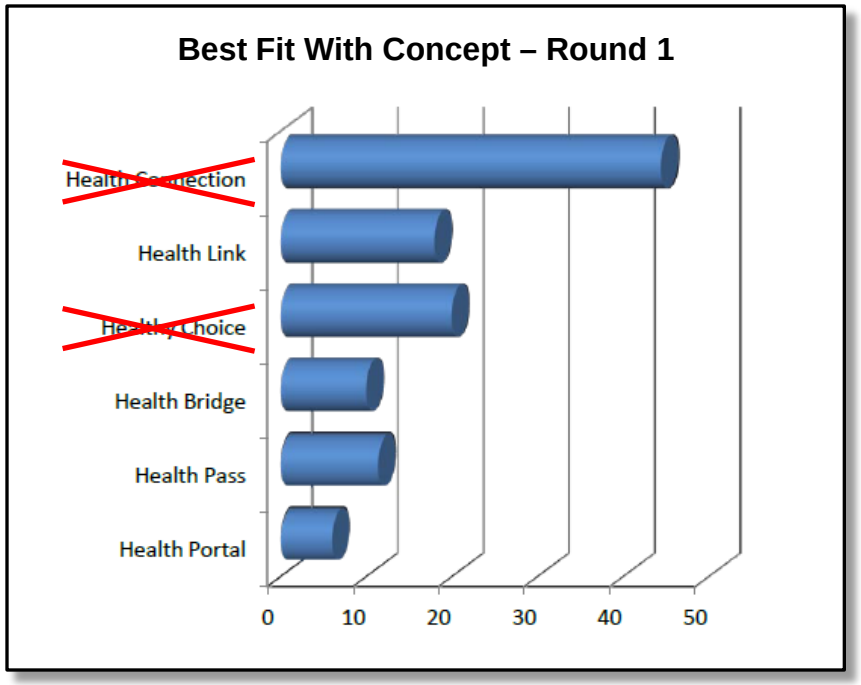


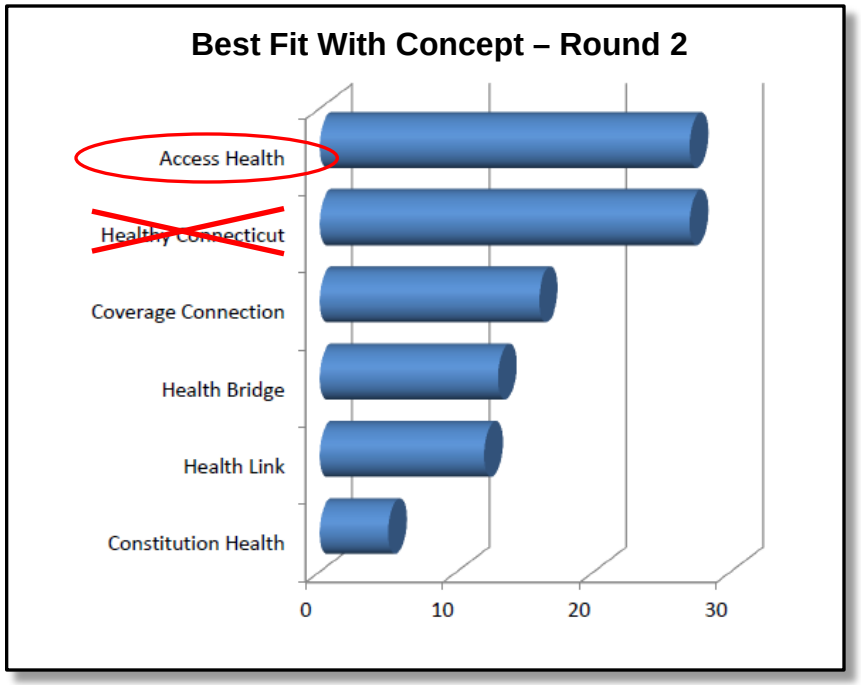


Name Development Update

- A full trademark and legal vetting was done on all front runners, with some names already in active use, or utilized in potentially problematic ways

- Final results of both research and legal review indicate **Access Health** provides best option for name moving forward



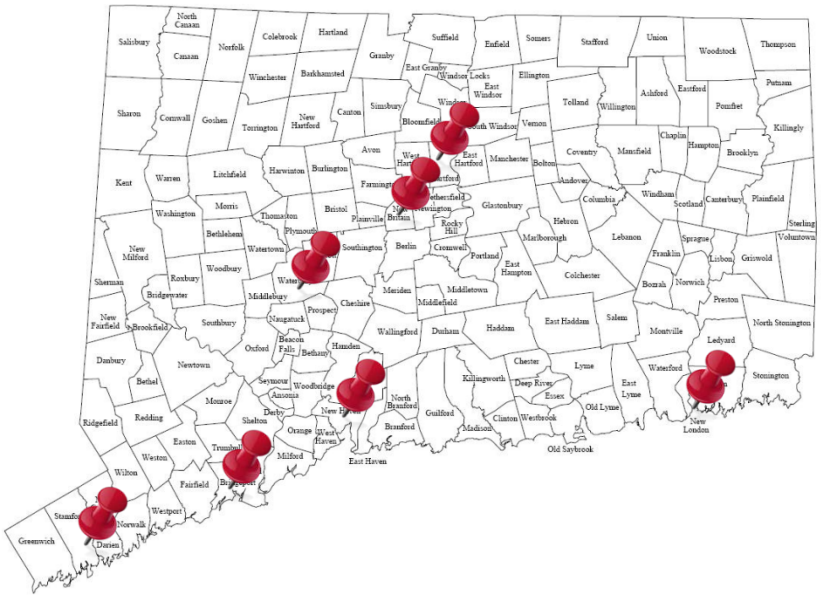


Town Hall Meetings:

Event Dates and Locations

LET'S CHAT.

www.healthychatct.com



- **Hartford, Tuesday, November 27**, Hartford Public Library
- **Waterbury, Thursday, November 29** Waterbury City Hall
- **New London, Tuesday, December 4** Mitchell College
- **New Haven, Thursday, December 6** Hill Regional Career High School,
- **New Britain, Tuesday, December 11** Central Connecticut State University
- **Stamford, Thursday, December 13** University of Connecticut Stamford
- **Bridgeport, Tuesday, December 18** Bridgeport Holiday Inn

Marketing RFP:

Vendor Selection

- RFP was issued on September 18th, with all submissions in to the Exchange by October 17th.
- A total of eight agencies expressed interest in submitting an RFP, with three agencies selected for finalist presentations based on the quality of their proposals
- Vendor presentations occurred the week of October 22nd.
- Scores were compiled for each vendor across seven major categories of evaluation, based both on the information in the RFP submission as well as the in person presentation.

pappas macdonnell

Marketing & Communications:

Call, Click or Chat!

860-418-6420
to talk directly

www.ct.gov/hix
to sign up for updates.

@ExchangeCT

www.healthychatct.com

Finance Update

Finance Update

Accomplishments

- Change of Grantee from OPM to CT HIX
- Business Credit Cards
- 457 B Salary Deferral Plan for staff
- Finance Staffing
- Exchange Financials Statements
- Department Expense Budgets

Finance Update

Change of Grantee from OPM to CT HIX

- 7 Artifacts filed with the Center for Consumer Information and Insurance Oversight (CCIIO) on October 19, 2012
- Expect change to occur early December

Business Credit Cards

- MasterCard through People's United Bank
- Business expenses only
- Being issued to those likely to travel

457 B salary Deferral Plan

- Part of the defined contribution method selected
- State 457 B Plan through ING Financial Services
- Payroll Deductions began November 15, 2012

Finance Staffing

- Posted 3 positions beginning November 5th
- Decisions to be made by mid-December

Exchange Financial Statements - Balance Sheet

Connecticut Health Insurance Exchange
Balance Sheet
October 31, 2012

ASSETS	
Current Asset	
Cash	$ 1,426,896
Prepaid Expenses	89,206
Total Current Assets	1,516,102
Capital Assets	
Furniture & Equipment	14,974
Software	37,609
Total Capital Assets	52,583
TOTAL ASSETS	$ 1,568,686
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	$ 23,508
Accrued Expenses	1,302,204
Total Liabilities	1,325,712
Net Assets	
Invested in Capital Assets	52,584
Restricted Net Assets	190,390
Total Net Assets	242,974
TOTAL LIABILITIES & NET ASSETS	$ 1,568,686

Exchange Financial Statements - Profit & Loss

Connecticut Health Insurance Exchange
Statement of Income, Expenses and Changes in Net Assets
For Month & Year to Date period ended October 31, 2012

	October	October 4 Months YTD
Income		
Grants Awards		
Federal Level 1 Grant	$1,534,800	$ 3,169,110
Total Income	1,534,800	3,169,110
Expenses		
Salaries & Fringe Benefits	$ 174,629	$ 619,991
Consultants	1,276,535	2,773,540
Equipment	1,321	8,739
Travel	1,280	36,322
Other Administrative	9,902	27,459
Total Expenses	$ 1,463,667	$ 3,466,049
Increase (Decrease) in Net Assets	$ 71,133	$ (296,939)
Net Assets, Beginning as of Period	$ 171,841	$ 539,913
Net Assets, End of Period	$ 242,974	$ 242,974

Department Expense Budgets

Category		October			October YTD	
	Budget	Actual	Variance	Budget	Actual	Variance
Salaries	$ 174,629	$ 174,629	$ 0	$ 619,991	$ 619,991	$ 0
Consultant	1,276,535	1,276,535	0	2,773,540	2,773,540	0
Equipment	1,321	1,321	0	8,739	8,739	0
Travel	1,280	1,280	0	36,320	36,320	0
Other Administrative	9,902	9,902	0	27,459	27,459	0
Totals	$ 1,463,667	$ 1,463,667	$ 0	$ 3,466,049	$ 3,466,049	$ 0
By Department						
	Budget	Actual	Variance	Budget	Actual	Variance
Administrative	$ 53,692	$ 53,692	$ 0	$ 490,966	$ 490,966	$ 0
Finance	25,527	25,527	0	57,811	57,811	0
IT	1,274,466	1,274,466	0	2,199,147	2,199,147	0
Legal	33,044	33,044	0	83,552	83,552	0
Marketing	22,090	22,090	0	458,986	458,986	0
Operations	24,307	24,307	0	50,187	50,187	0
Plan Management	30,541	30,541	0	125,400	125,400	0
Totals	$ 1,463,667	$ 1,463,667	$ 0	$ 3,466,049	$ 3,466,049	$ 0

Next Steps

- Mock Financial and Federal Single Audit
- Fiscal 2012 Financial and Federal Single Audit by Independent Accountant
- Grantee Change
- Operationalizing financial information and metrics
- Sustainability modeling

QHP Solicitation Requirements

Agenda

1. Initial QHP Solicitation
2. Outstanding “Issues for Review”
3. Exchange Purchasing Model
4. Vote on Recommendations

QHP Solicitation Process

States are required to certify plans as "**qualified**" for inclusion on their Exchange.

Only certified Qualified Health Plans, or QHPs, will be eligible for affordability subsidies, including:

- advanced premium tax credits and cost sharing reductions through Individual Exchange
- small business tax credits through SHOP Exchange

Sec. 1301 [of the Affordable Care Act]. Defines **a Qualified Health Plan (QHP)** as a plan that:

1) has in effect a certification (which may include a seal or other indication of approval) that it meets the Act's certification criteria issued or recognized by each Exchange through which such plan is offered;
2) provides the Essential Health Benefits package; and
3) is offered by a health insurance carrier that:
   a) is licensed and in good standing to offer coverage in each state in which the carrier offers coverage under this title;
   b) agrees to offer at least one QHP in the silver level and at least one plan in the gold level in each such Exchange;
   c) agrees to charge the same premium rate for each QHP of the carrier without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the carrier or through an agent; and
4) complies with the regulations developed by the Secretary and such other requirements as an applicable Exchange may establish.

Principles of QHP Certification

Consumer Focused:

Engage carriers which provide value to its clients—consumers and small employers. Sustainability of the Exchange depends upon it certifying QHPs and offering services that are valued by its clients.

Choice and Quality:

Ensure consumers have a range of choice between current and new carriers on the Exchange. Ensure those carriers which serve Connecticut best with choice, network and value see the Exchange as their premier avenue to the people of Connecticut.

Transparency:

Facilitate informed choice of health plans and providers by consumers and small employers. Ensure carriers provide the clinical, quality, network and cost metrics needed for consumers to make an informed choice.

Continuous Improvement:

Engage carriers that are committed to reducing health disparities and fostering health equity in Connecticut by evolving to serve consumers as the market and consumer needs change. Provide an effective forum for carrier to promote wellness and prevention through innovate plan design and delivery systems and for consumers to make their evolving needs known to carriers. Be a catalyst for delivery system reform while being mindful of the Exchange's impact on and role in the broader health care delivery system.

General Reforms Impacting the Market

General ACA reforms include:

- No medical underwriting
- No denial of coverage due to a pre-existing condition
- Strict limits on out-of-pocket expenditures (and further limits on deductibles for small group coverage)
- Minimum medical loss ratio ("MLR") established
- Quality rating standards and enrollee information
- Minimum coverage requirements:
  - "Essential Health Benefits"
  - Extensive preventative services provided at no cost
  - Standardizes coverage levels based on actuarial value (i.e. metal tier)
- New, rating factor standards reduce risk selection:
  - Elimination of industry rating
  - Elimination of gender rating
  - Compressed age band ratio – approx. 5:1 to 3:1
  - Rates must be set for entire benefit or policy year
  - Exchanges must receive rate increase justification prior to rate increase implementation

Minimum QHP Certification Requirements

Minimum QHP certification requirements include:

- Annual information concerning rates, covered benefits, and cost sharing requirements
- Consideration of justification for rate increases
- Carrier must provide coverage information to the Exchange, including:
  - Claims payment and practices
  - Enrollment and disenrollment data
  - Data on denied claims and rating practices
  - Cost-sharing information and out-of-network coverage and payments
- Carrier must be accredited on basis of local performance
- Carrier must comply with quality improvement standards. For example:
  - Improving patient safety and lowering hospital readmissions
  - Reducing health disparities
  - Creating ACOs and promoting of patient-centered medical homes
  - Funding of electronic medical records
- Carrier must:
  - Disclose and report quality and outcome measures; and,
  - meet required member satisfaction standards.
- Carrier must comply with carrier risk adjustment program
- QHP must include “essential community providers” and meet minimum network standards

Connecticut QHP Certification Requirements

Recommended Connecticut-specific QHP certification requirements include:

- No substituting Essential Health Benefits with actuarially equivalent benefit
- Allowing wellness incentives
- Consideration of QHPs with less than statewide coverage
- Promoting greater consumer transparency:
  - For each QHP, the “Summary of Benefits and Coverage,” including each of the coverage examples, defined by HHS, and;
  - For each carrier:
    - “Certificate of Coverage”
    - Most recent CAPHS data and NCQA star ranking for most comparable product
    - Most recent MLR and projected MLR for 2014, for non-group and/or small group markets
    - Criteria for establishing medical necessity
  - Exchange will use requested quality and performance information to develop a quality rating system that relates quality to price (to be implemented in later years)
  - Publication on Exchange website the carrier’s justification for rate increases

“Issues for Review”

Outstanding Issues for Review:

Certification Period and “Lock Out”

Mix and Number of Plans

Stand-Alone Dental

Rating Factors

Network Adequacy

Purchasing Model

Comments on QHP Certification Requirements

Certification Period & Lock-Out

- Carriers consistently expressed opposition to the lock-out period given the tight timeframe for a Oct 1, 2013 open enrollment date that may limit carrier's ability to participate in 2014 (due to system readiness, program and regulator changes from HHS). Another carrier, still opposing the lock-out period, added that if it is applied, it should be applied consistently.
- One carrier expressed that given this is such a new and dramatically different program, carriers need the ability to enter or leave on an annual basis.

Mix and Number of Plans

- Carriers consistently expressed desire to retain flexibility to offer any combination of the different plan levels available within the metal levels as long as meet the requirement to offer one gold & silver plan.
- One carrier suggested that carriers should be encouraged to differentiate offerings within federal guidelines to appeal to consumers & employers alike (e.g. high deductible health plan vs. copay plan vs. narrow network plans).
- Another carrier reasoned that the Exchange should not define "meaningful differences" because the requirements for EHB and metal tiers
- Carriers were in favor of allowing, but not requiring, Platinum plans.
- Carriers feared that limiting carriers to just two plan designs per tier will needlessly limit consumer choice.

Comments on QHP Certification Requirements

Accreditation and Ranking

- NCQA commented that with respect to accreditation of new Exchange products, NCQA has designed an 'add-on' survey, which allows plans to do this under a streamlined review. Connecticut could either (a) require plans to follow NCQA's add-on process, which provides a more detailed assessment of the elements that are comparable or (b) have QHP Issuers submit their own attestation.
- NCQA offered suggestions on clarifying requirement for NCQA star rankings.
- NCQA offered the suggestion that the Exchange should clarify to carriers that they should submit CAHPS and star rating/plan ranking data on their Connecticut product that most resembles their Exchange offering.
- NCQA suggested that the Exchange should amend its QHP Solicitation to identify when QHPs would need to start submitting quality data on their Exchange products.
- NCQA suggested that by the Exchange require by January 1, 2016 a QHP Issuer's Exchange product be accredited and submit performance data.

Comments on QHP Certification Requirements

Dental Benefits

- Clarification requested on stand-alone vision. *Response: The QHP Solicitation does not address stand-alone vision and all carriers must provide pediatric vision services as outlined in the EHB.*
- One carrier recommended against pricing dental services separately, arguing that it would significantly increase the cost of pediatric dental services. Another carrier was in favor of offering stand-alone dental plans for either children only, adults, or both.
- Carriers asked for clarification on dental tiers and defining preventative-only v. full benefit coverage.

Network Adequacy

- One commenter and several advisory committee members recommended as the standard for Network Adequacy resemble Connecticut's Medicaid Managed Care contracts.
- One commenter provided data on the number of residents served by federally-qualified health centers (315,000; 95% of whom are below 200% of FPL) and argued that the Exchange should require plans to contract with 100% of the FQHCs.

Comments on QHP Certification Requirements

Active Purchasing

- One commenter and several advisory committee members recommended that we negotiate premiums with insurers on behalf of consumers. Massachusetts was offered as an example of successful active purchasing that Connecticut should look to replicate. (Note: Rate negotiating only occurred in Massachusetts' Comm Care Exchange).
- Beyond rate negotiations the same commenter argued that active purchasing also provides Important levers to improve the quality of offerings, encourage payment reform and support critical health care delivery reform.

Miscellaneous

- One commenter expressed concern with short comment period [two weeks] offered by the Exchange in response to the Draft QHP Solicitation.
- A carrier suggested user fees only apply to carriers operating on Exchange, be considered a tax, exempt from MLR calculation and be assessed on a PMPM basis separate from premium.
- Clarification requested if Exchange will be responsible for providing enrollees with copies of materials to enrollees (i.e. Evidence of Coverage and/or Summary of Benefits).

Multi-Year QHP Certification and “Lock Out”

Recommendation:

Length of QHP certification for Initial Solicitation and “Lock Out” Period
Staff and the Joint Advisory Committee recommend that the Exchange’s initial QHP solicitation be for a two-year QHP certification, but reserves the right to admit existing or newly licensed carriers for 2015 with a one-year QHP certification if the Exchange deems such an exemption would be in the best interest of the consumers. All rates will need to be approved annually by CID, according to state regulation. Staff and the Joint Advisory Committee further recommend that if a certified QHP carrier ceases participation in the Exchange in 2015, the carrier be denied re-entry for a minimum two (2) years. The Exchange would consider appeals to this exclusion during the next general solicitation only after conducting a thorough review of the carrier’s new application.

Standardize Plan Design

Recommendation:

Standardizing benefit plan design
To increase comparability of carriers, staff and the Joint Advisory Committee recommend that a QHP carrier be required to submit the standard plan for each the Gold, Silver and Bronze tiers. The Exchange will define one (1) standard plan design for each the Gold, Silver and Bronze tiers that includes the deductible, co-payment and coinsurance mix, subject to adjustment after release of federal actuarial value calculator. The Exchange will eliminate standards for out-of-network benefits (though they still must meet CID regulations). The Exchange will require consumer transparency and disclosure of QHP coverage for non-emergent out-of-network care at both the plan and provider level.

Number and Mix of QHPs

Joint Advisory Committee Recommendation:

For both the Individual Exchange and SHOP Exchange (although a carrier does not need to participate in both exchanges), a QHP carrier **must submit at a minimum** the following mix of plans:

- One (1) Standard Gold Plan
- One (1) Standard Silver Plan
- One (1) Standard Bronze Plan

But **no more than** (including the above standard plans):

- **One (1) Platinum Plan**
- Two (2) Gold Plans
- Two (2) Silver Plans
- Two (2) Bronze Plans

For the Individual Exchange only, a QHP carrier **must** submit:

- Three (3) required actuarial value ("AV") variations for at least the standard Silver Plan
- One (1) child-only QHP for each metal tier for which a carrier submits a plan

And **may** submit:

- One (1) Catastrophic Coverage Plan

Number and Mix of QHPs

Staff Recommendation:

For both the Individual Exchange and SHOP Exchange (although a carrier does not need to participate in both exchanges), a QHP carrier **must submit at a minimum** the following mix of plans:

- One (1) Standard Gold Plan
- One (1) Standard Silver Plan
- One (1) Standard Bronze Plan

But **no more than** (including the above standard plans):

- **Two (2) Platinum Plan**
- Two (2) Gold Plans
- Two (2) Silver Plans
- Two (2) Bronze Plans

For 2015 plan year, the Exchange will consider allowing certified QHP carriers to submit an additional non-standard Bronze, Silver, and Gold plan

For the Individual Exchange only, a QHP carrier **must** submit:

- Three (3) required actuarial value ("AV") variations for at least the standard Silver Plan
- One (1) child-only QHP for each metal tier for which a carrier submits a plan

And **may** submit:

- One (1) Catastrophic Coverage Plan

Pediatric and Stand-Alone Dental

Recommendation:

Separately pricing pediatric dental benefits
Staff and the Joint Advisory Committee recommend that the Exchange require QHP carriers to separately rate their pediatric dental benefit. If a QHP includes pediatric dental services, potential enrollees will be automatically assigned to the carrier's dental benefit, but the enrollee will retain the option of selecting another carrier's dental plan if desired. Staff and Joint Advisory Committee recommend that actuarial certification to the metal tiers not apply to stand-alone dental visions. Rather, they meet a the high/low designation as required by the preliminary rule proposed by HHS. All stand-alone dental plans must provide coverage for the full dental benefits, as included in the "essential health benefits" for pediatric dental services.

Standardizing Rating Factors

Recommendation:

Standardize Rating Factors
Tobacco. Staff and Joint Advisory Committee recommend that the Exchange prohibit carriers from including tobacco use as a rating factor in the Individual Exchange. (Connecticut General Statute 38a -567 excludes tobacco use as a rating factor for small groups.)
Family. It is possible that federal rules may standardize both family composition tiers across the market. If this is the case, the Exchange may not need any additional options related to this issue. If the federal government does not act, staff and Joint Advisory Committee recommend that the Exchange standardize family composition structure by on current industry standards, but allow carriers to determine tier ratios.
Age. Per ACA reforms QHPs will be subject to a 3:1 age factor rating. Staff and Joint Advisory Committee recommend that the Exchange allow carriers to determine tier ratios.
Geography. Staff and Joint Advisory Committee recommend that the Exchange establish allowed geographic regions but follow industry standards and allow carriers to determine tier ratios between regions.
The Exchange's QHP offerings will comply with all CID regulations.

Network Adequacy Requirements

Joint Advisory Committee Recommendation:

Network adequacy requirement:

A QHP carrier must ensure that the provider network of each of its QHPs meets these standards:

1) The network for each of its plans is URAC or NCQA accredited with respect to provider adequacy;
2) It includes essential community providers ("ECP") of a sufficient number and geographic distribution to ensure reasonable and timely access to a broad range of such providers for low income, medically underserved individuals in the service area;
3) The network is, and continues to be, sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay;
4) The network is consistent with the network adequacy provisions of section 2702(c) of the PHSA; and,
5) The network of providers for its standard plan offerings is, and continues to be, substantially the same as the network of providers it offers to its largest plan offered outside of the Exchange.

The Exchange will monitor network adequacy by:

1) The Exchange will require each carrier to provide the criteria used to define the adequacy of its network, including but not limited to, geographic distance standards to providers and timeliness of appointment scheduling. Such standards shall include information on variation of standards by provider specialty. All such standards shall be made available to the public and consumers on the Exchange.
2) Contracting for an ongoing independent secret shopper review and ongoing independent monitoring process to validate sufficiency of the network and to assure that all services will be accessible without unreasonable delay. All data and reports of the independent review and monitoring entity shall be made readily available to the public and consumers on the Exchange.

Network Adequacy Requirements

Staff Recommendation:

Network Adequacy Requirement
The staff agrees with the Joint Advisory Committee's recommendation, except do not recommend the requirement that the Exchange contract with an independent secret shopper and have an ongoing independent monitoring process.

Essential Community Providers

Advisory Committee Recommendation:

Sufficiency of Essential Community Providers
With respect to ECPs, sufficiency shall be defined as carriers having contracts with: 1) At least 75% of the ECPs located in each county in which the QHP operates. 2) 100% of the federally qualified health centers (“FQHC”) or “look-alike” health center in each county in which the QHP operates. A QHP is not required to contract with an FQHC or “look-alike” health center that refuses to accept the relevant Medicaid PPS rate. The ECPs in Connecticut include: 1) 340B Essential Community Providers: Non-hospital and hospital entities located in Connecticut and listed in HRSA’s 340B non-hospital and hospital entities list. 2) Disproportionate Share Hospitals 3) Federally Designated Indian Health Services Facilities

Essential Community Providers

Staff Recommendation:

Sufficiency of Essential Community Providers

With respect to ECPs, sufficiency shall be defined as carriers having contracts with:

1) **At least 66% of the essential community providers located in any county in Connecticut; and,**
2) **At least 80% of the federally qualified health centers (FQHC) or "look-alike" health center in Connecticut.**

The Exchange will define the essential community providers broadly to include:

- Any provider that serves low income and underserved communities and meeting criteria of the ACA

Short of meeting such standards, staff recommends that carriers be allowed to evidence a good faith effort to contract with ECPs by, for example, providing contract terms accepted by some providers, and offered to, but rejected by, ECPs.

With respect to FQHC, a carrier must pay the claim of an enrollee at the relevant Medicaid PPS rate, or may pay a mutually agreed upon rate to the FQHC, provided that such rate is at least equal to the QHP issuer's generally applicable payment rate.

Managed Competition

An Effective Purchasing Model in an Evolving Marketplace

"Active Purchasing" v. "Managed Competition"

- **It's not an "either-or" choice.** States seeking to establish their own exchanges do not need to, nor will they be able to, choose either an "Active Purchasing" model or a "Any Willing Carrier" model. The Exchange's "managed competition" will have features of both models.
- Creating an efficient and transparent market will force carriers to compete on price and value.
- Policymakers must consider exchanges' interactions with broader insurance market.
- Exchange will structure QHP certification requirements so that it offer the "right" products and service to attract consumers
- Exchange needs to "partner" with health plans to attract and serve consumers
- Exchanges can be effective market innovators. Success in managing program costs will depend on the capacity of Exchange and carriers to foster new, innovative coverage models.
- **Health reform is iterative.** The Exchange's position relative to carriers, consumers, providers and the general market must evolve in 2015 and 2016, based on strategic objectives and experience

"Managed Competition"

Features of Exchange's managed competition model:

- Increase competition on price and quality by aligning benefits and cost-sharing across QHPs
- Increase competition by attracting new health plans
- Improve access, quality & service, by:
  - Requiring QHPs to contract with essential community providers and to report routinely on access issues
  - Rigorous standards for measurable quality improvement over time
  - Score and prominently display an index of carriers' claims payment, dispute resolution, MLRs, and other public data
  - Using Navigators and requiring carriers to add customer service resources specially trained to deal with new enrollees
- Promote delivery system and payment reform by encouraging unique product designs from carriers
- Promote cost containment by rigorously reviewing the justification for QHP rate increases that exceed overall medical inflation indexes, or some other trigger point below HHS' 10% trigger

Why Not Negotiate Rates for 2014

- **Exchange not well-positioned to set rates for 2014**
  - Rates have to be the same in and out of the Exchange, but the Exchange will have a relatively small market share (less than 5% of CT market in initial years)
  - Unlike the State Employee Plan or other large employer groups, the Exchange is not a direct purchaser that can promise many enrollees to one or two carriers
  - Connecticut is a prior approval state: all rates must be approved by the Connecticut Insurance Department
- **Carriers face huge challenges for 2014, even w/o the uncertainties of rate-setting**
  - Significant new financial risks to carriers for 2014 in the non-group market
  - Significant operational costs for carriers to participate in the Exchange.
- **Rates will be constrained by other mechanisms**
  - Reforms to Medical-Loss-Ratio already limit administrative overhead of carriers
  - The Exchange creates an efficient market that should help individuals and employers make value-based purchasing decisions
  - Subsidies are pegged to the second-lowest costing Silver plan, so carriers will compete for this extremely price-sensitive population

Recommended Purchasing Model

Joint Advisory Committee Recommendation:

The Joint Advisory Committee recommends a managed competition model:

1. The Exchange's purchasing model will reflect its principles for QHP certification. For its Initial Solicitation and to provide consumers transparent choice and carrier competition, the Exchange should contract with any carrier that meets the standards for QHP certification for the standard plan design defined in its QHP Solicitation, except as provided in 2 below.
2. In the event that there is an adequate number of Qualified Health Plans available to allow for sufficient consumer choice, at the time of the initial Solicitation or at any time thereafter, the Exchange should consider not offering for sale one or more otherwise certified QHPs on the basis of price.
3. After its initial Solicitation, the Exchange should develop a plan to move along a continuum from "any willing carrier" toward "active purchaser" starting with the next solicitation.
4. The Connecticut Insurance Department must approve all forms and rates before a plan may be certified by the Exchange.
5. The Exchange will require carriers to submit a narrative outlining how they will attempt to better coordinate care and control costs, improve chronic illness management, reduce medical error, or otherwise promote health care delivery and payment reform for the benefit of the consumer.

Recommended Purchasing Model

Staff Recommendation:

Managed Competition
The staff agrees with the Joint Advisory Committee's recommendation, except it does not recommend the requirement to develop a plan for active purchasing.

QHP Solicitation Process

Date	Activity
November 26	Extension for Public Comment
November 29	Board Approval of QHP Certification Requirements
December 7	Final Release QHP Solicitation
December 31	Deadline for Notice of Intent to Respond to Initial QHP Solicitation
Early January 2013	Begin QHP Carrier Support
Early January	Release of Standardized Plan Design
Mid January	Release of Model Contract

Adjournment

Appendices

Multi-Year QHP Certification

Should failure the initial QHP certification be for a two-year period? Should failure of a QHP carrier to participate in Exchange in 2014 inhibit participation by the carrier until (at least) 2016?

Pros (for Two Year Certification and Lock Out):

- Prohibiting carriers from participating in succeeding years if they fail to participate in year one, may motivate more carriers to participate initially.
- Carriers that participate in the initial year will have the benefits of securing a larger market share in the Exchange than those that have to wait until 2016; this will build consumer relationships and trust with the carrier and may provide a competitive advantage to carriers who do participate in Initial Solicitation.
- Reduces the administrative burden for carriers in 2015.
- Allows the next Certification process, in mid-2015, to be informed by a fully-lagged 12 month claims experience and customer satisfaction.
- Offers continuity in QHP benefit design.

Cons (for Two Year Certification and Lock Out):

- A two year certification could delay implementation of further reforms.
- A two year certification may be imprudent given magnitude of reforms being implemented in 2014 and potential for unintended consequences.
- Prohibiting new carriers to enter the market could lead to a more limited number of carriers for protracted time frame.
- Limiting carriers may compromise choice for consumers wishing to enroll through the Exchange.
- Alternatively, a more limited, one-year QHP certification could be provided for those who enter in 2015.

Carrier “Lock Out” Period

If a QHP carrier ceases participation in the Exchange, should the carrier be prevented from rejoining for two (or three) years?

Pros:

- Encourages prolonged participation by the carrier in the Exchange market.
- May preclude “gaming” by carrier who may opt-out temporarily due to a perceived competitive advantage.
- Minimizes consumer confusion regarding carrier options.

Cons

- If Exchange participation is low, and a carrier drops coverage due to financial insolvency or other technical issues, the Exchange should want to reintroduce that carrier as soon as they are deemed solvent or the deficiency is adequately addressed.
- May discourage initial carrier participation

Mix and Number of QHPs

How many health plans should a carrier be required and/or allowed to offer through the Exchange?

Pros (to limiting mix/number of products/plans):

- Allowing too many products from each plan could be confusing to consumers
- Limiting the number of options may better help Exchange meet its promise to Connecticut consumers that it will "increase access, improve affordability and simplify shopping."
- While distinguishing product factors are necessary to create the "meaningful" choice sought by consumers, too much choice is unhelpful
- Federal requirements to meet EHB and actuarial value are significant and inherently limit number of variations a carrier can design, thereby limiting opportunities for significant differences for each metal tier

Cons (to limiting mix/number of products/plans)

- Limiting plan offerings could limit innovation among QHPs and lower choice among products with meaningful distinctions (e.g. Gatekeeper model, Accountable Care Organization, Tiered Networks)
- Because of significant federal requirements, QHPs offered by a carrier will be necessarily distinctive and so needlessly limiting their number could disadvantage consumers choice.
- Consumers can use metal tiers and/or other filters to facilitate comparisons among QHPs
- Limiting the number of plan designs could put the Exchange at a competitive disadvantage to outside market, if offered plans are not among most popular.
- If a standard plan is required, limiting plan options further limits opportunities for innovation among QHPs

Allowance for Platinum QHPs

Should carriers be required, prevented, or given the option of offering Platinum QHPs?

Pros (of offering Platinum):

- If Platinum benefits are common in the external market then not offering them in the Exchange will disadvantage the Exchange in attracting employers and unsubsidized individual enrollment
- Proportion of plans sold by five major carriers with an "AV" of 90% or greater, according to study by *Gorman Actuarial, LLC*:
  - 0.5% of plans sold in Individual market
  - 25% of plans sold in small group market
- Particularly in the small group market, there may be consumer demand for a richer plan design.
- Risk adjustment programs should alleviate some of the adverse selection concerns

Cons (of offering Platinum):

- Platinum level coverage may not attract a high level of enrollment.
- Maximum out-of-pocket limits (for In-Network essential health benefits) reduces utility of richer plans with higher actuarial values
- Offering Platinum will increase potential for "market adverse selection" impact (i.e. raising premiums across the carrier's book of business), especially in SHOP

Standardize Plan Design

Should QHP carriers be required to submit one or more standardized plan designs for one or more metal tiers as a part of their application to participate in the Exchange?

Pros (of requiring Standard Plan Design(s)):

- Makes it easier and faster for consumers to compare like products and make better-informed purchasing decisions.
- Give consumers confidence that they can choose a lower-priced or less well-known plan, opening market to greater competition.
- Limits carriers ability to attract healthy individuals and discourage high-risk individuals. Narrows the opportunity for insurers to compete mainly on risk selection.

Cons (of requiring Standard Plan Design(s)):

- QHPs must already cover the same benefits and meet specific actuarial value levels so QHPs will be comparable
- May discourage carrier participation
- May discourage innovation by the carriers and limit their efforts to implement value-based benefit design and provider reimbursement strategies to contain costs.
- Exchange could be put at a competitive disadvantage if carriers can sell innovative new benefit designs outside the Exchange
- Carriers need variability and flexibility in meeting the ACAs product requirements and would like to avoid further standardization.
- Developing one or more standard benefit designs will take time and could delay Solicitation process.

Pricing Pediatric Dental

Should pediatric dental services be priced separately? (Alternative is to allow QHP carriers to bundle services.)

Pros (of separately pricing pediatric services):

- Only enrollees selecting a Child-only or Family plan would need to select a stand-alone pediatric dental plan. Adults without any children will not be subsidizing the cost of pediatric dental.
- Increases transparency of premium pricing
- Increases viability of stand-alone dental plan offerings participating in the Exchange
- Dental is not currently provided as part of major medical policies
- May increase likelihood that enrollees purchase stand-alone dental for adults
- According to proposed federal rules any dental plan must have a reasonable annual limitation on cost-sharing

Cons (of separately pricing pediatric services):

- Adults without any children will not be subsidizing the cost of pediatric dental. Therefore, the cost associated with pediatric-only services will not be as widely distributed across the market. This will increase the PMPM cost of pediatric dental for families and/or child-only QHPs by not spreading the cost across the entire pool
- Increases the number of choices required of enrollee.
- Embedding dental benefits (with medical) offers administrative ease and simplicity for the consumer and the Exchange.
- Would allow for clinical integration between medical and dental benefits.
- A separate annual limit would apply without regard to EHBs provided by the major medical QHP and without regard to out-of-network services.

AV Requirement for Stand-Alone Dental

For stand-alone dental plans, should carriers be required to offer plans across all, any, or specific metal tiers?

Pros (of requiring specific tiers for dental):

- Offering a stand-alone plan along the same tier as the most popular comprehensive QHP may attract consumer to the plan.

Cons (of requiring specific tiers for dental):

- There is no regulation requiring that stand-alone dental plans be offered on separate tiers.
- Cost-sharing in a stand-alone dental plan is already high, it may not be practical to expect different levels of cost-sharing or different tiers of stand-alone dental plans. Changing cost-sharing in order to meet the AV standards of various metal tiers may be difficult to accomplish with a stand-alone dental plan
- Preliminary rule of November 26, 2012 proposes a “low/high” level of coverage equivalent to actuarial value of 75%/85%

Benefit Tiers for Stand-Alone Dental

For stand-alone dental plans, should the Exchange consider selling two benefit tiers of stand-alone dental plans: (1) preventive only; and (2) full benefits?

Pros (of offering preventative only plans):

- Allowing for two different benefit options may increase consumer choice, especially for those who are new to the insurance market, and may not be inclined to purchase a full benefits package that they feel they may not use.

Cons (of offering preventative only plans):

- Pediatric dental services must include full benefits as required in Essential Health Benefits
- A preventive-only plan is of limited value and could cause confusion among consumers who believe they are may be fully insured
- Because stand-alone dental plans must comply with QHP certification standards, allowing for two separate levels of benefit may increase the administrative burden of the Exchange
- A low-cost “Access Only” plan that is not insurance could provide a practical alternative without the same level of regulation

Tobacco Rating

Should the Exchange make tobacco-use a required rating factor in the Individual Exchange?

Pros (of requiring tobacco rating):

- Similar to a tobacco tax, higher premiums for tobacco users provide an additional incentive to stop
- Tobacco use increases an individual's expected health care costs that are borne by all enrollees
- Promotes health and well-being

Cons (of requiring specific tiers):

- Tobacco rating is cumbersome to administer and susceptible to risk selection strategies
- A higher than average percentage of lower income individuals use tobacco and would be required to pay the surcharge
- The premium tax credit is calculated based on premiums before any tobacco-use adjustments are applied. This means that subsidized enrollees must pay the entire cost of any tobacco use surcharges regardless of their income.
- Tobacco is addicting, and it is not clear that a premium surcharge would be an effective incentive to stop using tobacco
- Though allowed in the non-group market, tobacco rating is not currently used by carriers and so the Exchange would need to reach consensus for the complicated calculations

Standardizing Rating Factors

Should the Exchange require carriers to agree to standardized rating factors (for geography, age, household size, and, if applicable to the non-group market, tobacco use) across all QHPs sold through the Exchange?

Pros (of standardized rating factors):

- ACA reduces the number of rating factors in the SHOP and Individual Exchanges and so further standardizing tiers and ratios between tiers would not be too significant
- Limits the ability of plan to select based upon risk

Cons (of standardized rating factors):

- The state does not currently have standardized rating factors and so the Exchange would need to reach consensus for the complicated calculations
- Unnecessary to standardize rating factors beyond limits
- Carriers may be able to react more quickly and nimbly to market changes, utilization patterns and actual costs than the Exchange
- Carriers have different cost structures by area (with different provider networks and rates). Standardized ratios may not be actuarially sound or fairly represent costs. This could lead to market withdrawals and other undesirable outcomes.
- The law already has caps/floors for many of these. Given the 3-to-1 limit on age-based rate variation, potential variation of age factors across carriers is significantly reduced

Network Adequacy Requirements

What should be the Exchange's network adequacy standard?

The ACA minimum is that "A QHP carrier must have a sufficient number and geographic distribution of [Essential Community Providers]." The definition of "sufficient" is left to Connecticut.

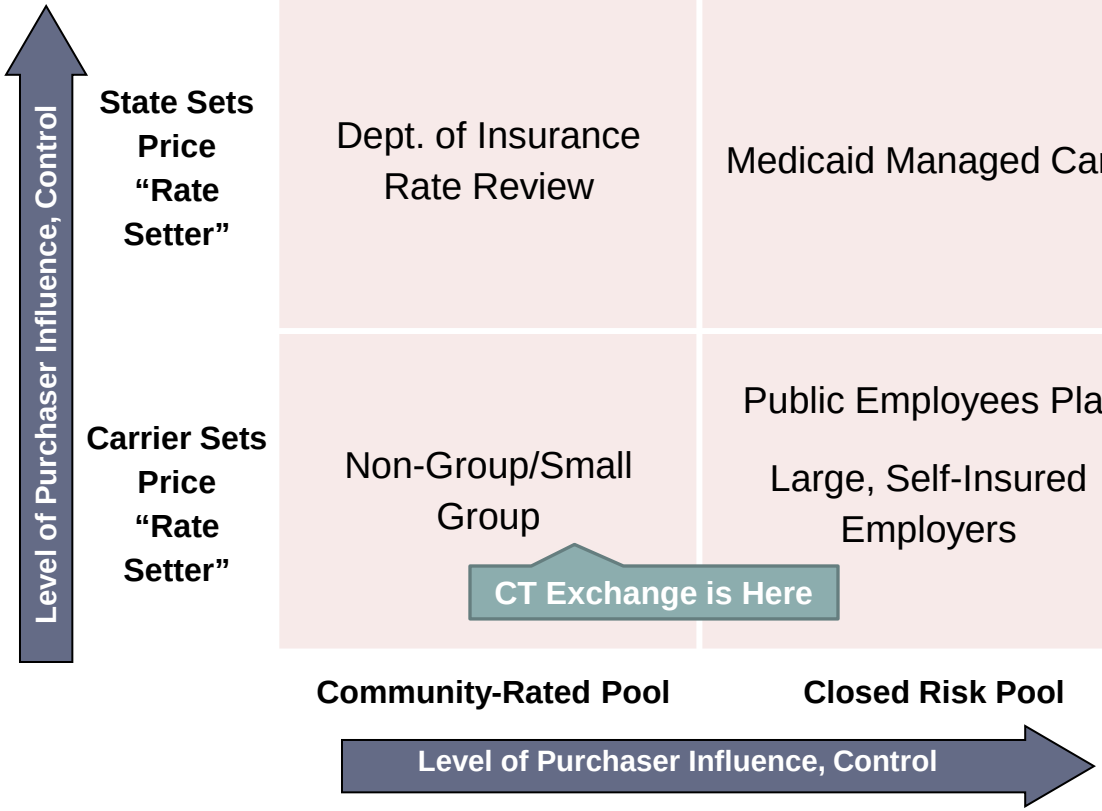
Pros (of requiring extensive network standard):

- Prevents carriers from profiling networks as a way to mitigate risk selection
- Protects established patient-physician relationships
- Allowing tiered or narrow networks, could disadvantage academic hospitals by seeing these higher-cost facilities residing in tiers with highest deductible and co-payments or being excluded from narrow networks.

Cons (of requiring extensive network standards):

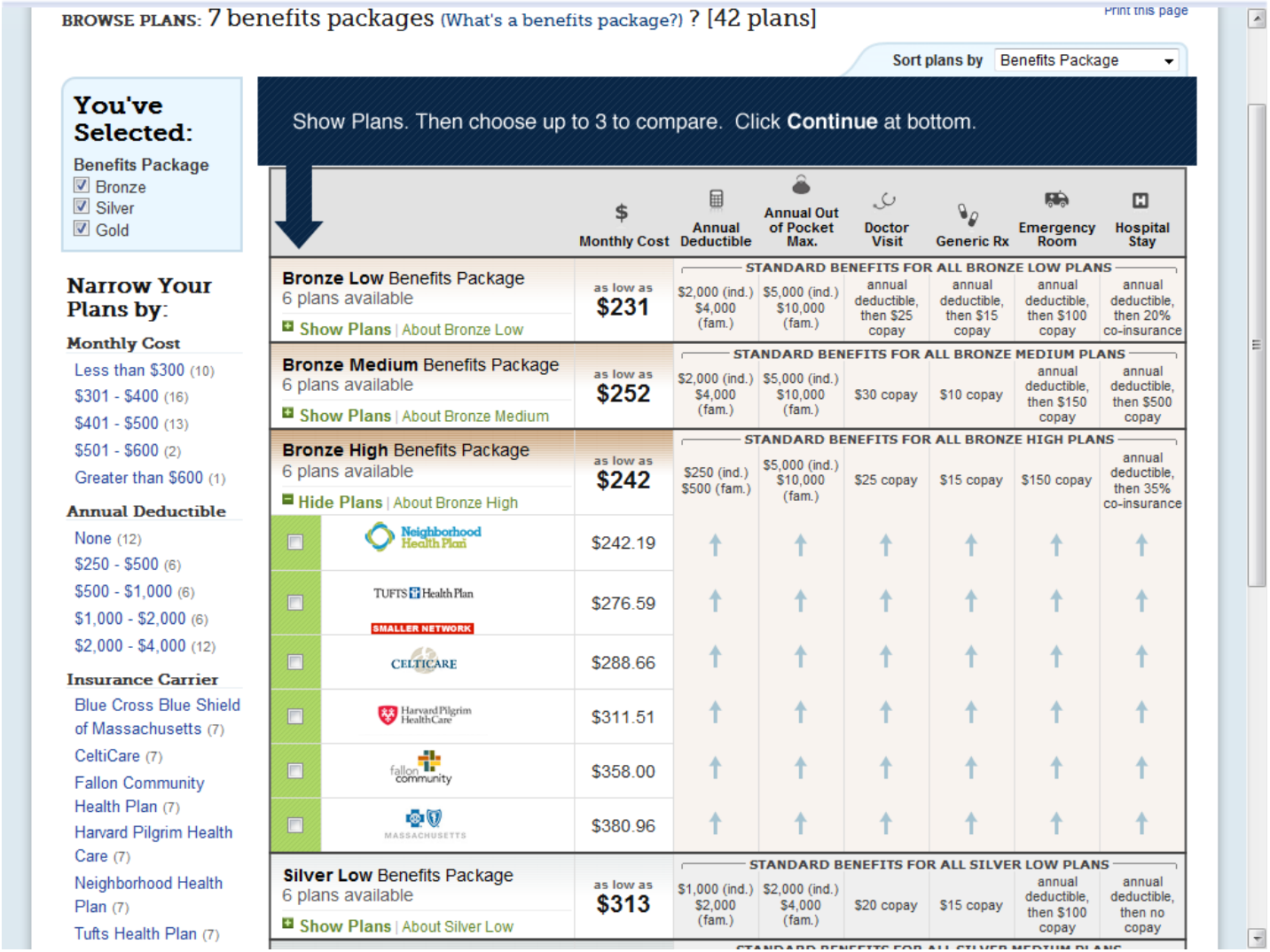
- Lowers carriers bargaining power vis-à-vis providers and hospitals.
- May discourage innovation by carriers to construct tiered and narrow networks
- Carriers are accredited by nationally-recognized professional agencies that already take into consideration network adequacy

Potential Types of Purchasers



Source: WAKELY CONSULTING GROUP

Price is King



BROWSE PLANS: 7 benefits packages (What's a benefits package?) ? [42 plans]

Print this page

Sort plans by Benefits Package

You've Selected:

Benefits Package
- ☑ Bronze
- ☑ Silver
- ☑ Gold

Narrow Your Plans by:

Monthly Cost
- Less than $300 (10)
- $301 - $400 (16)
- $401 - $500 (13)
- $501 - $600 (2)
- Greater than $600 (1)

Annual Deductible
- None (12)
- $250 - $500 (6)
- $500 - $1,000 (6)
- $1,000 - $2,000 (6)
- $2,000 - $4,000 (12)

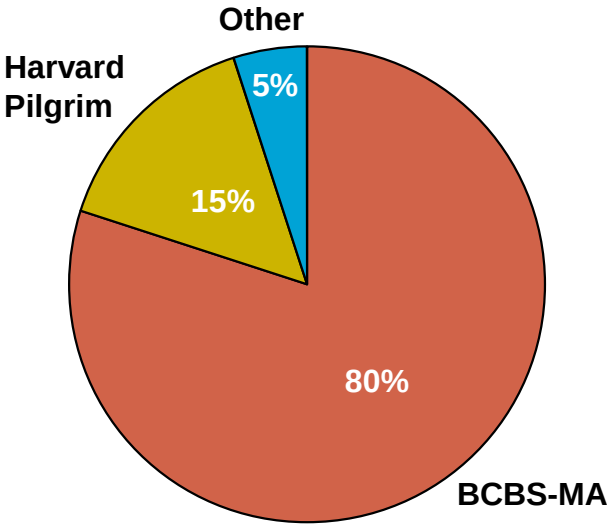
Insurance Carrier
- Blue Cross Blue Shield of Massachusetts (7)
- CeltiCare (7)
- Fallon Community Health Plan (7)
- Harvard Pilgrim Health Care (7)
- Neighborhood Health Plan (7)
- Tufts Health Plan (7)

Show Plans. Then choose up to 3 to compare. Click **Continue** at bottom.

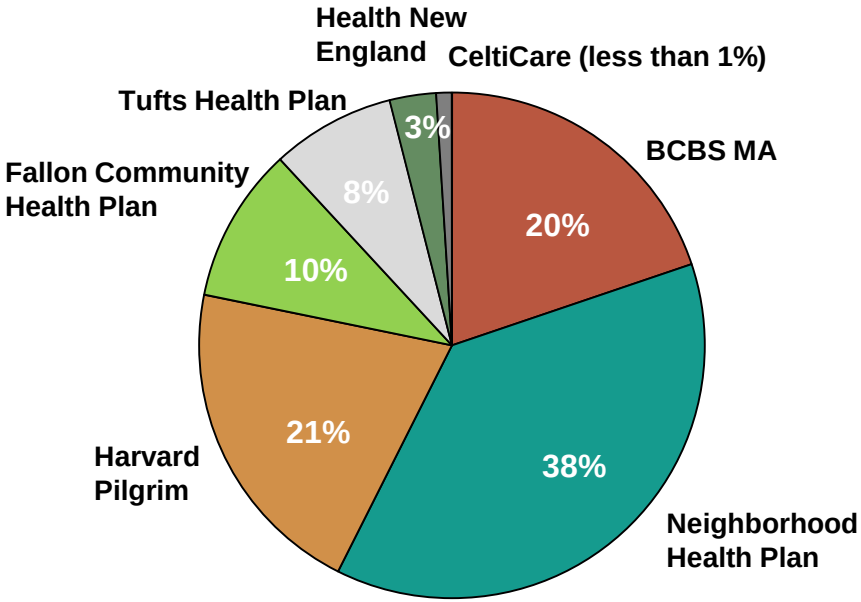
	Monthly Cost	Annual Deductible	Annual Out of Pocket Max.	Doctor Visit	Generic Rx	Emergency Room	Hospital Stay
Bronze Low Benefits Package 6 plans available Show Plans | About Bronze Low	as low as **$231**	STANDARD BENEFITS FOR ALL BRONZE LOW PLANS					
		$2,000 (ind.) $4,000 (fam.)	$5,000 (ind.) $10,000 (fam.)	annual deductible, then $25 copay	annual deductible, then $15 copay	annual deductible, then $100 copay	annual deductible, then 20% co-insurance
Bronze Medium Benefits Package 6 plans available Show Plans | About Bronze Medium	as low as **$252**	STANDARD BENEFITS FOR ALL BRONZE MEDIUM PLANS					
		$2,000 (ind.) $4,000 (fam.)	$5,000 (ind.) $10,000 (fam.)	$30 copay	$10 copay	annual deductible, then $150 copay	annual deductible, then $500 copay
Bronze High Benefits Package 6 plans available Hide Plans | About Bronze High	as low as **$242**	STANDARD BENEFITS FOR ALL BRONZE HIGH PLANS					
		$250 (ind.) $500 (fam.)	$5,000 (ind.) $10,000 (fam.)	$25 copay	$15 copay	$150 copay	annual deductible, then 35% co-insurance
☐ Neighborhood Health Plan	$242.19	↑	↑	↑	↑	↑	↑
☐ Tufts Health Plan (SMALLER NETWORK)	$276.59	↑	↑	↑	↑	↑	↑
☐ CeltiCare	$288.66	↑	↑	↑	↑	↑	↑
☐ Harvard Pilgrim HealthCare	$311.51	↑	↑	↑	↑	↑	↑
☐ Fallon Community	$358.00	↑	↑	↑	↑	↑	↑
☐ Blue Cross Blue Shield Massachusetts	$380.96	↑	↑	↑	↑	↑	↑
Silver Low Benefits Package 6 plans available Show Plans | About Silver Low	as low as **$313**	STANDARD BENEFITS FOR ALL SILVER LOW PLANS					
		$1,000 (ind.) $2,000 (fam.)	$2,000 (ind.) $4,000 (fam.)	$20 copay	$15 copay	annual deductible, then $100 copay	annual deductible, then no copay

Managed Competition in Action

Massachusetts Pre-Reform Non-Group Market Share
Based on 2005 Membership, 10 Players



Massachusetts Post-Reform Non-Group Market Share (Non-subsidized Exchange)
Based on 2011 Membership, 7 Players



- Neighborhood Health undercut BCBS-MA pricing on the order of approx. one-third, rapidly eroding share in a market of markedly increased transparency
  - Lower pricing driven by more narrow networks and the ability to operate without a broker network, resulting in administrative fees less than half of BCBS-MA

Source: http://www.marylandahu.com/downloads/mahu_exchange_study.pdf