

Striving for meaningful choice:

Non-group health plans on the
Massachusetts Health
Connector product shelf

Massachusetts Health Connector

January 2019



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Executive Summary

The Massachusetts Health Connector's health insurance product strategy has evolved over time in response to customer, carrier, and regulatory influences. At the heart of this evolution is a policy interest in providing the number and types of plans that empower consumers to find the right plan for their needs, without overwhelming them with options. To that end, the balance of plans that are "standardized" in benefit design, offering easier consumer comparability, against "non-standardized" plans developed by carriers, allows for greater flexibility and deference to market trends. This brief analyzes historical trends in product offerings, provides details on enrollment among plans in 2018, and compares the Health Connector to the broader Massachusetts market and beyond.

In 2018, the Health Connector offered 52 plans, including 13 non-standard plans, from eight carriers through its non-group shelf. The majority of health plans on the non-group shelf are considered "standardized" because they adhere to common coverage of 21 major benefits across carriers. Outside these 21 benefits, carriers are allowed to vary cost sharing. In addition to standardized plans, carriers are allowed to offer several non-standardized plans that they believe add value for consumers. Both standardized and non-standardized plans have historically been organized into metallic tiers based on relative richness of benefits. Despite this variety, 2018 enrollment within each metallic tier was heavily concentrated in a few plans. Within each tier, there is no clear preference for standardized versus non-standardized plans, suggesting that once a consumer selects a metallic tier, benefit design may be less influential in consumer decisions than premium costs and provider networks. In 2019, the Health Connector modified its product shelf to respond to federal policy changes and provide members with a range of affordable coverage options with the intention to continue to take a responsive and flexible approach in 2020.

Introduction

The Massachusetts Health Connector was established by Chapter 58 of the Acts of 2006. Its mission is to serve as a health insurance marketplace where consumers can compare and shop for health plans. In 2014, it transitioned to become the Commonwealth's Health Benefits Exchange under the Affordable Care Act (ACA). Although a primary focus of the Health Connector's role in the broader Massachusetts health care market has been in offering subsidized health plans, first through the Commonwealth Care program and now through the ConnectorCare program which represents 77 percent of total Health Connector membership, the focus of this brief is on non-group plan offerings outside these programs. Prior to 2014, the Commonwealth Choice program served unsubsidized members above 300 percent of the Federal Poverty Level (FPL) (\$73,800 for a family of four in 2018). Under the ACA, there are federal tax credits available to individuals up to 400 percent FPL (\$98,400 for a family of four in 2018), and ConnectorCare adds additional state subsidies for households up to 300 percent FPL. This leaves a small range of members (approximately 6 percent or 14,000 individuals) between 300 and 400 percent FPL who are only eligible for federal subsidies and who may apply them to any non-group plan other than a catastrophic plan, allowing them nearly as many choices as unsubsidized members.

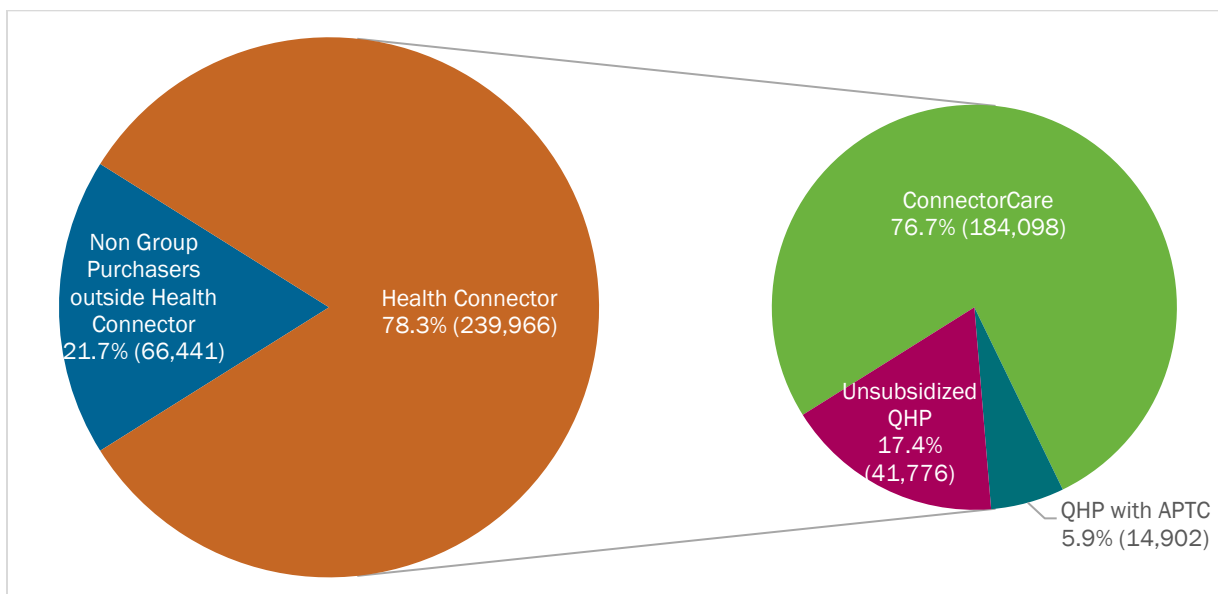
This brief is designed to provide data and analysis relative to the breadth of choices offered since the Health Connector's inception to members purchasing outside the curated plan sets of Commonwealth Care or ConnectorCare. Although subsidized plans represent a larger share of the Health Connector's membership, there are a limited number of standardized plans serving those

members. Through examination of the way in which consumers select a single plan from the dozens available, the Health Connector will continue to refine its approach to plan offerings as well as tailoring decision support tools.

Health Connector History

Chapter 58 of the Acts of 2006 instituted a number of health care market reforms, in addition to creating the Health Connector. Among them was a merger of the small group and individual insurance markets. Merging these two market segments created one unified risk pool, from which rates are set for both individual and small group commercial insurance products. Within the merged market (which includes a total of 749,054 lives), the Health Connector currently serves as the conduit to coverage for approximately 78 percent of all non-group purchasers and a smaller contingent of small groups (See Figure 1).¹

Figure 1: Health Connector Non-Group Membership within the MA Merged Market as of March



CHIA Enrollment Trends (August 2018)

The Health Connector began selling non-group unsubsidized plans effective July 1, 2007, under what was called the Commonwealth Choice program.² To determine which plans to sell, the Health Connector solicited proposals from carriers through a certification process known as the Seal of Approval (SOA), a process which continues today.³ All carriers with at least 5,000 covered lives in the Massachusetts merged market must submit a proposal for consideration by the Health Connector, but the Health Connector awards the Seal of Approval at its discretion.⁴

Early Days

The initial SOA process sought five different types of plans.⁵ A “premier” plan offered low enrollee cost sharing, and these plans became the Gold metallic tier after the ACA introduced “metallic tier” nomenclature. Two “value” plans offered mid-range benefits with higher point-of-service cost sharing, similar to what is now the Silver tier. One “minimum creditable coverage” and one “young

adult” plan provided lower premiums and higher cost sharing for members, comparable to today’s Bronze and Catastrophic plan offerings, respectively. Young adult plans (YAP) were limited to ages 19 to 26, inclusive. Both the minimum creditable coverage and Young Adult plans were offered with and without prescription coverage.

Beginning July 1, 2007, six carriers were approved to sell a total of 42 plans through the Health Connector (Figure 1).⁶ The Health Connector specified the general tiers of coverage as noted above, but the benefit design of each was left to the carriers, resulting in a product shelf with all non-standard plans. Tiers were roughly based on actuarial value (AV), or the share of costs for a standard population covered by the carrier rather than the consumer. The Health Connector provided a sample set of benefits for the Gold level plan and allowed carriers to vary benefits within an (AV) range of +/- 5 percent of that design. Benefit levels for the Silver and Bronze plans were specified relative to the AV of the Gold plan the carrier designed: Silver plans could be 72.5 percent to 87.5 percent of the value of the Gold plan, and Bronze plans could be 58 percent to 62 percent of the value of the Gold plan.⁷ The latitude offered to carriers in terms of AV also allowed for broad variations in plan richness, particularly on the Silver tier.

Standardization

Beginning on January 1, 2010, the Health Connector shifted its product shelf strategy to offer a more limited number of benefit designs on each metallic tier. Standardization was designed to allow consumers to make “apples to apples” comparisons across carriers. Focus groups conducted with both Commonwealth Choice members and non-members suggested that three benefit designs and five carriers per tier was an optimal combination of choice and simplicity.⁸

The Health Connector standardized a set of common benefits for plans on each tier.⁹ The change to all standard plans was popular among consumers, but some carriers expressed continued interest in having flexibility in plan design without having to increase the overall number of products they offered through Commonwealth Choice.¹⁰ In addition to standardizing benefits, the Health Connector also required that plans be offered on the carrier’s broadest commercial network of providers, though carriers were allowed to offer Silver and Bronze plans on both their broadest network and on an alternate network if they wished.¹¹

Post-Standardization Modifications

In response to consumers and carriers, the SOA approach for plans effective July 1, 2011, through December 31, 2012, was to generally maintain a base of standardized plans while also streamlining product offerings and allowing carriers more product design flexibility.¹²

For 2013, the Health Connector took a dual approach to the SOA, maintaining existing plans while also inviting carriers to propose additional, non-standardized plans.¹³ The invitation also included offering standardized designs on narrower provider networks beyond the broadest commercial network requirement on Silver and Bronze plans. This approach allowed for administrative stability in the period leading up to ACA implementation while also refreshing the product shelf with plans carriers felt were popular or innovative in the broader market. Specifically, this proposal addressed concerns that the standardized offerings were not consistent with market trends, especially among small businesses. Because Massachusetts merged the non-group and small group markets into a single risk pool, carriers were required to make their Health Connector product offerings available to

both non-group and small group members. The Health Connector received feedback that small businesses were looking for plans that helped them achieve lower premiums without sacrificing comprehensive coverage, such as plans with limited or tiered networks. Carriers supported this expansion of the Health Connector’s offerings because they could provide existing plans that were popular in the outside market.¹⁴

The resulting 2013 product shelf added 22 new options, half of which were standardized plans offered on alternative networks, and half of which were non-standardized plans. The 11 non-standardized plans represented seven unique designs, two of which were offered on three networks, resulting in six distinct options for consumers.¹⁵

Figure 2: Health Connector Standardized Plans, 2007 – 2018

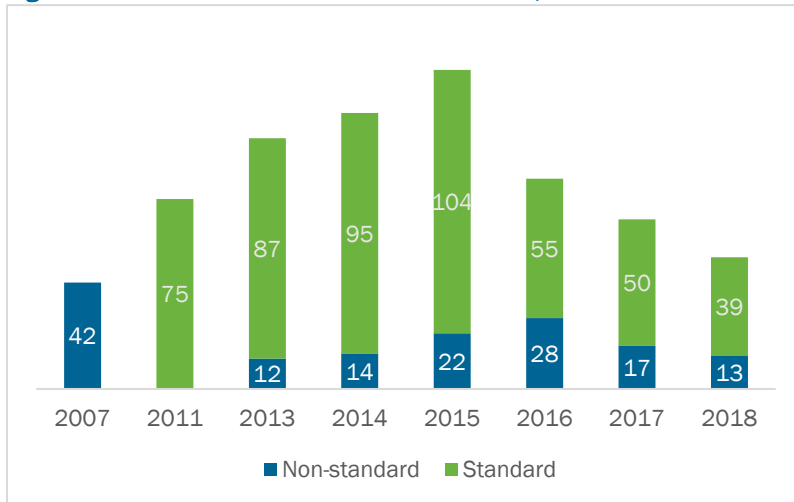


Figure 2 highlights the varying number of plans offered on the Health Connector product shelf between 2007 and 2018 along with the Exchange’s approach to plan standardization. The SOA process recognizes a need to strike a balance between choice and simplicity for enrollees in order to facilitate an apples-to-apples comparison while offering a range of robust options.

ACA Implementation

The SOA plan certification for coverage effective January 1, 2014, took into account requirements for plans and Exchanges under the ACA, and in 2015 minimal changes to the product shelf in order to allow for a smoother transition to a new website platform. The SOA process itself was already substantially compliant with the ACA’s plan certification requirements and required minimal amendment to meet new federal rules. The content of the SOA, however, was vastly different than in past years, mainly because the Health Connector’s subsidized membership transitioned to having coverage through enriched Silver tier plans rather than Commonwealth Care plans, which had previously been segmented from the non-group market.

The ACA, following Massachusetts’ example, designated metallic tiers to differentiate plans in Exchanges, but added a new Platinum tier. Despite this similarity in design, however, the ACA defined metallic tiers by AV. Historically, the Health Connector tended to standardize plan designs by defining cost sharing parameters for specific benefits, rather than overall AV.¹⁶ Under the Health Connector’s standardization, plans in the same tier may still have varied in their AV by more than the *de minimis* range of +/- 2 percent allowed under the ACA. Furthermore, the AV of pre-ACA plans in

each Health Connector tier tended to be higher than the level set by the ACA. For example, most plans designated as Bronze prior to the ACA would have been considered Silver or Gold level plans in 2014 and beyond.¹⁷

ACA Stabilization

In 2016, the Health Connector sought to simplify the consumer shopping experience by reducing the total number of plans available by about one-third.¹⁸ This reduction in plans was a direct response to consumer behavior, eliminating plan designs that were least popular among consumers. This strategy also created more differentiation among the remaining plan designs, to support consumers in understanding the available plan options. Although the Health Connector's website was stable during this period, robust decision support tools were not yet available to consumers. The Health Connector opted to limit carriers to offering only three non-standardized plans rather than limiting the number of carriers participating on the Exchange.¹⁹

In 2017, the Health Connector worked to further simplify the consumer shopping experience by streamlining product offerings and bolstering system functionality to conduct “apples-to-apples” comparison shopping. To achieve these goals as a part of the 2017 SOA, the Health Connector eliminated the second standardized Gold plan design, standardized the Bronze tier and standardized additional cost sharing categories. The overall SOA strategy focused the number of allowable plan offerings on the QHP product shelf and instituted a cap on the number of allowable offerings on the QDP shelf. In 2017, the SOA was also leveraged to influence product designs of Marketplace plans to address the population health priorities in the Commonwealth, through pediatric dental coverage and opioid use disorder therapy. In future years, the Health Connector plans to explore additional opportunities to address chronic disease management through value-based insurance design (VBID).²⁰

Preparing for Uncertainty

Prior to the 2018 plan year, the Health Connector and Exchanges across the country faced ongoing uncertainty as to whether the federal government would continue to pay Cost-Sharing Reductions (CSRs) for 2018. Although carriers are obligated to provide CSR-enriched coverage for eligible ConnectorCare members, the federal government's threatened withdrawal of CSR funding meant carriers and the Commonwealth needed to work together to identify a solution for continued funding of those plans. The Health Connector partnered with the Massachusetts Division of Insurance (DOI) and carriers to develop two alternative pathways, using two sets of rates, to prepare for the risk that CSR payments may be discontinued.²¹ Thus, the 2018 SOA process prioritized protecting coverage to the greatest extent possible, maintaining market stability, and preventing undue disruption for members and carriers. One set of rates assumed an ordinary course of business, including standard annual premium changes. The second set of rates accounted for the federal CSR withdrawal by allowing a significant increase exclusively for Silver tier QHPs sold on-exchange by ConnectorCare carriers, which would have the effect of increasing federal premium subsidies in lieu of cost sharing subsidies being available.²²

Less than two weeks before the start of Open Enrollment for 2018 coverage, the federal government announced that it would immediately terminate CSR payments, leading the Health Connector and DOI to use the “CSR withdrawal loaded” Silver tier non-group QHPs.²³ This strategy allowed carriers

participating in ConnectorCare to replace missing federal revenue and continue to offer affordable plans to low and middle income individuals. This strategy also allowed all ConnectorCare and many Silver tier members who only receive Advance Premium Tax Credits (APTCs) to be held harmless in the increase in Silver plan rates because of the consequent increase in APTCs. However, unsubsidized Silver tier enrollees experienced the full impact of these premium increases. Unsubsidized members from the five impacted carriers ended up facing premium increases that not only accounted for regular market trends but also an additional percentage from the “Silver load.”²⁴

The Health Connector worked to ensure this population was aware of all of the options available to them to get into a new plan without a “federal CSR withdrawal load” including: enrolling directly with their carrier “off-exchange” in a nearly identical Silver tier product without the CSR-related rate increase; shifting to a different metallic tier plan from that carrier through the Health Connector; or shopping for an entirely new plan from a different carrier through the Health Connector. While some unsubsidized members impacted by the termination of CSRs moved out of loaded plans, many did not.

Responding to Consumer Needs

The Health Connector designed its 2019 product shelf to meet shifting member needs and federal dynamics, with tailored strategies for ConnectorCare, unsubsidized and APTC-only non-group, and small group.²⁵

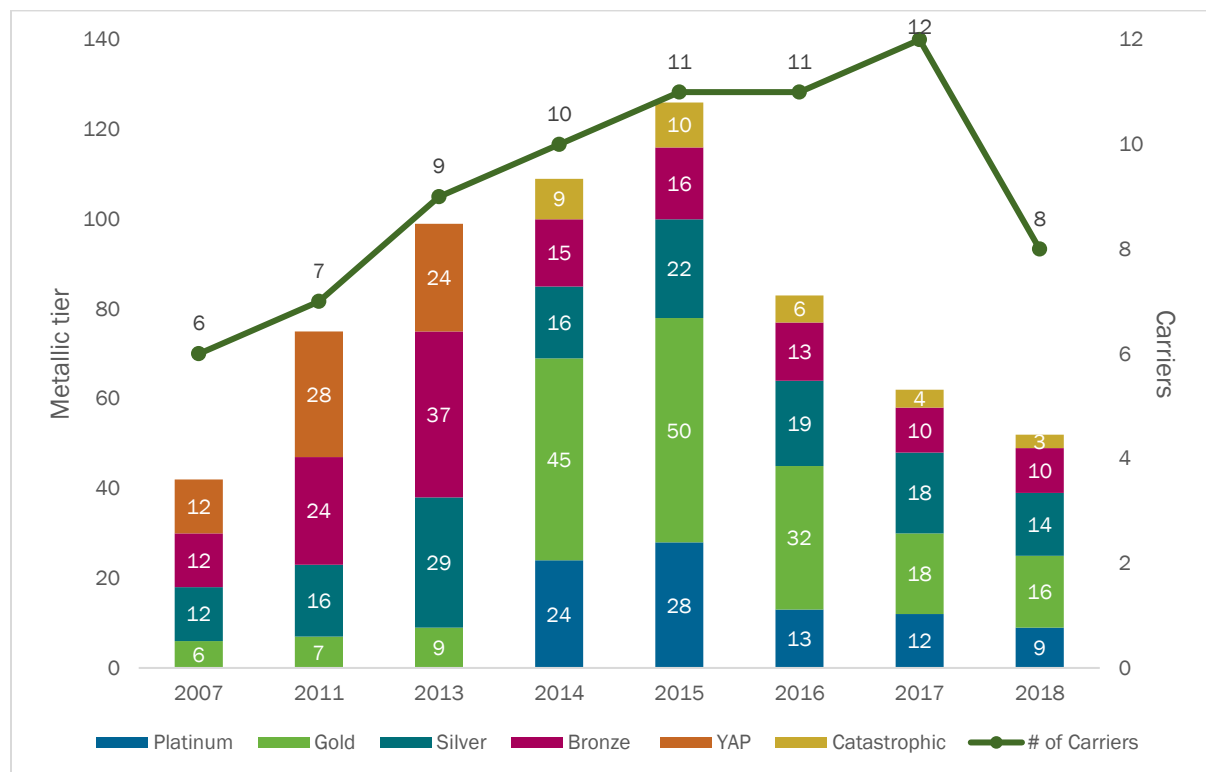
Figure 3: 2019 SOA Strategy

ConnectorCare	Unsub and APTC-only Non-group	Small Group
<p>Maintain existing ConnectorCare program design with no member facing changes.</p> <p>Offer a non-group Silver tier that is better equipped to offer a sustainable ConnectorCare program</p>	<p>Expand Standard plan offerings to support unsubsidized individuals seeking alternatives to high-premium “CSR-loaded” Silver plans</p> <ul style="list-style-type: none"> • Require a Low Gold offering • Require a Standard High Bronze offering (no waivers permitted) 	<p>Offer small group enrollees the full suite of non-group plans, as well as expanded plan offerings to support the unique needs of small groups and their employees</p> <ul style="list-style-type: none"> • Require a Standard Low Silver HSA-compatible offering • Require a PPO offering <p>Continue employee choice options, allowing employers to choose from a traditional “one plan” model, as well as a “one carrier” and “one level” model</p>

In order to minimize the impact of federal CSR withdrawal on the ConnectorCare program, the Health Connector limited 2019 non-group Silver offerings to standard plans only, with high actuarial value and no coinsurance. Increasing the actuarial value of the plans means a higher percentage of services, are paid for by premiums rather than cost sharing. While the approach will yield long-term stability for the ConnectorCare program, it entailed near-term disruption for some members from the closure of five non-standard Silver plans. Unsubsidized and APTC-only enrollees in the closing non-standard Silver plans were mapped to Standard Silver plans upon renewal.

In 2019, new Gold and Bronze plans were introduced as to the Health Connector product shelf as alternatives to Silver plans. By expanding existing tiers of coverage, the Health Connector aimed to offer a wider selection of value options with richer benefits and, in some cases, lower premiums for individuals and families receiving APTCs or no subsidies at all. The Health Connector will monitor enrollment in these new plan options and offer an analysis of uptake at the end of Open Enrollment 2019.

Figure 4: Health Connector Product Shelf by Metallic Tier and Number of Carriers, 2007 – 2018



Note: During 2014, technological system limitations prevented many individuals from enrolling in the Health Connector plans highlighted in Figure 4.

Present Day Health Connector Enrollment

In 2018, Silver was the most popular tier in Massachusetts and nationwide.²⁶ It was likely popular elsewhere because it is the only tier to which cost-sharing reductions can be applied. In Massachusetts, these cost-sharing subsidies are applicable within ConnectorCare plans, which are not discussed in this brief. However, even among non-ConnectorCare members, the Silver tier had

nearly twice as many enrollees as other tiers which may be, in part, due to members losing their ConnectorCare eligibility and remaining enrolled in underlying Silver plans without subsidies.

Within each metallic tier, Health Connector enrollment was concentrated heavily in a small number of plans. Given that the majority of benefits and plans were standardized, the main differences within each tier were premium and provider network. For the purpose of data analysis, direct comparison of premiums within the tier is not possible in the aggregate because availability of and rates for the same plan vary by the seven rating regions in the state. However, the most popular plans for each tier were all in the lowest quartile for that tier, on average. The most popular Silver and Catastrophic plans were the lowest cost plan in their tier in all rating regions where they were offered.

The most popular plan in 2018 was a Tufts Health Direct plan on the Silver metallic tier. The plan, marketed with the plan name “*Non-Standard: Tufts Health Direct Silver 2500 with Coinsurance II,*” had almost 15 percent of total non-ConnectorCare non-group enrollment in January 2018, nearly 1,500 more members than the next popular plan.

This plan diverged from the standardized Silver design in its use of coinsurance rather than copays for many services, such as laboratory services, x-rays, and imaging, inpatient services, and outpatient surgery. For example, where the standard Silver design subjected inpatient services to a \$1,000 co-pay (after deductible), the Non-Standard Tufts Direct Silver 2500 plan applied 30 percent coinsurance (after deductible) in-network, and 100 percent coinsurance (after deductible) out-of-network (See Figure 4). Coinsurance is one way carriers can incentivize consumers to choose lower cost health care providers, rather than limiting provider networks. However, at present, it can be difficult for consumers to gather cost data that would allow them to comparison shop, despite a Massachusetts law requiring greater transparency on the part of carriers and providers, because of a lack of standardization in the definitions of procedures and what services or fees they include.^{27,28} This lack of transparency can create uncertainty for consumers, which can lead them to make sub-optimal choices when enrolling in a plan or seeking care.²⁹ The Health Connector has moved away from coinsurance for plans in 2019 due to these consumer impacts.

Other research supports the hypothesis that the popularity of the Tufts Direct Silver 2500 among Health Connector enrollees was due to cost. Several surveys of non-group consumers have found cost is the most influential factor in plan choice.^{30, 31, 32} Because this Silver plan had a premium lower than those of some Bronze plans, it is feasible that many consumers viewed the plan as a “good deal” providing the benefit level of Silver plan for the price of Bronze.

The Non-Standard Tufts Direct Silver 2500 is also a ConnectorCare base plan. ConnectorCare plans are built from a foundation of Silver plans (base plans) that meet Health Connector specifications and are enriched according to ConnectorCare standards. Since the program incentivizes carriers with low premium rates, ConnectorCare is largely based on Non-Standard Silver plans that rely primarily on coinsurance to keep rates low. These plans have historically posed a challenge for individuals who lose their ConnectorCare eligibility and remain enrolled in their base Silver plans without subsidies. ConnectorCare members who lose subsidies may be enrolled in the Non-Standard Tufts Direct Silver 2500 plan and may not switch out for many reasons including: low premiums, price sensitivity, confusion, low health literacy regarding plan design, or inertia.

Health Connector Plans in Context Today

The Health Connector serves roughly 78 percent of all non-group members in the merged market. Data from the Center for Health Information and Analysis (CHIA) enrollment report indicates 306,407 individuals enrolled in commercial plans as of March 2018. Unsubsidized Health Connector enrollment accounts for approximately 14 percent of overall non-group enrollment in the merged market; ConnectorCare accounts for another 60 percent of the non-group segment.

Compared to the rest of the Massachusetts market, the Health Connector offers more HMOs. Although HMOs and Preferred Provider Organization (PPO) plans make up approximately three-quarters of commercial enrollment, Point-of-Service (POS) plans are also popular plan designs, particularly in the self-insured market segment.³³ In the individual market segment, HMO plans account for 97 percent of enrollment, with PPO plans representing the remaining 3 percent. In 2018, the Health Connector did not offer any PPO products. However, for 2019, the Exchange is requiring each carrier to provide a PPO product on the small group shelf.

Narrow and tiered networks are more popular with individuals than they are with employers, but uptake is still fairly low in the individual market. The Health Policy Commission (HPC) estimates 3.5 percent of 2016 enrollees in fully insured commercial plans chose narrow network plans, but this number appears to be closer to 5 percent among commercial non-group enrollment.^{34,35,36} In 2018, most non-ConnectorCare members enrolled in more limited network plans. Though all carriers offer their broadest commercial network on-Exchange, the networks from ConnectorCare carriers are still much narrower than other carriers. Blue Cross Blue Shield, Neighborhood Health Plan, Harvard Pilgrim Health Care, and Tufts Premier enrolled roughly 30 percent of all non-ConnectorCare members in their plans. Historically, these carriers offer the broadest networks on the Health Connector product shelf. Enrollment in tiered network plans in the commercial individual market outside the Health Connector was around 16 percent in 2013, the latest year for which data is available, due largely to participation in Blue Cross Blue Shield plans.³⁷ No Health Connector plans offered a tiered network in 2018 or 2019.

Other ACA Marketplaces vary widely in their plan offerings, and differences in policy and regulatory environments makes comparisons among Marketplaces difficult.

- **Ten states, including Massachusetts, are considered “active” purchasers,** setting guidelines for carriers in terms of number and design of plan offerings. The remaining state-based and federally facilitated Marketplaces take a “passive” approach that allows any plan meeting baseline ACA requirements to appear on the Marketplace’s shelf.³⁸
- **Massachusetts, with eight carriers in 2018, was above the national average of four carriers participating in the Marketplace.** Only five states had more carriers, all of them much larger in terms of geography, if not population: New York, California, Wisconsin, Ohio, and Texas.³⁹

Despite growing interest in standardization of plan designs among states, the challenge of striking a balance between simplicity and choice for consumers is significant.⁴⁰ For plan year 2018, Massachusetts is among seven state-based Marketplaces (SBMs) that required standardized plans.^{41 42} Most states that standardize require one standardized plan at each metallic tier, but do not limit the number of non-standardized plans carriers may offer otherwise. HealthCare.gov began to offer standardized plans beginning in plan year 2017, though issuers were not required to provide

them. In addition to offering standardized options, the federal marketplace also provided differential display of these plans on HealthCare.gov. For 2019, HHS has stopped designing or noting these “simple choice” plan options, citing the need to encourage carriers to innovate and to promote free market principles. Despite this federal policy shift, state-based marketplaces remain able to standardize plans if they believe in the importance of enabling apples-to-apples comparisons across a variety of carriers in a given metallic tier.

Conclusions

While this brief offers an historical overview of the Health Connector’s non-group, unsubsidized plan offerings, there is a continued need for discussion about the future approach to the product shelf that takes into consideration consumer, market, and administrative perspectives. The majority of Health Connector enrollees would still prefer to choose from three to five health plans, according to a recent survey and focus groups conducted by the Health Connector.⁴³ To support consumer preference, the Health Connector can use its role as an active purchaser either to decrease the number of plans available overall or instead provide filters and other decision support tools to help consumers narrow down a broad variety of plans to view a more manageable subset to choose from.

Goals for 2020

Working to offer plans that are affordable and provide enrollees with quality coverage, as well as empowering them to choose the right plan through decision support tools, is a primary goal for the Health Connector. The Health Connector’s product shelf must respond to a dynamic and increasingly complex health care landscape. In 2020, the Health Connector will continue to take a responsive and flexible approach informed by consumer feedback to ensure the Exchange continues to meet the needs of Massachusetts residents.

Looking to the future

Looking ahead to the future, the Health Connector will prioritize three strategies to help consumers find the plan that meets their needs including decision support, affordability, and balance in plans.

Decision Support

The Health Connector continues to pursue technological solutions to help support consumers in identifying their priorities and viewing plans that best meet their needs. Current enrollment data suggests that consumers choose a plan based on price point within each tier. However, non-financial factors, such as provider choice, are also highly important dimensions of choosing a health plan. Consumers can currently filter plans by price, metallic tier, and carrier. In addition, a provider search tool implemented in late 2015 allows consumers to filter plans according to which ones have their preferred provider. The Health Connector intends to continue refining its shopping experience to empower its members to choose a health plan that best meets their needs.

Affordability

Affordability of health insurance is of paramount concern for individuals buying coverage as well as for the Health Connector and its stakeholder partners. Many individuals purchase coverage through the Health Connector, particularly those who need to buy their own insurance because they do not

have access to coverage from an employer or a government program. The Health Connector will continue to look for ways it can use its role in the marketplace to promote quality, affordable coverage for all state residents.

Balance in Plans

This brief highlights the complexity of achieving an effective balance between providing enough choice for consumers shopping for health insurance and ensuring that they are able to make meaningful comparisons between plans. Standardization of plans helps consumers understand what they are getting and make decisions based on price and provider network. De-standardization of plans allows carriers to explore innovative or alternative plan designs that may help consumers save money or access specialized benefits. Additional deliberation informed by past decisions and current research will help the Health Connector reach an optimal balance for all stakeholders.

Appendix

Appendix A. Health Connector Product Shelf, 2007-2018

	2007 Comm Choice begins	2011 Standardiza- tion begins	2013 Non-standard plans re- introduced	2014 QHPs begin to be sold	2015 Year 2 of QHPs	2016 Year 3 of QHPs	2017 Year 4 of QHPs	2018 Year 5 of QHPs
Total CommCare and/or ConnectorCare enrollment	150,998	158,805	216,865	80,706	120,673	136,676	167,975	178,359
Remainder of non- group enrollment	12,915	34,349	35,320	32,160	45,249	48,225	70,232	72,221
# of Carriers	6	7	9	10	11	11	12	8
Platinum	0	0	0	24	28	13	12	9
Gold	6	7	9	45	50	32	18	16
Silver	12	16	29	16	22	19	18	14
Bronze	12	24	37	15	16	13	10	10
YAP	12	28	24	0	0	0	0	0
Catastrophic	0	0	0	9	10	6	4	3
Total Medical Plans	42	75	99	109	123	83	62	52

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