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M E M O R A N D U M

To: Joint Fiscal Office; Office of Legislative Council; House Committee on Health Care; Senate Committees on Health and Welfare and on Finance; Health Reform Oversight Committee; Joint Fiscal Committee

From: Steven M. Costantino, Commissioner, Department of Vermont Health Access

Date: October 7, 2016

Re: Vermont Health Connect Updates – October 2016

I am pleased to share updates on Vermont Health Connect, preparation for open enrollment that starts on November 1st, and updates on the following topics:

1) Open Enrollment,
2) Qualified Health Plans and Rates,
3) Plan Comparison Tool,
4) Medicaid Renewals,
5) Customer Support Center,
6) Change Requests and Integration,
7) Appeals,
8) Grace Periods, and
9) Self-Service.

1. 2017 Qualified Health Plan Renewals and Open Enrollment

Open Enrollment on Vermont Health Connect (VHC) is less than a month away. Open Enrollment is the annual period when new customers can enroll in a health plan and existing customers can decide whether to change plans. 2017 Open Enrollment starts November 1st and runs until January 31st.

VHC's testing teams have been working closely with their carrier and payment processing partners and, thanks to the fact that there were no major system deployments this summer or fall, are well ahead of where they were last year. We expect to meet the goal of renewing customers into their 2017 health plans by December 15th.

If the customer decides to change plans, they will be able to so through January 31st (with an effective date of February or March if they make their request after December 15th). If they are happy with their current plan, they do not have to do anything other than continue to pay their bill.

Existing qualified health plan (QHP) customers should expect to get their renewal notice during the third week of October. This notice will explain the steps they can take when Open Enrollment begins.

2. 2017 Qualified Health Plans and Rates

Last month we certified the 2017 versions of the same 22 plan designs that Blue Cross Blue Shield of Vermont (BCBSVT) and MVP Healthcare (MVP) offered in 2016. The Green Mountain Care Board reduced proposed rate increases of 8.2% from BCBSVT and 8.8% from MVP to 7.3% and 3.7% respectively. Thanks to the federal Advanced Premium Tax Credits (APTC) and Vermont Premium Assistance (VPA), the impact of the increases will be softened for the three-quarters of individual QHP customers who qualify for those benefits.

BCBSVT did propose a 23rd plan, an additional high-deductible health plan, that was not certified for 2017. We are not opposed to the plan design, and will certainly be open to evaluating it for 2018. However, there were multiple reasons for staying the course for 2017. While the introduction of a new plan would provide more choice, it is not clear that Vermonters would benefit from an increase in the total number of plan offerings. Some national studies have shown that too many plan choices actually undermine consumer decision making. Furthermore, the addition of this particular plan at this time would have changed subsidies in such a way that customers who stayed in their current plan would see a significant rate increase. This fact is particularly noteworthy when you consider that more than 96% of individuals kept their same plan from 2015 to 2016.

We do agree that Vermonters could benefit from actively evaluating plan options to see if they might be able to save money compared to their previous year's plan choice. Ensuring that customers are actively considering all available options, then determining the value of adding even more options, is an endeavor that will take more than a few weeks. We aim to avoid this type of timing problem in the future by instituting a new rule that will require issuers to notify DVHA when they are offering new plans. This schedule will allow DVHA adequate time to consult with the issuers, share information about consumer demand in both the individual and small business sectors, conduct a thorough analysis of pros and cons, make an informed decision, and implement a coordinated outreach plan that will deliver the greatest benefit to the greatest number of Vermonters.

3. 2017 Plan Comparison Tool

One way we plan to promote health insurance literacy and active plan selection is through VHC's online Plan Comparison Tool. The tool helps customers estimate total costs of coverage based on family members' age, health, and income. We will be working with our insurance issuers and other partners to promote the tool and help customers say money by choosing the health plans that best meet their budget and medical needs.

The 2017 Plan Comparison Tool will be available later this month. If you'd like to explore the 2016 version of the tool, you can visit https://vt.checkbookhealth.org.

4. Medicaid Renewals

DVHA's Health Access Eligibility and Enrollment Unit (HAEEU) has stayed on schedule in its work to notify Medicaid customers about the need to renew coverage. HAEEU began contacting Medicaid for the Aged, Blind, and Disabled (MABD) customers at a rate of approximately 1,000 households per month in October 2015 and is now on the normal annual cycle. A larger population went through the renewal process for Medicaid for Children and Adults (MCA), also called "MAGI Medicaid" because eligibility is determined using federally defined Modified Adjusted Gross Income (MAGI).

MCA renewals notices were mailed at a rate of 9,000 households per month starting in the winter with customers who needed to be moved from the State's old ACCESS system into the VHC system. The

renewal process then continued with customers who had already enrolled through VHC. The vast majority of outreach work is now complete. Only about 3,000 households are being noticed in early October. Approximately 3,100 "mixed households" (i.e. those households with members in both QHP and MAGI Medicaid) will then be renewed during QHP Open Enrollment. At that point, all enrollees will have been engaged in the renewal process and the annual cycle will begin again.

Responses to the initial notice and reminder notice remain slow for each renewal group, but tend to pick up after the closure notice and in the weeks after closure. Fewer than half of MAGI Medicaid enrollees respond before receiving a closure notice, but close to three-quarters of the first two renewal groups (those that closed in April and May) have responded as of early October.

Frequently, enrollees wait until they need medical services before they re-enroll, which is problematic for two reasons. First, if they wait more than two months, they could be liable for the federal fee for not having health coverage. Second, before new coverage can be activated, federal rules require verification of the applicant's income – a process that is often quick but in some cases requires physical documentation. For these reasons, VHC continues to remind and encourage Vermonters to apply for coverage as soon as possible **and not to wait until they need medical services**.

5. Customer Support Center

Our Customer Support Center is back on track. After a challenging summer, customers can again have confidence that the vast majority of calls will be answered promptly.

August's call volumes were the highest of any month in over two years, including the last two open enrollment periods. High volumes were primarily driven by Medicaid renewals and were heavier than prior months as more renewing customers called in the months following their closure. Our Customer Support Center contractor Maximus had difficulty staffing at the level needed to handle this volume and the resulting wait times fell well short of their contracted service level agreements (SLA). These waits were an inconvenience for Vermonters and were unacceptable to DVHA. Following a series of meetings this summer, Maximus committed to reaching appropriate staffing levels and once again meeting their SLAs. DVHA has closely monitored their progress toward this commitment. In August they added 30 call service representatives in Chicago to serve as backup to their 80 representatives in Burlington. They continued to hire and train additional staff throughout September and also committed to stepping up their Vermont recruiting to ensure that their Vermont team can provide expected service levels.

Overall, Maximus staffing will exceed 200 representatives for open enrollment, higher than at any time in VHC's history, including a contingency of 50% over projected need to ensure that the company follows through on its commitment to Vermonters.

We are pleased to report that, starting September 23rd, Maximus has regularly had periods of time where idle representatives sat waiting for incoming calls so that they could pick up the phone on the first ring – a situation that had been very rare since the beginning of summer. Overall, Maximus answered two-thirds of calls within 24 seconds last week (week of 9/26) and is on pace to answer about three-quarters of calls with 24 seconds this week (week of 10/3).

Another positive to report is that the improved system has allowed Tier 1 customer service representatives at Maximus to resolve a higher percentage of calls on the phone without transferring to Tier 2 eligibility staff, providing faster service. Once Maximus returns to consistently hitting their prescribed SLAs, as they did reliably for most of 2015, we expect their use of the improved system to result in a better customer service experience for callers.

6. Change Requests and Integration

VHC continues to receive approximately 1,000 change requests per week across its QHP and Medicaid customer base. Fewer than 1,100 households are currently awaiting changes, and fewer than 100 of those involve households with an active QHP (i.e. changes that should be processed ahead of Open Enrollment to allow for a smooth automated renewal).

The goal is to complete changes requested between the 16th of a month and the 15th of the next month in time to be reflected on the following invoice. Nearly nine out of ten changes requested between 7/16 and 8/15 had been processed as of the week of 8/30, ahead of the early September invoice. **This is VHC's best performance in relation to this service level target yet, and continues to improve each month**.

The integration of transactions between VHC's system, insurance carriers' systems, and the payment processor's system has improved substantially since the completion of system development work in March and the subsequent Maintenance & Operations work with Optum. VHC's inventory of known errors is down 75% since March 1. Just as significantly, the number of "in flight" transactions – transactions that have been sent to a partner's system but are still awaiting a confirmation of whether it was successful or an error – has been cut by 84% since early May.

Now that major defects have been fixed, remaining problems are most often related to data discrepancies between systems. VHC's reconciliation team has new tools to track and fix these mismatches and is working through the inventory with our partners.

7. Appeals

In a typical month, DVHA receives more than 100 appeals filed by QHP and Medicaid members who are dissatisfied with a healthcare eligibility decision or termination. This creates a heavy workload for staff at DVHA and the Human Services Board (HSB). In June, DVHA implemented an internal review process to review appeals prior to sending to the Human Services Board (HSB). At that time, DVHA advised HSB that they were hoping the process would increase the quality of its decisions and reduce the number of appeals by 30%.

After three months, we are happy to report that the new process has actually resulted in an average 55% reduction of appeals (over 3 months). The review team will continue to follow the process, and refine as appropriate, in order to increase the quality and efficiency of eligibility decisions.

8. Educating Customers on Grace Periods

Under the rules of Vermont's Health Insurance Marketplace, insurance issuers are responsible for sending late notices (also called "dunning notices") and terminations. The federal rules guiding grace periods and the resulting terminations depend on whether or not the customer receives subsidies and can be confusing. For this reason, Vermont Health Connect staff collaborated with Vermont Legal Aid and representatives from all three insurance issuers to develop an informational sheet that the issuers include with their dunning notices. You can find a copy of the info sheet at:
http://info.healthconnect.vermont.gov/sites/hcexchange/files/VHC%20Grace%20Period%20Graphic_Combo.pdf

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On a related note, you might hear from some constituents who paid their bill on time and still received a late notice from MVP Healthcare. MVP reported that its' vendor erroneously mailed several hundred late notices last month to customers who had paid on time. They identified the accounts that were contacted in error and mailed a correction letter in late September. If a customer did not receive a correction letter, they should assume they were not involved. MVP is working with its vendor to ensure that this mistake is not repeated.

9. Self-Service Changes

If customers want to avoid the phones, they have the option of logging into their account and reporting most change requests online. Medicaid enrollees also have the option of renewing online, as long as their closure date hasn't already passed (if their coverage has been closed, then they would need to call). Customers can log in by clicking on the orange "Sign In" button in the upper-right-hand corner of VermontHealthConnect.gov.

This functionality was rolled out in August and has worked well. Customers who have never logged in will need to set up an online account, and those who haven't logged in for several months will need to request a password reset for security reasons.

VHC is contacting customers who do not have online accounts, as well as those with expiring passwords, to let them know that this option exists.