Introduction to Open Enrollment 2017

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We are coming to the Board today to share our current planning for Open Enrollment 2017, which will build upon our experience this past year and incorporate key changes to support member redeterminations and renewals going forward.

- The Health Connector experienced a successful Open Enrollment last year marked by stability and a high member retention rate

- This year, to ensure compliance with federal regulations and respond to consumer feedback received following our first year renewing members in the Health Insurance Exchange / Integrated Eligibility System (HIX / IES), there will be some changes to the process of annual redeterminations and renewals, along with other updates to the system, operational processes and member-facing communications

- We have a heavy development schedule to support this year’s changes; however, using lessons learned and advanced planning leave us well positioned for this year’s process
Open Enrollment 2016, the first year in which we renewed our population in the new HIX / IES system, was stable and provided good member experience.

**New and Renewing Enrollment**
- As of February 2016, we retained 94% of our renewing members, exceeding our 90% goal
- Members would seamlessly renew into their existing plan or a similar plan, allowing for continual coverage
- We enrolled over 36,000 new members who, prior to Open Enrollment, had never before been to our system

**Member Noticing and Billing**
- All notices went out on time to members and without issue
- Member bills were sent for new plans and rates in time for the December 23rd payment deadline

**Customer Service**
- Four new walk-in centers opened to expand individuals’ access to in-person assistance
- Our call abandonment rate and average speed to answer remained below the agreed upon service levels during Open Enrollment

**Systems and Planning**
- We adhered to a rigorous timeline for the introduction of new system functionality and business processes
- Batch processing and testing occurred as planned for processes never executed before by the HIX / IES project
Redeterminations & Renewals: Overview

The federal government requires that each year, individuals in Marketplaces have their eligibility redetermined and have their QHPs/QDPs renewed.

Redetermination: Eligibility
Annual process by which a Marketplace reassesses an individual’s eligibility for enrollment in or financial assistance paying for a Qualified Health Plan (QHP)/Qualified Dental Plan (QDP) by proactively reviewing federal data and requesting new information from a customer whose prior eligibility information does not reasonably match any new information obtained.

Renewal: Enrollment
Process prescribed by federal regulations that guarantees that eligible QHP/QDP enrollees be renewed into coverage for the following coverage year if they are still eligible. Includes guidelines on how to provide a like-plan for members in a mapping scheme in the event their same plan is not available or if their eligibility has changed.

Federal regulations provide three ways in which Marketplaces can conduct these processes:

1. Follow the federal regulations
2. Follow the model being employed by the Federally Facilitated Marketplace (FFM) for a given year
3. Develop a state-specific model that is approved by CMS
Redeterminations & Renewals: High-level Process

Preliminary Redetermination & Preliminary Notice
August

Payment for January 1 Coverage
December

Auto Renewal into Mapped Plan
November

Annual CCA Redetermination & Renewal Process

30 Day Review Period
(45 days for mixed households)
September
Member can update eligibility information

Final Eligibility & Renewal Notice
October
**Redeterminations & Renewals 2017**

*Four key updates will be made to our system to support the Health Connector’s annual redeterminations and renewals process to align with federal requirements.*

1. **First reversion to Internal Revenue Service (IRS) income data for renewals**
2. **First major batch process to retrieve the Failure to Reconcile (FTR) flag**
3. **First use of Redeterminations & Renewals Validation (RRV) service for Health Connector redeterminations and renewals**
4. **New process for mixed households (both Health Connector and MassHealth eligible individuals)**
Two key systems updates this year are related to federally required provisions to determine subsidy eligibility:

Reverting to Data Sources
- Last year, we used existing income in the system in line with the federal approach for new applicants
- This year, because we have now had a period of passive renewals, we will be checking income against state and federal data sources
- If an individual’s data source income is not compatible or if they did not manually verify their current benefit year income, they will have an opportunity to update their income if they need to do so, else they will be reverted to their data source income for the 2017 benefit year

Checking Advance Premium Tax Credit (APTC) Reconciliation Compliance
- If an individual does not properly file or reconcile their taxes after having received tax credits, they receive an FTR flag and are blocked from receiving subsidies
- Because so few individuals received tax credits in Massachusetts in 2014, this was a small, targeted batch last year
- This has significant implications as 2015 was the first year a substantial number of members received premium tax credits in Massachusetts and filing and reconciling may be a new process
Additionally, we will use a new federally required batch service to update eligibility, as well as implement a new process to address mixed households:

**Batch Eligibility Rechecks**
- This year, the Health Connector plans to use the RRV to retrieve data for redeterminations, not the Federal Data Services Hub (FDSH) as was used last year.
- This will require robust technical testing and adjustments to processes.

**Mixed Household Improvements**
- MassHealth members in mixed households will be processed as part of Health Connector redeterminations.
- New joint notice for mixed households with Health Connector members to provide one central location for members to find information about renewals.
- Notably, if there are MassHealth members in the household, that household may have to take action to maintain MassHealth benefits.
- Households without Health Connector enrolled members will receive a regular MassHealth renewal notice for their household.
Given our opportunity for advanced planning for this Open Enrollment, we tested both our materials and the online user interface with actual and potential members.

- **Web User Interface (UI)**
  - Assisters, Customer Service Representatives (CSRs) and staff were surveyed to indicate the greatest pain points in the application which were then tested with 20 diverse, non-Health Connector members in two locations
  - Priority areas included: the subsidy application question, questions around tax filing, reporting changes in the system, understanding the Eligibility Results page, and overall impressions of the site
  - In response to feedback received in these surveys, improvements to the UI are planned for an upcoming hCentive release in late summer

- **Notices & Communications**
  - Incorporated stakeholder feedback and held sessions with several current members at our walk-in center in Boston to review notices and garner feedback
  - Developed logic to better suppress unnecessary or duplicative notices
  - Reviewed lessons learned with consumer advocates, Navigators, carriers and internal staff to inform planning and updates
  - Working closely with MassHealth on mixed household communications and noticing
Consumer Support Goals

- Support enrollees through the renewals process, letting enrollees know which notices to expect and what information will be contained in each.
- Remind enrollees of the importance of filing taxes and reconciling tax credits in order to remain eligible for their subsidies.
- Encourage enrollees to update their application information and shop for a plan that fits their needs in 2017 while assuring them that no action is required if they have no changes to report and are happy with their current plan.
- Remind eligible but unenrolled individuals that they can return to their application and apply for 2017 coverage, if they need it, during the Open Enrollment period.

Open enrollment is November 1 through January 31. This is the time to choose a plan and enroll if you need insurance for 2016. It’s now easier than ever to enroll because:

- You won’t need to fill out a new application if you applied last year. Just update any information that may have changed.
- You can find plans with the doctors and hospitals you want using our new online Provider Search tool.
- You can get help! There are more places now where people can help you enroll. You can find places to get free, in-person help at: www.MAhealthconnector.org/help-center

Remember, you’ll need to choose a plan and pay your first premium before your new coverage can start.

OE 2016 communications that will be updated for OE 2017.
Draft Schedule Highlights

Planning for systems changes for Open Enrollment 2017 is underway, including detailed project plans for testing and batch processing. Close coordination with our vendor and agency partners positions us well for this Open Enrollment period.

- Our plan identifies specific dates for the production execution of business events
  - It addresses regulatory guidelines, business dependencies and the release schedule
  - The defined schedule allows the Health Connector to plan for member communications and operational impacts

- In addition, we are planning robust "Production-Like Testing": A comprehensive simulation of the renewals process
  - The benefits of this simulation are that testing is scaled based on the size and complexity of data and, additionally, data will come from applications and enrollments created over time
  - The scope of testing will include Preliminary Eligibility, Final Eligibility, Auto Enrollment and Renewal Invoicing
### Draft Open Enrollment 2017 Timeline

#### System Business Processes

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<th>June</th>
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- **R9 User Acceptance Testing (UAT)**
- **R9 Deployment**
- **UAT Code Drop 1**
- **UAT Code Drop 2**
- **UAT Code Drop 3**
- **PE Prod-Like Testing**
- **PE Smoke**
- **PE C1**
- **PE C2**
- **FE Prod-Like Testing**
- **FE Smoke**
- **FE C1**
- **FE C2**
- **FE C3**
- **FE Production**

#### Notices / Billing & Enrollment

- **Send PE notices**
- **Send renewal notices**
- **Window for reetermined individuals to edit app**

#### Seal of Approval / Plan Management

- **CCA review of proposed QHPs/QDPs**
- **7/14: CCA Board awards Conditional SOA**
- **7/1: State deadline for carriers to submit rates to DOI**
- **DOI Rate Review**
- **9/8: CCA Board awards Final SOA**
- **8/15: State deadline for final rates to be on file**
- **Final plan review/testing, upload of ConnectorCare plans, final rate review/testing, final service areas/zip codes testing**

#### Outreach

- **"What to Expect from OE" emails and postcards to renewing members**
- **DOR Letter**
- **OE Reminder to Eligible but Unenrolled**
- **Plan Selection and Payment Reminders**

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*DOI: Division of Insurance*
## 2016 Release Functional Scope

### Dec 2015 – Mar 2016 (3.0)

- **(HCR-46-3M)**: MH RFI Income-only expirations monthly batches

### R7.2 – Feb 2016

- Retroactive Eligibility/Override Eligibility
- Additional Advanced Program Determinations
- VLP 2/3
- Notice Improvements
- **CR-1108**: Switching De-Scoped Notices Requirements To Future Release; Deleting One Obsolete Notices Requirement
- **CR-1029**: Admin Closure Reasons
- **CR-1053**: Good cause reason code
- **CR-997**: Flag/Indicator for the Large Print & Braille Notices
- **CR-998**: Batch process change to support notices for Reasonable Accommodation functionality
- Turn DOR Interface ON
- **HCR-58**: Change text on Eligibility Screen when still eligible after timeclock expiration
- Premium Assistance Enhancements (R7.2.4)

### R8.0 – April 2016 (26.0)

- **(XXL) HCF-9**: MassHealth redeterminations
- **(L) CR-1058**: Voter Registration functionality
- **(TBD-L) HCR-47**: Full RFI ongoing expirations
- **(M) CR-1111**: Remaining disability functionality related notice
- **(TBD-M)**: Notice enhancements needed for RFI and redeterminations (including HCR-53; CR-1054; CR-1087; HCR-18)
- **(TBD-M)**: MMIS Codes Fixes – Phase 1
- **(TBD-M) HCF-26**: Auto-de-duplication of HIX applications
- **(TBD)**: New HSN Changes

### R8.1 – June 2016 (26.0)

### R9.0 – Aug 2016 (30.0)

- **(XL) TBD**: Open Enrollment 2017 Repairs
  - L Errors
  - Fixes to prevent incorrect termination of dental plans, fix how enrollment status and dates are displayed/consumed
  - Changes to CCA Renewals Process
  - Multiple Plan Effective Dates Available for Shopping
  - XMLs and Births
  - Fix to minimize Signature Page Errors
  - CR-1094: Consume BenefitEndDate for Dental Effectuation XML
- **(LL) HCF-39**: Renewal & Redetermination Validation (RRV) Batch
- **(L) HCF-18**: Application Reactivation
- **(M) HCF-11**: Address Standardization with USPS only
- **(TBD-M)**: MMIS Codes Fixes – Phase 2
- **(S) HCF-31**: Joint MH/CCA UI/UX Eligibility/Shopping overhaul
- **(S) HCF-43**: More user roles
- **(S) HCF-46**: Ability to check with carrier enrollment status on the enrollment page
- **(TBD)**: Overall SEP Redesign (CR-984; HCR-16; HCR-37; CR-1031)
- **(M) HCF-52**: MassHealth Spanish notices
- Plan Management

### R10.0 – Oct 2016 (20.0)

- **(TBD-XL)**: Streamlined renewals (SNAP and SSA interfaces)
- **(L) CR-1063**: Full Integration – Payment Portal
- **(M) ALM-5476**: Workaround: Transitional Medical Assistance
- **(TBD-M)**: MMIS Codes Fixes – Phase 3
- **(M) HCF-28**: Navigator/CAC Assister Portal
- **(TBD-L) HCF-23**: Periodic data matching—Phase 1 & Phase 2
- **(S) HCF-13**: FTR-Failure to Reconcile (scope to be decided upon completion of JAD sessions)
- **HCR-17**: SEP Redesign—Three SEP Events
- **SEP Reactivation of deceased profiles
- *HCF-13 to be confirmed once JAD sessions have been completed.*

### R11.0 – Feb 2017 (26.0)

- **(L) HCF-25**: Ability to support death/removal of HOH
- **(TBD)**: Health Safety Net Enhancements
- **(M) HCF-16**: Batch redeterminations (based on FPL/COLA adjustments)
- **(M) HCF-54**: 65 age cut (Medicaid and OHP populations - separate logic for each)
- **(M) HCF-56**: MassHealth MCO shopping
- **(M) HCF-36**: Full ESI functionality
- **(M) ALM-4567**: Retro Enrollment || Unable to Retro back the Plan start date to original plan effective start Date for Head of Household and entire family.
- **(M) HCF-55**: Medically frail indicator functionality
- **(S) CR-1095**: Add two new requirements for catastrophic eligibility.
- **(S) CR-1105**: Death of a subscriber with dependents
- **(XS) HCF-14**: Language permitting CCA to use IRS data for up to 5 years
- **(M) HCF-35**: Send data interface from HIX to MMIS (include CR-1112)
Business Events: Key Takeaways

• **Eligibility Redetermination**: All households with at least one QHP eligible member who is enrolled or who continues to be eligible for MassHealth or Health Connector coverage will have their eligibility redetermined for 2017.

• **Notices**: All QHP enrollees who applied for financial assistance, including those in mixed households, will receive a preliminary eligibility notice that includes the 2017 Federal Poverty Level of Health Connector members in the household.

• Health Connector-only households will be given 30 days, and mixed households 45 days, to review their application and make any changes before their renewal eligibility is finalized.

• MassHealth members who are sent a pre-populated form will be required to return to MassHealth to provide updated information (or else risk downgrade or loss of coverage) online, by phone or by paper.

• **Eligibility** will be finalized in batches or when an application is submitted during the review process.

• **Notices** will be sent to all households with at least one QHP enrolled member who continues to be eligible for a QHP in 2017, and will include pertinent information such as eligibility for the renewal year, renewal plan and rate, and APTC amount (for both QHP and QDP).

• All QHP enrollees who continue to be eligible for QHP renewal and who have not actively shopped for a new plan for January 1st will be mapped into a plan according to the following hierarchy: same plan → same carrier → lowest cost plan in same benefit level (QHP and QDP).

• Members remaining in the same carrier do not need to submit an initial payment to secure their January effectuation; they just need to keep paying the bill they receive in the mail each month for their next month’s coverage, which will likely be a different premium amount for 2017.

• Members changing carriers need to submit an initial payment to secure their enrollment for January.