



# Health Connector Strategic Plan: 2020-2022

Roadmap for Initial Implementation Steps in 2020

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# Overview & Background

**The Health Connector recently finalized its strategic plan for 2020-2022, which has been posted and shared with stakeholders. Today, we will apprise the Board of Directors as to its plan for implementation.**

- Last winter, the Health Connector began a process of collecting input to help inform the development of a strategic plan – a process that included:
  - Discussions with its Board of Directors
  - Analysis of member experience data and perspectives
  - Solicitation of stakeholder feedback
  - Evaluation of the health policy and market landscape (state and federal)
  - Lessons and opportunities evident as the Health Connector approaches its 14<sup>th</sup> year of serving as a state-based health insurance marketplace
- Today, we will apprise the Board on our general implementation approach and how we plan to measure progress towards the strategic plan's goals
  - First we would like to apprise the Board of key findings from a recently-fielded member experience survey that is germane to the Health Connector's strategic plan goals
  - We will also make a few 'closer look' stops on key projects and investments we are undertaking in pursuit of the strategic plan's goals

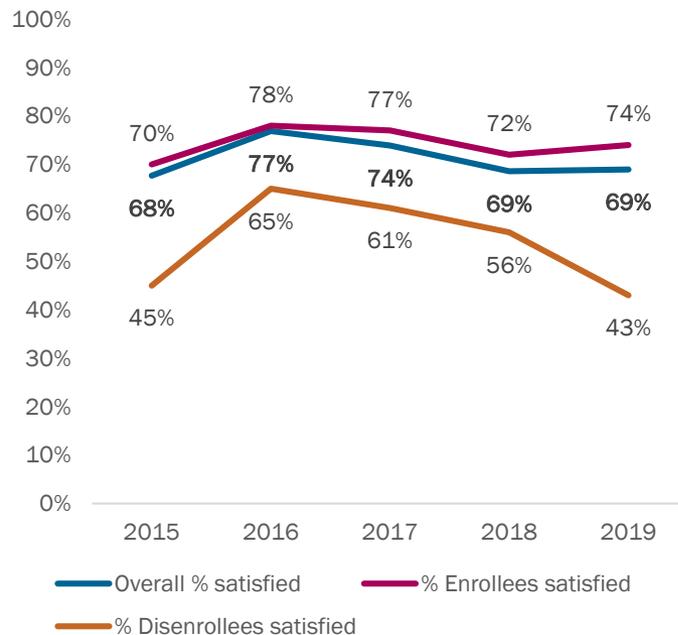


# **2019 Member Experience Survey Results**

# 2019 Member Experience Survey Results

In September, the Health Connector conducted a customer experience survey of 560 current and former members. Overall satisfaction was steady at 69%, was influenced by low rates of satisfaction from former members, and reveals key areas requiring focused attention.

Satisfaction Among Enrollees, Disenrollees, and Overall, 2015-2019



- Statistically, overall satisfaction in 2019 is not significantly different from any other year, but satisfaction among former members is significantly lower
- Good customer service continues to be the leading positive experience for members
- Top 3 areas of concern surfaced:
  1. **WEBSITE AND NOTICES:** Confusion about how to navigate the website and about noticing volume and content remain areas of frustration
  2. **COST:** Affordability and issues with deferred care due to cost are growing challenges reported by members
  3. **LOSING MEMBERS TO UNINSURANCE:** A growing percent of former members report now being uninsured

Some of the challenges members report in the 2019 member experience survey are areas that lend themselves to progress through CCA's strategic plan goals.

# Area for Improvement: Member Correspondence

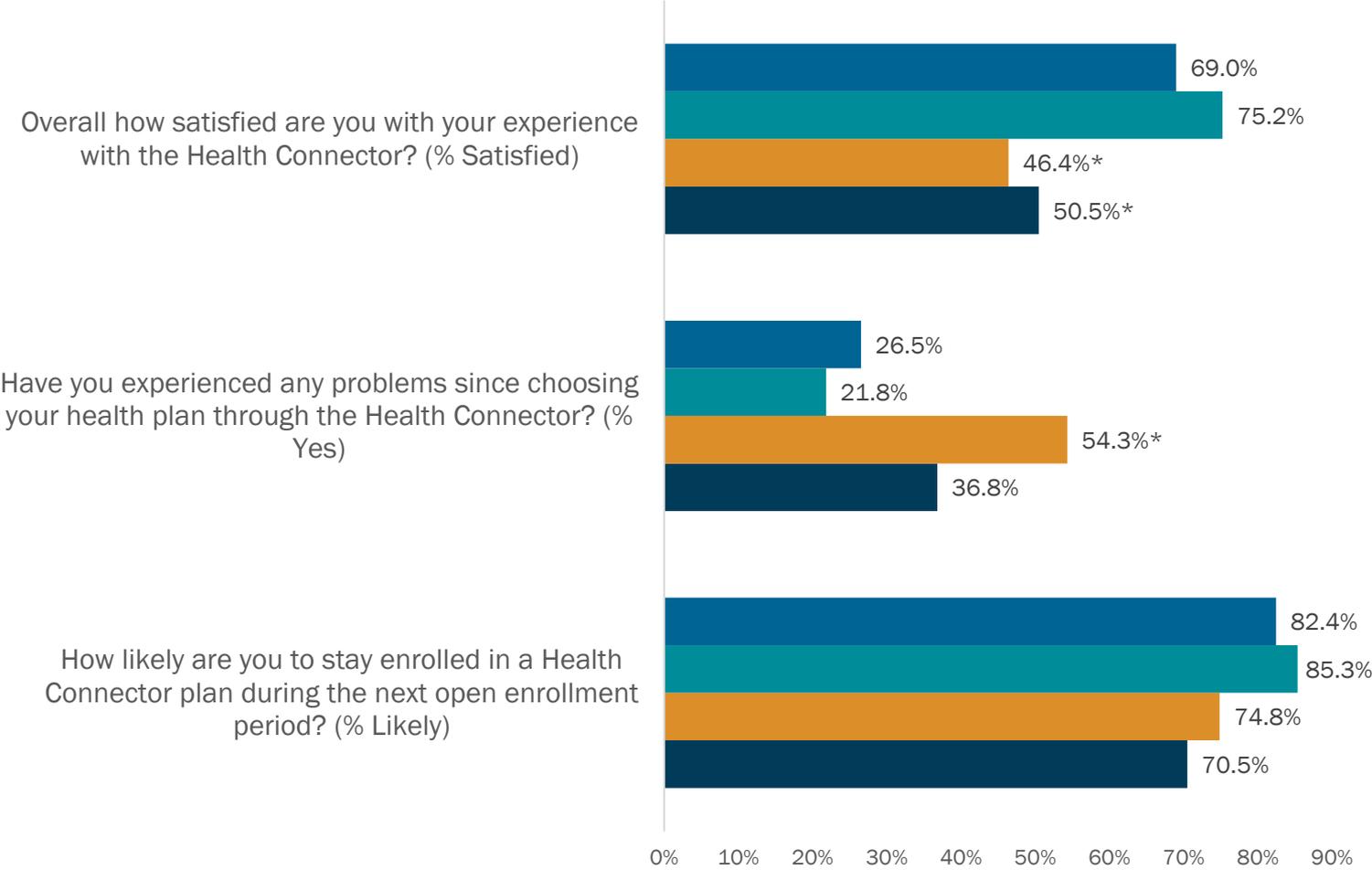
Be clearer in your communications. I filled out information online to update you about a change in income. I also uploaded the proof of income that was requested. I then received a letter in the mail saying the information I provided was not acceptable, but you failed to tell me which of the documents was not acceptable, or why. I had to call to find out. It turns out that there was no problem with the two docs I submitted (proof of work income), but you also wanted proof of investment income. That's fine, but why didn't you just tell me that in the letter? Why did I have to spend 15 minutes on the phone with a customer service person to find this out? This is wasteful of my time and Health Connector resources. 2. Stop sending so many copies of letters. In response to my income update, I must have received about 12 different letters, between me and my wife, telling me that we are ineligible .... That's fine, but why send so many letters? Can't you just send one letter?

Improve the website and communication. Sometimes I get multiple letters from HC sent to me the same day, but saying completely contradictory things. For example, one saying I have been approved and qualify for coverage assistance, and the other saying the complete opposite. So I'm confused as to which of the two I should believe.

Don't send conflicting mailings to customers. ...somehow my husband wound up denied health insurance in error and the response I was given was to just "ignore" that piece of information. Hope that was the right guidance...

# Non-ConnectorCare Members Less Satisfied

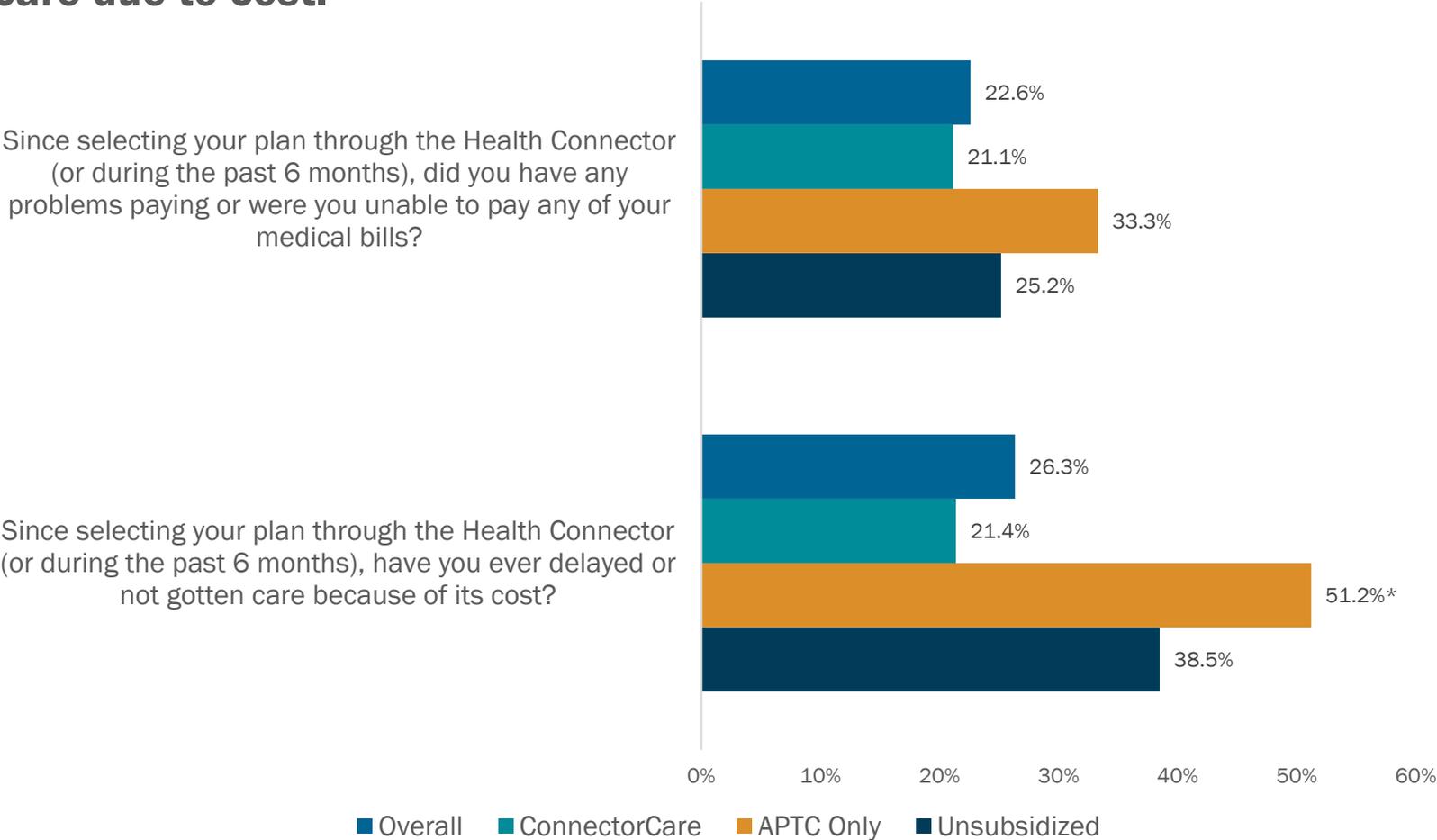
Unsubsidized and APTC-only members are significantly less satisfied than ConnectorCare members, similar to last year.



\*Significantly different from Overall

# Non-ConnectorCare Members' Challenges Related to Cost

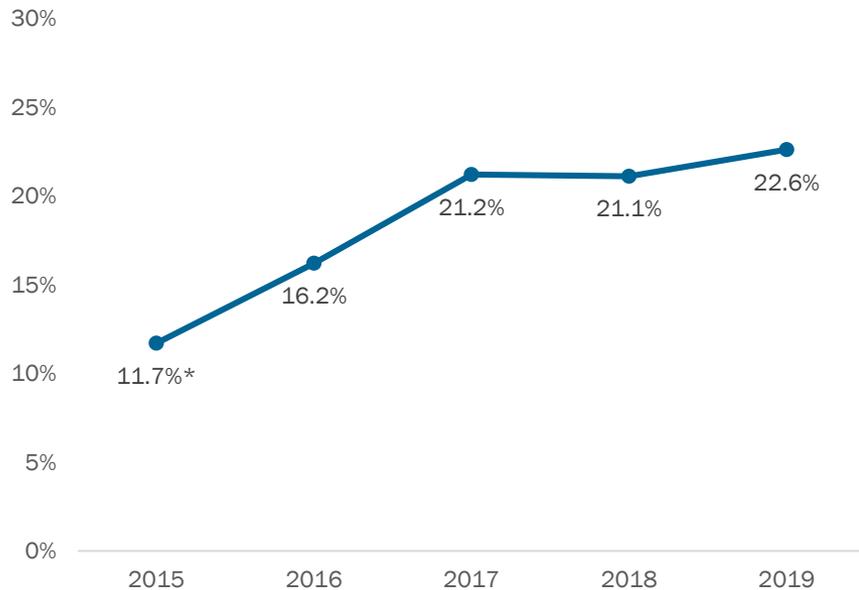
**APTC-only (and former members) in particular report facing barriers to care due to cost.**



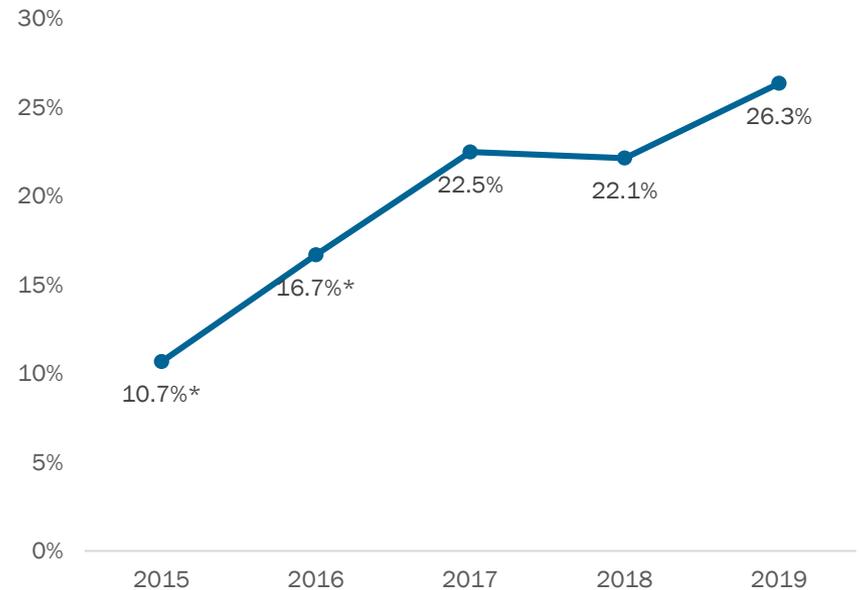
\*Significantly different from Overall

# Health Connector Members' Cost Barriers Have Been Rising

Since selecting your plan through the Health Connector (or during the past 6 months), did you have any *problems paying or were you unable to pay any of your medical bills?* (% Yes)



Since selecting your plan through the Health Connector (or during the past 6 months), have you ever *delayed or not gotten care because of its cost?* (% Yes)



Note: Data indicates that ConnectorCare enrollees (whose cost sharing is significantly subsidized) also report problems affording medical bills.

# Deferred Care Due to Cost

- Dental care** continues to be the predominant type of care members forgo due to cost, followed by **prescription drugs, diagnostic tests, and mental health care.**
- Although most categories reflect an increase in reporting over 2018, these changes are not significant and do not necessarily indicate an increase in the deferral of those types of care

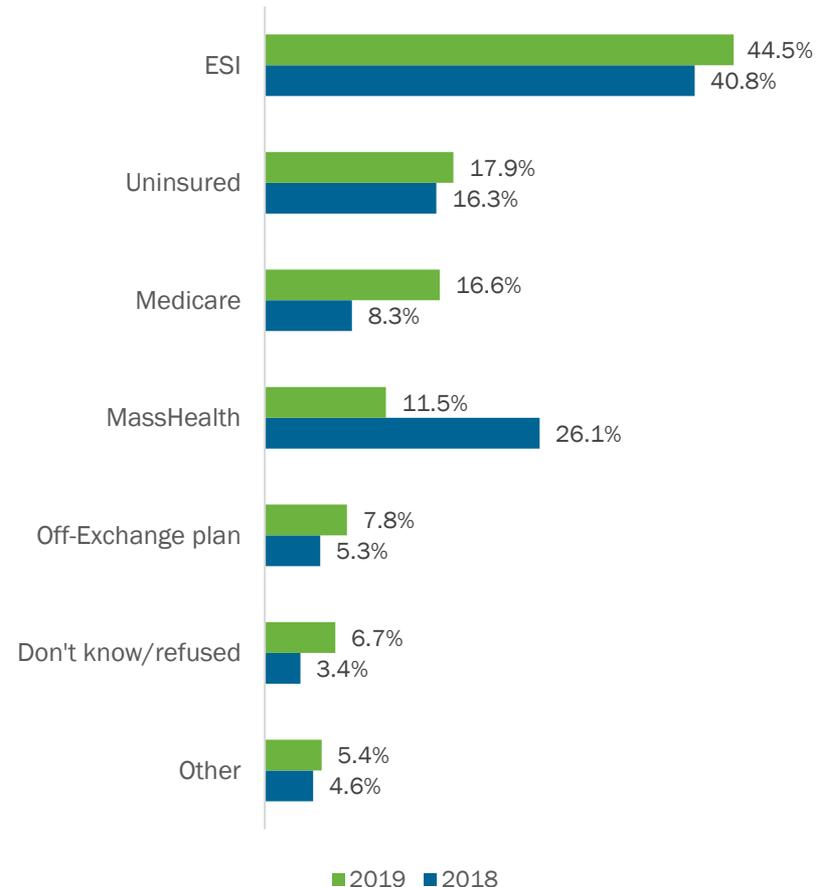
Type of Care Deferred	2019	2018	
Dental care including teeth cleaning and checkups*	64%	62%	Not Covered in Adult CCA Health Plans
Prescription drugs	32%	22%	Covered in CCA Health Plans
Diagnostic test (e.g. MRI, lab work, or x-ray)	30%	19%	
Mental health care or counseling	28%	19%	
Routine or preventive medical care (checkup, physical, well baby visit)	27%	18%	
Medical care for an illness or condition (flu, asthma)	24%	21%	
Medical care for an injury, accident or poisoning	14%	7%	
Rehabilitation services (physical or speech therapy)	13%	10%	
Emergency room care	13%	14%	
Outpatient care or outpatient surgery	7%	9%	
Surgery	7%	5%	
Hospital stay	4%	-	
Drug or alcohol use treatment or counseling	1%	-	
Vision care	1%	-	
Some other type of care	2%	-	
Unsure	4%	8%	

\*Note: Health Connector medical plans do not include adult dental coverage (though separate dental plans can be purchased through the Health Connector).

# Former Members' Current Sources of Coverage

- The number of members who shifted to MassHealth after disenrolling was down, while movement to Medicare was up.
- The number of former members reporting that they are now uninsured has risen.

Source of Coverage for Disenrollees, 2018 and 2019





**Overview of Strategic Plan:  
2020-2022**

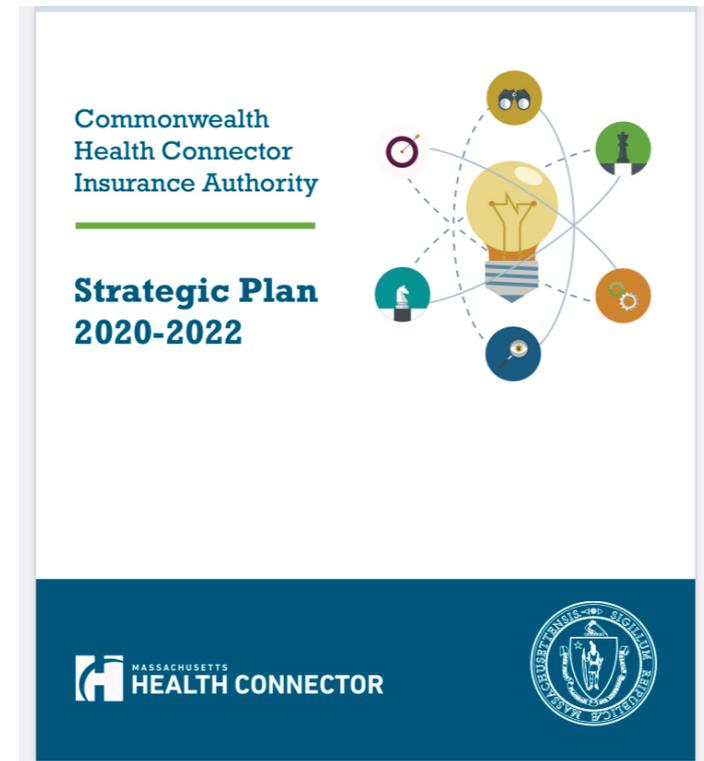
# Overview of Strategic Plan as a Whole

**The Health Connector's Strategic Plan for the upcoming period between 2020-2022 covers five key areas of focus.**

1. Strengthen the ConnectorCare program
2. Improve coverage and experience for our unsubsidized and APTC-only members
3. Improve our overall member experience
4. Better serve the small group market in Massachusetts
5. Cover the remaining uninsured

**Many of the goals articulated in the strategic plan speak to the challenges reported by our members.**

Plan available at: <https://www.mahealthconnector.org/wp-content/uploads/MA-Health-Connector-Strategic-Plan-2020-2022.pdf>



# (1) Strengthening ConnectorCare

## GOALS

- Provide members with affordable premiums and choice of carriers across the state
- Ensure members can easily access the health care they need
- Maximize stability and predictability in the design and financing of the program
- Simplify the member journey as much as possible

## FIRST STEPS

- **For staff development during 2020:**
  1. Network access study: Evaluation of the status of network adequacy in the ConnectorCare program, enhancing CCA's line of sight into any emerging challenges and to determine whether there are changes CCA should make to its approach to network standards for ConnectorCare
  2. Access to medical advances with programmatic implications study: Proactive evaluation of forthcoming medical advances (via engagement with carrier CMOs, assistance from outside experts, etc.) that will affect access/site-of-care and cost dynamics that may require reaction from state programs like ConnectorCare
  3. Development of member profiles and enhanced use of member perspectives: See slide 18
- **#1 and #2 baseline analyses will be shared with Board for discussion, and any resulting program adaptations can be incorporated into 2022 Seal of Approval strategy. The Board will also receive #3, which can be used to support Board discussions and decision-making.**

## (2) Improving the Experience of Unsubsidized Nongroup Members

### GOALS

- Ensure access to the full Massachusetts health insurance market and ensure availability of affordable plan options
- Expand and leverage scale of Health Connector unsubsidized non-group membership in the broader insurance market
- Offer tools that help members make informed choices about their coverage

### FIRST STEPS

#### For staff development during 2020:

1. Study off-exchange non-group purchasers via focus groups by Q2 of 2020 and synthesize other existing research and understandings
2. Compile array of research and understandings about unsubsidized shoppers and their preferred number of plan choices – *underway*

Items will be used to inform 2021 decision-making regarding decision support, customer service enhancements and directions, as well as 2022 Seal of Approval strategy

# (3) Better Serving the Small Group Market in Massachusetts

## GOALS

- Make it easier for groups to shop and enroll through Health Connector for Business (HCB)
- Drive down average premium costs for small businesses through on-Exchange competition and choice models
- Work with other agencies and small business community on policies and efforts to ensure stability and affordability of small group insurance market
- Bring new groups into the merged market that have not offered group coverage before

## FIRST STEPS

For staff development during 2020:

1. Start to conduct member experience surveys on HCB in the same fashion as the Health Connector's analogous research on its nongroup membership
2. Conduct an evaluation of other states' small group markets/on-Exchange SHOPS to understand impacts of particular market structures and market advantages
3. Launch anonymous browse tool so small employers can see value proposition of comparison shopping without creating an account first – *DONE as of 11/26/2019*
4. Participate in Governor's Merged Market Advisory Council to understand and respond to the affordability and stability dynamics in the merged market

Above mentioned exercises and deliverables will be used to inform program design of HCB, SOA for 2022, and any appropriate policy discussions & recommendations for the Board and others to consider for 2021.

# (4) Improving the Overall Member Experience

## GOALS

- Conduct a stable transition to new customer service vendors
- Design our web experience to be on par with other Marketplaces and e-commerce sites
- Look for ways to change policies, systems, and operations in ways that can improve the user experience for our diverse membership
- Explore ways to provide more in-person access in our communities
- Take a holistic approach to making notice improvements

## FIRST STEPS

For implementation and staff development during 2020:

1. Successful cut-over to new CXP vendors on June 1, 2020 - *underway*
2. Development of research-driven “member profiles” or “personas” (see next page for additional detail) – *underway*
3. Study and inventory needed changes to member noticing (FY 2021)
4. Study member transitions and avoidable coverage disruptions that could be mitigated or prevented by CCA business practices (FY 2021)
5. Create holistic plan for decision support and user interface/user experience (UI/UX) improvements - (TBD)

Above deliverables will be used to make recommendations for program and policy changes to be pursued in 2021 where possible.



## (4) Member Experience: Closer Look at Health Connector Member Profiles, or “Personas”

- Throughout the course of CCA’s strategic planning effort, a pervasive focus emerged: the need to be more member-focused in all of CCA’s policy, program, and business decisions
- To help better understand our members and to use evidence-based representative examples of them as an input in all critical decision-making, CCA is commissioning the development of member profiles or “personas”
- CCA is working with Northampton-based Communicate Health on this project and held a kick off in early December and work is underway

### What are “personas”?

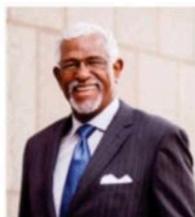
- Personas are a fictional archetype of a set of people who use your products or services. They are based on realistic, research driven descriptions of a typical user of a product or service
- Details about the personas’ needs, concerns and goals, as well as their background information help teams create a common, more targeted vocabulary describing a certain type of user
- These attributes, desires, and behaviors associated with personas help focus team efforts around a common goals
- Research-based personas create value for making design and user experience strategy decisions by better determining which features and functions to implement and prioritize

**The Health Connector plans to use the developed profiles to make more member-focused decisions about program design, communications, customer service, and business operations going forward.**

# (4) Member Experience: Closer Look at Member Personas Work (Cont'd)

Below are examples of personas work that Communicate Health developed for the Medicare program.

## Personas



Fred, the Analyst 

“ I feel pretty prepared – I’ve done a lot of research. I went on Medicare.gov to compare the carriers in my area. Now I’m doing side-by-side comparisons of a few options I’m seriously considering, but I’ll keep looking until I need to make my final selection.”

### Characteristics and attributes

Fiscally responsible, driven by data, meticulously organized, rooted in home town



Candice, the Disorganized Contemplator 

“ Medicare makes me feel depressed. There’s no way I can afford it. I don’t even know how I live on Social Security, let alone have Medicare taken out! **When I try to figure it out, I feel lost**, like it’s way too complicated. I’m not stupid – **I just get overwhelmed and give up.**”

### Characteristics and attributes

Close with her neighbors, disorganized, anxious about her future finances, skeptical of government programs



Maxine, the Seeker 

“ I don’t feel like this process is easy. To me, it’s like speaking another language. **I’ve watched all the videos and I’m still struggling!** I don’t understand it yet, but I know I have more research to do.”

### Characteristics and attributes

Driven by keeping her current doctors, organized, has family all over the country and travels often to see grandchildren, has a sense of adventure but doesn’t like to take big risks



Ralph, the Avider 

“ I put off learning about Medicare. **My wife kept complaining – she says if something happens we would be devastated.** I said, “My health is outstanding! Don’t bet on the insurance company, bet on me!”

### Characteristics and attributes

Prefers routines, stubborn, hard worker, sense of humor, fearless



# (5) Covering the Remaining Uninsured

Covering the remaining uninsured and preventing people from falling into uninsurance will require both intensifying outreach (see following slides), making more efficient use of existing administrative touchpoints with 200,000+ uninsured Massachusetts residents, and “looking within” to ensure CCA practices do not inadvertently result in uninsurance for former members.

## GOALS

- Explore new opportunities for outreach with the uninsured
- Find ways to avoid unnecessary disruptions to our members’ coverage
- Identify ways to better use the individual mandate for increasing coverage levels
- Navigate federal policy changes with an eye on maintaining coverage levels

## FIRST STEPS

Starting in 2020, the Health Connector will evaluate:

1. Increased mailings to Massachusetts residents that file on their state tax returns that they are uninsured from 1x/year to 2x/year
2. Explore opportunities that could allow the Health Connector to directly outreach to the uninsured using state individual mandate data
3. Begin exploring streamlined enrollment for individuals eligible for zero-dollar coverage and/or proactive personalized enrollment assistance
4. Establish outreach capability to focus on direct assistance for uninsured
5. Business, policy, or program changes the Health Connector could make to prevent members from falling out of CCA coverage into uninsurance
6. Increased funding for Navigator program for FY21-22 by \$500K to increase program capacity (adding 1-2 Navigators and increasing funding for Boston, Southcoast, Cape, and Western organizations between 25-50%, and select increases for other Navigators). Total Navigator spending would then be ~\$2.15M/year





## **(5) Covering the Remaining Uninsured: Closer Look at Navigator Program Overview and Goals**

The Health Connector's Navigator program facilitates access to affordable, quality health insurance coverage options using culturally and linguistically appropriate methods for eligible Massachusetts residents.

The Navigator program is an outreach, education, and enrollment assistance program required for all Health Insurance Marketplaces by the Affordable Care Act (ACA). The program has three key goals:

1. Provide outreach to uninsured residents,
2. Provide in-person assistance to those currently enrolled in coverage, and
3. Raise awareness of the availability of health insurance and subsidized plans through the Health Connector

The Health Connector's customer experience survey data suggests a strong demand for Navigators among enrollees.

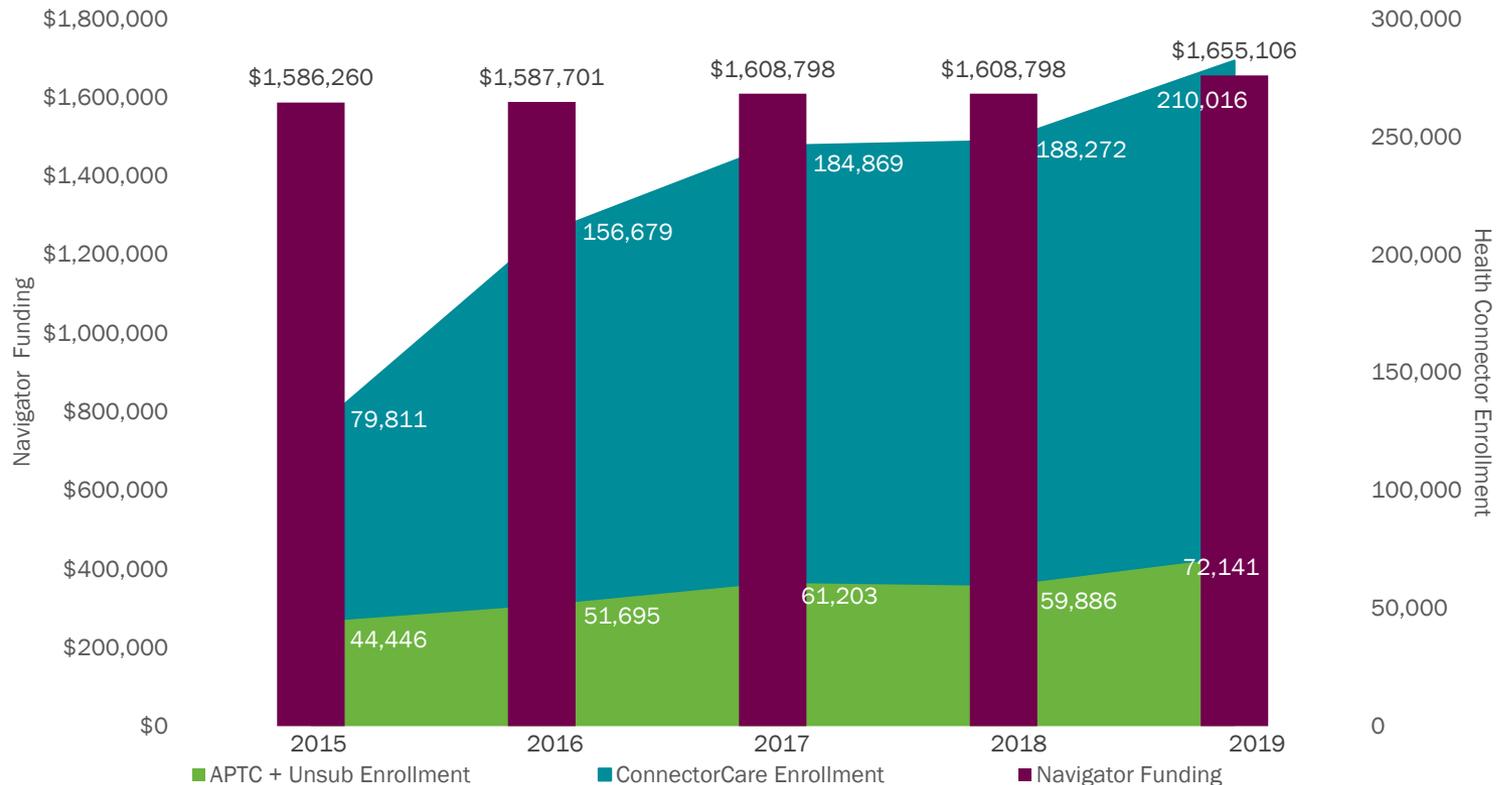
- Nearly one-third of both 2017 and 2018 survey respondents indicating that they would like free, in-person help to pick a plan that best fits their preferences and needs
- In 2018, nearly three-fourths (73%) of those receiving assistance from a community group, Navigator, provider or assister were satisfied with the experience

**“No Wrong Door” Policy in Practice: Navigators are trained to assist with the application and enrollment of all individuals and families seeking coverage.**



## (5) Covering the Remaining Uninsured: Closer Look at Navigator Funding and Enrollment 2015-2019

Navigator funding has remained stable with 4.3 percent growth in four years, while membership has grown 66.6 percent over that same time.





## **(5) Covering the Remaining Uninsured: Closer Look at Plan to Enhance Navigator Program for FY21-FY22 Cycle**

**This spring, the Navigator program will release an RFP for the Navigator program for the FY21-FY22 grant cycle, presenting an opportunity to leverage the program to help achieve the Health Connector’s strategic goal of reaching uninsured residents and preventing coverage losses.**

- Near-level funding with rapid enrollment growth limits the grantees’ ability to effectively fulfill all of the program goals (increase awareness, reach the uninsured, support current members)
  - Several organizations have directly voiced this concern and have been struggling to meet demand. This concern is especially pronounced in the Cape, SouthCoast, and Western regions of the state—all areas with higher-than-average rates of uninsurance
  - Navigators book out appointments well into Open Enrollment and are having a more difficult time assisting everyone that comes to them during the busy OE season
  - New federal policies have increased the demand, with confusing policies like the effective repeal of the individual mandate, public charge, and the rise of “gray market” plans
- On average, State-Based Marketplaces spend \$13.37/uninsured person on their Navigator programs. The Health Connector spends \$4.63
- Additionally, there are several geographic areas of the state that are in need of additional Navigator support:
  - Lowell, the fourth-largest city in Massachusetts, does not have a Navigator presence
  - Recent data from the BCBSMA Foundation’s *The Geography of Uninsurance* report suggests that many Boston zip codes are hot spots for uninsured residents. However, the program’s Boston investment is lagging behind the need to serve more residents in the state’s largest city



# **Tools for Progress & Measurement**

# Internal Process for Implementing and Measuring Strategic Plan Goals

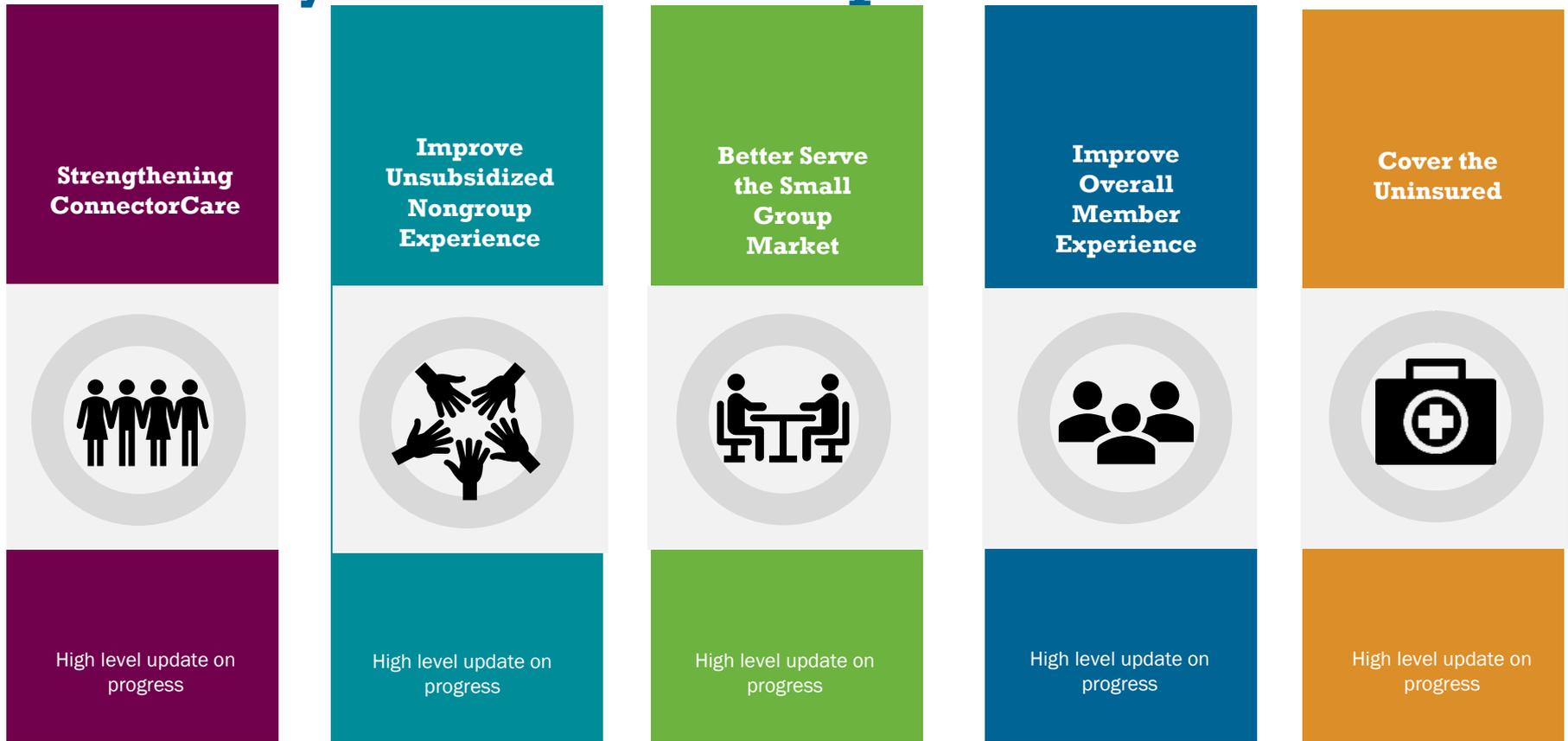
- Monthly senior staff meetings dedicated to strategic plan projects
- Staff owners for specific action areas assigned
- Incorporation of strategic plan into staff goal development and performance evaluations, and agency-wide staff meeting agendas
- Project planning will incorporate re-assessment, identification of risks/needs as they develop

# Apprising the Board and the Public on Strategic Plan Implementation Progress

**Health Connector staff are committed to ensuring its Board, its members, and the public have a clear line of sight into the agency's goals and its progress towards achieving those goals.**

- Plan to report to Board each December at annual strategically focused meeting
- Also plan to issue mid-year dashboard reports to Board with evaluative updates on progress, challenges, and relevant developments
- CCA will also report on its progress towards strategic goals in its annual report to the General Court, which is typically submitted in the last quarter of the calendar year

# CCA 2020-2022 Strategic Plan: Primary Dashboard Template



Beyond primary dashboard, staff will also present more detailed inventory of work underway, including milestones, challenges, and relevant learnings and decisions.

# Wrapping Up and Looking Ahead

- Staff look forward to commencing implementation of the Health Connector's 2020-2022 strategic plan
- We will keep the Board apprised of progress and challenges
- We welcome any and all input now and along the implementation path ahead