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MARYLAND HEALTH BENEFIT EXCHANGE

September 2, 2015

The Honorable Edward J. Kasemeyer
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Building
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chair
House Appropriations Committee
121 House Office Building
Annapolis, MD 21401-1991

RE: 2015 Joint Chairmen's Report, Page 25, D78Y01.01 Maryland Health Benefit Exchange -- Report on Connector Entities

Dear Chair Kasemeyer and Chair McIntosh:

Pursuant to page 25 of the Joint Chairmen's Report of 2015, the Maryland Health Benefit Exchange (the Exchange) regarding the Report on Connector Entities, with a due date of October 1, 2015, we respectfully request an extension. Our anticipated submission date is February 12, 2016.

As Executive Director of the Exchange, I have approved this request.

We request this extension so that we might have sufficient time to receive and analyze public comment regarding the Connector Entity Program.

We are currently in the process of conducting a Request for Information (RFI), or public survey, about the Connector Entity Program. The feedback that we will receive from consumers, stakeholders and other members of the public is critically important for development of an up-to-date, comprehensive Connector Entity report to the JCR.

The survey was issued on August 18, 2015, and will close on September 8, 2015. Results from the survey will be compiled and analyzed, and will then be used to develop an updated program design. The Exchange will then issue a Request for Proposals (RFP) for the Connector Entity Program based on the updated program design. The Exchange anticipates that the process of conducting a survey, analyzing results, program design, RFP development, legal review, and approval by the Exchange's Board of Trustees will require approximately 16 weeks.

Thank you for your consideration.

Sincerely,

Carolyn Quattrocki

Executive Director

CC: Cathy Kramer, Department of Legislative Services
Simon Powell, Department of Legislative Services
Jordan More, Department of Legislative Services
Sarah Rice, Assistant Attorney General, Maryland Health Benefit Exchange

MARYLAND HEALTH BENEFIT EXCHANGE

December 11, 2015

The Honorable Edward J. Kasemeyer
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Building
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chair
House Appropriations Committee
121 House Office Building
Annapolis, MD 21401-1991

RE: JCR 2015 (D78Y01.01) – Maryland Health Benefit Exchange, Connector Entities

Dear Chairman Kasemeyer and Chairwoman McIntosh:

Pursuant to page 25 of the Joint Chairmen's Report for the 2015 Session, the Maryland Health Benefit Exchange (MHBE) respectfully submits this narrative report on the Connector Entity program. Specifically, the JCR required the MHBE to report on the role of, and expectations for, connector entities in shaping enrollment, and how the role of connector entities is expected to evolve in coming years.

Should you need more information or have any questions regarding this report, please do not hesitate to contact Michele Eberle, Chief Operating Officer, at (410) 547-1278 or michele.eberle@maryland.gov.

Sincerely,

Carolyn Quattrocki
Executive Director

Enclosure

c: Michele Eberle, Maryland Health Benefit Exchange
Cathy Kramer, Maryland Library and Information Services (Electronic)
Sarah Albert, DLS Library and Information Services (Electronic and Hand-Delivery)

The Connector Entity Program in Maryland
Evolving Roles and Expectations

A Narrative in response to the Joint Chairmen's Report

on the Fiscal 2016 State Budget

Submitted by

The Maryland Health Benefit Exchange

December 15, 2015

Restatement of the Information Request: *D78Y01.01 Maryland Health Benefit Exchange (MHBE) Budget Amendments. The committees request the Maryland Health Benefit Exchange (MHBE) to report on the role of, and expectations for, connector entities in shaping enrollment, which has been lower than expected. Specifically, MHBE should report on how the role of connector entities is expected to evolve as MHBE has now completed its second open enrollment period. Original due date October 1, 2015; extension due date December 15, 2015.*

I. Introduction and Background

The federal Patient Protection and Affordable Care Act (PPACA or ACA) signed into law in March 2010 was intended, among other things, to expand the availability and affordability of health care coverage with the overall goal of reducing the number of uninsured people nationally. The ACA mandated that a health insurance exchange be made available in all states, and the Maryland Health Benefit Exchange Act of 2011[1] established the Maryland Health Benefit Exchange (MHBE) as Maryland's state-based health insurance marketplace. In coordination with the Department of Health and Mental Hygiene, the Department of Human Resources, and the Maryland Insurance Administration, MHBE's mission is to reduce the number of Maryland residents who have no health insurance. MHBE's consumer portal, created thereafter and known as Maryland Health Connection (MHC), provides a marketplace for individuals, families, and small businesses to apply for insurance affordability programs and enroll in health care coverage.

The original Exchange System, which was to become available at the launch of the first open enrollment period on October 1, 2013, failed and had to be replaced. The replacement system was implemented in time for the second open enrollment period, which began November 15, 2014 and ended February 15, 2015 (with a one-time tax season extension until April 30, 2015). At the time of this writing, the third open enrollment period is underway, having begun November 1, 2015, and scheduled to conclude January 31, 2016, for 2016 coverage. Despite the failure of the first system, MHC was able to enroll 81,000 Maryland residents into Qualified Health Plan (QHP) coverage. During year two, which was the first open enrollment period with a functioning system, MHC enrolled 122,000 residents into QHPs. Although enrollment in health care coverage through the exchange was lower than expected the first year, the rate of uninsured in Maryland dropped from roughly 15% to 7.9% after the first open enrollment, and to an estimated 5% after the second open enrollment period. This drop in the State's rate of uninsured is due to both QHP enrollments and the more than 200,000 new enrollees who have been added to state Medicaid plans since January 1, 2014, as a result of Medicaid expansion.

All health insurance marketplaces must offer their consumers multiple pathways for application and enrollment including through an on-line website, by telephone, by paper application, or with in-person assistance.[2] MHBE's in-person assistance is provided through its Connector Entity program, which employs certified navigators and assisters to perform education, outreach, and eligibility and enrollment assistance. In addition, in-person assistance with Medicaid applications continues to be provided by agency caseworkers at local Departments of Social Services and County health departments, although

[1] Full implementation of the ACA and the benefits of health care reform were provided in a series of Bills passed by the Maryland General Assembly over a three year period – the Maryland Health Benefit Exchange Act of 2011, the Maryland Health Benefit Exchange Act of 2012, and the Maryland Health Progress Act of 2013. The Act of 2012 more specifically addressed the parameters and requirement of the Navigator program.

[2] 45 CFR 155.405(c)(2).

the degree to which this assistance is available at local DSS offices varies somewhat from jurisdiction to jurisdiction. In-person assistance with QHP applications and enrollment may also be provided by licensed and authorized producers; in-person assistance with all insurance affordability program applications and QHP enrollment may be provided by consumer application counselors working for an Application Counselor Sponsoring Entity. Of all consumer assistance workers, only Navigators have the additional role of community outreach and education mandated by the ACA.

II. Overview of Maryland's Navigator Program

MHBE realized early on that the success of MHC depended on reaching thousands of previously uninsured Marylanders.[3] Navigators are the individuals defined by the ACA which are required to provide information and assistance about insurance affordability and enrollment in the marketplaces. The ACA requires Exchanges to develop Navigator programs and fund them through grants, and offers a broad outline of the funding requirements, eligibility criteria, duties, and standards, while still leaving states significant flexibility in designing their own programs.[4] MHBE, in consultation with the Maryland Insurance Administration (MIA) and stakeholder groups, developed the Maryland Connector Program, which is organized geographically (see Figure A) to provide outreach and enrollment services by region employing both certified Navigators and non-certified staff.[5] MHBE encourages organizations within each region to collaborate to provide a coordinated network of services. All organizations that partner with the prime connector entity are subject to the same grant agreement terms and conditions as the connector entity and are subject to regulatory oversight by the MIA. MIA oversight includes training, testing, and certification standards for individual Navigators employed by the Connector Entities.

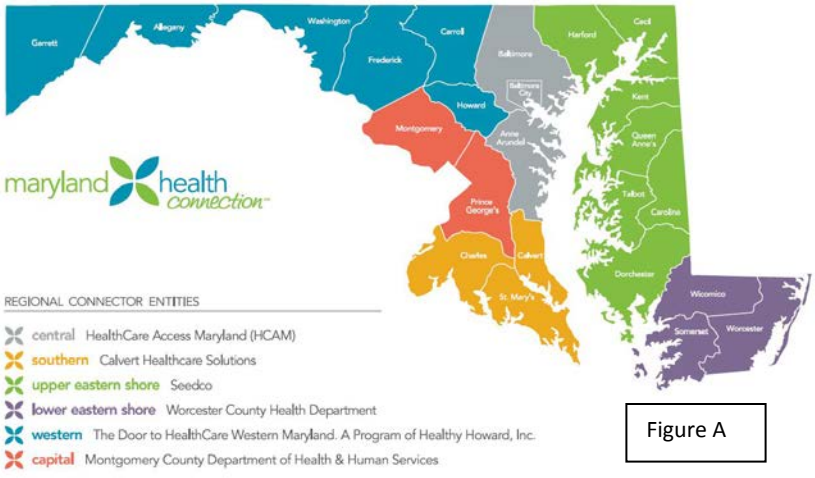

Figure A

[3] Recommendations for a Successful Maryland Health Benefit Exchange, 12/23/11; *http://dlslibrary.state.md.us/publications/mhbe/hb166ch2(5)_2011.pdf*

[4] 45 CFR 155.210

[5] Non-certified staff or "Assisters" were heavily utilized in year one, less so in year two, and still less in year three. This shift was due in part to separate funding through Federal start-up funds, and in part because they are unable (by statute) to complete QHP enrollments. This meant that QHP eligible households, or split eligibility households, had to make an additional appointment with a Navigator to complete enrollment instead of being able to complete their enrollment with one person during one appointment. Although their role in enrollment assistance was more limited, Assisters made vital contributions to overall outreach efforts in their regions.

The goal of the connector program was to provide effective, local outreach and enrollment services to individuals who did not have insurance and who would be more inclined to receive information from trusted messengers and seek assistance within their own community. The intent of the regional approach was to ensure all populations were being appropriately served. Although a single connector or "prime" entity was made responsible for contracting with MHBE, it was expected and encouraged that the prime awardee would partner with other organizations in the region best situated to meet the needs of the entire region, particularly for vulnerable and hard-to-reach populations. The connector entity is responsible for organizing all partners and services across the region and provides a single point of responsibility for engagement with the MHBE and the MIA. Using appropriate staff, the connector program helps consumers learn about, apply for, and enroll in an appropriate health insurance product, including Medicaid, the Maryland Children's Health Program (MCHP), and subsidized and non-subsidized qualified health plans (QHPs).

Navigators are tasked with the following functions:

- Conduct public education
- Distribute fair, accurate, and impartial information about enrollment into health plans and the availability of tax credits
- Facilitate enrollment in health plans
- Provide referrals to applicable agencies for enrollees with grievances, complaints, or questions
- Provide information in a culturally and linguistically appropriate manner
- Maintain expertise in eligibility, enrollment, and specifications for insurance affordability programs including financial assistance for QHPs and Medicaid programs

While the Connector program is available to serve all individuals, it must target vulnerable and hard to reach populations including consumers with limited English proficiency, those with limited education, individuals who live in especially remote or rural areas, and older (non-Medicare) adults, as these groups are less likely to apply on line without assistance. Older consumers between the ages of 55-64 are especially high utilizers of the Exchange, representing 20,000 QHP enrollments in 2014 and over 30,000 QHP enrollments in 2015, or approximately 25% of QHP enrollments in each year.

Connector Entities deployed 202 Navigators during the first open enrollment period and 268 during the second open enrollment period; currently 164 Navigators are certified to assist Maryland residents with health care applications and enrollment. From October 1, 2014 to September 30, 2015, Connector staff visited with more than 140,000 consumers, and assisted with over 80,000 applications, as detailed in the chart below.

Oct. 1, 2014 to Sept. 30, 2015	Capital Region	Central	Western	Southern	Upper Shore	Lower Shore	**Total**
Consumer encounters with Connector staff	50,363	32,048	32,443	5,896	10,985	8,837	**140,572**
Encounters where an application was started	45,175	28,269	16,020	5,234	10,456	5,441	**110,595**
Encounters where an application was completed / eligibility determined	20,254	25,759	15,387	5,132	9,779	5,016	**81,327**

Encounters where an individual chose a QHP (could include those who started elsewhere)	7,080	9,318	4,609	1,485	3,167	914	**26,573**
Encounters where an individual completed an application and qualified for Medicaid	18,249	15,209	10,288	3,118	6,188	3,385	**56,437**

Over 6,000 consumer surveys completed during the same period reflect consumers "strongly agree" with questions about satisfaction with in-person assistance provided by Connector Entity staff (5,993), with another 139 consumers expressing "moderate" agreement. (Two consumers reported a neutral experience, and only nine consumers found the experience unsatisfactory.)

III. Navigators as key members of the Maryland's in-person customer service team

Navigators are key members of the Exchange's customer service team, but they are not the only consumer assistance workers helping Marylanders apply for coverage and enroll in the marketplace. The Exchange is required to provide a seamless entry into coverage across qualified health plans and Medicaid under the ACA's No Wrong Door policy. The ACA and accompanying regulations require eligibility determination, enrollment, and transition between programs to be seamless from the view of the consumer. The Exchange's customer service team consists of both professional and volunteer consumer assistance workers who work in concert to provide application and enrollment assistance to Maryland residents. Depending on the applicant's situation and needs, she may need assistance from more than one type of consumer assistance worker. A brief overview of the other types of consumer assistance workers puts into context the role of the Navigator program in MHBE's customer service programs.

A. Application Counselor Sponsoring Entities (ACSE)

The Application Counselor Sponsoring Entity (ACSE) program assists consumers with trained counselors who are certified by MHBE and sponsored by community-based organizations, health care providers, units of state or local government, and other entities authorized by MHBE. The program designates ACSEs who agree to employ, retain and monitor Certified Application Counselors (CACs) to help Marylanders get coverage through Maryland Health Connection. The designations cover a two-year term and may be renewed for an additional two years.

In the last year, MHBE has worked hard to increase the number of ACSEs from 29 to 53, and the number of CACs throughout Maryland has grown from 140 to 253. ACSEs and CACs have provided invaluable assistance to thousands of Marylanders seeking to enroll in health insurance. In addition, in view of MHBE's limited resources, the ACSE program is also an important component of future consumer assistance in Maryland because, while it provides training for CACs, MHBE does not provide any other financial support to the ACSEs or CACs.

Since ACSEs do not receive funding, however, dedication of CACs to Exchange enrollment is also subject to competing priorities within ACSE organizations and continued alignment of health care enrollment with each organization's primary mission. In addition, CACs assist consumers with applications and enrollment through the consumer-facing portal and are thus unable to complete applications for more

complex households or when a consumer encounters other difficulties in the enrollment process. More complex issues are handled through an internal or "worker" portal to which the CACs do not have access.

B. Authorized Producers

As of September 30, 2015, the MHBE had 1,123 Authorized Producers, or insurance brokers; 986 of these work in the individual market (the balance are SHOP-only). In the individual market, 27,555 people were enrolled in QHPs by a total of 645 producers from January 1, 2015 to September 30, 2015. Half of all producer-assisted enrollments were performed by 59 producers and one-quarter of all producer-assisted enrollments were performed by 20 producers. Producers are the acknowledged experts in the private carrier market, and they continue to be an important component of consumer assistance. MHBE has also worked hard to increase its engagement with brokers. For example, it recently completed enhancements to the producer portal to allow easier connection between producer and consumer, and it instituted a pilot project with the Call Center that allows real-time phone transfer of QHP eligible consumers to producers for plan shopping and selection. These enhancements are expected to improve producer participation and producer-facilitated enrollments. Producers are generally not well-trained on Medicaid issues and there is no compensation arrangement for Medicaid enrollments, so producers are of more limited assistance to consumers who have "split" households (some household members are QHP eligible, others are Medicaid eligible) or who are subject to frequent churning.[6] One internal estimate puts split households at 17% of QHP enrollments on the Exchange.

C. Agency Partner Caseworkers

Through partnerships with the Department of Health and Mental Hygiene and the Department of Human Resources, hundreds of caseworkers in local health departments (LHDs) and local departments of social services (LDSSs) have participated in MHC training and have participated in the process of transferring cases from the legacy CARES system into MHC. In addition, each of the six regional connector programs have memorandums of understanding with each LHD and LDSS identifying how residents in their respective counties can best be served by the training, expertise, and resources available between the agencies and the connector program partners. Unlike Navigators, caseworkers cannot assist consumers with QHP enrollment, but they are State experts in Medicaid eligibility and enrollment. In addition, agency partner staff perform many important behind-the-scene tasks at the Exchange such as verifying documents, processing paper applications, and solving inter-system glitches between MHC and MMIS, the Medicaid Management Information System hosted by DHMH.

IV. The evolving role of the Connector/Navigator program

In the months leading up to the first year of open enrollment, Connector programs focused heavily on start-up activities: partnership building and creating outreach plans for their communities, establishing staff schedules, working with MHBE on reporting metrics, and participating in MHBE sponsored policy and systems training. In this first year, with less emphasis on producer involvement and before the ACSE program was implemented, Connector staff, along with local agencies, were the primary in-person

[6] "Churning" refers to lower-income households moving in and out of Medicaid eligibility due to inconsistent earnings and fluctuations above and below the applicable Federal Poverty Limit percentages for household size.

resources for consumers. Almost as soon as open enrollment launched, it quickly became apparent that the need for in-person assistance would be higher than anticipated as consumers struggled with the troubled IT system and the call center was overwhelmed with the volume of callers seeking assistance. Initially, it was imagined that Connector staff could be mobile, attending events and enrolling consumers in place, but the technical challenges of the system quickly made these efforts implausible. Instead, staff had to remain in offices with State network connections and consumers seeking in-person assisters primarily found them through word of mouth, community events, and referrals from community agencies.

Connector programs largely shifted their goals from how many applications completed to how many enrollments successfully effectuated, and to escalating post-enrollment coverage and billing issues to technical, policy, and carrier relations staff at MHBE. Navigators shifted from outreach activities to becoming technical experts on a challenging system. Consumers often had to schedule multiple repeat appointments to complete an application and receive an eligibility determination, resulting in less available appointments for others seeking assistance. Connector program leadership and lead navigators became an important source of feedback for identifying system issues and helping MHBE develop new system, policies, and procedures to effectuate enrollment which demanded the bulk of their time for the months of open enrollment and beyond. (A long special enrollment period was provided after the first open enrollment officially ended to allow consumers who were "stuck" in the system to become enrolled.)

Almost as soon as open enrollment (extended) ended, Connector programs made plans to provide additional training to their staff to prepare for the second year of open enrollment. In addition to learning an entirely new system for the second year, most Navigator staff also received more extensive training on Medicaid eligibility rules, cultural competence, and strategies for teaching health literacy. Connector programs also revisited their outreach plans, increasing their community partner networks and hiring, where possible, bilingual staff to reach non-English speakers.

As the second year of open enrollment started, Navigators quickly became proficient with the new system. Originally the new system was designed so that Navigator staff only worked on the consumer portal, but MHBE realized early on that it would be beneficial for Navigators to help consumers apply and enroll through the worker portal, which allows the consumer assistance personnel to work through complex and challenging scenarios more effectively. The ACSE program was in its first year, and CACs worked only on the consumer-facing portal, so in many jurisdictions more complex cases were referred first to Navigator staff to resolve before more intransigent problems were escalated to MHBE. At this point, most of the Navigator staff already had a year of experience on MHBE policies and systems which proved invaluable both to their own programs and to other consumer assistance workers in their communities.

Navigator and local agency staff in most jurisdictions learned to rely on one another to assist Medicaid cases through the system, sharing various levels of expertise with the system and their user roles within it, especially as large volumes of Medicaid renewals began to transition out of CARES and into the MHC system. In most instances, Navigator staff had scheduled weekly hours at the local agency offices. For the Navigator, physical presence in the local office meant they could easily be available to QHP eligible consumers, especially those churning out of Medicaid or members of split eligibility households. Eligibility for enrollment of the previously uninsured population into expanded Medicaid outpaced QHP eligibility nearly 4:1, so Navigators were an important resource to local agencies moving Medicaid redeterminations from one system into another.

The experience of the last two years has also demonstrated that residents need continuing in-person assistance with maintaining and renewing coverage, post-enrollment issues, reporting changes, enrolling outside of open enrollment during Special Enrollment Periods, and churning between insurance affordability programs. Navigators have become experts in reporting, handling, and/or escalating system issues that impede successful application or enrollment, helping consumers with a multitude of post-enrollment billing questions and issues, and in the intricacies of Medicaid eligibility rules and programs, especially in jurisdictions where the local agencies have relied on them more heavily to process Medicaid eligibility cases. Perhaps most importantly, Navigators have become a trusted and knowledgeable source for application and enrollment assistance in the communities they serve.

V. Future Vision for the Connector Entity program

The vision of a much simplified, online enrollment system is still evolving. As the system continues to improve, many consumers will be able to enroll on a self-service basis, or with assistance offered by the Exchange's call center. As has been learned in previous roll-outs of such systems (Medicare, Children's programs), however, no matter how simple and streamlined the eligibility and enrollment system, many people may miss the opportunity to obtain health coverage without personalized help.

Many studies, reports, surveys, and anecdotal stories have emphasized the need for in-person assistance. As one example, Enroll America reported that individuals who received in-person help with enrollment were twice as likely to complete the process successfully and that African-Americans, Latinos, and young adults were more likely to enroll after multiple follow-up contacts from an outreach or enrollment contact (Enroll America, 2014). They also found that that in-person assistance was particularly important for communities of color and communities with limited English proficiency. When MHBE offered a survey on the Connector program to stakeholders earlier this year, the importance of in-person assistance to both eligibility determinations and QHP enrollment was ranked high in importance by survey respondents.

While authorized producers are able to provide expert assistance with enrollment into QHPs, and agency caseworkers continue to be the State's Medicaid experts, Navigators are uniquely situated by regulation, training, and system access, to provide education and enrollment assistance across all insurance affordability programs offered through the Exchange. As the ASCE program grows, and CACs catch up with the experience and expertise of Navigators, they will become an increasingly important part of an integrated and well-coordinated consumer assistance program.

Many factors drive the need for such a coordinated approach including the ACA's "no wrong door" mandate, administrative efficiency and financial realities, as well as consumer needs. These circumstances make it vital that consumer assistance workers be experts in and provide information about the full array of programs. While Connector programs and ACSEs each have unique relationships with the Exchange, it will also be important to have strong memoranda of understanding in place that define the interaction between their respective staff and the LHD and LDSS caseworkers, and the roles and responsibilities of each State agency -- DHR, DHMH, and MHBE – especially in the administration of Medicaid programs.

Additionally, all consumer assistance workers are an important source of information to the Exchange, offering first-hand experience with system issues and barriers to enrollment. MHBE expects to continue

to offer structured opportunities for assistance workers to be in ongoing contact with the Exchange, helping to identify the processes that are working and flag those that need refinement. As MHBE makes improvements or changes to policy or procedures, a routine forum for sharing information will also ensure that consumer assisters are current on all relevant issues impacting coverage.

As the vision of a coordinated consumer assistance network is implemented, the Connector program will be most effective and relevant when it integrates the major components of health insurance access (outreach and education, enrollment and retention, and health use literacy) into a mutually supportive and iterative approach that utilizes the technical proficiency of its well-trained and certified staff and both formal and informal partnerships with an increasing network of local, community-based organizations that offer entry to the most hard-to-reach populations of uninsured.

It is anticipated that in the coming years more producers and CACs will be trained and become proficient with MHC application and enrollment, and more opportunities for consumers to find in-person assistance where and by whom can best help them will become available. This provides the opportunity for Connector programs to act as regional Hubs to MHBE, expanding the number of ACSEs and CACs; integrating producers into QHP enrollment opportunities; providing technical assistance with complex cases to the producers and CACs in their region through a dedicated hotline; handling additional application processing responsibilities through expanded user roles in the system; acting as a coordinator for communication between consumer-facing staff and MHBE policy and operations staff; contributing to marketing and communication ideas with local knowledge to expand community awareness; identifying and implementing training needs; and improving health literacy.

There are challenges to creating this framework: MHBE must identify effective pathways of support for all consumer assistance workers, and much of the seamlessness of this approach for the consumer depends on robust partnerships between all of the entities and with MHBE. In addition, during the first two years of Exchange implementation, reaching uninsured consumers was not difficult; many were waiting in line for the opportunity to enroll in affordable health care coverage. The remaining population of uninsured will be more difficult to find, educate, and enroll. These challenges are especially significant in rural areas – where low population density, lack of public transportation, and a smaller number of health care providers contribute to decreasing consumer motivation to seek health care coverage.

VI. Conclusion

The importance of in-person assistance to enhance enrollment and retention is clear, and it is applicable to a broad population of persons trying to access health care, not just the currently uninsured. The challenge is organizing the efforts of so many willing partners into an integrated and coordinated consumer assistance network. This framework will allow consumer assistance programs to evolve with consumer needs and to strengthen enrollment pathways. Translating this framework into actionable steps will pose challenges, but MHBE has already begun to address them through ongoing system enhancements, development of user tools, expansion of the ACSE program, improvements to producer integration, and through the willingness of its partners and stakeholders to continue to support, question, and monitor the Exchange's progress. It is the hope of MHBE's staff and leadership that these efforts can truly bring together outreach, enrollment, and informed use of the health care system to provide Maryland residents with the best possible experience in successfully accessing the health care options created by the ACA.