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Vermont House Health Care Committee

VLCT's has a 30 plus year history in assisting Vermont municipalities meet their health insurance needs. We have worked hard to help municipalities to adapt to the recent changes in health system. My comments are meant to be constructive. It is important to learn from experience and use these lessons to improve moving forward.

I. Review Prior Year Testimony and What VLCT Did to Help with Transition to VHC
   a. Last Year's Testimony- 1-16-2013- some highlights:
      1. YOU ONLY GET ONE CHANCE TO MAKE A GOOD FIRST IMPRESSION!
      2. Exchange plans are not HDHP friendly. High maximum out of pocket costs, much higher than current plans.
      3. Customer service is key. Design program for convenience of customers, not administrators.
      4. Lots of hand holding, boots on the ground.
   b. What did VLCT do? We connected with all 291 municipalities that are members of VLCT and are small employers offering health insurance to their employees. Some highlights include:
      - Attended and presented at 70 selectboard meetings.
      - Conducted 138 in person meetings (with managers and employees).
      - Prepared 87 plan comparison charts and provided them to municipalities.
      - A multitude of phone consultations and email communications.
      - Navigators available at Town Fair on October 3.
      - Two sessions on health reform and VHC at Town Fair.
      - Coordinating Navigator appointments for VLCT members.
      - Presentation at Vermont Municipal Clerks and Treasurers Association conference.
      - Presentation at New England GFOA meeting in Manchester, VT.

II. No Vermont Municipalities set up their 2014 health insurance through the VHC web portal.
   a. All were placed direct with health insurers or extended their plans.
   b. Employer impact- fewer health plan choices than last year.
   c. Employee impact- the same or fewer choices than last year.

III. VHC did not make a good first impression.
   a. OVER PROMISED AND UNDER DELIVERED

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b. Overly optimistic and sugar coated. This created high expectations that were not met. Up until the day of the VHC launch state officials told us everything was good to go.

-Last spring legislators were told the VHC website would launch by September 1 to allow people to take a look and give it a spin.

-Navigators were told during August and early September training that the site would be live by about September 15 to allow for online training on system use. What was actually available for the online training was screen shoots of a sample version of the web site that was rife with misinformation.

-Just days before the October 1 launch state officials said everything was on track. On Friday, September 27, Mark Larson, Commissioner of the Department of Vermont Health Access, was quoted saying "Vermont Health Connect will be ready to support Vermonters and the purchase of their health coverage on October 1…" (Vermont Digger article)

-The morning after the launch VHC officials said the October 1 website problems were due to high usage - about 8500 users visited the site. By later in the day the Commissioner allowed that there were some technical problems, not high usage, that were behind the slow access.

-State officials acknowledge that there were technical problems but said that they had expected these all along.

-Shortly before its October 1 launch word came out that the VHC website would not be able to accept payments because the connectivity with the participating health insurers had not yet been tested. This system is still not operational for employer groups.

c. If this was private sector it would have failed.

IV. High Deductible Health Plan (HDHP) Challenges

a. Higher Out of Pocket (OOP) maximums will result in more underinsured Vermonters.

b. Mapping issues. There are probably people who do not yet realize that their OOP maximums have doubled.

c. Three month extension issues and choices. Changing to or from a HDHP with a short plan year creates problems.

d. Loss of tax credits for individuals who contributed to HSA accounts.

V. Customer Service

a. At overall management level customer service was unacceptable!

1. Over promised-- under delivered.
2. Lack of consistent information.
3. Lack of timely information.
4. DECISIONS DUE TO WEB SITE PROBLEMS WERE TIED TO ADMINISTRATIVE NEEDS, NOT CUSTOMER NEEDS!

b. Excellent effort by folks at customer contact level, but uneven. Many well intentioned and friendly assisters/phone assisters lacked adequate training.

c. Long waits on hold for call center:

On Monday, October 7 we called the small business hotline with a question on behalf of a member. We had to wait on hold for 10 minutes before speaking to a

live person. The answer we received, after the call was "escalated", was contrary to what we expected with no backup justification, such as referring to ACA or VHC rules and regulations. Worse than that, it appears that the answer we received was legal advice being provided by a non-attorney. And even worse than that… we got informal responses to the same question from three different attorneys, two well respected Vermont based labor attorneys and one national ACA expert attorney, and they all agreed on the answer to the question. First it is amazing that three attorneys agree, but even more amazing and disconcerting was that their answer was very different than the one given by VHC.

d. Inconsistent response to emailed questions.

Customer service from VHC has been spotty. During the summer we sent a question to VHC via the "contact us" button on their website and did not get a response, or even receive an acknowledgement of receipt, for three weeks. Later VHC did respond to requests in a timely manner; however, the answers to questions were not always correct. Sometimes email inquiries have again gone into an abyss.

e. Failure of outreach to small businesses. No direct contact from VHC as best we could tell.

f. Process for handling Protected Health Information. This was overly intrusive. Work arounds required someone to sign an application that they knew was incorrect under penalty for perjury.

g. Health insurers, BCBS and MVP saved the day in our view.

VI. Coverage Issues

a. Working Medicare eligible employees from under 20 employee employers had to enroll in Medicare Part B because Medicare became primary in many instances for the first time. This is because they no longer were in an Association Group. This added a cost of $105 per person, likely after tax, for those impacted. This has a big impact on household budgets. How many employees may not have been aware of this change and have not enrolled in Medicare Part B? What will happen to their coverage?

b. HDHP plan participants were given options for plans with much higher out of pocket maximums. Was this a result of an administration bias against these plans? Richer HDHP plans could have been developed. Some employees were mapped to new HDHP plans in VHC. The may be in for a rude surprise if they have substantial medical costs.

VII. Plan Design Issues

a. Dental subject to deductible. MVP and BCBS plans differ. How can this be if the state designed the plan?

b. BCBS Gold Blue for You Plan was initially listed on VHC website as an HDHP plan.

c. Wrong premiums on website.

VIII. Plan Extensions- Unfair Trade Practices

a. August DFR Bulletin to insurance agents and health insurers.

b. Problems with short year.

1. HDHP issues.
2. Deductible carry over issues. Deductibles carry over but not co-pays and etc. Also deductible carry over does not apply if there is a change in insurers. Also there are potential OOP maximum issues when changing plans.

IX. Going Forward

a. You only get one chance to make a good first impression. How can this damage be repaired?
    1. Better transparency and timely information.
    2. Don't over promise.
    3. Deliver on promises.
    4. BETTER CONSIDER THE NEEDS OF YOUR CUSTOMERS!
b. Dealing with employers who extended plans for three months. Short time frame already. For an April 1 effective date the process must start in early February, say no later than February 7. This means if the payment and enrollment functions are not fully operational at that time a new Plan B must be implemented. This likely means direct enrollment through the insurers.
c. How to deal with folks who "didn't get the message".
d. Plan designs for next year. Consider Gold level HDHP with lower OOP maximum.
e. Provide solutions for working Medicare eligible people.