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Agency of Human Services

Vermont Health Connect Update on Project Development, Operations, and Enrollment Data

Submitted to the
House Committee on Health Care,
Senate Committees on Health and Welfare and on Finance,
Health Reform Oversight Committee,
and Joint Fiscal Committee

Submitted by

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Prepared by Vermont Health Connect at the direction of 2015 Act 58 Sec. C. 106 to deliver an update by September 1, 2015

August 21, 2015

Contents

Project Development (updates as of August 18, 2015)

Status of Deliverables Related to Fall System Upgrades

Vermont's contract with Optum to deliver fall system upgrades, including Automated Renewals functionality, went into force on July 1. The upgrades will be deployed in the following stages:

- Hot Fix 2 & 3 – Updates necessary to deploy prior to Automated Renewals
- Release 2b – Automated Renewals
- Release 2c – Additional upgrades not critical to Automated Renewals

The first task under the new contract was finalizing a delivery schedule for Automated Renewals. This was completed on July 13 and consisted of a dozen deliverables. The following deliverables have been completed as of August 18:

- Automated Renewals (Release 2b) Requirements – Completed August 4
- Scope Work Breakdown Structure – Completed August 6
- Automated Renewals (Release 2b) Design – Completed August 12
- Automated Renewals (Release 2b) QA Test Plan – Completed August 14
- Development Code Drop 2 – Completed August 17

Status of Deliverables – Open

Open Deliverable	Status Update, August 18, 2015	Action to Closure
Renewals (Release 2b) Test Design	In Progress	The State is reviewing SIT test cases to be complete by late August. The State is generating UAT test cases by late August. Regression test cases to be developed by Optum by August 28.
Renewals System Integration Testing (SIT) Execution	In Progress	Optum to work longer hours and weekends to complete.
Renewals End-to-End Test Execution	Scheduled for September, Expected On Time	
Renewals User Acceptance Testing Test Execution (Component and End-to-End Combined)	Scheduled for September, Expected On Time	
Renewals Implementation Plan	Scheduled for September, Expected On Time	

Renewals Go/No-Go Decision (Final Decision to go-live)	Scheduled for September, Expected On Time	
Renewals (R2b) Successful Go-Live (Site Available to Back office, Ops, Public)	Scheduled for September, Expected On Time	

Automated Change Open Deliverable	**Status Update, August 18, 2015**	**Action to Closure**
Training Materials Development Complete	In Progress and On Schedule	All training material is prioritized into three distinct categories. Critical functionality (high volume) was trained prior to implementation, followed by additional training sessions post-implementation. Priority focus is to train on fully validated processes whenever possible.
Training Complete	In Progress and On Schedule	All training material is prioritized into three distinct categories. Critical functionality (high volume) was trained prior to implementation, followed by additional training sessions post-implementation. Priority focus is to train on fully validated processes whenever possible.
Release 1 User Validation Test Complete	In Progress and On Schedule	Ongoing. As additional types of change requests are validated and incorporated into business processes and training, they are verified by end users at Vermont Health Connect, Benaissance, and the insurance issuers.

Risks – Open and Recently Mitigated

Open Risks

The following items have been identified as risks to the timing or scope of the project.

- Development, testing, and execution of a system enhancement to support business processes for corrections of operational errors and system errors that are returned from the carriers (834 errors) needs to be finalized in order to complete the most complex remaining change requests and prepare for fall system upgrades. In July, a schedule was developed with qualified insurance carriers to implement a system enhancement to support business processes required for completion of these change requests.
- Vermont Health Connect's hosting is transitioning from CGI to Optum. In mid-August the State received Authority To Connect approval from the Centers for Medicaid and Medicare Services (CMS) and began migrating data to the production environment. The timing of the data center migration involved in this transition poses a risk to the development timelines for fall system upgrades. The VHC project team and the hosting team need to remain closely aligned on schedule and upcoming activities to avoid any negative impacts. The Project Manager assigned to the hosting contract by the Health Services Enterprise Project Management Office is being included in VHC project planning activities to ensure this alignment occurs.

Recently Mitigated Risk (Closed in July)

The following risk that was identified in last month's report has since been mitigated:

Former Risk	Comment
If the Department of Financial Regulation (DFR), Green Mountain Care Board (GMCB) and Department of Vermont Health Access (DVHA) approve the 2016 rate and form applications for Dentegra Insurance Company, Dentegra will need to be added to the marketplace as a fourth carrier in time for 2016 open enrollment. This onboarding will significantly increase the workload of Vermont Health Connect's Design, Development & Implementation team and Operations team. The risk is that this increased workload could impact other work related to the fall system upgrades, which include renewals functionality. This implementation risk is separate from the rate and form review process.	Dentegra will not be participating in the marketplace as a carrier for 2016 open enrollment.

Actions to Address State Auditor's Recommendations (updates as of August 18, 2015)

State Auditor Douglas Hoffer released a report in April that included a set of recommended actions for Vermont Health Connect. The following table outlines these recommendations as well as Vermont Health Connect's work to address the findings with updates as of July (middle column) and August (right-hand column).

Notable updates for the past month include:

- Regarding the recommendation to include in future VHC system development contracts clauses that provide monetary consequences tied to the contractor's performance (Finding #2), VHC has been working with legal counsel to develop a competitive process consistent with Bulletin 3.5 for small business (SHOP) functionality.
- Regarding the recommendation to document the roles and responsibilities of each of the organizations that provide system and operations support to VHC, including explicitly laying out decision-making responsibilities and collaboration requirements (Finding #3), DCF and DVHA signed a Memorandum of Understanding in July. The effort to finalize job descriptions across the matrixed unit is ongoing.
- Regarding the recommendation to establish a process and expeditiously perform reconciliations of enrollment data between the VHC system and the relevant Medicaid system (Finding #6), the Medicaid reconciliation project has been initiated. The scope of the project has been specified and defined. Medicaid data experts are working with Optum on data requirements, data mapping & data transfer processes.

Topic/Finding	VHC Status Update July 2015	VHC Status Update August 18, 2015
1. Expeditiously complete the VHC project management plan documents for the 2015 releases, including a scope statement, requirements traceability matrix, and test plan	All documents described in the column to the left relate to Release 1, Automated Change Processing, and have been completed. The Integrated Master Schedule for Release 2, Automated Renewals, was completed on July 13. The scope statement and test plan are scheduled to be complete on July 29 and the requirements traceability matrix by September 15.	All documents described in the column to the left relate to Release 1, Automated Change Processing, and have been completed. The Integrated Master Schedule for Release 2, Automated Renewals, was completed on July 13. The scope statement and test plan delivery dates have been revised, with the scope statement due on August 21, and test plan on August 26. The requirements traceability matrix is due on September 15.
2. Include in future VHC system development contracts clauses that provide monetary consequences tied to the contractor's performance.	The Optum contract has been amended again (amendment 8) to add $18 million in services on a time and materials basis through the end of 2015. Risks of performance are not addressed in the contract, and will be managed through the contract	VHC has been working with legal counsel to develop a competitive process consistent with Bulletin 3.5 for small business (SHOP) functionality.

	management process. A new one-year Maintenance and Operations contract was entered into on June 30 with Optum for a fixed monthly price; there are stringent service levels and service credits which mimic those of the hosting contract.	
3. Document the roles and responsibilities of each of the organizations that provide system and operations support to VHC, including explicitly laying out decision-making responsibilities and collaboration requirements.	The State has finalized job descriptions for Supervisors, Mentors, and Benefit Program Specialist (BPS) staff. The State is on track to complete additional job descriptions by the end of July. The MOU draft is under legal review and is on track for completion in July.	The MOU between DCF and DVHA was signed in July. The effort to finalize job descriptions across the matrixed unit is ongoing.
4. Include expected service levels or performance metrics in future VHC system development and premium payment processor contracts and establish mechanisms to track contractor performance against the performance levels in these agreements.	**Maintenance & Operations** - the next contract covers the period July 1, 2015 through June 30, 2016 (State FY16). This contract is written as firm fixed price, not time and materials, and includes provisions for service level agreements, payment credits, and performance metrics. This contract was executed on June 30, 2015. **Hosting** – the new contract includes payment for performance provisions for transition services, recommended service level agreements, payment credits, and performance metrics. This contract was executed on May 14, 2015 and covers the period February 1, 2015 through December 31, 2017. **Premium Processing** - the next contract will include provisions for service level agreements, payment credits, and performance metrics. The vendor has reviewed and approved SLAs and performance requirements, and the contract is currently	The Maintenance & Operations and Hosting contracts have been executed, including provisions for service level agreements, payment credits, and performance metrics. The premium processing contract will include provisions for service level agreements, payment credits, and performance metrics. The target completion date has been moved to August 30, 2015, covering an additional year of service. Once the State receives final agreement with the Vendor, internal approval process will commence.

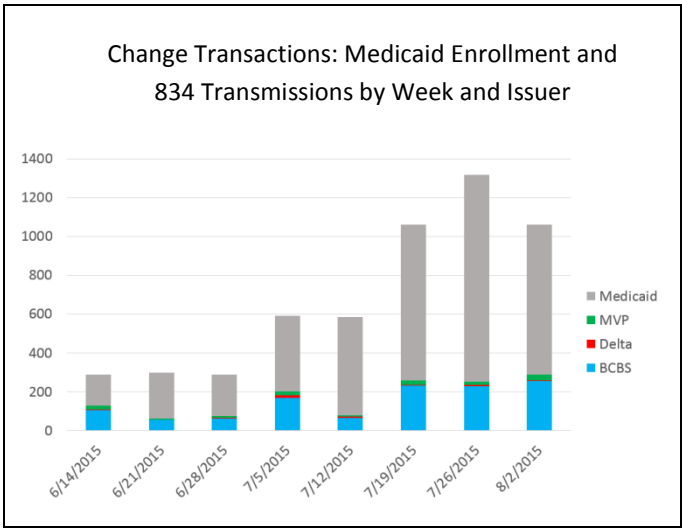
	undergoing legal review prior to final sign-off. The target completion date is July 31, 2015, covering an additional year of service.	
5. Establish a process and expeditiously perform reconciliations of enrollment data between the VHC, Benaissance, and the carriers' systems	Regarding reconciliation of 2015 cases the priorities are to: • Use data that was collected at the end of May (before Release 1) to identify discrepancies between systems; • Analyze discrepancies to identify specific cases to be fixed; • Identify processes to correct discrepancies between VHC and Benaissance and VHC and the three carriers; • Correct root causes of discrepancies identified; • Design, develop & implement a new automated reconciliation reporting process, working with Optum, Benaissance & the carriers to assure appropriate data formats & data exchange protocols. Regarding reconciliation of 2014 cases, work focused on bringing the balance of VPA dollars in the Benaissance system to $0. Much progress was made as the current 2014 VPA balance stands at approximately $20,000. We are sequencing the work on the non-VPA balance as there are two operational processes that must first occur: provide refund to some customers as needed, and send "late payment" notices for BCBSVT customers who have outstanding premium balances during the fourth quarter 2014. Once these two processes have been completed we will begin to address the non-VPA balance. The target is to have the 2014 non-VPA balance at $0 in September with the vast majority	Regarding reconciliation of 2015 cases: • Data collected at the end of May (before Release 1) was used to "correct" a VHC formula for calculating CSR (Cost-Sharing Reduction) values that caused more than 1,500 one penny discrepancies with BCBSVT; it wasn't that the pennies were so important, but that 834 errors could result from the discrepancies; • Most other discrepancies could not be corrected due to lack of staff to resolve discrepancies due to other priorities and lack of processes to correct cases and/or fix systems due to continuing development efforts. • Discrepancy data from all systems was updated at the end of July; needed data corrections & systems fixes will be identified & pursued • A long-term reconciliation process is being developed, tested & implemented; a data feed from BCBSVT has been successfully received & MVP, Northeast Delta Dental & Benaissance are in the works; ultimately, weekly reporting, analysis & correction is anticipated. Regarding reconciliation of 2014 cases: Work continued on bringing the Benaissance VPA balance to $0 and is nearing completion. We expect to be complete by the end of August. As mentioned last month the non-VPA balance will be

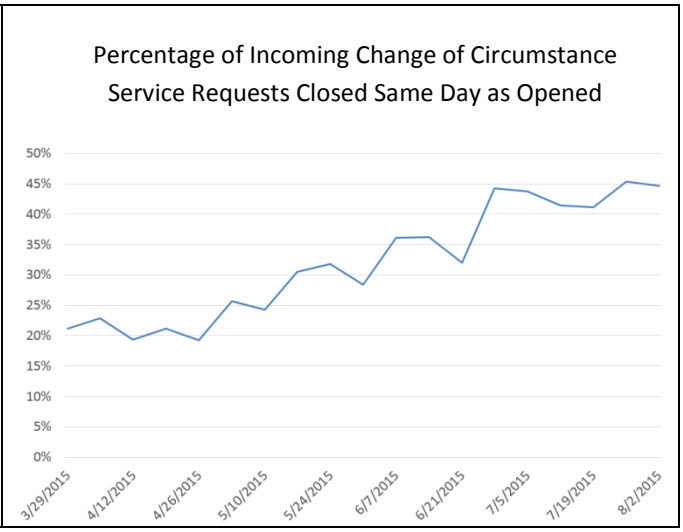
	of it cleaned up in the month of August.	addressed in August. By the end of August our goal is to have a $0 VPA balance, a significantly reduced non-VPA balance, and a plan to reduce the balance to $0 in September.
6. Establish a process and expeditiously perform reconciliations of enrollment data between the VHC system and the relevant Medicaid system(s).	See #5 above and note that automated reconciliation continues to be under development.	The Medicaid reconciliation project has been initiated. The scope of the project has been specified and defined. Medicaid data experts are working with Optum on data requirements, data mapping & data transfer processes.
7. Reconsider decisions that have complicated the premium payment processing function, including the requirement that the full premium payment be at Benaissance without exception before remittance to the carriers and the split of the billing and dunning/termination processes between different organizations.	DVHA has initiated discussions with its payment processing and insurance issuer partners to modify payment processing methodologies to ensure payment processing occurs in the most efficient manner. Further analysis of options has been deferred until 2014 and 2015 reconciliation activities are complete.	DVHA has initiated discussions with its payment processing and insurance issuer partners to modify payment processing methodologies to ensure payment processing occurs in the most efficient manner. Further analysis of options has been deferred until 2014 and 2015 reconciliation activities are complete.
8. Establish a process to terminate Dr. Dynasaur recipients in the VHC system who meet the State's termination criteria.	VHC has completed definition of requirements for grace periods and termination of non-payment of premium for Dr. Dynasaur recipients. The State is using the contract management process to ensure that the appropriate vendor resources are avaiaible to design, deliver, and implement this functionality within the remaining VHC delivery schedule. Development of an interim manual workaround has been complicated by the identification of technical and policy challenges, and a new target date for an interim process has not been identified. The rulemaking that we originally intended to begin in May, 2015 has been delayed. A separate rulemaking effort that needed to	Optum's current contract with Benaissance does not allow for new Benaissance development work. The contract only includes integrating current Benaissance functionality into the VHC system. A change request has been entered to both Optum and Benaissance to process this functionality in staged releases, including schedule and cost. When the State receives those estimates, which are due by August 29th, leadership will decide the best approach to obtaining the functionality.

	be complete prior to commencement of this change was adopted on June 30, 2015 and will go into effect on July 15, 2015. The new rulemaking effort will be start after this current rule goes into effect, with an anticipated completion in early 2016.	
9. Expeditiously develop VHC financial reports to implement stronger financial controls.	Revisions to the premium processing contract have been made, including a requirement for the vendor to work with the state to design and implement financial reports. The vendor has reviewed and approved SLAs and performance requirements, and the contract is currently undergoing legal review prior to final sign-off. The target completion date is July 31st, 2015.	Revisions to the premium processing contract have been made, including a requirement for the vendor to work with the State to design and implement financial reports. The vendor has reviewed and approved SLAs and performance requirements, and the contract is currently undergoing legal review prior to final sign-off. The target completion date has been moved to August 30th, 2015. There were several aspects of the contract that needed review by general counsel, Benaissance counsel and State Risk Management to ensure that potential exposure was minimized by proper insurance coverage to protect the State especially as Benaissance acts as fiduciary for the custodial checking account. The needed input and expertise has delayed the signing of the contract.
10. Obtain and review reports from Benaissance that provide detail on the makeup of the balance in the VHC bank account and monitor this account to ensure that payments are being remitted appropriately and in a timely manner.	See #9 above	See #9 above
11. Establish a process and expeditiously perform reconciliations of payment data among the VHC, Benaissance, and the carriers' systems.	See #5 above and note that automated reconciliation continues to be under development.	See #5 above and note that automated reconciliation continues to be under development.

Operations Update (data through July 31, 2015)

Change Processing



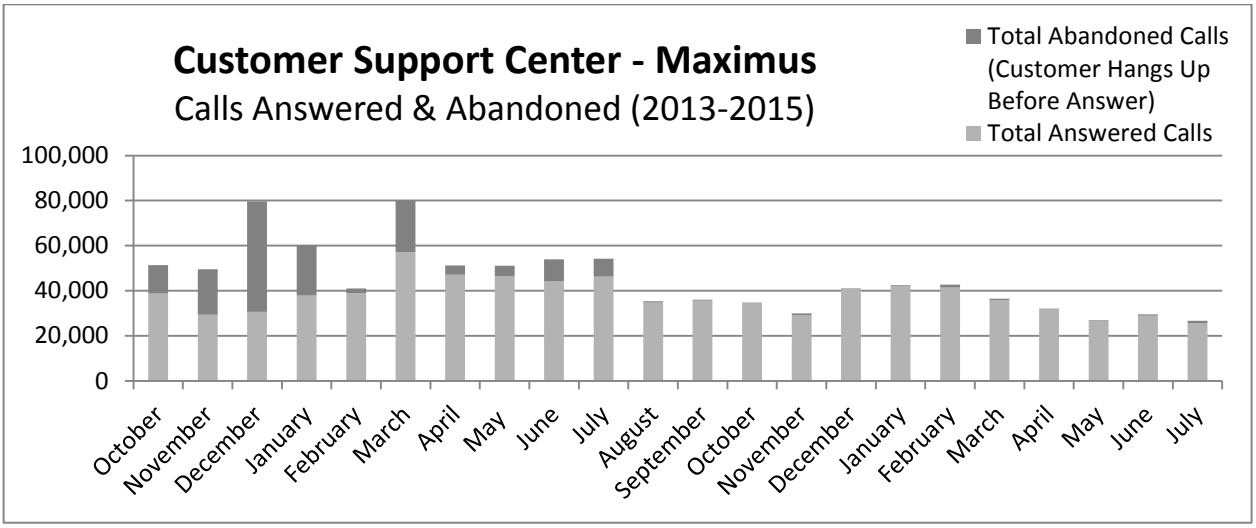


Using the new technology that was deployed at the end of May, Vermont Health Connect and its insurance issuer partners continue to work through the queue of requested changes to customer accounts. Some changes, known as "qualifying events," allow customers to sign up for health insurance or change health plans outside of the annual Open Enrollment period. Examples of qualifying events include getting married or losing job-sponsored insurance. Other changes, such as income changes, can impact the amount of financial help a customer receives. Finally, some changes are simply adjustments to personal information, such as a name change, an address change, or even a preference to be called on their cell phone instead of their home phone.

As of July 31, just under 5,700 households had change requests waiting to be processed. June and July marked the first months this year that Vermont Health Connect processed more change requests than it received. Even accounting for roughly 100 incoming requests per day, approximately 4,600 fewer households were awaiting changes on July 31 than at the time of the system upgrades.

Much of this progress can be attributed to the advances that customer service staff have made processing changes in real-time. In July, Maximus added income changes to the types of change requests that their staff processes immediately over the phone. By the end of July, nearly half of new Change of Circumstance service requests were closed on the same day they were opened – oftentimes while the customer was on the phone. Trainings are in process to have staff complete several additional types of changes for customers while they are on the phones in August, including requested terminations, citizenship status, and pregnancy. Because customer outreach is so time-consuming, the ability to process changes in real-time is freeing up staff to make significant progress on the queue of change requests.

Customer Support Center (Maximus Call Center)



Last Month

July marked the start of a new contract amendment with Maximus, the State's long time Medicaid call center service vendor and original VHC call center vendor for Level 1 customer service. This amendment provides a one-year extension, running through June 2016, with the option for an additional year. This amendment ensures that the State can maintain continuity of services using existing knowledge and infrastructure while completing the procurement process for its Medicaid Management and Information System (MMIS). Saturday morning hours had seen low demand and have been eliminated for Fiscal Year 2016 as a cost-saving measure. As of July, the Customer Support Center is now open Monday-Friday 8am-8pm to ensure customers can access help outside of normal business hours.

In July, the Customer Support Center answered 25,542 calls and had 1,093 customer hang ups for an abandoned rate of 4.1 percent. More than three out of four calls (77%) were answered in less than 30 seconds, down from 84% in June but up from 55% in July 2014. The uptick in wait times was largely attributed to an increase in training sessions as staff continue to expand the types of change requests that they process over the phone. Nine out of ten calls (90%) were able to be resolved without transferring.

Open Enrollment

This year's Open Enrollment ran from November 15 to February 15. The Customer Support Center answered more than 120,000 calls, an increase over the same three month period last year, while largely avoiding long waits and missed calls. Last year's Open Enrollment abandoned rate of 35.7% (over the six-month period) was cut to 1.7%.

The average wait time during this year's Open Enrollment was 40 seconds. By comparison, the average wait at the HealthCare.gov call center was more than 12 times as long (eight minutes and 16 seconds).

Nearly all calls (98%) were answered in less than four minutes, compared to just over half (53%) during the first Open Enrollment. Four out of five calls (83%) were answered in less than 30 seconds.

System Performance and Traffic

Month	Unscheduled Downtime (minutes)	Availability	Avg Page Load Time (seconds)	Max Peak User	Visits
May 2015	0	100.00%	2.0	82	30,926
June 2015	0	100.00%	0.5	69	34,837
July 2015	400 (170 for portal, 230 for pay pages-only)	99.87%	0.6	93	37,116

Last Month

Vermont Health Connect's web traffic increased to 37,000 visits in July and average page load was around ½ a second for the second straight month – more than three times faster than the months prior to the system upgrade.

Vermont Health Connect's systems achieved 99.87 percent availability in July, down from 100 percent in the two prior months. The availability metric measures the amount of time systems are up and running relative to the amount of time they are expected to be. Scheduled maintenance periods, such as those that occur from 1am to 5am each morning, are not counted.

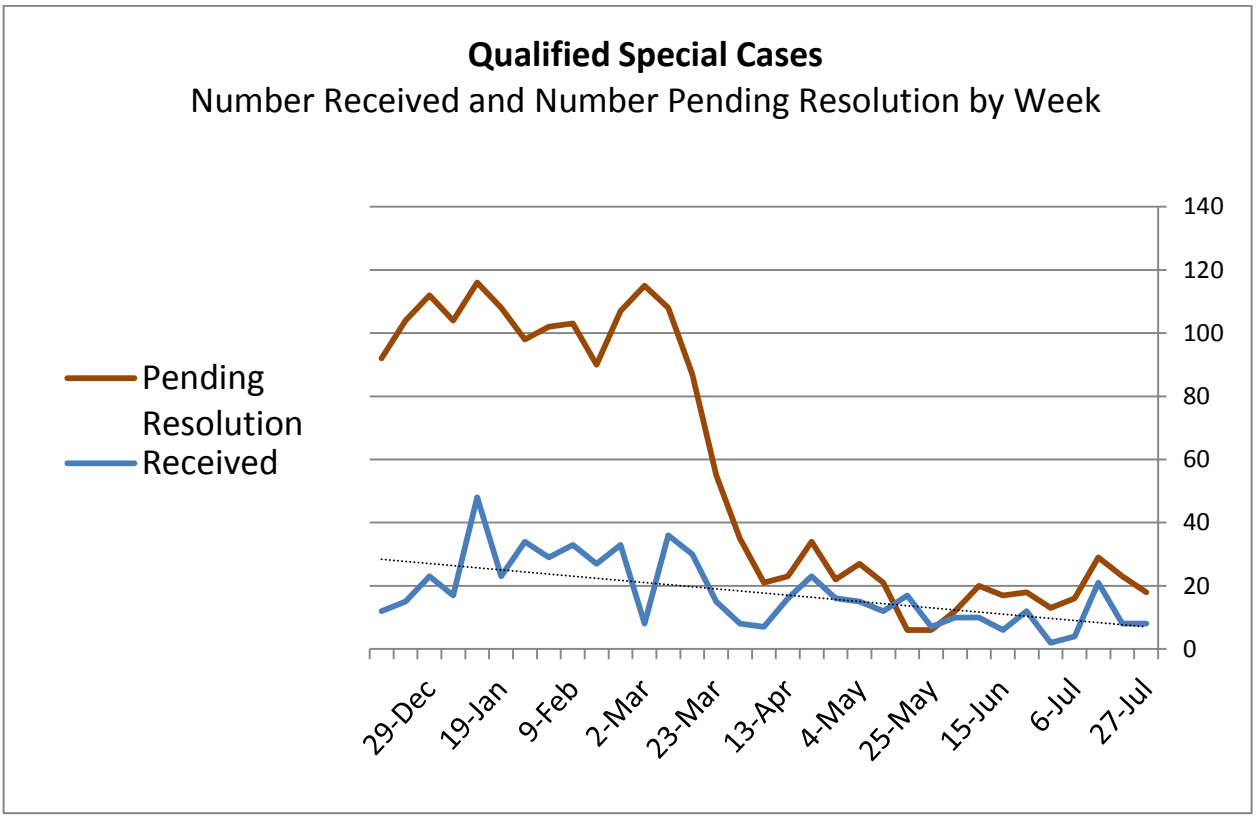
Three events accounted for this downtime. The last, on July 28, related to the hosting environment and resulted in Vermont Health Connect's portal being unavailable for just under three hours. The first two related to the payment processor (Benassaince) and resulted in the site's pay pages being unavailable for just under four hours between the two days.

Open Enrollment

Vermont Health Connect's system was stable throughout this year's open enrollment period. Of note:

- More than 270,000 website visits from November through February.
    - The three busiest days were the first weekday and last two weekdays of Open Enrollment (Monday 11/17, Thursday 2/12, and Friday 2/13).
- Only three incidents during Open Enrollment (11/15-2/15), compared to more than 400 during last year's Open Enrollment. All three were resolved the same day.
- Less than one hour of total unscheduled downtime during Open Enrollment.

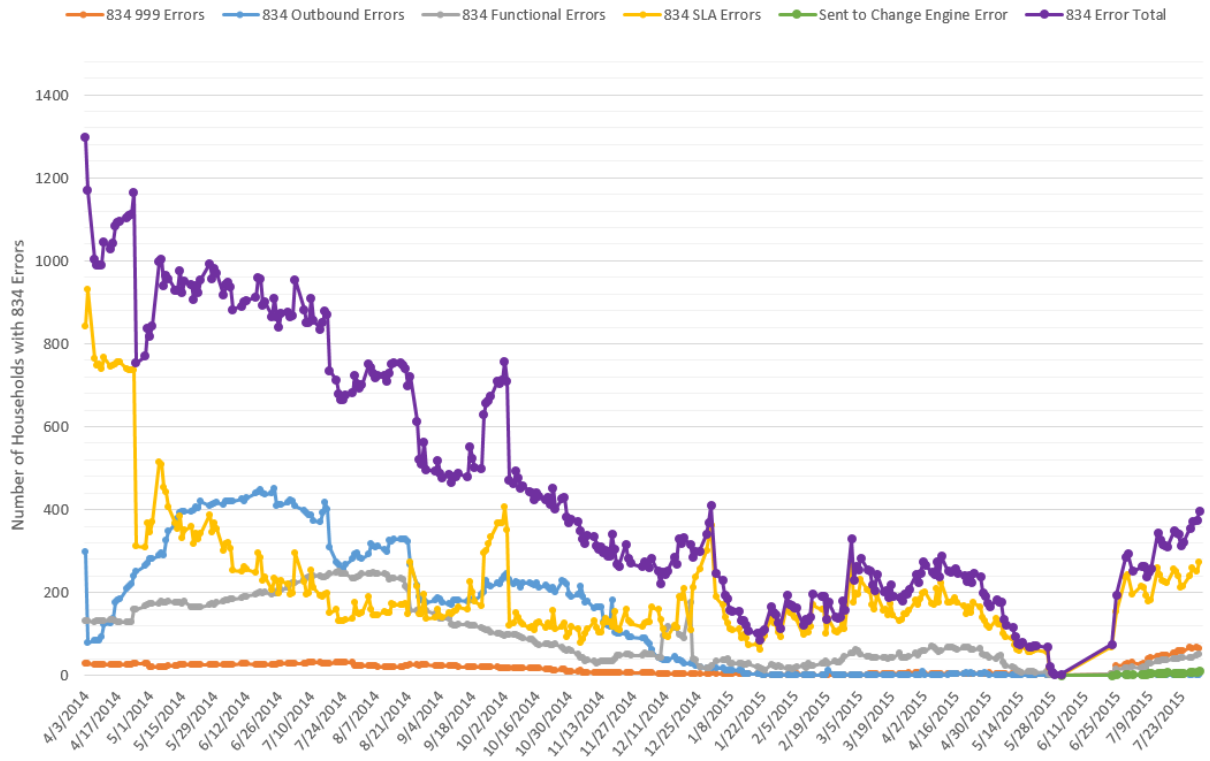
Qualified Special Cases



Qualified Special Cases are cases that are escalated to a dedicated customer service team due to their complexity, medical or financial urgency, or inability to be resolved through normal channels.

Revamped training earlier this year resulted in a reduction in the number of cases that needed to be escalated. Combined with strong work by the dedicated team, the number of pending Qualified Special Cases was cut 80 percent (from 115 to 22 cases) over a nine-week period this spring. Progress continued throughout the month of May and the team ended the month with just six open cases. The process of adjusting to the new system in June saw a temporary uptick in the number of cases awaiting resolution, though still significantly lower than winter levels.

Carrier Integration



Vermont Health Connect continues to work to resolve 834 transaction and premium processing errors. An 834 is an electronic file sent from VHC to an insurance carrier with information about an individual or family's enrollment information. An 834 error indicates that this electronic file has not yet been successfully processed for some reason. Optum is assisting the State in streamlining the resolution process and identifying mechanisms for reducing the generation of errors.

Vermont Health Connect was successful in reducing the inventory of 834 errors from over 1,000 in early 2014 to approximately 20 by the end of May 2015. It is important to note that as VHC continues to enroll Vermonters into coverage there will always be some number of electronic enrollment files that have been sent but not yet fully processed. The number of 834 errors will never reach zero.

As mentioned in last month's report, major system updates can be expected to cause a temporary rise in 834 errors. Indeed, the May system upgrades were followed by an increase in errors. In addition, a dramatic increase in integration activity – such as has been the case as Vermont Health Connect ramps up change processing - can be expected to be accompanied by a proportional increase in errors.

The vast majority of errors have been a type of error known as Service Level Agreement (SLA) errors. SLA refers to an agreement that, within 24 hours of receiving an 834 file from Vermont Health Connect, insurance carriers will respond with either a confirmation that coverage has been effectuated, a rejection, or a request for more time. This allows Vermont Health Connect to confirm that the information in its system and the insurers' systems is aligned. Because insurance carriers do not process files on weekends and holidays, more SLA errors tend to show up on Mondays and Tuesdays in comparison to the rest of the week.

A large number of cases with SLA errors have the correct information in the VHC, carrier, and payment processor systems and just need a snapshot with the correct statuses to confirm successful integration. Fortunately for these customers, because their coverage or change has already taken effect on the insurance carriers' systems, they can typically use their health plan benefits seamlessly while Vermont Health Connect and the carriers iron out the confirmation. Other cases need a new snapshot to update all systems with matching information. Optum's solution of a "forced snapshot" is expected to begin processing these types of cases in batches beginning in late August or early September in order to consistently clear the queue.

Cases receiving 999 errors often pertained to an issue with alternate phone numbers not being compatible with a carrier's system. This issue has been resolved. Relevant cases are being retriggered and cleared.

Vermont Health Connect's 834 enrollment team continues to work collaboratively with the Optum Maintenance & Operations (M&O) team to identify, issues, patterns, defects and resolutions for all 834 errors. The two teams meet every Tuesday and Thursday to address errors, error resolution and work with the carriers to address errors that might be caused by carrier systems.

Verifications

The Vermont Health Connect system utilizes the Federal Data Services Hub (federal hub) at the time of application to verify Social Security Number, citizenship, Immigration Status, MAGI-based Income (for Medicaid for Children and Adults, or MCA Medicaid), and Annual Income (for QHP with subsidy). Immigration status is being verified through the FDSH, but there is a smaller than expected number of applicants being verified. This result has been logged with Optum and they are currently exploring the root cause. MAGI-based Income functionality was launched in January, but also resulted in a lower than expected number of applicants being verified. Optum reports that it has developed a solution which will be deployed in late August.

In an attempt to reduce the burden on applicants to provide verification items, there were two major efforts to use already verified information in the State's legacy ACCESS system to verify the Social Security Numbers, Citizenship, and Immigration status of individuals in the VHC system. Following these efforts, State staff identified QHP customers – approximately 2,400 households – who need to provide supporting documentation and developed an outreach plan.

Federal rules require that an exchange notices customers and gives 90 days for them to provide appropriate documentation. State staff intend to commence noticing the last week of August. If any items remain unresolved after 90 days, Vermont Health Connect will proceed with disenrollment for 2016. Termination notices will include information about full-cost individual direct enrollment as well as the availability of special enrollment periods should documentation subsequently become available outside of open enrollment.

Regarding income verification, State staff initiated a manual effort to use the Department of Labor's quarterly wage data in ACCESS to verify income for MCA Medicaid in the VHC system. This work has now been paused in advance of Optum's deployment of the late August solution. Unverified cases will then be re-submitted to the federal hub and State staff will follow up with outreach for further documentation as needed.

In-Person Assistance

In July, the Vermont Health Connect Assister Program focused on training and certifying Navigators, Certified Application Counselors, and Brokers for the coming year. Together, these Assisters ensure that Vermonters in every corner of the state have access to in-person assistance if they need help understanding health insurance or signing up for a plan.

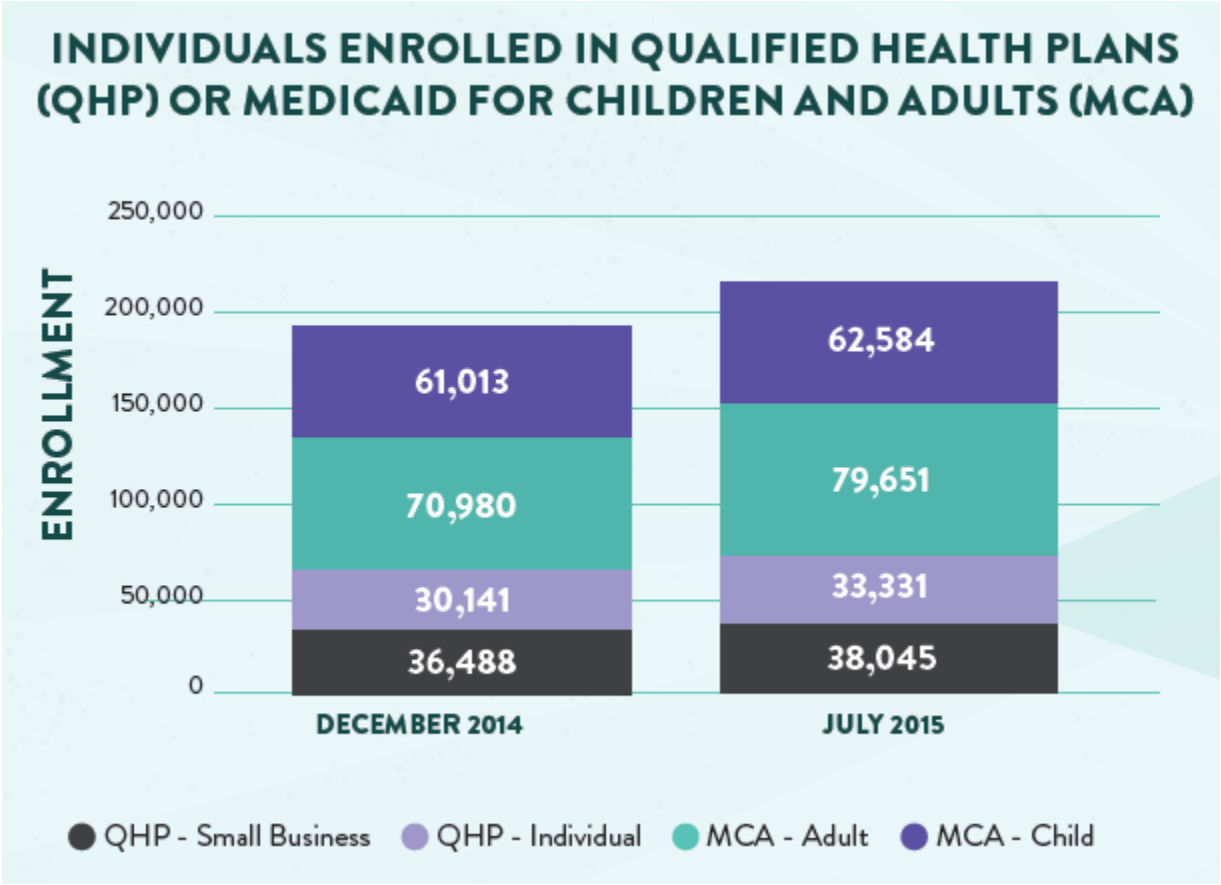
The Assister Program also compiled year-end data from 2015 Navigator Organizations. The reports show that Navigators exceeded their FY2015 targets for in-person enrollment assistance as well as education and outreach. Of note, the Navigators collectively conducted 42,048 consultations with Vermonters – defined as unique interactions of ten minutes or more -- exceeding their goal of 34,790 consultations.

Community organizations, district offices, pharmacies and other partners across the state also play an essential role in connecting Vermonters to in person assistance. The state's libraries are a key focus of this summer's outreach work. Over the last two years, Vermont Health Connect has partnered with libraries across the state to display enrollment information and host sessions with Assisters. VHC is expanding that relationship this summer. Working in conjunction with the State Librarian and regional Department of Libraries staff members, VHC has engaged library directors on the types of materials, events, and support they need in advance of 2016 open enrollment. Additional webinars and preparation efforts are slated for September, after plan design and rate information is released.

Vermonters can find an Assister near them by using the directory or interactive map at http://info.healthconnect.vermont.gov/find or by calling 1-855-899-9600 (toll-free).

Enrollment Update (data through July 31, 2015)

Current Coverage



[1]

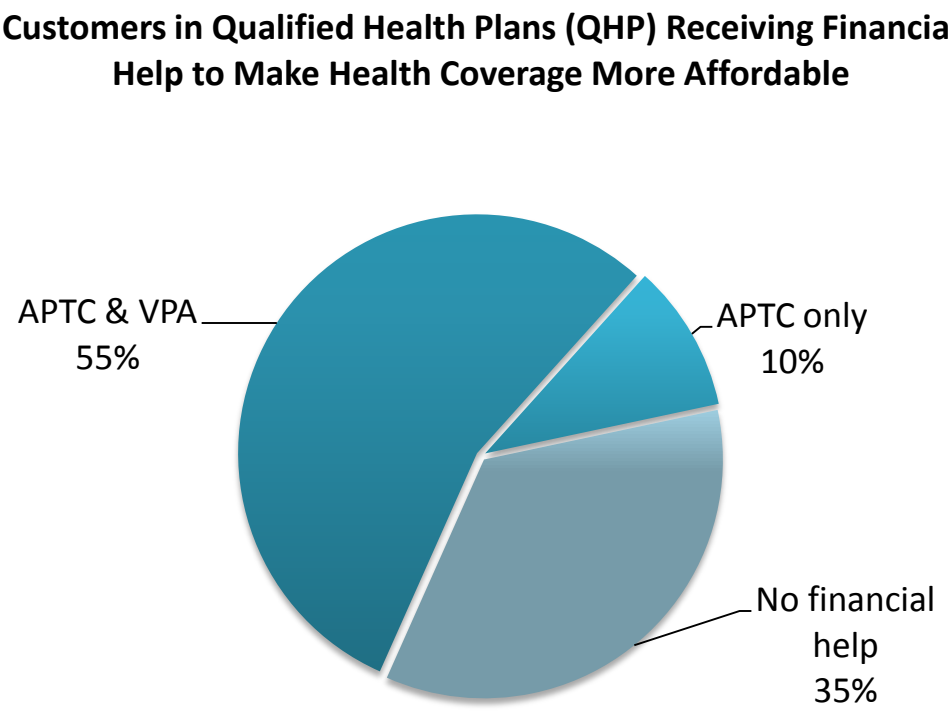
A combination of reports from insurers, VHC, and the State's legacy ACCESS system suggest that Vermont is continuing to reduce its second-lowest-in-the-nation uninsured rate. The number of Vermonters covered by Vermont Health Connect Qualified Health Plans (QHPs) increased by nearly 5,000 from December to July, while the number covered by Medicaid/Dr. Dynasaur increased by more than 10,000. This growth was driven by a strong turnout during the QHP Open Enrollment (November 15 to February 15) and beyond.

Of customers in QHPs:

- Over half (52%) are female,
- Nearly three in five (58%) are between the ages of 45 and 64,
- Over half (56%) are in Silver plans (see Financial Help section for additional selection breakdowns).

[1] Effectuated enrollments for Small Business QHP (direct enrolled) as reported by insurers to VHC. Dec. 2014 Individual QHP as reported by insurers to Center for Medicaid and Medicare Services (CMS). July 2015 Individual QHP as reported by insurers to VHC. Medicaid for Children and Adults (MCA) as reported by Vermont Health Connect and Vermont's legacy ACCESS system. MCA includes Dr. Dynasaur and CHIP but does not include Medicaid for the Aged, Blind, and Disabled (MABD).

Financial Help – Premium Assistance



Between Medicaid/Dr. Dynasaur and premium assistance, nearly nine out of 10 individual customers receive financial help to make health coverage more affordable.

Of individuals in private health plans (QHPs) in 2015:

- Nearly two out of three (65%) qualified for federal Advanced Premium Tax Credits (APTC).
- More than half (55%) qualified for Vermont Premium Assistance (VPA) and cost-sharing reductions (CSR).

The amount of financial help varies depending on household size and income. For example, an individual making less than $46,680 or a family of four making less than $95,400 a year may qualify for some assistance. Of customers receiving financial help:

- The typical (median) individual, who has an income of just under $24,000 per year, receives approximately $340 in APTC and VPA per month and pays $120 for a Silver health plan that costs $460 per month.
- The typical (median) family receives $813 in APTC and VPA per month and pays $495 for a plan that costs $1,308 per month.

Financial Help – Cost-Sharing Reductions

Two out of three (67%) Vermonters who qualify for cost-sharing reductions (CSR) are taking advantage of it, by selecting a Silver Plan. One in six (18%) of these CSR-eligible customers selected a Bronze plan. The Bronze plan could save them hundreds of dollars if they don't need any medical services. If they have high medical needs, however, the Silver plan could save them thousands in out-of-pocket costs.

There are four levels of CSR, which Vermonters qualify for based on household income relative to the federal poverty level. Vermonters with lower incomes qualify for CSR levels that offer steeper reductions in out-of-pocket costs. Consider:

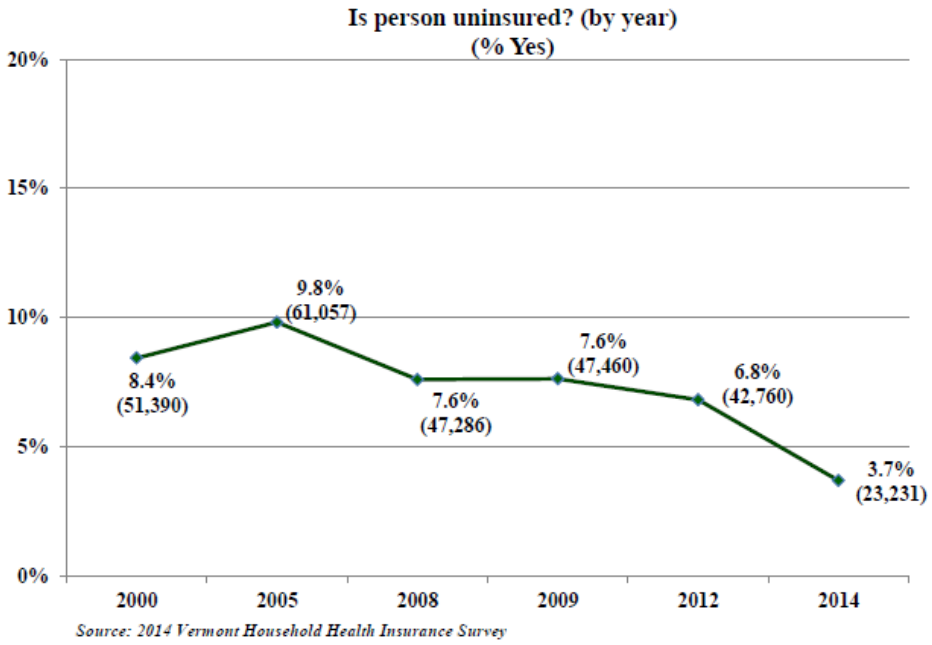
- The typical (median) individual receiving CSR is enrolled in a Standard Silver 87 plan with a $600 medical deductible and $1,250 maximum out-of-pocket (compared to a $1,900 medical deductible and $5,100 maximum out-of-pocket in an unsubsidized Standard Silver plan).
- This individual, who has an income of just over $21,000 per year, also receives $362 in premium assistance, which allows them to purchase a $466 Standard Silver plan for $104 per month.

Vermonters who qualify for the two less generous levels of CSR could conceivably have a lower total cost in a Gold or Platinum plan, depending on their medical needs. Notably, Vermonters who qualify for the two most generous levels of CSR can expect a lower total cost in a Silver plan even if they have high medical needs. Vermont Health Connect has continued to engage CSR-eligible customers, especially those who qualify for the most generous CSR levels (Silver 87 and Silver 94), to make sure they understand how cost-sharing reductions work and what they mean for their total health care costs. These outreach efforts include:

- More customized CSR explanations included last fall on 2015 version of online Subsidy Estimator,
- CSR information in notices,
- Increased emphasis on CSR in call center staff training,
- Outbound calls during open enrollment to make sure Silver 87 and 94-eligible customers understood CSR and that this was likely their last chance to change 2015 plans (barring a qualifying event),
- Additional engagement in advance of 2016 plan selection for both new and renewing customers.

Vermont Health Connect and the State's Uninsured Rate

The percentage of uninsured Vermont residents in 2014 has decreased compared to 2009 and 2012.



The Vermont Household Health Insurance Survey (VHHIS) provides the most comprehensive look into the state of health coverage in Vermont. In January we learned that Vermont's uninsured rate was cut nearly in half over the past two years. With just 3.7% (23,000) of our population uninsured, Vermont is second in the nation in health coverage. Vermont leads the nation in terms of insuring our children, having cut the number of uninsured children in our state from nearly 2,800 in 2012 to fewer than 1,300 in 2014.

Nonetheless, until every Vermonter has quality health coverage, there will be room for improvement. With strong numbers of new applicants coming to Vermont Health Connect in 2015, Vermont is continuing to move closer to the goal of ensuring that all Vermonters are covered.