State of Vermont
Agency of Administration
Health Care Reform
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REPORT TO THE VERMONT LEGISLATURE

Vermont Health Connect Report

In accordance with Act 48 of 2011, Section 2(a)(2)(C)

Submitted to
The General Assembly

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Department of Vermont Health Access/Vermont Health Connect

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Introduction

The State of Vermont launched its Health Benefits Exchange, Vermont Health Connect (VHC), on October 1, 2013. VHC was recognized for having the highest per capita enrollment for 2014 among the states. Moreover, it was recently reported that Vermont's uninsured rate (the number of Vermonters without insurance) was cut nearly in half over the past two years.[1] Approximately 23,000 Vermonters, 3.7% of Vermont's population, remain uninsured. This rate puts Vermont second in the nation in health care coverage.

This success enrolling Vermonters into coverage was achieved due to the hard work and continued efforts of State staff and many partners, including Navigators and other assisters, health insurance carriers, customer service, and technical contractors. At the close of calendar year 2014 certain marketplace IT functionality has yet to be implemented, and there is remaining development work to be continued into 2015. Notwithstanding these technological challenges, VHC has successfully implemented open enrollment for 2015 coverage including the renewal of existing QHP enrollees and over 7,000 new QHP and Medicaid enrollments.

Required under Act 48 Sec 2(a)(2)(C), this report briefly summarizes the development of VHC, provides a current operational and enrollment update, describes VHC's qualified health plans, looks ahead to 2015 priorities, and describes progress in obtaining a federal waiver under section 1332 of the Affordable Care Act.

Summary of VHC Development

The Affordable Care Act mandated the establishment of a health benefits exchange in all states by 2014. Since October 1, 2013, Vermont Health Connect has been operational as Vermont's health benefits exchange. Prior to this federally-mandated launch date,[2] the State executed contracts and took internal steps to implement all required exchange functions, including qualified health plan (QHP) certification, customer support, and streamlined eligibility and enrollment.

QHP Certification

QHP certification is discussed in more detail below. In short, VHC entered agreements with three health insurance carriers to offer QHPs through VHC. All QHPs provide essential health benefits and undergo a rate review process to ensure transparency and fairness in premium rates.

Customer Support

Customer support functions, according to federal rules, include a toll-free call center, an outreach and education program, a Navigator program for in person assistance, and an informational website. VHC has successfully established each of these.

- *Call center*. The State contracted with Maximus, the State's existing Medicaid support vendor, for expanded Vermont Health Connect call center activities. This contracting approach to extend the current DVHA call center allowed the State to leverage existing

[1] 2014 Vermont Household Health Insurance Survey, Department of Financial Regulation Insurance Division
[2] 45 CFR 155.410(b)

knowledge and infrastructure, and provide an effective transition for customers entering Vermont Health Connect.

The Vermont Health Connect Customer Support Center is operating and meeting contracted service levels. The call center serves Vermonters enrolled in both public and private health insurance coverage, providing Level 1 call center support, which includes phone applications, payment, and basic application questions.

The call center is also the entry point for individuals requiring greater levels of assistance with case resolution. Call center staff transfer calls to the Health Access Eligibility Unit (HAEU) for resolution and log service requests which are escalated to appropriate resolver groups, which may include HAEU, VHC's Support Services Unit (SSU), or VHC's payment support team.

- *Outreach and Education*. Prior to the launch of VHC, the State implemented an ambitious outreach and education campaign, as well as a comprehensive training plan. These efforts continue in full force.

  Outreach and education efforts target uninsured and underinsured populations, including young adults (18-34), in order to direct them to the VHC website or an in-person assister where they can learn more about VHC and get assistance enrolling into coverage. These efforts include informational materials, earned media, paid media, social media, and grassroots engagement.

  VHC also regularly consults with stakeholders through its formal Medicaid and Exchange Advisory Board, as well as conferences and public meetings hosted by stakeholder groups. The State collaborated with key stakeholders, including insurance carriers, brokers, small business owners, consumer advocates, and community partners, in the development of the project.

  A robust training program complements outreach and education efforts. Training is available to state staff, stakeholders, and outreach partners.

- *In-person Assistance*. The ACA created the Navigator function to educate individuals and families about the availability of qualified health plans, provide them with fair and impartial information regarding plans that best fit their needs, and help them enroll in their plan of choice. Vermont's Act 48 confirms the five duties of Navigators required by the ACA, and also requires Navigators to facilitate enrollment in Medicaid, Dr. Dynasaur, VPharm, and other public health benefit programs.

  Navigators must meet specific certification criteria, including related experience, organizational infrastructure, and accessibility standards. Each organization undergoes a comprehensive training program that meets federal and state guidelines. The State has developed a tiered Navigator organization management structure to ensure that a sufficient number of organizations are distributed across the State and among eligible populations to provide enrollment assistance and outreach.

VHC also has a Certified Application Counselor (CAC) program. These are individuals who may have already provided health insurance enrollment support in an organization and become certified to do so with Vermont Health Connect. Examples include case workers and financial counselors at hospitals, clinics and social service agencies.

All told, VHC has 204 certified in-person assisters working throughout the state.

- *Informational website*. VermontHealthConnect.gov meets federal standards by allowing customers to easily compare plans and estimate eligibility prior to shopping and enrolling. The website includes many additional informational resources including frequently asked questions, an in-person assistance map, and other tools to assist customers' decision-making. The site was updated for 2015 with a new Subsidy Estimator that has been improved over last year's edition based on feedback received from customers and assisters. The most notable changes are to provide more detailed information for households who qualify for Medicaid and/or cost-sharing reductions.

Eligibility and Enrollment

Vermonters are able to apply for health care coverage through VHC by paper, in person, over the phone, and online, as required under the ACA and Act 48. VHC has made improvements to the application for 2015. Specifically, the application has been improved with easier-to-understand questions, explanations and definitions of difficult terms, and clearer instructions.

A website to facilitate eligibility determinations for and enrollment in health care coverage is a fundamental requirement of the exchange. Much has been reported about the technological challenges VHC has encountered in the development of its website and these are summarized below. It is important to note, however, that the basic online functions are operational for both QHP and Medicaid enrollment. When information is provided by an applicant, the VHC system stores that information, verifies it against electronic data sources, and produces an eligibility determination according to federal rules. The applicant can then easily select a plan and enroll in coverage. VHC, unlike many other state exchanges, also provides online payment processing for the customer.

With respect to the development of the IT system, in December 2012 the state entered into a contract with CGI Technologies and Solutions, Inc. (CGI), to perform software integration and hosting services for the exchange. While VHC provided open enrollment for 2014 coverage as required, it was limited by deficiencies in the functionality of the VHC information technology (IT) platform, inhibiting the intended consumer experience and efficient operations. In particular:

- Functionality to allow employers and their employees to enroll in VHC plans was not deployed successfully in time for employers to enroll employees into coverage for January 1, 2014. As a result, individuals in the small group market were encouraged to enroll directly in VHC plans through Vermont's insurance carriers through 2015.

- Testing and deployment of change of circumstances (COC) functionality was not completed in time to service Vermont customers. As a result, reported changes are made through a manual process.

- The VHC system lacked automated renewal functionality to systematically facilitate enrollment in a 2015 plan. As discussed below, the State instead implemented open enrollment and renewals for 2015 through a largely manual process.

After many months of working with CGI to advance deployment of needed functionality and improve performance and delivery, the State of Vermont and CGI made a mutual decision to transition the remaining development work to a new systems integration vendor. This decision was made in consultation with the federal government and was announced publicly on August 4, 2014. The Termination Agreement transitions system integration services from CGI to a successor, OptumInsight, Inc. (Optum).

Technological deficiencies have required VHC to implement a number of manual workarounds which have led to operational backlogs. In particular, VHC accrued backlogs related to reported changes in circumstances, paper applications, and eligibility notices. The State sought additional resources to assist in the remediation of backlogs and to move forward operationally. Specifically, VHC contracted with Optum to document deficiencies in the State's operating model and to provide a stabilization plan to remediate identified risks. Using the findings from Optum's August 2014 assessment, the State developed a comprehensive Operational Stabilization and Renewals Plan. The plan uses a combination of state and vendor resources to reduce operational backlogs—as described in the following section, improve the efficiency of manual processes to overcome gaps in functionality, and deliver open enrollment for 2015.

Unrelated to IT development, the State also experienced challenges transitioning Medicaid beneficiaries from the legacy eligibility system, ACCESS, into VHC. Vermont's original transition plan required that Medicaid Children and Adults (MCA) enrollees begin to have their eligibility determined in VHC by September 2014. In July, however, the State became aware that a larger than expected number of members (approximately 14,000) did not renew their Medicaid/Dr. Dynasaur coverage during the months of April, May and June. Due to the magnitude of this issue, Vermont received CMS approval to reinstate eligibility for these individuals and has temporarily delayed processing of ACCESS Medicaid renewals. As noted below, Vermont has also asked that all Medicaid renewals be delayed into 2015 to allow time for effective noticing and outreach subsequent to completion of all open enrollment activities. The State is actively working with CMS to solidify its approach which will likely involve restarting legacy renewals in late spring or early summer. The State is exploring additional outreach and application strategies to increase the transition rate once Medicaid renewals resume.

In summary, Vermont Health Connect is currently providing Vermonters with access to quality, affordable health care coverage – in many cases, for the first time. VHC has facilitated enrollment for a large percentage of individuals and small businesses in Vermont. It has a robust outreach and education program and other resources to assist its customers. The State's utmost priority is enrolling Vermonters into appropriate coverage and preserving access to care. Where

technological and other challenges have hindered that, VHC has implemented workarounds to ensure the health and well-being of its customers.

Operational Update

VHC's priorities are ensuring coverage for Vermonters and improving customer experience as well as operational efficiency. This section summarizes VHC's current areas of focus in its operations.

Open enrollment/Renewals

Open enrollment for 2015 began on November 15, 2014 and runs until February 15, 2015. Existing enrollees' renewal of coverage for 2015 has taken place as follows:

- Each enrolled household received a standard renewal notice in October describing open enrollment and the renewals process, and reminding them of the requirement to report changes of information affecting eligibility. The notice also explains that QHP enrollees need not do anything to maintain coverage and will be mapped into a 2015 plan based on their 2014 plan selection if they do not select a new plan and that Medicaid coverage will continue, subject to verification.
- As a preliminary step, Vermont's QHP issuers mapped all enrollees onto 2015 plans. Then, VHC redetermines eligibility for all QHP enrollees using the current manual interim change process. This process involves withdrawing an individual's 2014 application, re-entering their data (including any changes reported), and completing plan selection on behalf of the consumer.
- Following redetermination, enrollees receive a notice of decision describing their updated eligibility. Their subsequent bill reflects the premium due for 2015 coverage. Everyone eligible for a QHP had until December 31 to select a new insurance plan for January 1 coverage and has until February 15 to make changes to 2015 coverage.
- Where VHC does not complete a QHP renewal prior to the end of 2014, the State will ensure the household receives a January 1, 2015 effective date for 2015 coverage.

This renewals process applies to QHP enrollees as well as mixed Medicaid/QHP households. VHC conducted a comprehensive assessment to define the staffing levels needed to support the manual renewals process. Due to resource limitations, the State delayed the start of Medicaid-only renewals for December, January, and February. Medicaid-only households will be renewed in late spring or early summer after automated change in circumstances functionality is delivered.

This resource assessment also identified the need for additional staff beyond the levels provided for by internal VHC staff and Optum augmentation. VHC leadership, therefore, solicited volunteers across the Agency of Human Services to assist in the processing of renewals during the six-week period between November 15 and December 31. Two hundred twenty state staff

responded and were trained to complete a variety of tasks including quality checking and closing of no-change renewals, address updates, and triaging change renewals. Volunteers worked from several different locations across the state and completed VHC renewals assistance on December 31, 2014.

Tax readiness

Beginning with the 2014 tax year, Americans above the filing threshold will have to report on their tax filings that they had health care coverage or an exemption from the requirement to have health care coverage or they will have to pay a tax penalty.[3] Individuals who received advanced premium tax credits (APTC) will also need to reconcile the amount they received to the correct subsidy amount based on their income.[4] VHC's goal is to enable all individuals and stakeholders to file taxes accurately and meet federal requirements.

In order to achieve this goal, VHC has taken operational steps to ensure the accuracy of enrollees' APTC data and execute required reporting to the federal government and to consumers. Specifically, the State sent its first report to the IRS in November. Federal reporting will culminate in a final file sent to CMS in January, along with the mailing of 1095A notices to VHC enrollees by January 31 to support their tax filing. The State does not currently anticipate challenges in meeting these timelines.

The State is also continuing a targeted outreach effort supported by enhanced Vermont Health Connect customer service. It is important to note that VHC cannot provide federal tax advice, and customer service efforts will be to educate enrollees about the process and correctly reporting errors where applicable.

Primary audiences for the outreach effort include Vermont Health Connect customers, small businesses, and tax preparers. For many months, State staff has been providing information to tax preparers about the new tax filing requirements. Currently, Vermont Health Connect is planning a statewide coordinated outreach effort targeting trained Assisters, Volunteer Income Tax Assistance (VITA) Clinics, and local agencies, so that individuals can comfortably discuss their needs and get help. The State will partner with the Office of the Health Care Advocate to develop guidance for individuals and small businesses related to filing year 2014. It will also work to prepare large employers for their responsibilities for 2015. (Large employers have no ACA tax filing obligations in 2014.) The State will also work with relevant partners to host public events where Vermonters will be directed to resources to help with their tax questions as well as enroll in a health insurance plan.

Over the coming months, the State will focus efforts and mobilize resources so that the call center will be trained and internal processes established to support customers through the process of tax filing. Call center staff will be able to handle questions and correct errors on the 1095A tax

[3] ACA, Sec. 1501
[4] 26 CFR 1.36B-4

form sent to all Vermonters with VHC plans. For all other tax-related issues, the call center cannot provide tax advice, but it will point customers to resources such as those described above and be prepared to provide referrals to the IRS and local tax professionals.

The State is engaging the following partners to ensure that information flows together seamlessly.

- Vermont Department of Taxes
- Office of the Health Care Advocate
- Assisters and their affiliated organizations
- Maximus
- Vermont Health Connect Operational Staff
- Professional tax preparation agencies
- Small Business Associations
- The State's Chambers of Commerce
- 2-1-1
- Voluntary Income Tax Assistance (VITA)
- Blue Cross and Blue Shield of Vermont
- MVP Health Care

Backlog Remediation

VHC continues to work on elimination of backlogs, with a focus on remaining change of circumstances (COC) requests. The State has implemented staff augmentation through the vendor Optum in order to work these requests and to reduce errors. While significant progress has been made to reduce the State's inventory of requests over the past three months, new COC requests continue to come in and will need to be manually resolved until functionality is available.

VHC has also seen considerable improvement in 834 transactions and in premium processing. 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.

IT/Functional Priorities

The State has identified functional gaps and prioritized the delivery of additional technological capabilities. In preparation for deployment of remaining functionality, VHC staff performed a gap analysis to identify and prioritize remaining functionality. Areas identified for future development include functionality that will support new operations, such as IRS 1095 reporting, as well as automating and enhancing current manual workaround processes, such as change of circumstance and renewals. Prioritization was based on meeting legal and policy obligations,

ensuring coverage for Vermonters, improving customer experience, and enhancing operational efficiency.

The resulting scope of work for 2014/2015 covers capabilities in two focus areas: functional and IT infrastructure. (IT infrastructure includes items such as security and data architecture.) The first functional priority, which has been completed, was the loading of 2015 plans and eligibility rules to support the 2015 open enrollment period, including renewals. Remaining functional priorities include IRS reporting, automated change of circumstance, automated Medicaid and QHP renewals, and implementation of the small business exchange. Full development of requirements and scheduling of delivery is contingent upon attainment of CMS funding and continued negotiations with the systems integrator.

2014 Enrollment Update

During 2014, over 115,000 Vermonters used Vermont Health Connect to enroll into coverage for at least part of the year. More than 80,000 used VHC to access Medicaid, while 37,000 used VHC to enroll in QHPs. Some Vermonters migrated from Medicaid to QHPs, or vice versa, due to seasonal work, changes in income, or other factors.

Approximately 118,000 Vermonters are enrolled in MAGI Medicaid - the newly expanded Medicaid program. In addition to the 80,000 enrolled in MAGI Medicaid on the Vermont Health Connect system, an additional 38,000 will continue to be served by the legacy ACCESS system until their redetermination in 2015. More than 33,000 individuals were automatically transitioned from the Catamount (CHAP) or Vermont Health Access Program (VHAP) to Medicaid by the State in January 2014.

Finally, more than 36,000 small business employees and families enrolled in VHC plans directly through VHC's insurance carrier partners.

All told, approximately 190,000 Vermonters were covered by VHC plans (QHP and MAGI Medicaid) in 2014.

Vermonters Covered by VHC Health Plans (QHP and MAGI Medicaid)

2014 Enrollees	Individuals Effectuated (Enrolled)
Enrolled through VHC System*	**115,415**
MAGI Medicaid	80,176
Individual/Family QHP	37,239
Small Business QHP - Insurers^	**36,488**
MAGI Medicaid - ACCESS^	**38,181**

*Sub-totals exceed total because an individual could have been in both QHP and Medicaid over the course of 2014.
^Active enrollees as of December 2014.

2014 QHP Enrollees and Financial Help	% Eligible
Premium Tax Credits	64%
Vermont Premium Reduction	54%

Through VHC, many Vermonters received financial help with their health care coverage. Over 23,000 (64%) of QHP enrollees qualified for tax credits to make their coverage more affordable. Nearly 20,000 (54%) also received Vermont Premium Reduction (VPR). The median monthly APTC and VPR amount of Vermonters receiving financial help was $382. The sum total of APTC and VPR paid on behalf of Vermonters for 2014 was more than $7.3 million.

Nearly 20,000 Vermonters also qualified for cost-sharing reductions. Cost-sharing reductions (CSR) lower the amount of out-of-pocket payments for enrollees. These discounts are automatically applied to enrollees at certain income levels who enroll in a silver plan. Nearly 14,000 of these Vermonters enrolled in a Silver plan and received CSR. Combining Medicaid, APTC/VPR and CSR, just under nine out of ten individuals who enrolled through VHC benefitted from some form of financial help.

Among QHP enrollees, over 32,000 enrolled in QHPs from Blue Cross and Blue Shield of Vermont and nearly 5,000 enrolled in QHPs from MVP Health Care. The ACA requires that exchanges offer plans at standardized actuarial value or "metal" levels: Platinum, Gold, Silver and Bronze. Across carriers, over 20,000 (55%) enrollees chose silver plans. The next most popular was bronze with nearly 8,000 (20%), followed by platinum and gold with more than 4,000 enrollees each (13% and 12% respectively). Fewer than 400 Vermonters enrolled in catastrophic plans.[5]

2014 Enrollments	Individuals Enrolled	% of Total QHP Enrollments
Silver	20,314	55%
Bronze	7,617	20%
Platinum	4,824	13%
Gold	4,421	12%
Catastrophic	351	1%

2015 Enrollment Update

Open enrollment for 2015 runs from November 15, 2014 to February 15, 2015. Therefore, VHC cannot provide a comprehensive picture of 2015 enrollment at this time. However, as of December 31, 2014 – the last day for new applicants to confirm a QHP for January 1 coverage – 7,210 individuals who are new to VHC had confirmed 2015 health plans. This includes 3,018 individuals in QHPs and 4,192 individuals in Medicaid or Dr. Dynasaur plans.

After a new customer checks out a plan, they receive an invoice and have 21 days to make an initial premium payment. Their plan selection is then processed and sent to the insurance carrier, completing the enrollment process. As of January 12, 2015, 7,239 have completed the enrollment process and have an active health plan (i.e., effectuated enrollment). Of those who have completed the process, 2,202 are on a Qualified Health Plan and 5,037 are on Medicaid or Dr. Dynasaur.

[5] Catastrophic plans are available to qualified individuals who are under 30 or who have received a hardship exemption from the ACA's shared responsibility requirements. 45 CFR 155.301(h)

Additionally, 23,629 current enrollees had been confirmed into 2015 health plans as of December 31, 2014.

Due to staffing constraints and the manual complexity of the renewals process, the State will continue to process renewals through March 31, 2015. There is an escalation process in place to ensure that individuals with access to care issues receive coverage when needed. Finally, as noted above, VHC has made a system change such that the default effective date for 2015 coverage is January 1, 2015, even if the renewal is processed thereafter.

Qualified Health Plans

There are two medical carriers offering plans on Vermont Health Connect to individuals and small businesses: Blue Cross Blue Shield of Vermont (BCBSVT) and MVP Health Care (MVP), and one dental carrier (Northeast Delta Dental). Act 48 included a prohibition on the sale of health insurance outside of the exchange.[6] Therefore, all Vermonters seeking individual or small business (defined as 50 employees or less[7]) health coverage must purchase a plan certified as a VHC Qualified Health Plan (QHP). For 2014 and 2015, individuals obtain an eligibility determination, apply and pay for their QHP coverage through VHC. As noted above, small businesses apply and pay for coverage directly with the medical and dental carriers, selecting from among the same QHP options available to individuals.

Vermont Plan Management Structure:

The State has a cross-agency structure for reviewing and certifying plans on VHC including the Department of Financial Regulation (DFR) and the Green Mountain Care Board (GMCB) in addition to the plan management responsibilities of VHC. According to Act 48, DFR serves as a conduit for most benefit plan mandates and issue resolution with the Vermont carriers as well as performing the benefit design/forms review and plan certification processes. The GMCB provides programmatic oversight within the State, and conducts the annual rate review and a public hearing process required for all carriers in the State. VHC is responsible for selection of approved plans to offer on the exchange, the maintenance of accurate benefit plan information, and the public display of the information on the VHC website and in printed materials.

Qualified Health Plan Changes 2014 – 2015:

In 2012, the Department of Vermont Health Access (DVHA) issued a request for proposal (RFP) to begin the process of 2014 plan selection by inviting interested carriers to submit plans. This process culminated in entering contracts with the aforementioned QHP carriers for 2014. For 2015, VHC determined that QHPs would remain essentially the same, except for minimal changes required to comply with federal and state mandates.

[6] 33 VSA 1811(b)
[7] 33 VSA 1811(a)(3)

The ACA requires that exchanges offer plans at standardized actuarial value or "metal" levels.[8] In 2014 and again in 2015, both MVP and BCBSVT offered "standard" plans with identical benefits in all metal levels: Platinum, Gold, Silver and Bronze. There are also Silver and Bronze-level high-deductible plans offered by both carriers that can be paired with Health Savings Accounts (HSAs). Both medical carriers offer "non-standard" plans in the Gold, Silver and Bronze metal levels, where the carrier plans offered unique alternatives for applicants, still within the required actuarial values. Northeast Delta Dental eliminated one of its plans, the *Pediatric Low Option Plan*, for 2015, directing all applicants and renewing enrollees to the *Pediatric High Option Plan*. Appendix A provides a brief summary of the 2014 - 2015 benefit changes.

QHP Rate Review

Each year, carriers submit proposed rates to the GMCB who then conducts a review, analysis, public hearing and approval process lasting approximately 90 days. Carrier rate submissions are supported by extensive actuarial analysis based on claims experience from prior periods and projected enrollment and cost trends. Findings from the GMCB's comprehensive analysis of carrier submissions and from the public comment hearings may require the carrier to revise and resubmit rates before receiving final approval. For the 2015 plan year:

- BCBSVT requested a 9.8 per cent average rate increase and received final approval for a 7.7 per cent increase.
- MVP requested a 15.3 per cent rate increase and received a 10.9 per cent final rate increase.
- Northeast Delta Dental received an average 2.45 per cent rate increase for its plans.

Appendix B provides a comparison between 2014 and 2015 individual premiums.

2016 Qualified Health Plans

For 2016, Vermont Health Connect has initiated a streamlined process that eliminates the RFP step used previously, and continues its partnership with current carriers through the annual schedule of plan and rate submission and approval steps already in place. A public notice was issued by DVHA in December 2014 to alert other carriers wishing to submit QHP applications of the required steps and timing for 2016.

Financial Sustainability

To date, Vermont Health Connect has been nearly entirely funded by federal exchange establishment grants. Originally, this funding was only available through the first year of operations (i.e. 2014). This spring, the federal government (CMS) announced that state based marketplaces could seek an extension of their grant project period beyond the first year of operations where the grantee reasonably required additional time to complete the design,

[8] ACA, Sec. 1302(d).

development, and implementation of activities that were part of the grantees' approved work plan under a specific grant.[9] CMS went on to clarify that state based marketplaces could seek additional grants with one year project periods for establishment activities beyond the first year of operations.[10] The final establishment grant application deadline was November 14, 2014.

This fall, VHC requested and received approval for no-cost extensions for its Level 1C and Level 2 establishment grants. Shortly thereafter, VHC submitted a supplemental funding request under its Level 1B, 1C, and 2 establishment grants as well as a new grant request. These funds are needed to cover additional IT development with the State's new systems integrator, as well as continued staff augmentation through open enrollment to support ongoing manual work. CMS responded to these requests in December, however, the amounts granted were lower than requested. VHC is working on a re-baseline exercise in light of the reduced amounts received from CMS. Once that work is complete, an analysis of the scope of the IT development work will be conducted in order to finalize a contract for the completion of VHC functionality in 2015 with the State's new systems integrator.

VHC is preparing its portion of the State budget for state fiscal year 2016, which includes revisions for January to June 2015 and budgeting exercise for July 2015 to June 2016. The funding for VHC operations comes from the VHC Interdepartmental fund and Global Commitment fund. The VHC sustainability budget will be presented to the Legislature for approval as part of the Governor's FY16 budget proposal.

Potential Legislative Changes

At this time, DVHA does not have specific recommendations for statutory changes related to Vermont Health Connect. The most significant legislative priority for the continued operations of Vermont Health Connect will be support for the proposed budgets for operations and continued development VHC functionality.

State Innovation Waiver

Act 48 contemplated the establishment of the Vermont health benefit exchange as the foundation for Green Mountain Care. Before Vermont can fully implement Green Mountain Care, it needs the federal government to waive certain parts of the Affordable Care Act. The ACA requires states to have Health Benefit Exchanges offering health insurance plans[11] and administering federal subsidies to individuals to make the plans more affordable.[12] Individuals pay a penalty if they do not have health care coverage.[13] Large employers pay a penalty if they do not offer

[9] http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/no-cost-extension-faqs-3-14-14.pdf
[10] http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ_1311_project_FAQs_periods.pdf
[11] ACA, Subtitle D, Parts I & II.
[12] Section 36B of the Internal Revenue Code of 1986.
[13] Section 5000A of the Internal Revenue Code of 1986.

affordable and adequate health care coverage.[14] Starting in 2017, the federal government can waive a state's obligation to any or all of the above provisions and allow the state to implement its own innovative health care coverage programs as long as its program maintains the following parameters:

- Coverage of the same amount or more people than under the ACA[15]
- Coverage that is as comprehensive or more comprehensive than coverage under the ACA[16]
- Coverage that is as affordable or more affordable than coverage under the ACA[17]
- A health care system that is deficit neutral for the federal government[18]

To date, the State has engaged in a number of conversations with Federal partners at the IRS and HHS (CMS/CCIIO) about Vermont's application under 1332. These discussions, as well as a detailed analysis of what waiver provisions are necessary to implement Green Mountain Care, are included in the following report: Green Mountain Care: A Comprehensive Model for Building Vermont's Universal Health Care System, which was submitted to the legislature on December 30, 2014[19].

[14] Section 4980 of the Internal Revenue Code of 1986.
[15] ACA, Section 1332(b)(1)(C); 42 U.S.C. 18052(b)(1)(C).
[16] ACA, Section 1332(b)(1)(A); 42 U.S.C. 18052(b)(1)(A).
[17] ACA, Section 1332(b)(1)(B); 42 U.S.C. 18052(b)(1)(B).
[18] ACA, Section 1332(b)(1)(D); 42 U.S.C. 18052(b)(1)(D).
[19] The report may be found online at http://hcr.vermont.gov/GMC_Report_2014

Appendix A: 2014-2015 QHP Benefit Changes

Carrier & Plan Name	2014 Benefit	2015 Benefit
BCBSVT & MVP: Standard Platinum	Deductible: $100 Ind/$200Fam	Deductible $150 Ind/$300 Fam
BCBSVT & MVP: Standard Silver	PCP Visit Co-Pay: $20	PCP Visit Co-Pay: $25
	Specialist Visit Co-Pay: $40	Specialist Visit Co-Pay: $45
BCBSVT & MVP: Standard Bronze	Rx Deductible $200 Ind/$400 Fam	Rx Deductible $300 Ind/$600 Fam
BCBSVT & MVP: Silver HDHP	Rx Max Out-of-Pocket: $1,250 Ind/$2,500 Fam	Rx Max Out-of-Pocket: $1,300 Ind/$2,600 Fam
BCBSVT & MVP: Standard Bronze HDHP	Rx Max Out-of-Pocket: $1,250 Ind/$2,500 Fam	Rx Max Out-of-Pocket: $1,300 Ind/$2,600 Fam
BCBSVT: Blue Rewards Bronze HDHP	Rx Max Out-of-Pocket: $1,250 Ind/$2,500 Fam	Rx Max Out-of-Pocket: $1,300 Ind/$2,600 Fam
MVP Vitality-Plus Gold	Medical Deductible: $500 Ind/$1000Fam	Medical Deductible: $350 Ind/$700 Fam
	Rx Deductible: $75 Ind/$150 Fam	Rx Deductible: $100 Ind/$200 Fam
	Medical Max Out Of Pocket: $5,100 Ind/$10, 200	Medical Max Out Of Pocket: $5,300 Ind/$10,600
	Rx Max Out of Pocket: $1250 Ind/$2500 Fam	Rx Max Out of Pocket: $1300 Ind/$2600 Fam
	Ambulance: $50 Copay	Ambulance: Deductible then $50 copay
	Emergency Room: 20% co-insurance	Emergency Room: Deductible, then $200
	Rx Preferred Brand: $50 co-pay	Rx Preferred Brand: $50 co-pay
MVP Vitality-Plus Silver	Medical Deductible: $1,700 Ind/$3400 Fam	Medical Deductible: $1,800 Ind/$3600 Fam
	Rx Deductible: $200 Ind/$400 Fam	Rx Deductible: $250 Ind/$500 Fam
	Medical Max Out-of-Pocket: $5,100 Ind/$10,200 Fam C	Medical Max Out-of-Pocket: $5,300 Ind/$10,600 Fam
	Rx Max Out of Pocket: $1250 Ind/$2500 Fam	Rx Max Out of Pocket: $1300 Ind/$2600 Fam
	Primary Care Office Visit: $10	Primary Care Office Visit: $15
	Specialist Office Visit: $40	Specialist Office Visit: Deductible, then $50
	Urgent Care: $60	Urgent Care: Deductible then $60
	Ambulance: $100	Ambulance: Deductible then $100
	Emergency Room: $400	Emergency Room: Deductible, then $250
	Rx Generic (Tier 1): $12	Rx Generic (Tier1): Deductible, then $12
	Rx Preferred Brand (Tier 2): $60	Rx Preferred Brad (Tier 2): Deductible then $40
MVP Vitality-Plus Bronze	Medical Max Out-of-Pocket: $6350 Individual/$12,700 Fam	Medical Max Out-of-Pocket: $6600 Individual/$13,200 Fam
	Rx Max Out-of-Pocket: $1250 Ind/$2500 Fam	Rx Max Out-of-Pocket: $1300 Ind/$2600 Fam
Northeast Delta Dental	Pediatric Maximum Out of Pocket (MOOP) expense: $1,000 per child	Pediatric Maximum Out of Pocket (MOOP) expense: $350 one child/$700 two or more children

Appendix B: 2014-2015 QHP Rate Comparison

(Premiums for individuals)

Category	Plan Name	2014 Rate Single	2015 Rate Single	2015 $ Increase	2015 % Increase
Standard Plans	BCBSVT Platinum	$582.79	**$624.18**	$41.39	7.10%
	MVP Vitality Platinum 150	$594.30	**$646.77**	$52.47	8.83%
	BCBSVT Gold	$497.06	**$541.75**	$44.69	8.99%
	MVP VT Vitality Gold 750	$513.83	**$572.84**	$59.01	11.48%
	BCBSVT Silver	$425.19	**$465.61**	$40.42	9.51%
	MVP Silver	$427.51	**$484.95**	$57.44	13.44%
	BCBSVT Bronze	$359.47	**$395.78**	$36.31	10.10%
	MVP Vitality Bronze HMO 3500	$336.13	**$382.35**	$46.22	13.75%
	BCBSVT Blue Rewards CDHP Silver	$412.83	**$436.20**	$23.37	5.66%
	MVP Vitality HDHP Silver	$428.58	**$456.19**	$27.61	6.44%
	BCBSVT Blue Rewards CDHP Bronze	$362.34	**$384.02**	$21.68	5.98%
	MVP Vitality HDHDP Bronze	$366.22	**$390.03**	$23.81	6.50%
Blue Rewards Plans	Blue Rewards Gold	$460.37	**$493.87**	$33.50	7.28%
	Blue Rewards Silver	$395.26	**$428.14**	$32.88	8.32%
	Blue Rewards Bronze	$341.15	**$360.49**	$19.34	5.67%
MVP VT Vitality Plus Plans	MVP Vitality Plus Gold 350	$521.59	**$576.02**	$54.43	10.44%
	MVP Vitality Plus Silver HMO 1700	$419.17	**$460.09**	$40.92	9.76%
	MVP Vitality Plus Bronze HMO 3000	$341.95	**$387.82**	$45.87	13.41%
Catastrophic Plans	Blue Rewards Catastrophic	$213.68	**$228.24**	$14.56	6.81%
	MVP Secure VT	$195.61	**$208.66**	$13.05	6.67%