VERMONT

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Agency of Human Services

M E M O R A N D U M

To: Rep. Ancel, Chair, Health Reform Oversight Committee
Sen. Ashe, Chair, Health Reform Oversight Committee

From: Steven M. Costantino, Commissioner, Department of Vermont Health Access

Cc: Hal Cohen, Secretary, Agency of Human Services

Date: April 16, 2015

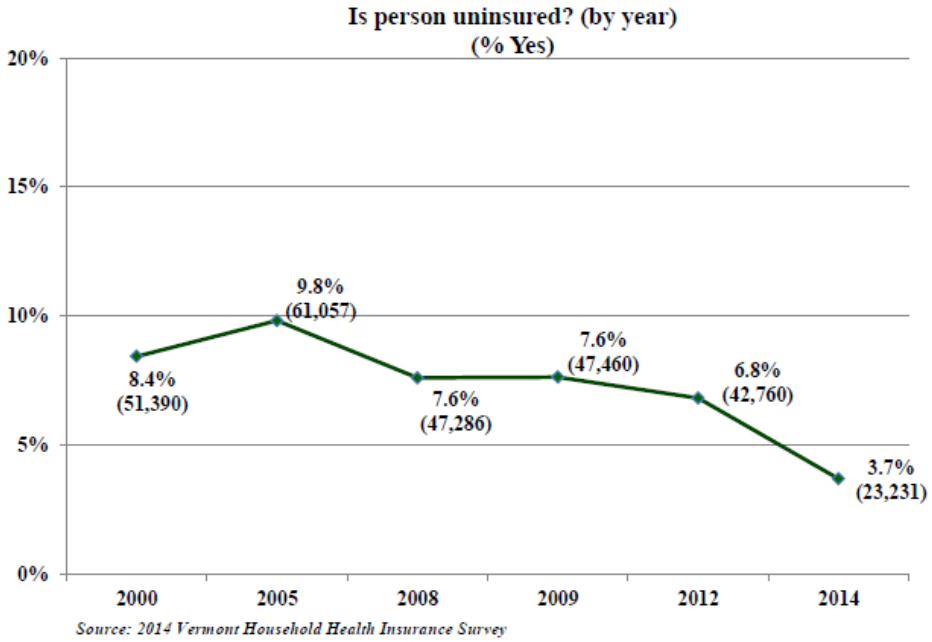
Re: Vermont Health Connect Report – March 2015

At your request, I am providing the following update on the Health Benefits Exchange (Insurance Marketplace), Vermont Health Connect. If the committee has questions about the structure or contents of this update or future updates, please contact me.

Current Coverage Numbers

VHHIS

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



Source: 2014 Vermont Household Health Insurance Survey

Even when our system is upgraded with improved reporting functionality, the Vermont Household Health Insurance Survey (VHHIS) will remain the most comprehensive look into the state of health coverage in Vermont.

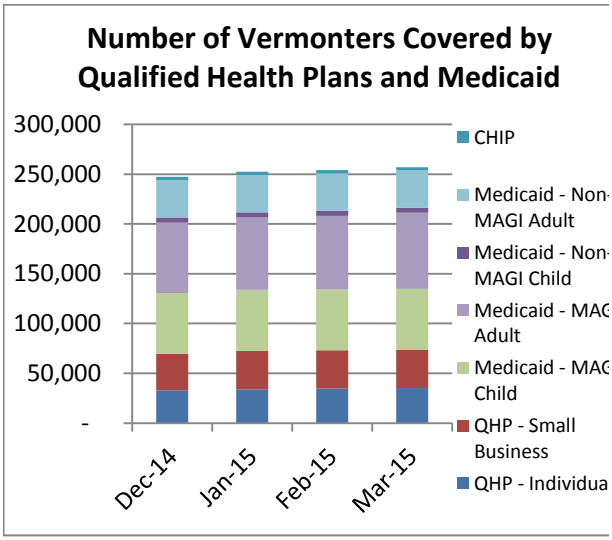
In January we learned that Vermont's uninsured rate was cut nearly in half over the past two years.

- With just 3.7% (23,000) of our population uninsured, Vermont is #2 in the nation in health coverage.
- Vermont is #1 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, Vermont has room for improvement – and Vermont Health Connect is well-positioned to help.

- HHIS also reported that over half of Vermont's uninsured children would qualify for Dr. Dynasaur and three in ten uninsured adults would qualify for Medicaid.
- With strong numbers of new applicants coming to Vermont Health Connect during open enrollment – and many qualifying for Medicaid and Dr. Dynasaur – we are confident that we are continuing to move closer to our goal of ensuring that all Vermonters are covered.

New Enrollments and Current Coverage: QHP and Medicaid



	Dec-14	Jan-15	Feb-15	Mar-15
QHP - Individual	33,027	34,038	34,693	35,158
QHP - Small Business	36,488	38,543	38,312	38,230
Medicaid - MAGI Child	61,013	61,193	61,142	61,596
Medicaid - MAGI Adult	70,980	72,749	74,071	76,187
Medicaid - Non-MAGI Child	5,083	5,064	5,026	4,978
Medicaid - Non-MAGI Adult	37,527	37,616	37,610	37,635
CHIP	3,216	3,240	3,223	3,222
ALL QHP	**69,515**	**72,581**	**73,005**	**73,388**
ALL MEDICAID & CHIP	**177,819**	**179,862**	**181,072**	**183,618**

Note: QHP numbers as reported by insurers; Medicaid numbers as reported by Vermont Health Connect and ACCESS. MVP's March numbers are yet to be reported; assume steady from February.

A combination of reports from insurers, VHC, and the State's legacy ACCESS system suggest that Vermont is to 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 4,000 from December to March, while the number covered by Medicaid increased by nearly 6,000.

Of note:

- All Vermonters who had QHPs through the end of 2014 have been auto-mapped into 2015 plans by BCBSVT and MVP while Vermont Health Connect finishes processing renewals. As of the end of March, approximately three quarters (73.4%) of renewals had been completed.
- MVP's March numbers are yet to be reported. The numbers above assume steady February-to-March numbers for MVP individuals and small business.

Individuals New to VHC Since Start of 2015 Open Enrollment		
By Coverage Start Date		
Coverage Start Date	**Qualified Health Plan (BCBSVT & MVP)**	**Medicaid & Dr. Dynasaur**
January*	3,829	7,448
February	594	2,917
March	1,155	1,519
April	150	44
Total	**5,728**	**11,928**

*January Medicaid numbers include individuals who enrolled during QHP Open Enrollment and received earlier start dates (because Medicaid enrollment is year-round and has retroactive start dates)

Increase in Medicaid Enrollment since Expanded Medicaid

State	State Medicaid & CHIP Enrollment			National		
	Total Medicaid & CHIP Enrollment (January 2015) (Preliminary)	Comparison of January 2015 data to July-September 2013 Average Enrollment		Total Medicaid & CHIP Enrollment, all States (January 2015) (Preliminary)	Comparison of January 2015 data to July-September 2013 Average Enrollment	
		Net Change	% Change		Net Change	% Change
Vermont	179,514	18,433	11.44%	69,975,289	11,151,468	19.29%

Source: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-State/vermont.html

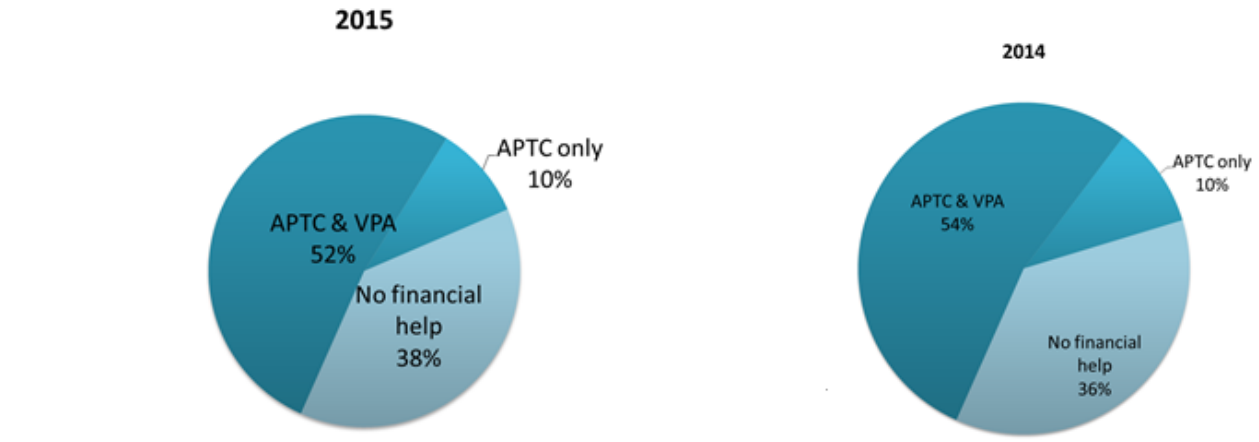
Earlier this winter, the Center for Medicaid and Medicare Services (CMS) posted numbers on Medicaid.gov showing an inordinately large increase in Medicaid enrollment over the last year-and-a-half. They recently posted the correct numbers (above), showing an increase in Medicaid & CHIP enrollment of 18,433 from summer 2013 to January 2015. This increase aligns with the roughly 21,000 increase from 2012 to 2014 reported by the 2014 Vermont Household Health Insurance Survey.

The earlier discrepancy was due to a difference in the types of programs that were included in the 2015 figures, as opposed to the baseline. At CMS's request, partial benefits program recipients are now excluded from the 2015 numbers in order to provide an apples-to-apples comparison with the baseline.

The Medicaid.gov report shows that Vermont's increase (+11%) in Medicaid enrollment has been smaller than the national increase (+19%). This should not be a surprise. With a strong record of insuring our citizens, and now the second lowest uninsured rate in the nation, Vermont had less room for growth than many other states.

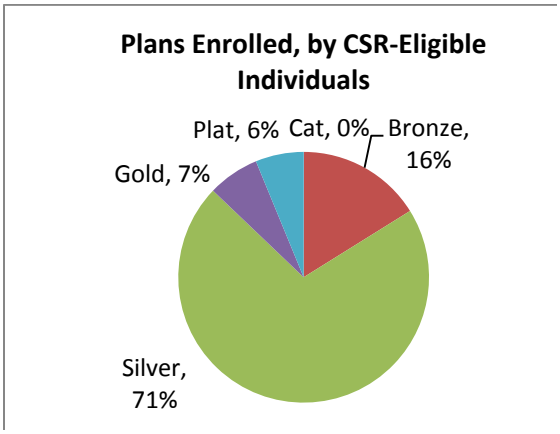
Financial Help

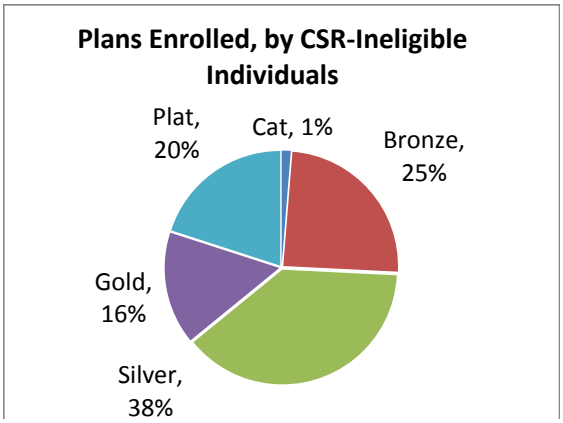
Customers in Private Health Plans (QHP) Receiving Financial Help to Make Health Coverage More Affordable



- Between Medicaid/Dr. Dynasaur and premium assistance, nearly nine out of 10 Vermont Health Connect customers receive financial help to make health coverage more affordable.
- Of customers in private health plans in 2015:
  - Three out of five (62%) qualified for federal Advanced Premium Tax Credits (APTC).
  - More than half (52%) qualified for Vermont Premium Assistance (VPA) and cost-sharing reductions (CSR).
  - The proportion of QHP customers qualifying for APTC was slightly higher in 2014 (64%). This figure has been on the rise over the last couple months (was 58% in late January). We expect that this is due to uneven renewal processing. Specifically, individuals who didn't receive financial help were probably more likely to have a fast renewal because their renewal was less likely to be impacted by income changes and eligibility redetermination. It is reasonable to expect that it will be closer to 2014 levels once the final quarter of renewals are fully processed.

Plan Selection





- Most (seven in 10) Vermonters who qualify for cost-sharing reductions are taking advantage of it, by selecting a Silver Plan.
- One in seven (16%) CSR-eligible customers selected a Bronze plan. This could save them hundreds of dollars if they don't need any medical services. If they have high medical needs, however, they could pay thousands more in out-of-pocket costs.
- 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.
- 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.
- 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:
    - 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,
    - Early February outbound calls to make sure Silver 87 and 94-eligible customers 1) understood CSR and 2) that this was likely their last chance to change plans for 2015 (barring a qualifying event),
    - Additional engagement in advance of 2016 plan selection for both new and renewing customers.

Tax Filing: 1095-A

Vermont Health Connect mailed 25,600 initial 1095-A forms at the end of January, followed by smaller batches of corrected 1095-A forms each week starting March 6. A 1095-A form or forms was mailed to every customer who purchased a Bronze through Platinum plan through Vermont Health Connect in 2014. Vermonters who enrolled only in dental, catastrophic, and Medicaid/Dr. Dynasaur plans did not receive 1095-A forms.

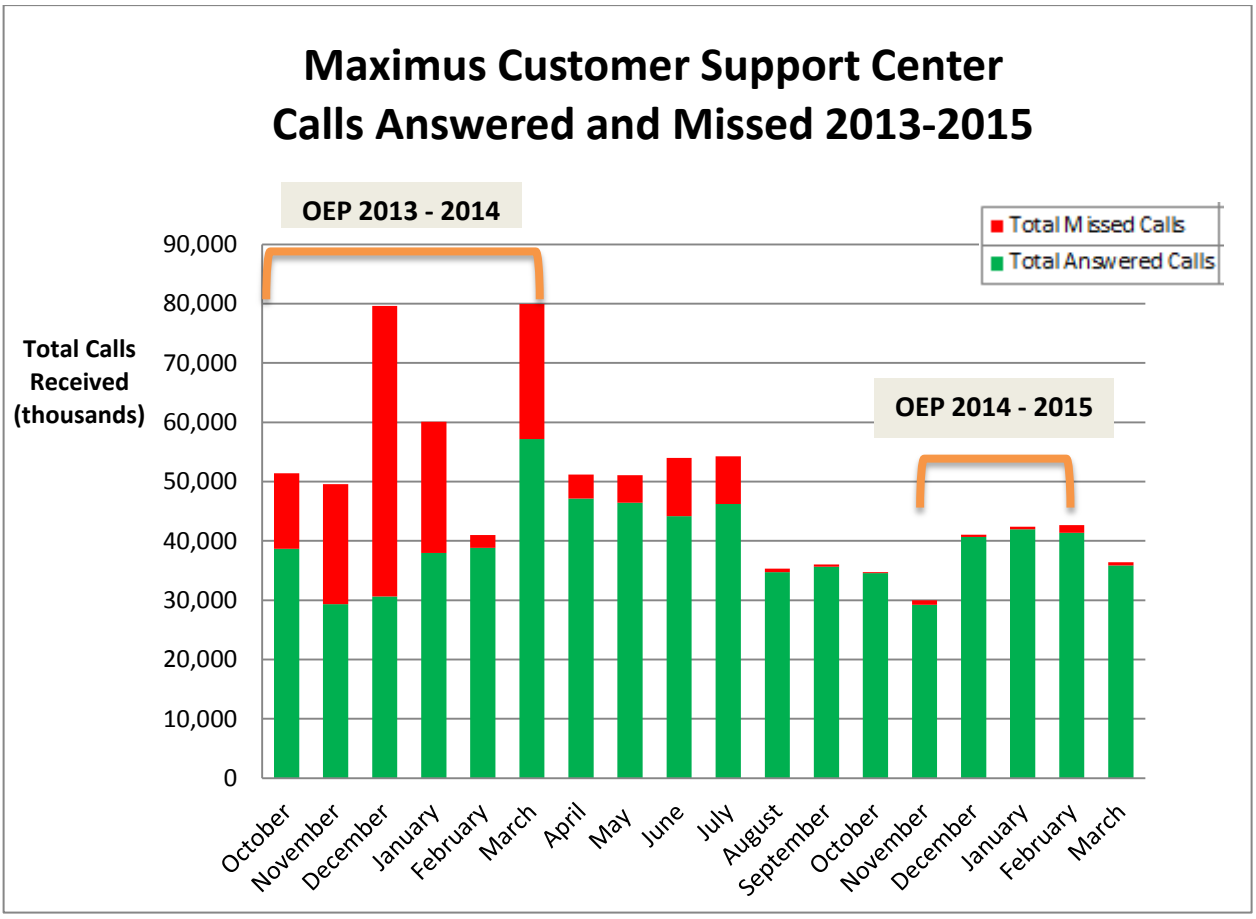
Corrected forms include:

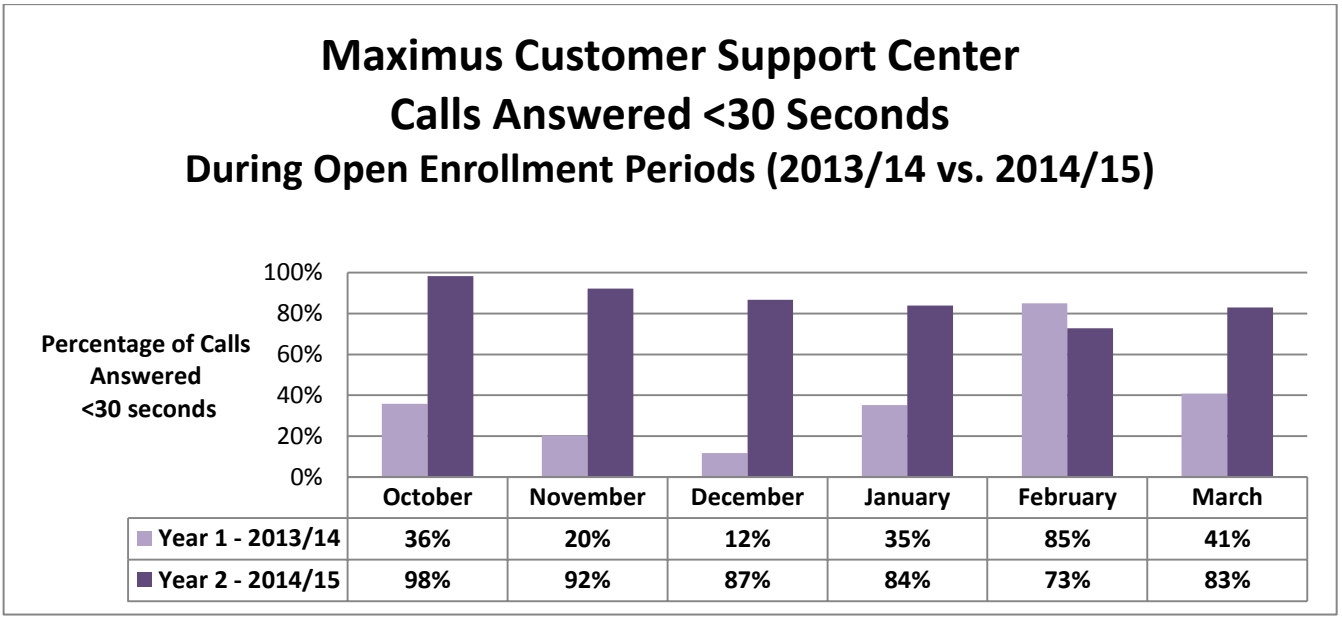
- Address changes
- Change of Circumstance (CoCs) requests processed after January 15
- Premium payments for December coverage received after January 15

Vermont Health Connect created a reconsideration process for 1095-A corrections. This process is offered to customers after Vermont Health Connect's 1095-A resolution group has reviewed the case for potential corrections to the form. Within 30 days, customers can request that a panel conduct a paper review by filling out a Request for Reconsideration form. After a panel review, the DVHA Legal Division writes a summary of its decision and closes the case.

In March, the IRS announced that anyone who enrolled in qualifying Marketplace coverage, received an incorrect 1095-A form, and filed a tax return based on that form does not need to file an amended tax return. This means taxpayers have choices related to late-arriving corrected 1095-A forms. They don't have to amend their return if the corrected 1095-A comes after they file, but they still have the option to amend if they so choose. Vermont Health Connect reminded Vermonters that the marketplace can't give tax advice but that individuals may want to consult with their tax preparers to determine if they would benefit from amending.

Customer Support Center (Maximus Call Center)





	October	November	December	January	February	March
Year 1 - 2013/14	36%	20%	12%	35%	85%	41%
Year 2 - 2014/15	98%	92%	87%	84%	73%	83%

Last Month

In March, the Customer Support Center answered 35,874 calls and missed 487 for an abandon rate of 1.3%. The average wait time was 28 seconds. Four out of five calls (83%) were answered in less than 30 seconds. This was an improvement over both the prior month and the prior March, although both of these comparison months included an open enrollment period.

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 abandon 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.

Assister Program

Vermont Health Connect has approximately 180 active Navigators and Certified Application Counselors in communities across the state. In addition, there are about 180 active Brokers.

Since July 1, 2014:

- Using outreach tools such as social media, state fairs, career fairs, and community forums, Assisters have had a total of 1,090,298 unique outreach interactions with customers.
- There have been more than 29,000 Assister Outreach events across the state.
- Assisters have provided more than 17,000 individual consultations (defined as a unique encounters of 10 minutes or more).
- Assisters have supported in the completion of over 7,400 applications and enrollments.

The current grant period runs through June 30, 2015. The VHC Assister Program is currently undergoing a review and program evaluation to assess how it can most effectively supporting Vermont Health Connect's mission and goals in the future. The program evaluation has involved surveys and interviews with grant managers, Brokers, Navigators and other stakeholders.

Escalated 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.

Recent rounds of training throughout Vermont Health Connect's various teams have resulted in 1) a reduction in the number of cases that need to be escalated and 2) an increase in the rate at which this dedicated team can resolve cases. As a result, the number of pending Qualified Special Cases has fallen to its lowest level in five months.

Over the course of the four weeks ending April 3, the team received 89 new cases, down from 111 over the previous four weeks. Over the same period, the team resolved 179 cases, up from 98 over the previous four weeks. Together this resulted in a decrease in the number of Qualified Special Cases pending resolution from 115 to 35, a 70% drop.

Recently completed cases include:

- Generating 1095-A corrections,
- Issuing refunds for overpayments,
- Correcting renewals,
- Finding and applying payments.

Qualified Special Cases

Received, Resolved, and Pending

WEEK OF	Received	Resolved	Net Resolved	Pending Resolution
30-Mar	8	28	20	35
23-Mar	15	47	32	55
16-Mar	30	61	31	87
9-Mar	36	43	7	108
2-Mar	18	8	(10)	115
23-Feb	33	18	(15)	107
16-Feb	27	40	13	90
9-Feb	33	32	(1)	103
2-Feb	29	25	(4)	102
26-Jan	34	44	10	98
19-Jan	23	31	8	108
12-Jan	48	36	(12)	116
5-Jan	17	25	8	104
29-Dec	23	15	(8)	112
22-Dec	15	3	(12)	104
15-Dec	12	1	(11)	92

COC Processing

Change of Circumstance (COC) requests are changes to 2015 health plans, income, or household information. These requests, which were being made at a rate of approximately 125 per day in 2014 and early 2015, have recently slowed to 75-100 per day. Nonetheless, COC processing has continued to be a heavy lift, and will continue to be a major challenge until key functionality is delivered in late May to allow staff to quickly process changes.

Vermont Health Connect continues to prioritize medically urgent and financially urgent cases. Requested changes to 2015 health plans, income, or household information are processed with an effective date that is determined by federal rules. For example, a change that was reported between January 16 and February 15 is made effective retroactive to March 1.

With the end of open enrollment, Vermont Health Connect added new capacity to process change requests. First, the Customer Support Center (Maximus) began working 2015 CoCs in February. In addition, the Health Access Eligibility Unit (HAEU) trained all eligibility staff to process CoCs, effectively expanding HAEU's COC-processing team from 16 staff to more than 60. By late March, these resources began to make meaningful progress in COC processing in the Vermont Health Connect system, processing a greater number of changes than were being newly reported.

The manual workarounds to integrate processed changes with the payment processor and insurers' system have remained a major challenge. To address this challenge, new resources were added to double the capacity of the integration team, known as the Lion's Den. In late March, the team's move to Essex was accelerated as staff volunteered to move ahead of noticed schedule in order to get a jump start on training new staffers.

Renewals Processing

2015 Renewals - Active and Closed					
Renewal Cases	**Awaiting Triage**	**In Process**	**In QC**	**Awaiting Integration**	**Total Closed**
as of April 1	**187**	**2,440**	**222**	**3,346**	**16,600**

Important notes about the numbers above:

- *These renewing customers do have current coverage – they have been auto-mapped by their 2014 insurance carriers and have current coverage, even though it is not up-to-date in the VHC system.*
- *"Cases" refers to service requests, not households; one household could make separate change requests and thus have multiple service requests over the course of the renewal process.*

Like COC processing, renewal processing has been a painstaking effort with manual workarounds. Vermont Health Connect is nearing the end of the process and is committed to finishing prior to the implementation of COC functionality in May.

Most of the remaining renewals are Eligibility/Plan Change Renewals or Age-offs and Program Change Renewals.

Eligibility/Plan Change Renewals are cases of households that are making changes to their health plan, income, or household information. These renewals are completed in a two-step process: first they are processed as a no-change renewal, then they are processed as a Change of Circumstance, retroactive to January 1.

Age-offs refer to households with a member whose eligibility is changing by virtue of their birthday (e.g. turning 26 and no longer qualifying to stay on a parent's plan or turning 65 and gaining Minimum Essential Coverage by virtue of qualifying for Medicare). Program changes refer to households with a member(s) whose eligibility changed by virtue of increases to the federal poverty level (e.g. a Vermonter whose income was 139% of 2013 FPL, which then became 137% of 2014 FPL, thereby newly qualifying them for Medicaid even though their income was unchanged).

Medicaid Renewals – Legacy System Renewals

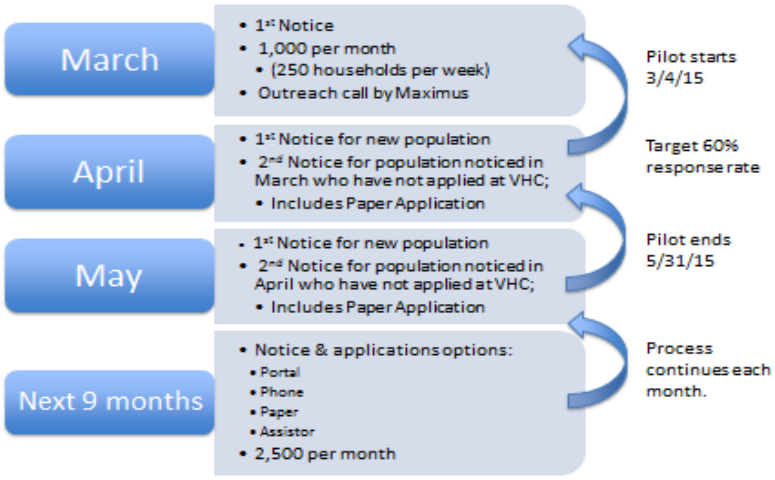
In early March, Vermont Health Connect began to implement its plan to transition 26,000 households from the State's legacy ACCESS system to Vermont Health Connect to receive their MAGI Medicaid eligibility determination.

The plan begn with a pilot of highest income households, as they are the most likely to no longer be eligible for Medicaid. The pilot involved small numbers of renewals, scheduled over a three-month period of time to allow Vermont Health Connect to assess the success of its renewal strategy. Once the strategy is refined and Vermont Health Connect understands which method of outreach is most successful, the monthly renewal cadence will increase to allow for the legacy system transition to be completed by March 2016.

The eligibility team began sending 250 notices per week, beginning the first week in March. The first notice tells the recipient that they need to apply at Vermont Health Connect within 30 days, but does not include a closure date. At the same time, customer service representatives (CSRs) at Maximus make two to three attempts to reach each household by phone. If they reach a recipient, the CSRs offer to guide them through a phone application.

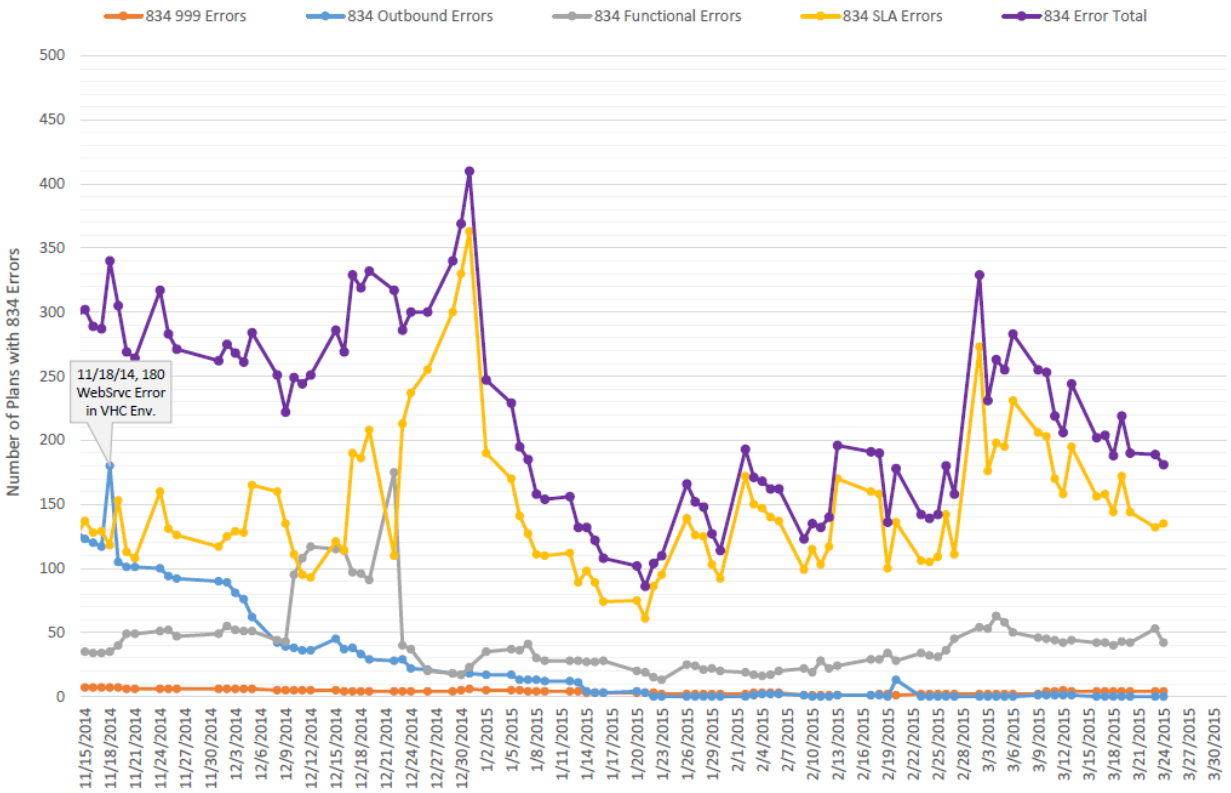
Four weeks after the first notice, the eligibility team will send a second notice to those who haven't yet applied. This notice includes a paper application and asks households to either call the Customer Support Center or complete and mail the application within 30 days.

Four weeks after the second notice, the eligibility team will consider a process to close Medicaid in ACCESS.



Target: 26,000 renewals communicated, processed, or closed within one year

Carrier Integration



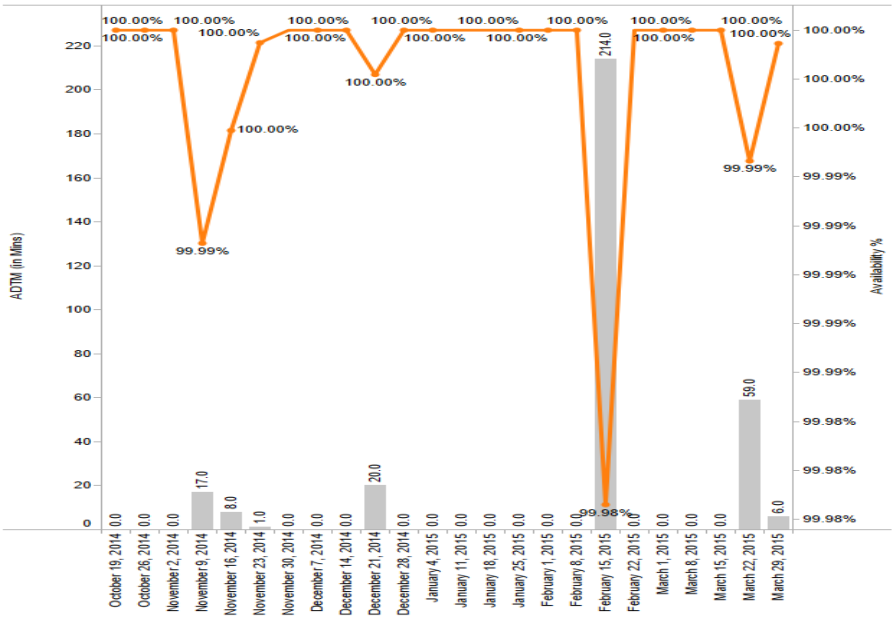
Vermont Health Connect continues to work to resolve 834 transaction and premium processing errors. An 834 is an electronic file sent from VHC to an insurance carrier with information about an individual or family's enrollment information. An 834 error indicates that this electronic file has not yet been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

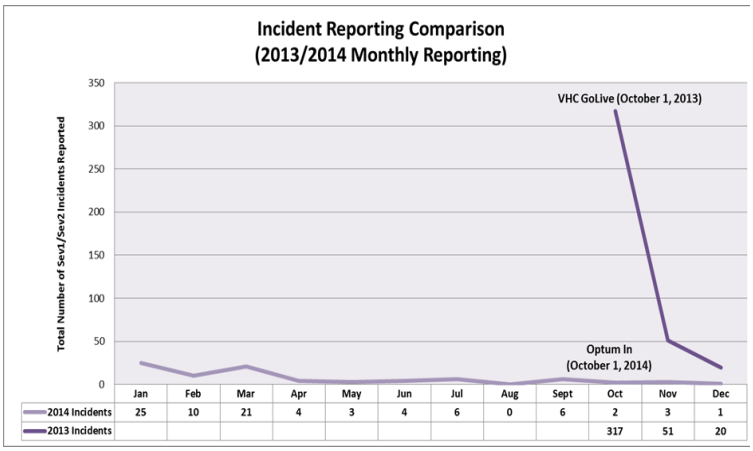
The State was successful in reducing the inventory of 834 errors from over 1,000 last spring to under 100 by January. Errors ticked up in February with heavy volume toward the end of open enrollment, then declined throughout March, with fewer than 200 as of March 24.

Vermont Health Connect is also currently collaborating with BCBSVT to modify the 834 resolution process. BCBSVT made a change in their system to not accept duplicate contact IDs. As a result, Stage 2 834 errors (errors that occur before a customer is effectuated) require an entirely new process which is now being piloted, modified and finalized. Vermont Health Connect and BCBSVT hold weekly sessions to finetune the process and go over difficult cases. The new process does add several additional steps, thus the resolution time for each BCBSVT error has increased. The process for resolving Stage 3 834 errors (errors that occur after a customer is effectuated) with BCBSVT was not impacted.

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.

System Performance and Traffic





Month	Avg. Page Load Time (sec)	Max. Peak User	Visits
November 2014	4.5	596	51,193
December 2014	3.9	600	75,381
January 2015	4.8	345	72,542
February 2015	5.0	510	73,206

Our system was stable throughout this year's open enrollment period, thanks to our partners at Optum.

- 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. This does not include the scheduled maintenance that occurs overnight.
- Three incidents since the end of Open Enrollment have resulted in the site being unavailable for short periods. The longest incident occurred early in the morning of February 19. After 214 minutes of downtime, service was restored when a corrupted file was recovered.

2015 Milestones

Now that 2015 open enrollment is over, Vermont Health Connect is focused on continuing to make technology improvements to ensure a better customer experience for Vermonters. A series of milestones have been developed that we believe are realistic and achievable. However, if those milestones are not met, we have developed a contingency plan that will be pursued.

We have identified critical milestones to assess Vermont Health Connect's progress.

- By the end of May – The vendor Optum is expected to deliver "Change of Circumstance" technology which will allow customer service staff to significantly reduce the amount of time it takes to process account changes.
- By October – Customer service staff is expected to process changes that are reported by the 15th day of a month in time to be reflected on the next invoice.
- By October – The vendor is expected to deliver the technology needed to enable a smooth renewal and enrollment process for 2016 health plans.

If Vermont Health Connect fails to deliver improved service for Vermonters, we will pursue a move to a Federally-Supported State-based Marketplace (FSSBM).

- There are three federal marketplace options, all of which use the healthcare.gov web platform and federal call center.
- Of the three federal options, the FSSBM allows states to maintain the most authority over their health plans, which would enable Vermont to preserve such health reform efforts as Blueprint for Health and payment reform.
- There are drawbacks.
    - The federally supported marketplace would only serve as the enrollment gateway for private health insurance plans.
    - Medicaid applicants would still come through Vermont Health Connect and VHC would still need to be finished for this purpose.
    - Families with both a private health insurance plan for some and Medicaid or Dr. Dynasaur for others– as well as those who transition between programs – would need to call two different phone numbers and deal with two separate call centers. Any issues signing up for private health insurance would go to the federal government's call center.
- As policymakers, we need to weigh the costs and benefits of making such a move.

Important questions remain. Answers will be clearer by fall.

- *Will the Supreme Court allow customers of federally supported marketplaces to benefit from tax credits that reduce the cost of health insurance?*
    - This is a critical consideration, given that Vermonters received over $50 million in premium tax credits last year.
    - The decision expected in June. After the decision, the state will work with federal partners to understand the potential impact on Vermonters.
- *Will Vermont be able to continue to offer state premium and cost-sharing assistance to individuals and families purchasing qualified health plans through the federally supported marketplace?*
    - No states that use a federal marketplace currently offer such help to their citizens. And none have been able to achieve an uninsured rate as low as Vermont's.
    - Without this help, a Vermonter earning $35,000 would pay $524 more per year in premiums and could pay as much as $2,300 in additional out-of-pocket costs.
    - Administration will explore alternative premium and cost-sharing models, including any additional costs or implementation issues.

- *Will the Department of Financial Regulation and the Green Mountain Care Board's review of health plan designs and rates be impacted by new federal deadlines?*
- In November, the Chief of Health Care Reform will report to the Joint Fiscal Committee on these questions and on Vermont Health Connect's performance on critical milestones, together with a recommendation on the best path forward.
- If the Joint Fiscal Committee makes a decision to transition to the FSSBM model by December 1, the Administration will then file requests for federal permission, propose necessary changes to state law, and work with our federal partners and contractors to make the move in time for the 2017 open enrollment period.