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Agency of Human Services

Vermont Health Connect Update on June 2015 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

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Project Development

Status of Deliverables Related to Fall System Upgrades

Vermont's contract with Optum to deliver fall system upgrades, including renewals functionality, went into force on July 1. The first step is to finalize a delivery schedule. A detailed list of deliverables from this schedule will be provided in the Vermont Health Connect July 2015 Report next month.

Status of Deliverables – Open

Open Deliverable	Status Update, July 1, 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, Benaisance, 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.

- 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.

- 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. An appropriate schedule will be developed with VHC’s insurance issuer partners in July.
- Vermont Health Connect’s hosting is transitioning from CGI to Optum. 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 June)

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

Former Risk	Comment
<p>The State of Vermont has defined the scope of Optum’s fall system upgrades. In addition, the State submitted the final draft contract for this work to CMS on April 15. CMS then approved the contract in late May, sending it back to the State for final review and execution in advance of the July 1 target date. Until this contract is in force, however, the lack of an executed contract will be listed as a risk to the timeline for fall upgrades.</p>	<p>Contract met July 1 target for execution and is now in force.</p>

Actions to Address State Auditor’s Recommendations

On April 14, State Auditor Douglas Hoffer released a report that included a set of recommended actions for Vermont Health Connect. The following table outlines these recommendations as well as Vermont Health Connect’s original response and a status update.

SAO Recommendation	Original VHC Response, April 2015	VHC Status Update, July 2015
<p>1. Expeditiously complete the VHC project management plan documents for the 2015 releases, including a scope statement, requirements traceability matrix, and test plan.</p>	<p>The dates for completion for the documents are: Baseline Integrated Master Schedule: Completed April 3 Requirements documentation: Completed April 5 Scope Statement: Completed April 8 Requirements Traceability matrix: Draft under review April 8; completion target April 10 Test plan: Completion target April 14</p>	<p>All documents described in the column to the left relate to Release 1, Automated Change Processing, and have been completed.</p> <p>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.</p>
<p>2. Include in future VHC system development contracts clauses that provide monetary consequences tied to the contractor’s performance.</p>	<p>Section VII.A.6 of Agency of Administration Bulletin 3.5 addresses Penalties and Retainage. Following standard contracting procedures the project team did consider, and made a substantial effort in negotiations to obtain monetary consequences tied to contractor's performance. The contractor was taking over work-in-progress from another contractor under troubled conditions and the unknowns made either fixed-price or monetary penalty difficult to achieve at a responsible price. We will continue to work to include those conditions in future contracts wherever appropriate.</p>	<p>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 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.</p>
<p>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.</p>	<p>Vermont Health Connect is now completing a reorganization designed to provide improved customer service. As part of this we are updating all documentation of roles and responsibilities, and these will fulfill the recommendations laid out in the audit report. This will include updating as needed the various project charters and memoranda of understanding (MOU) that govern the participation of the multiple organizations involved.</p>	<p>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.</p>

<p>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.</p>	<p>Specific service levels are not generally applicable in a development contract, where monitoring of deliverables is the critical activity, but are an important component of all Hosting and Maintenance-and-Operations contracts. The new contract awaiting acceptance by the premium processing service provider does incorporate specific service level agreements; and stipulates the performance monitoring reports to be provided.</p>	<p>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.</p> <p>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.</p> <p>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 undergoing legal review prior to final sign-off. The target completion date is July 31, 2015, covering an additional year of service.</p>
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<p>5. Establish a process and expeditiously perform reconciliations of enrollment data between the VHC, Benaissance, and the carriers' systems.</p>	<p>We have begun a reconciliation process with the carriers using an interim solution supported by our contractors. We will complete all reconciliations necessary for a successful deployment of the next release by the end of May. The system capability to support enrollment and financial reconciliation between the VHC, Benaissance, and carrier systems is included in the scope of the May 30th release. This release will provide the reporting mechanisms needed to identify discrepancies across all of the systems and perform monthly reconciliations.</p>	<p>Regarding reconciliation of 2015 cases, the priorities are to:</p> <ul style="list-style-type: none"> • 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. <p>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 of it cleaned up in the month of August.</p>
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<p>6. Establish a process and expeditiously perform reconciliations of enrollment data between the VHC system and the relevant Medicaid system(s).</p>	<p>The system capability to support enrollment and financial reconciliation between the VHC, Benaissance, and Medicaid systems is included in the scope of the May 30th release. This release will provide the reporting mechanisms needed to identify discrepancies across all systems and allow monthly reconciliations going forward. Once this occurs we will use the process we are developing to reconcile data to ensure that all of the individuals who are eligible for and enrolled in Medicaid are correctly recorded in each system to ensure that claims are only paid for services allowed under the enrollee's specific Medicaid program.</p>	<p>See #5 above and note that automated reconciliation continues to be under development.</p>
<p>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.</p>	<p>While the cause of the most challenging billing issues today will be addressed with the May 30th release, we agree that many of the underlying policies create unnecessary difficulty for customers. For example, the 100% premium paid before remittance requirement does not reflect common industry practice that accepts a small shortfall as a complete payment and bills the balance with the following month's premium. A full reconsideration of the premium payment processing function is a critical next step, with participation of the premium processor, all carriers, and Medicaid. This is planned to occur when the 2014 reconciliation is complete so that we are in a position to review the decisions with the benefit of information from the reconciliation.</p>	<p>VHC 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.</p>

<p>8. Establish a process to terminate Dr. Dynasaur recipients in the VHC system who meet the State’s termination criteria.</p>	<p>This recommendation relates to Dr. Dynasaur recipients who are delinquent in their premium payments. The state intends to initiate a rulemaking process to revise a DCF promulgated Medicaid eligibility rule (HBEE section 64.00 Premium Rules and 70.02 Premium Obligation) to implement necessary changes relating to termination for non-payment. Rule changes would allow for a 60-day grace period, and eliminate the requirement for past due premium payments prior to re-enrolling individuals whose coverage was terminated for non-payment of premiums. The rulemaking process takes approximately six months from start to finish. Rulemaking is anticipated to begin in May of 2015 with scheduled completion by the end of calendar year 2015. Effective January 2014, the state started to transition enrollment and re-enrollment for MAGI Medicaid determinations into VHC. New enrollments are currently being processed in VHC, however, due to resource and system constraints, and with the approval of CMS, annual renewal of Medicaid beneficiaries has been delayed in VHC and for those still in the Legacy system, including some Dr. Dynasaur recipients. Vermont will be in compliance with standard Medicaid rules regarding non-payment of premiums once all Dr. Dynasaur enrolled children are transitioned into VHC. The state is actively working with CMS on a migration plan to restart Medicaid renewals. The final timeline depends upon CMS approval of the plan. Programming for system functionality in VHC to terminate coverage for non-payment of premiums following a 60-day grace period is scheduled for September 2015 and implementation will be consistent with the revised rule.</p>	<p>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 available to design, deliver, and implement this functionality within the remaining VHC delivery schedule.</p> <p>Development of an interim manual process has been complicated by the identification of technical and policy challenges, and a new target date for an interim process has not been identified.</p> <p>The rulemaking that we originally intended to begin in May has been delayed. A separate rulemaking effort that needed to be complete prior to commencement of this change was adopted on June 30 and will go into effect on July 15. The new rulemaking effort will be started after this current rule goes into effect, with an anticipated completion in early 2016.</p>
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<p>9. Expediently develop VHC financial reports to implement stronger financial controls.</p>	<p>The DVHA business office has worked with the contractors to get the necessary reports by the end of April 2015 in order to complete the interrelated reviews and reconciliations identified in recommendations 9, 10, and 11. The system capability to support enrollment and financial reconciliation between the VHC, Benaissance, and the carriers' systems is included in the scope of the May 30th release. This release will provide the reporting mechanisms needed to identify discrepancies across the three systems.</p>	<p>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 31.</p>
<p>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.</p>	<p>The DVHA business office has worked with the contractors to get the necessary reports by the end of April 2015 in order to complete the interrelated reviews and reconciliations identified in recommendations 9, 10, and 11. The system capability to support enrollment and financial reconciliation between the VHC, Benaissance, and the carriers' systems is included in the scope of the May 30th release. This release will provide the reporting mechanisms needed to identify discrepancies across the three systems.</p>	<p>See #9 above</p>
<p>11. Establish a process and expediently perform reconciliations of payment data among the VHC, Benaissance, and the carriers' systems.</p>	<p>The DVHA business office has worked with the contractors to get the necessary reports by the end of April 2015 in order to complete the interrelated reviews and reconciliations identified in recommendations 9, 10, and 11. The system capability to support enrollment and financial reconciliation between the VHC, Benaissance, and the carriers' systems is included in the scope of the May 30th release. This release will provide the reporting mechanisms needed to identify discrepancies across the three systems.</p>	<p>See #5 above and note that automated reconciliation continues to be under development.</p>

Operations Update

Change Processing

Households Awaiting Changes				
	26-May	6-Jul	change	% change
Total	10,272	7,372	-2,900	-28%

Households Awaiting Changes (households not mutually exclusive)				
	26-May	6-Jul	change	% change
Households with a QHP	5,141	3,875	-1,266	-25%
Households with Medicaid	5,963	3,870	-2,093	-35%

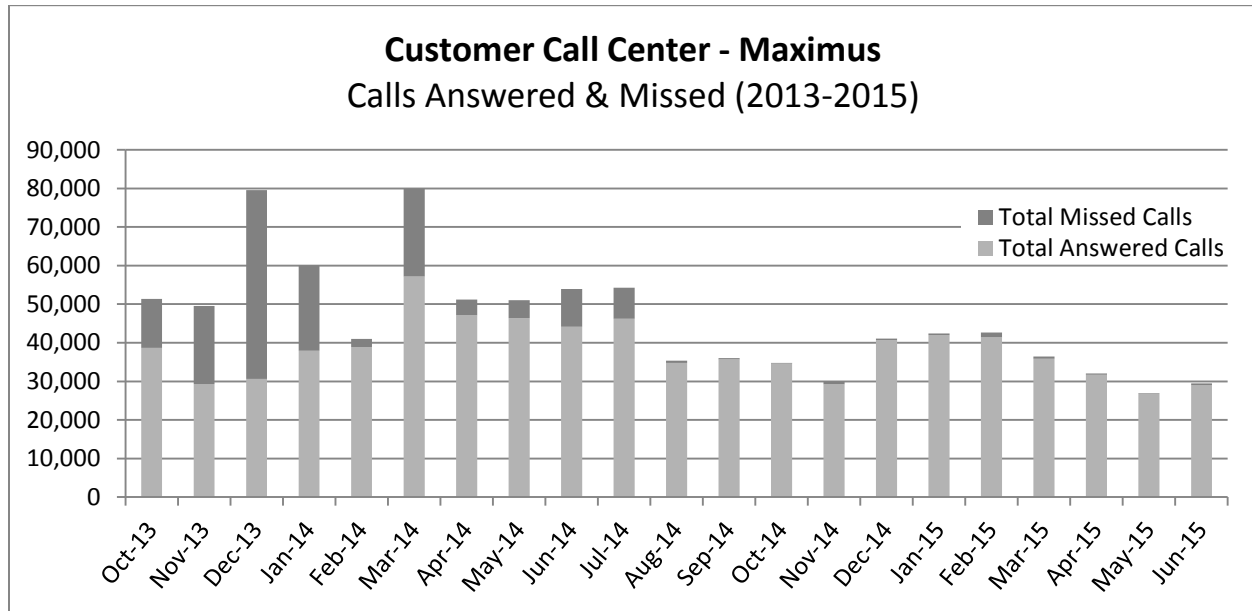
Using the new technology that was deployed at the end of May, Vermont Health Connect and its insurance issuer partners are continuing to ramp up their processing of changes to customer accounts. Some changes, known as “qualifying events,” allow customers to sign up for health insurance or change health 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 6, just under 7,400 households had change requests waiting to be processed. This marked the first time this year that Vermont Health Connect processed more change requests than it received. Even accounting for roughly 100 incoming requests per day, 2,900 fewer households were awaiting changes on July 6 than at the time of the system upgrades.

Vermont Health Connect is continuously adding to the types of changes that are being processed with each insurance issuer. Because each new category of change request needs to be validated in the insurance issuers’ systems as well as in Vermont Health Connect’s and its payment processor’s systems, some plans have seen more changes processed than others. For example, more Medicaid plans have been processed than qualified health plans (QHP). As a result, the number of households awaiting a Medicaid change has been reduced by 37% while the queue of households awaiting a QHP change has been reduced by 28%.

The initial wave of work in the new system has also found a high number of cases that require clean-up from the old system but do not actually require changes to health insurance plans. For example, of the service requests related to Blue Cross Blue Shield of Vermont health plans that have been worked and closed, nearly three-quarters (74%) did not require updates to the Blue Cross system. While this is good news for Vermonters, in the sense that fewer households are awaiting changes to their actual coverage, the service requests from the old system still need to be researched and addressed by staff, however, regardless of whether a change ultimately needs to be processed to the insurance issuers’ systems.

Customer Support Center (Maximus Call Center)



Last Month

In June, the Customer Support Center answered 28,994 calls and missed 449 for an abandon rate of 1.5 percent. The average wait time was 31 seconds. This was an increase over May (12 seconds) but an improvement over Open Enrollment (40 seconds). More than eight out of ten calls (84%) were answered in less than 30 seconds, compared to six out of ten (61%) in May 2014. More than nine out of ten calls (94%) were able to 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 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.

System Performance and Traffic

Month	Unscheduled Downtime (minutes)	Availability	Avg Page Load Time (seconds)	Max Peak User	Visits
April 2015	40	99.99%	2.17	86	42,284
May 2015	0	100.00%	2	82	30,926
June 2015	0	100.00%	0.5	69	34,837

Last Month

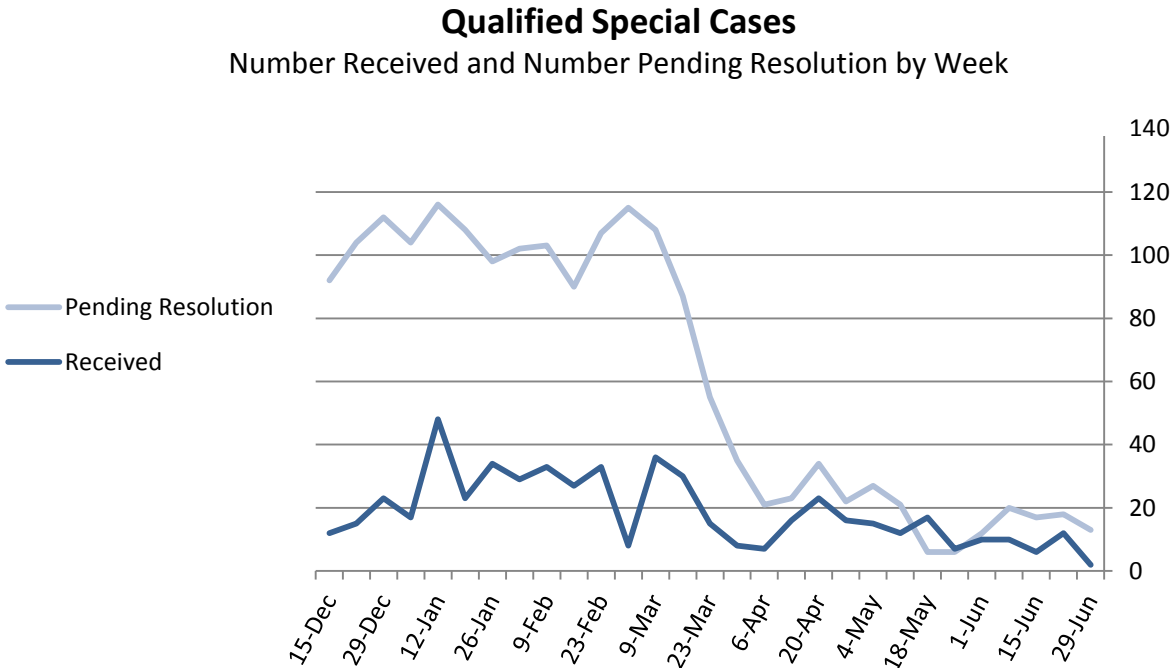
Vermont Health Connect's systems were stable in June, achieving 100 percent availability for the second consecutive month. The availability metric measures the amount of time systems are up and running relative to the amount of time they are expected to be. Scheduled maintenance periods, such as those that occur from 1am to 5am each morning, are not counted. Vermont Health Connect closed out the second quarter of the calendar year with less than one hour of total unscheduled downtime.

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.

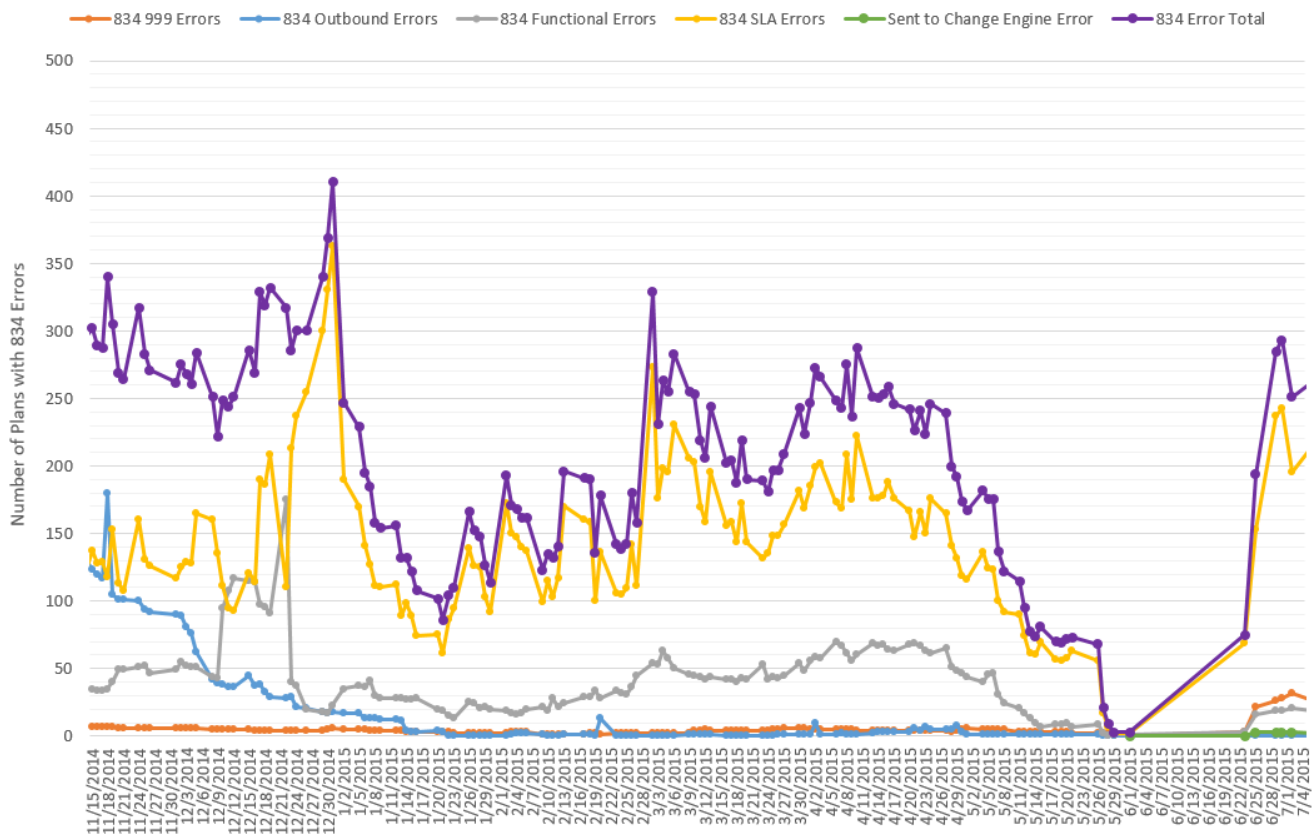
Qualified Special Cases



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. The vast majority of these errors were 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 rejection or a confirmation that coverage has been effectuated. 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.

Vermont Health Connect has identified two system issues that are causing 90 percent of recent SLA errors and has prioritized these two issues for Optum resolve. Fortunately for 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.

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.

In Person Assistance

In June, the Department of Vermont Health Access (DVHA) announced the selection of five grantees representing fifteen Vermont Health Connect Navigator organizations for 2015-2016. These organizations will ensure that Vermonters in every corner of the state have access to free in-person assistance if they need help understanding health insurance or signing up for a plan.

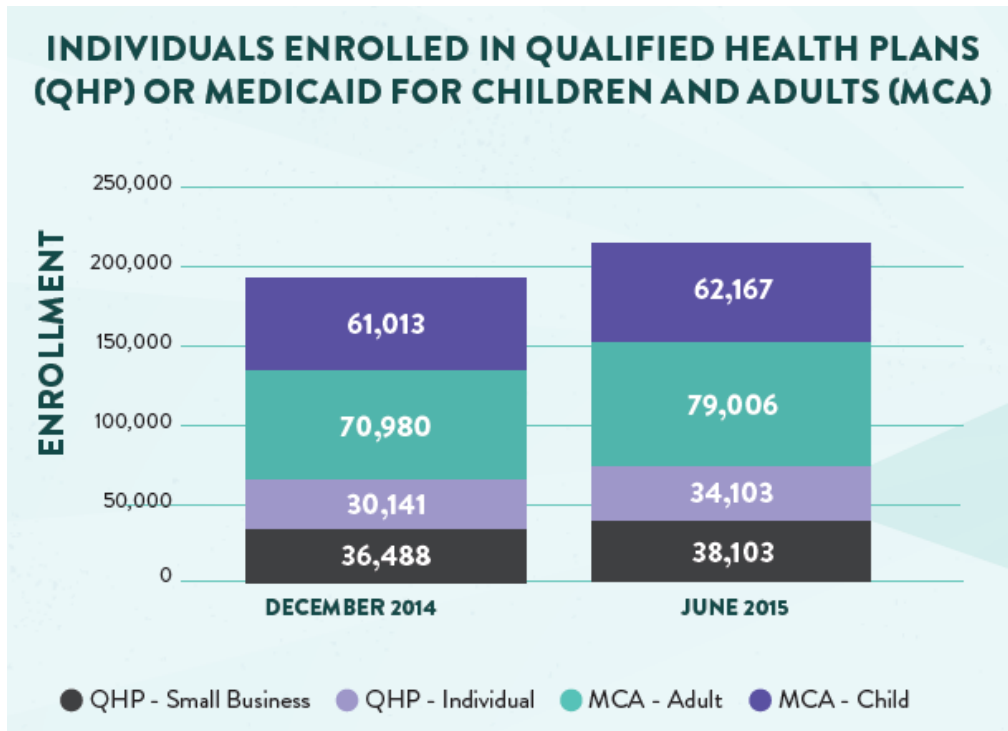
Navigators, together with Brokers and Certified Application Counselors, form Vermont Health Connect's network of trained and certified Assisters. When combined with the health insurance marketplace's online tools and toll-free Customer Support Center, these Assisters enable Vermonters to find help online, by phone, and in-person.

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 is engaging library directors on the types of materials, events, and support they would like to collaborate on this summer in advance of 2016 open enrollment.

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

Current Coverage



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 more than 5,000 from December to June, while the number covered by Medicaid/Dr. Dynasaur increased by more than 9,000. This growth was driven by a strong turnout during the QHP Open Enrollment (November 15 to February 15) and beyond.

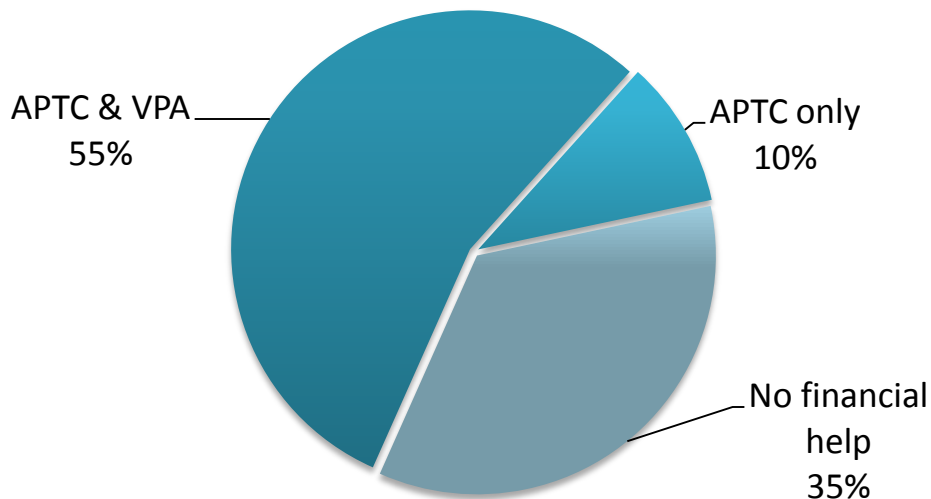
Of customers in QHPs:

- 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 page 15 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). June 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

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



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.

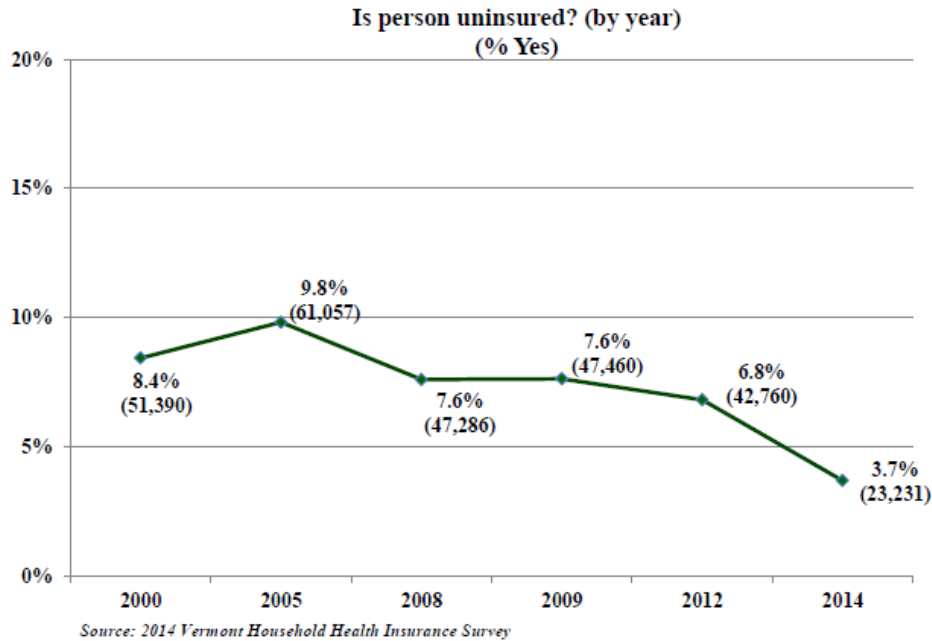
Vermonters who qualify for the two less generous levels of CSR could conceivably have a lower total cost in a Gold or Platinum plan, depending on their medical needs. Notably, Vermonters who qualify for the two most generous levels of CSR can expect a lower total cost in a Silver plan even if they have 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.