LAWRENCE MILLER
Chief of Health Care Reform

State of Vermont
OFFICE OF THE GOVERNOR

TO: HCHC, SCHW, SCF, HROC, JFC
FROM: Lawrence Miller, Chief of Health Care Reform
Date: October 26, 2015
RE: Vermont Health Connect Monthly Report

I am pleased to submit the sixth monthly report in conformance with Section C.106 of the budget bill.

This report serves as the re-cap of key operational and enrollment metrics for September while also outlining what Vermonters can expect for the upcoming 2016 Open Enrollment starting on November 1. In order to provide the most up-to-date information available, it also covers project development work and efforts to address the State Auditor's recommendations through October 16.

Even so, new updates continue to roll in by the day.

Last Monday (10/19), we received confirmation that our technical teams had successfully addressed defects revealed in this month's testing of automated renewal functionality. Having mitigated the threat of unexpected and unfixable issues arising during testing, we were able to close a risk that had been identified in this monthly report, and in past reports.

On Tuesday (10/20), we received formal approval from CMS to utilize a direct enrollment approach for operation of our Small Business Health Options (SHOP) Marketplace in 2016.

On Wednesday (10/21), we completed deployment of the system updates that are now allowing us to generate renewal files.

In short, it was a busy week and a week that bolstered my optimism that the difference between last year's open enrollment and this year's will be night and day.

To be clear, we don't expect 100% smooth sailing. We expect that there will be cases that can't be processed until customers provide more information; that call volume spikes will occasionally result in higher than average wait times; that there will always be some number of transmissions to the carriers' and payment processor's systems that result in error.

We do expect, however, that smooth sailing will be the rule and not the exception. Vermonters should expect that their 2016 subsidies and plan options will be available at the start of Open Enrollment; that their calls will generally be answered promptly; that their change requests will typically be processed

promptly. And they should expect that, when challenges do arise, customer service staff will be on hand to help.

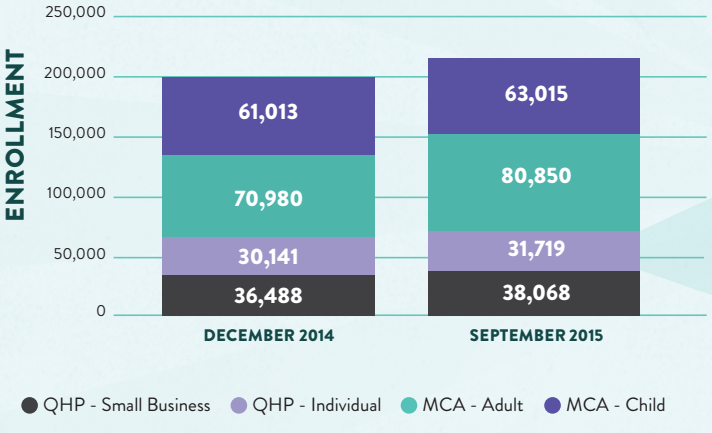
Earlier this year we mapped out a “Plan A” renewal plan based on allowing Vermonters to use self-service plan selection during open enrollment, with the option of easily renewing online, by phone, by paper, or by doing nothing and simply allowing their current health plan to roll into a new coverage year. We also prepared a contingency plan which consisted of a major staff augmentation to manually process over 20,000 applications.

I am pleased to report that we are following Plan A.

VERMONT HEALTH CONNECT SEPTEMBER 2015 DASHBOARD

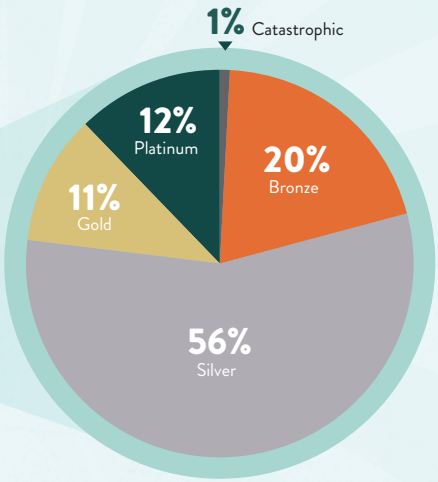
COVERED VERMONTERS

INDIVIDUALS ENROLLED IN QUALIFIED HEALTH PLANS (QHP) OR MEDICAID FOR CHILDREN AND ADULTS (MCA)



Note: 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). September 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).

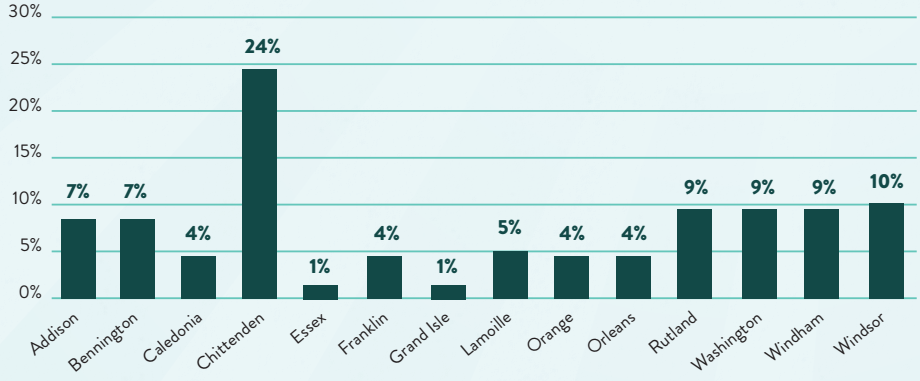
QHP INDIVIDUAL COVERAGE BY METAL LEVEL

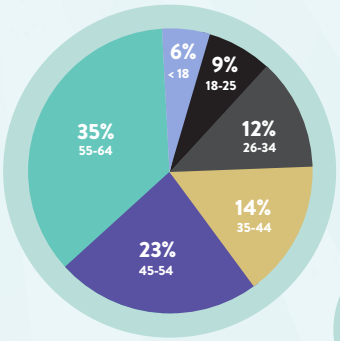


DEMOGRAPHICS

WHO IS COVERED BY QUALIFIED HEALTH PLANS?

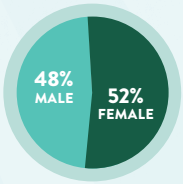
Individual QHP Population by County





AGE
- < 18
- 18-25
- 26-34
- 35-44
- 45-54
- 55-64

GENDER



CUSTOMER SUPPORT

ONLINE

WEBSITE AVAILABILITY* IN SEPTEMBER 2015:
99.91%
(was 99.98% in August)

*Percentage of time web portal was up and running outside of scheduled maintenance period.

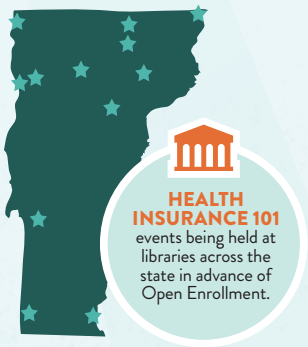
BY PHONE

89%
OF CALLS ADDRESSED BY INITIAL REPRESENTATION (NO TRANSFER).
(Down from 91% in August.)

AVERAGE WAITING TIME IN SEPTEMBER 2015:
1.4 MINUTES

77%
of calls answered in under 30 seconds, compared to 61% in August.

IN PERSON



Published 10/19/2015

FINANCIAL HELP

WHO'S RECEIVING FINANCIAL HELP TO PURCHASE A QHP AND WHAT ARE THEY PAYING FOR HEALTH CARE?

INCOME
< $35,010 INDIVIDUAL
< $71,550 FAMILY OF FOUR

< 300% Federal Poverty Level

ELIGIBLE FOR:
- Advanced Premium Tax Credits
- Vermont Premium Assistance
- Cost-Sharing Reductions

55% of enrolled individuals

300% - 400% Federal Poverty Level

ELIGIBLE FOR:
Advanced Premium Tax Credits Only

10% of enrolled individuals

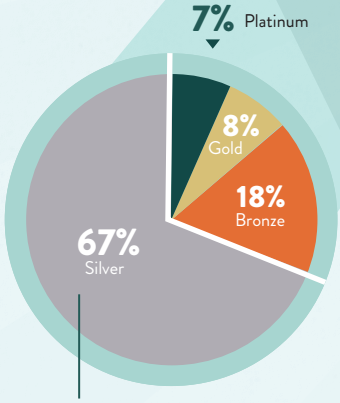
> 400% Federal Poverty Level

NOT ELIGIBLE FOR:
Financial Help

35% of enrolled individuals

INCOME
> $46,680 INDIVIDUAL
> $95,400 FAMILY OF FOUR

PLAN SELECTION

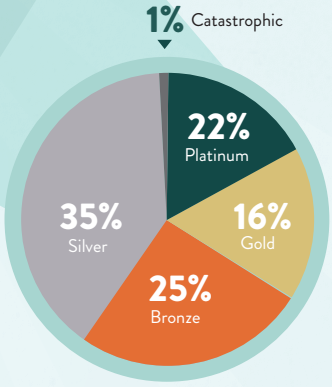


PLAN SELECTION AMONG INDIVIDUALS ELIGIBLE FOR COST-SHARING REDUCTION

PREMIUM

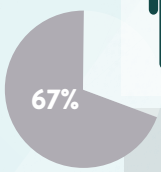
MONTHLY PREMIUM FOR MOST COMMON SILVER PLAN*

PLAN SELECTION



PLAN SELECTION AMONG INDIVIDUALS NOT-ELIGIBLE FOR COST-SHARING REDUCTIONS

POSSIBLE TOTAL COSTS (PREMIUM & OUT-OF-POCKET)



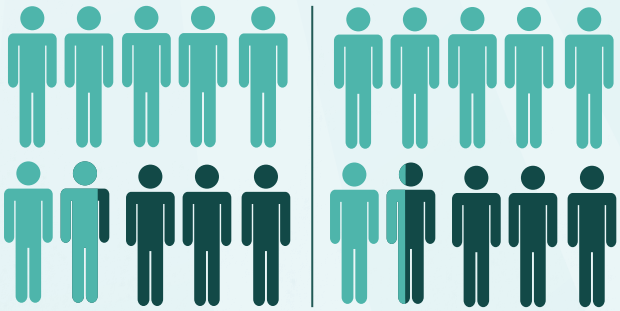
Typical (median) individual receiving Cost-Sharing Reductions**
Income: $21,500
Plan Type: BCBSVT Standard Silver 87 Plan

AFTER SUBSIDY
Premium: $104 Deductible: $600
Maximum Out-of-Pocket: $1,250

vs.

FULL PRICE
Premium: $466 Deductible: $1,900
Maximum Out-of-Pocket: $5,100

QHP INDIVIDUALS RECEIVING FINANCIAL HELP



69% of new enrollments

64% of re-enrollments

VERMONT HEALTH CONNECT

*The BCBSVT Standard Silver Plan is the most common plan.

**Note: There are four tiers of cost-sharing reductions. Depending on income, an individual in a Standard Silver CSR plan could have a deductible between $100 and $1,900 and a maximum out-of-pocket between $500 and $4,000. The median CSR customer is in a Silver 87 plan detailed above.

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Agency of Human Services

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

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

Submitted by

Lawrence Miller, Chief of Health Care Reform
Vermont Agency of Administration

Hal Cohen, Secretary
Agency of Human Services

Steven M. Costantino, Commissioner
Department of Vermont Health Access

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

October 26, 2015

Contents

2016 Open Enrollment and Renewal

Overview

2016 Open Enrollment begins November 1 and runs until January 31. Much like Medicare open enrollment, this is the once-a-year opportunity for Vermonters with Vermont Health Connect qualified health plans to change plans if they wish. It is also an opportunity for Vermonters without health coverage and Vermonters who want an alternative to COBRA coverage or an unaffordable employer-sponsored health plan to come to Vermont Health Connect.

Current customers will be mailed a letter in late October to let them know that they are automatically being renewed. As long as they keep paying their monthly bill, they will be mapped to the 2016 version of their qualified health plan. If they want to change health plans or add household members to their plan for 2016, they will be able to do so by calling the Customer Support Center or logging into their online account after November 1.

Vermont Health Connect's insurance carrier partners – Blue Cross Blue Shield of Vermont, MVP Health Care, and Northeast Delta Dental – have worked closely with the health insurance marketplace to update their systems and are helping Vermonters prepare for the coming Open Enrollment. After customers receive Vermont Health Connect's renewal notice, the carriers will follow up with mailings that provide information on each customer's 2016 plans and rates.

Customers with Medicaid and Dr. Dynasaur coverage are on a different schedule that is not necessarily tied to Open Enrollment. They will receive a letter in the mail when it's time for them to renew.

New customers can fill out an application for health insurance online at VermontHealthConnect.gov, call the Customer Support Center to apply over the phone, or set up an in-person appointment with an Assister in their community. If they're interested in first seeing how much financial help they might qualify for, they can click on the Subsidy Estimator at VermontHealthConnect.gov, By signing up for health coverage, Vermonters can avoid having to pay the individual shared responsibility fee when they file their federal taxes.

2016 Health Plans and Rates

After November 1, customers will be able to log into their online accounts or call the Customer Support Center and select the 2016 health plan that is right for them. In the meantime, they are welcome to go to VermontHealthConnect.gov and click on 'Health Plans' to view information on the plan designs and rates.

Most of the plan designs are similar to 2015 plans, although some deductibles, maximum out-of-pockets, and cost-sharing requirements have shifted to keep the plans in line with required actuarial values (AV) for each metal level. One notable addition to the menu of qualified health plans is a Gold High Deductible Health Plan (HDHP). Both BCBSVT and MVP are offering versions of this plan that requires no co-pays or co-insurance once the deductible is met.

Carriers requested, and the Green Mountain Care Board approved, smaller premium increases for 2016 than they did for 2015. Specifically, BCBSVT premiums increased 5.9% on average (compared to 7.7% for 2015), while MVP premiums increased 2.4% on average (compared to 10.9% for 2015).

Two out of three customers receive financial help to lower the cost of health insurance. Many of these customers will find that their monthly bill is not increasing. This is because the cost of each health plan increases by a different amount, and financial help also increases each year. In fact, because the federally specified benchmark for financial help – the second lowest-cost Silver plan – saw a larger increase than some of the most popular health plans, many customers who qualify for Advanced Premium Tax Credits will actually see a decrease in their monthly bill for 2016. For example, a couple earning $50,000 per year will pay $435 for a Standard Silver plan (after receiving $533 in APTC and VPA). In 2015, they would have paid about $20 more. Similarly, an individual earning $30,000 per year will pay $187 for a Standard Silver 73 plan with cost-sharing reductions. In 2015, they would have paid about $10 more.

Vermonters can see estimated financial help for their household size and income by clicking on the Subsidy Estimator at VermontHealthConnect.gov.

Full-Cost Individual Direct Enrollment

Full-Cost Individual Direct Enrollment is a new option this fall for Vermonters who are not interested in applying for financial help to reduce monthly premiums or out-of-pocket costs. “Direct Enrollment” refers to the process of signing up for health insurance through an insurance carrier, rather than through Vermont Health Connect. “Individual” refers to the fact that this process is for individuals and families who are buying insurance on their own, not through an employer. “Full-Cost” means that Vermonters who choose to direct enroll cannot receive financial help to reduce the cost of monthly premiums and/or out-of-pocket costs. If a Vermonter wants to apply for financial help, they must enroll or renew through Vermont Health Connect.

Here are eight facts about Full-Cost Individual Direct Enrollment:

1. Both Blue Cross Blue Shield of Vermont (BCBSVT) and MVP Healthcare (MVP) will offer Full-Cost Individual Direct Enrollment for calendar year 2016.
2. Full-Cost Individual Direct Enrollment customers cannot apply for Advanced Premium Tax Credit (APTC), Vermont Premium Assistance (VPA), or Cost-Sharing Reductions (CSR) through either the state or federal government.
3. Full-Cost Individual Direct Enrollment does not include Medicaid or Dr. Dynasaur.
4. Full-Cost Individual Direct Enrollment customers will be billed directly by the carrier.
5. A customer who receives APTC through Vermont Health Connect in 2015, but decides to direct enroll with a carrier for 2016, will not receive tax credits in 2016.
6. A customer wishing to direct enroll for January 2016 can contact BCBSVT or MVP to apply prior to December 15 for January 1 coverage. Customers can authorize BCBSVT or MVP to terminate their coverage through Vermont Health Connect as of the end of 2015.
7. A customer can switch from Full-Cost Individual Direct Enrollment back to a Qualified Health Plan through Vermont Health Connect only during Open Enrollment or during a Special Enrollment Period (if they qualify for one).
8. When a customer switches from Full-Cost Individual Direct Enrollment to Vermont Health Connect, and chooses a plan with the same carrier, any payments toward deductibles and other out-of-pocket costs will be carried over for that calendar year.

Project Development (updates as of October 16, 2015)

Status of Deliverables Related to Fall System Upgrades

On October 1, Vermont Health Connect deployed the technology upgrade necessary to automate the 2016 renewal process. This deployment marked a major milestone and significantly diminished the risk that the State would need to exercise the manual renewal contingency mapped out this summer.

The ensuing weeks consisted of honing the new technology and training staff on how to use it in preparation for Open Enrollment, which begins on November 1. The goal is to give all qualified health plan customers a "passive renewal," meaning that they will be mapped to the 2016 version of their plan and can avoid a gap in coverage simply by continuing to pay their bill. To achieve this goal, a file will be generated to communicate with the Federal Data Services Hub and determine 2016 eligibility for each customer account. Processing of change requests will be suspended until the passive file is generated and validated. Transmission of change requests to the carriers' systems will be suspended until the carriers confirm that the passive renewals have been effectuated.

Customers who want to actively engage in the renewal process by, for example, changing health plans or adding household members to their plan, will be able to log onto their account or call the Customer Support Center during Open Enrollment. They will then be able to see how much financial help they will qualify for in 2016, view their health plan options, and make the choices that best meet their needs.

Risks – Open and Recently Mitigated

Open Risks

The following items have been identified as risks to the timing or scope of Vermont Health Connect's upcoming projects.

- Inflexible delivery dates pose a risk in the event that unexpected issues arise during testing.
- Outside dependencies carry a risk to any project's deadlines, and the automated renewal deployment is very independent on insurance carrier engagement. Frequent meetings and collaboration are chief among the efforts to mitigate this risk.
- While the Centers for Medicaid and Medicare Services (CMS) approved Vermont Health Connect's proposal to have small businesses direct enroll with insurance carriers for 2016, the lack of an approved plan or vendor contract for SHOP poses a risk for 2017.
- A plan for Medicaid customer billing needs to be finalized and approved.
- Execution of system enhancements to support business processes for corrections of operational errors and system errors that are returned from the carriers (834 errors) need to be finalized. In August, Optum and Vermont Health Connect teams developed a path to resolution for critical 834 errors. In September, this path was pursued and resulted in a sharp decrease in the inventory of 834 errors. Additional processes need to be completed and operational work transitioned from Optum to state staff before this risk can be considered closed.

Actions to Address State Auditor's Recommendations (updates as of October 16, 2015)

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

Notable updates for the past month include:

- Regarding the recommendation to expeditiously complete the Vermont Health Connect project management plan documents for the 2015 releases, including a scope statement, requirements traceability matrix, and test plan (Finding #1), testing for Release 2b ended on September 29th. The requirements traceability matrix (RTM) will be revised based on the results of the release testing effort. The RTM is directly tied to the Vermont Health Connect release schedule. As such, the RTM will be finalized after the final scheduled release.
- Regarding the recommendation to document the roles and responsibilities of each of the organizations that provide system and operations support to Vermont Health Connect (Finding #3), the matrixed DCF-DVHA unit has updated roles & responsibility documents for eligibility, operations leadership, and workforce management teams.
- Regarding the recommendation to establish a process to terminate Dr. Dynasaur recipients in the Vermont Health Connect system who meet the State's termination criteria (Finding #8), a revised scope of work for the required Medicaid billing functionality was completed by Benaissance on October 5. The State is now working with Optum to complete the integration sizing of the revised scope.

Topic/Finding	Vermont Health Connect Status Update, Sept 2015	Vermont Health Connect Status Update, Oct 2015
1. Expeditiously complete the Vermont Health Connect project management plan documents for the 2015 releases, including a scope statement, requirements traceability matrix, and test plan.	The scope statement and test plan for Release 2, Automated Renewals, has been finalized. The requirements traceability matrix will be revised and updated upon completion of testing, currently scheduled to conclude on September 25.	Testing for Release 2b ended on September 29. The requirements traceability matrix (RTM) will be revised based on the results of the release testing effort. The RTM is directly tied to the Vermont Health Connect release schedule. As such, the RTM will be finalized after the final scheduled release.
2. Include in future Vermont Health Connect system development contracts clauses that provide monetary consequences tied to the contractor's performance.	Vermont Health Connect has been working with legal counsel to develop a competitive process consistent with Bulletin 3.5 for small business (SHOP) functionality.	Vermont Health Connect has been working with legal counsel to develop a competitive process consistent with Bulletin 3.5 for small business (SHOP) functionality.

3. Document the roles and responsibilities of each of the organizations that provide system and operations support to Vermont Health Connect, including explicitly laying out decision-making responsibilities and collaboration requirements.	The MOU between DCF and DVHA was signed in July. The effort to finalize job descriptions across the matrixed unit is ongoing.	Following the MOU that was signed between DCF and DVHA, the matrixed unit has updated roles & responsibility documents for eligibility, operations leadership, and workforce management teams. Vermont Health Connect is now turning its attention to the enrollment unit, with the goal of completing job descriptions by the end of the year. Leadership is also finalizing an updated organizational chart that provides additional clarity on decision making and collaboration requirements.
4. Include expected service levels or performance metrics in future Vermont Health Connect system development and premium payment processor contracts and establish mechanisms to track contractor performance against the performance levels in these agreements.	The Maintenance & Operations and Hosting contracts have been executed includes provisions for service level agreements, payment credits, and performance metrics. The premium processing contract includes provisions for service level agreements, payment credits, and performance metrics. The contract has been finalized, with a retroactive effective date of July 1, 2015.	The Maintenance & Operations and Hosting contracts have been executed includes provisions for service level agreements, payment credits, and performance metrics. The premium processing contract includes provisions for service level agreements, payment credits, and performance metrics. The contract has been finalized, with a retroactive effective date of July 1, 2015.
5. Establish a process and expeditiously perform reconciliations of enrollment data between the Vermont Health Connect, Benaissance, and the carriers' systems	Regarding reconciliation of 2015 cases: • Resources have now been made available to reconcile the most recent data – refreshed from all systems at the end of July and then again from several of the systems at the end of August – and needed processes have been identified. Cancelled policies have been communicated to BCBSVT and coverage period discrepancies are being researched for appropriate correction. Premium amount and premium assistance discrepancies are next in the queue. • A long-term reconciliation process is being developed, tested & implemented; a data feed from	Regarding 2015 reconciliation: • All discrepancies on coverage periods, premiums, and premium assistance amounts on BCBSVT policies as of 8/25 have been reconciled at Vermont Health Connect, BCBSVT, and sent for updating at the payment processor where needed. • Discrepancies on coverage periods are currently being investigated for all MVP and Northeast Delta Dental (NEDD) policies as of September 15; the Vermont Health Connect system is being updated real time, as needed, while updates are being sent for processing to the

	BCBSVT has been successfully received and data feeds from MVP, Northeast Delta Dental & Benaissance are in the works; ultimately, weekly reporting, analysis & correction is anticipated. Regarding reconciliation of 2014 cases: • Information will be provided to Benaissance by the end of the week of September 14. The balance of unallocated VPA dollars is expected to be minimal after Benaissance processes the information. At that point staff will stop work on the unallocated VPA dollars. Given the minimal balance and the significant effort required to investigate each case represented in the VPA balance, additional processing will no longer be an effective use of resources. Ongoing operations work will maintain the balance near zero from this point forward. • Working together, Vermont Health Connect and BCBSVT completed 2014 reconciliation. The net result will be a payment to BCBSVT of $1.6 million upon final review of agreed- a data feed from BCBSVT has been successfully received and data feeds from MVP, Northeast Delta Dental upon numbers by an independent auditing firm. • Benaissance and Vermont Health Connect plan to clear out unallocated non-VPA dollars (i.e. customer payments) utilizing a series of steps that address the various combinations of plans (i.e. BCBSVT, MVP, Medicaid and Delta Dental).	carriers and payment processor where needed. Premium and premium assistance amount discrepancies are next in the queue. • The approach for long-term reconciliation reporting process is being modified to better suit the needs of the state. The solution will build on the development already in progress while implementing a more effective front-end product for state users. • Financial reconciliation will be addressed following completion of the reconciliation of system enrollment data. Regarding 2014 reconciliation: • A solution is currently being drafted to further address enrollment data reconciliation between the carrier, payment processing, and Vermont Health Connect systems given the inter-relationships of present system limitations, operational resources, and business processes available. • A solution was formulated and is being executed to remediate all Unallocated Customer Payment monies on BCBSVT plans. A similar plan is being considered for MVP and NEDD plans and is pending data and collaborative conversations with the involved parties.

6. Establish a process and expeditiously perform reconciliations of enrollment data between the Vermont Health Connect system and the relevant Medicaid system(s).	The Medicaid reconciliation project has been initiated. The scope of the project has been specified and defined. Medicaid data experts are working with Optum on data requirements, data mapping & data transfer processes.	The approach for the reconciliation reporting process is being modified to better suit the needs of the State. The solution will build on the development already in progress while implementing a more effective front-end product for state users. Given the modified approach and the subject matter, the first actionable data within Medicaid reconciliation will dovetail with 1095B efforts.
7. Reconsider decisions that have complicated the premium payment processing function, including the requirement that the full premium payment be at Benaissance without exception before remittance to the carriers and the split of the billing and dunning/termination processes between different organizations.	DVHA has initiated discussions with its payment processing and insurance issuer partners to modify payment processing methodologies to ensure payment processing occurs in the most efficient manner. Further analysis of options has been deferred until 2014 and 2015 reconciliation activities are complete.	DVHA has initiated discussions with its payment processing and insurance issuer partners to modify payment processing methodologies to ensure payment processing occurs in the most efficient manner. Further analysis of options has been deferred until 2014 and 2015 reconciliation activities are complete.
8. Establish a process to terminate Dr. Dynasaur recipients in the Vermont Health Connect system who meet the State's termination criteria.	The State is working to contract with a vendor to deliver system functionality to perform non-payment termination of Dr. Dynasaur recipients as needed. The State has received estimates from Benaissance and Optum. The estimates are being reviewed to determine options for moving forward.	The estimates from Benaissance and Optum were completed on August 20. The State is working directly with Benaissance to deliver a more cost-effective solution. Scope meetings with Benaissance were completed as of September 25. The sizing of the revised scope of work was completed by Benaissance on October 5. The State is now working with Optum to complete the integration sizing of the revised scope for leadership review and consideration.

9. Expeditiously develop Vermont Health Connect financial reports to implement stronger financial controls.	The premium processing contract includes provisions for service level agreements, payment credits, and performance metrics. The contract has been finalized, with a retroactive effective date of July 1, 2015.	The premium processing contract includes provisions for service level agreements, payment credits, and performance metrics. The contract has been finalized, with a retroactive effective date of July 1, 2015.
10. Obtain and review reports from Benaissance that provide detail on the makeup of the balance in the Vermont Health Connect bank account and monitor this account to ensure that payments are being remitted appropriately and in a timely manner.	See #9 above	See #9 above
11. Establish a process and expeditiously perform reconciliations of payment data among the Vermont Health Connect, Benaissance, and the carriers' systems.	See #5 above and note that automated reconciliation continues to be under development.	See #5 above and note that automated reconciliation continues to be under development.

Operations Update (data through October 1, 2015)

Change Processing

On October 1, Vermont Health Connect announced that the backlog of change requests had been cleared; that the marketplace was operating at a vastly improved customer service level for change requests; and customers would be able to report many changes online. This accomplishment marked a major milestone and was made possible by new technology that was deployed at the end of May. In turn, it helped paved the way for the deployment of automated renewal functionality.

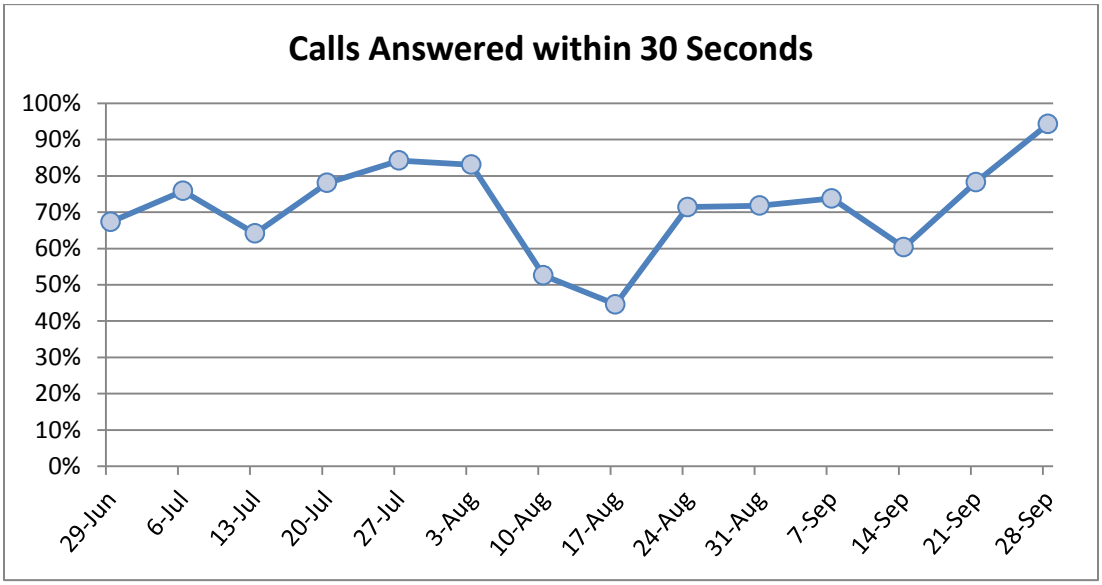
Vermont Health Connect continues to receive approximately 125 change requests per day. Some changes, known as "qualifying events," allow customers to sign up for health insurance or change health plans outside of the annual Open Enrollment period. Examples of qualifying events include getting married 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.

In addition to actually building and testing the automated renewal technology, one of the necessary precursors to its deployment was overcoming the historical backlog of change of circumstance requests, which had grown as high as 10,272 in May. Reaching that milestone was made possible by the successful deployment of automated change functionality at the beginning of June. Over the summer Vermont Health Connect staff worked through the backlog, processing change requests – such as changing an address or adding a family member to a plan – that had been a primary source of frustration for customers.

Starting in October, an improved customer service standard has been set for change requests: customers who report a change by the 15th of a month can expect to see that change reflected on their next bill.

Starting October 1, self-service change requests functionality was turned on so that customers could report many of the most common changes through a self-service function on the Vermont Health Connect website. The backlog of change requests had prevented Vermont Health Connect from turning on this functionality. Now that the backlog is cleared, customers are able to use this functionality.

Customer Support Center (Maximus Call Center)



Last Month

In September, the Customer Support Center answered 27,108 calls and had 1,428 customer hang ups for an abandoned rate of 5%. More than three out of four calls (77%) were answered in less than 30 seconds, up from 61% in August. The last week of the month saw a particularly strong performance, with 94% of calls answered within 30 seconds. The average wait time for the month was 1.4 minutes. Nearly nine out of ten calls (89%) were able to be resolved without transferring.

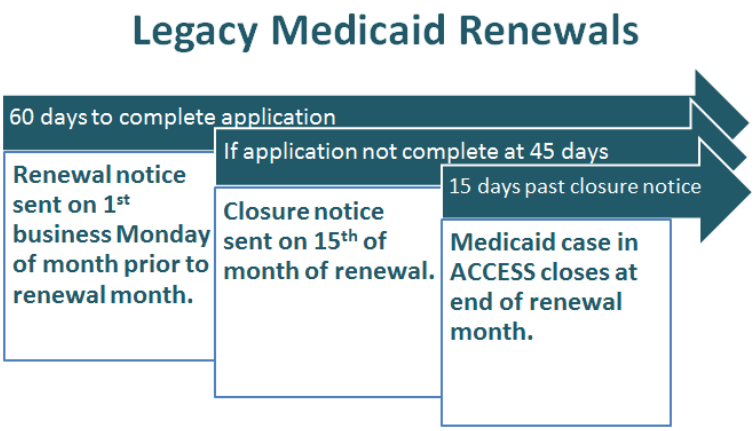
Last Open Enrollment

The last Open Enrollment ran from November 15, 2014 to February 15, 2015. 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. The first Open Enrollment's abandoned rate of 35.7% (over the six-month period) was cut to 1.7%.

The average wait time during the last 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.

Medicaid Renewals



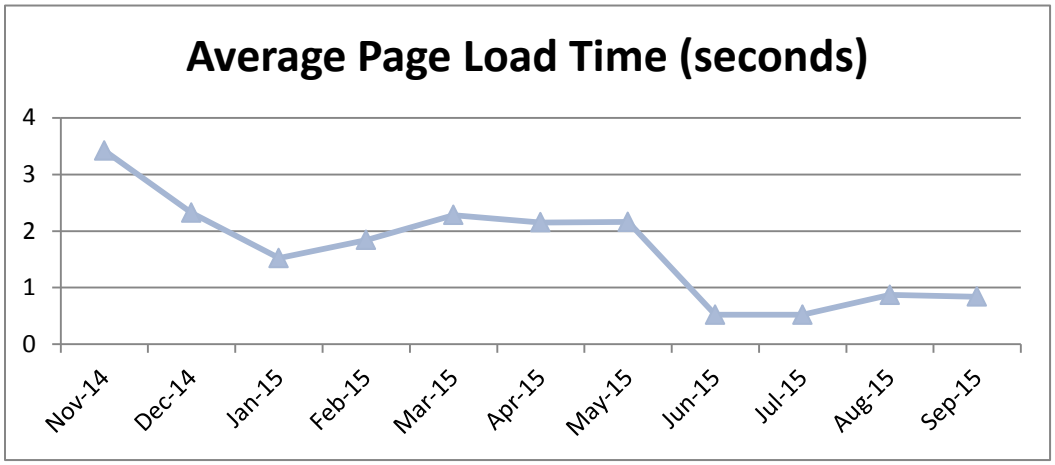
DCF and DVHA's matrixed eligibility and enrollment unit is beginning the renewal process for 27,000 households with accounts on the State's legacy ACCESS system. Starting in November and continuing each month until September 2016, Vermont will mail notices to 1,500 – 2,500 households that have at least one Medicaid for Children and Adults (MCA) beneficiary to tell them that it is time to renew. The renewal process will involve applying for coverage through Vermont Health Connect and determining whether they are eligible for MCA or for qualified health plans (QHP) with financial help.

After receiving a renewal letter, customers will have nearly 60 days to enroll by submitting an application online, by phone, or on paper. Customers who don't reply will receive a reminder and then their Medicaid case will be closed. Those who still qualify for MCA can re-enroll at any time. Those who qualify for a QHP will have a 60-day Special Enrollment Period from the time their Medicaid ends, after which they could have to wait until the following open enrollment to enroll in coverage.

Additionally the matrixed eligibility and enrollment unit will start to contact 13,000 Medicaid for the Aged, Blind and Disabled (MABD) customers for renewal, at the rate of about 1,000 MABD customers per month. Unlike MCA, MABD renewals consist only of paper applications and their accounts will remain in ACCESS, not Vermont Health Connect.

Finally, rolling renewals for MCA recipients who are already in the Vermont Health Connect system are tentatively set to begin in January. The goal is to complete Medicaid renewals before Open Enrollment in fall 2016.

System Performance and Traffic



Month	Availability	Avg Page Load Time (seconds)	Max Peak User	Visits
July 2015	99.87%	0.52	93	37,116
August 2015	99.98%	0.87	126	43,975
September 2015	99.91%	0.84	101	50,799

Last Month

Vermont Health Connect's web traffic increased to more than 50,000 visits in August. Average page load time remained under one second – significantly faster than the load times prior to the spring system upgrade.

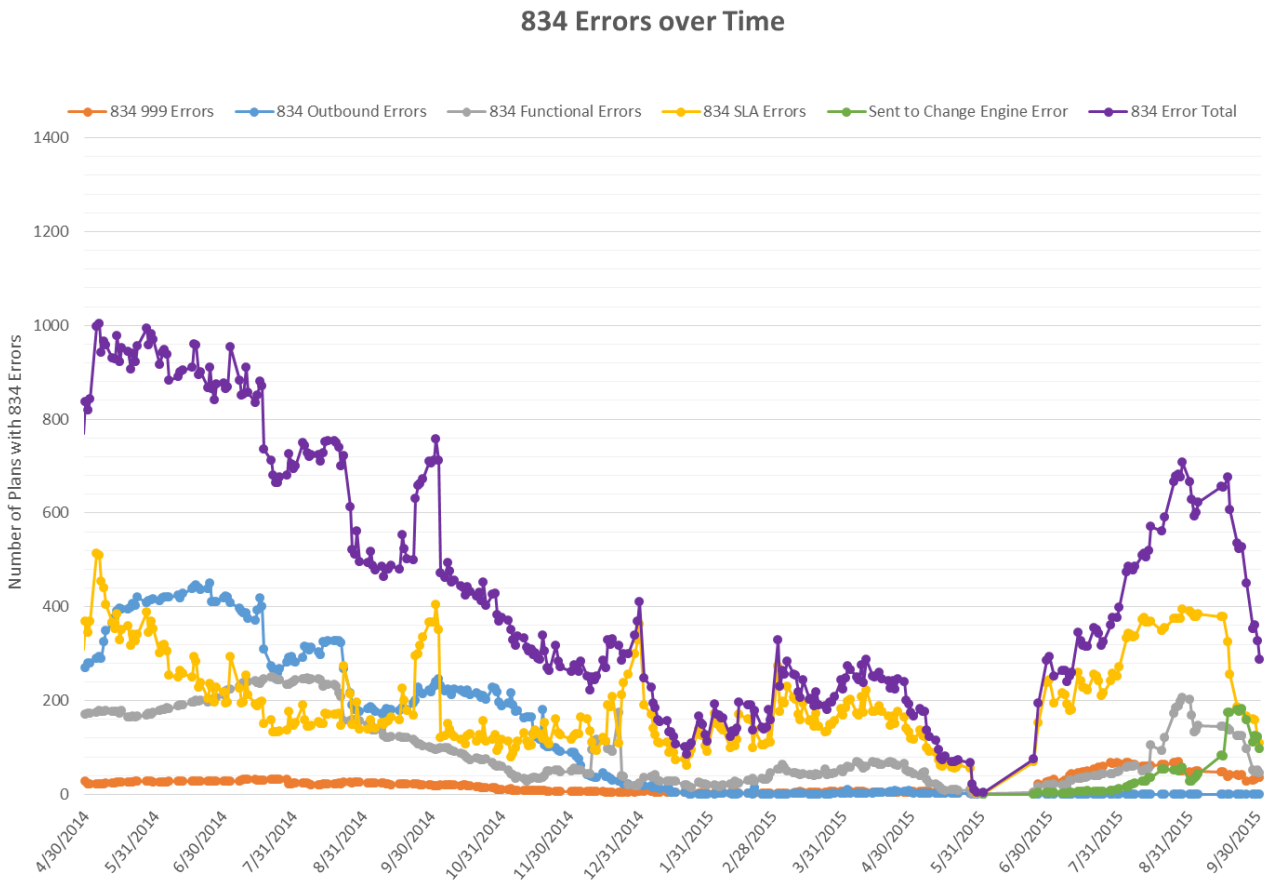
Vermont Health Connect's systems achieved 99.91% availability in August, landing in between the July and August performances in that regard. The availability metric measures the amount of time systems are up and running relative to the amount of time they are expected to be. Scheduled maintenance periods, such as those that occur from 1am to 5am each morning, are not counted.

Last Open Enrollment

Vermont Health Connect's system was stable throughout the last Open Enrollment. Of note:

- More than 270,000 website visits from November 2014 through February 2015.
    - 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 the second Open Enrollment (11/15/14-2/15/15), compared to more than 400 during the first Open Enrollment. All three were resolved the same day.
- Less than one hour of total unscheduled downtime during Open Enrollment.

Carrier Integration



Vermont Health Connect made significant progress last month in reducing the inventory of 834 transaction and premium processing errors. An 834 is an electronic file sent from Vermont Health Connect to an insurance carrier with information about an individual or family's enrollment information. An 834 error indicates that this electronic file might not have been successfully processed. Over the last two weeks of September the inventory of 834 errors was cut by more than half, from nearly 700 to about 300.

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 insurance carriers on errors that might be caused by carrier systems.

It is important to note that as Vermont Health Connect 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. Therefore, the number of 834 errors will never reach zero. In addition, a dramatic increase in integration activity – such as was the case when customer service staff worked through the backlog of change requests this summer - can be expected to be accompanied by a corresponding increase in errors.

Verifications

Federal guidelines require all state health insurance marketplaces – including Vermont Health Connect – to confirm that customers meet eligibility requirements. The Vermont Health Connect system utilizes the Federal Data Services Hub (federal hub) at the time of application to verify:

- Social Security Number, citizenship and/or immigration status for all customers wishing to purchase a qualified health plan (QHP) through the marketplace;
- MAGI-based Income for Medicaid for Children and Adults (MCA) enrollees;
- Annual Income for QHP enrollees who will be receiving a subsidy.

If attempts to verify customer information through the federal hub are unsuccessful, Vermont Health Connect must ask customers to provide documentation. In an attempt to reduce the burden on applicants, State staff conducted two efforts to use already-verified information in the State's legacy ACCESS system to verify the Social Security Numbers, citizenship, and immigration status of individuals in the Vermont Health Connect system. Following these efforts, State staff mailed notices in late August to the remaining 3,126 customers who needed to provide supporting documentation. Customers were asked to mail copies of verification items or, if they prefer, to bring the copies to their local Economic Services Division (ESD) district office.

Federal rules require that an exchange gives customers 90 days to provide appropriate documentation. If any items remain unresolved after 90 days – and after additional reminder notices are mailed at the 30-day and 60-day marks – Vermont Health Connect will proceed with disenrollment for 2016. Termination notices will include information about full-cost individual direct enrollment as well as the availability of special enrollment periods should documentation subsequently become available outside of Open Enrollment.

As of October 1, more than 1,400 households had submitted verification items. The first reminder notice was set to mail on October 5.

In-Person Assistance

On September 28, in partnership with Vermont's community libraries, Vermont Health Connect kicked off a series of "Health Insurance 101" workshops with an event at the Alice M. Ward Memorial Library in Canaan. The sessions are free to the public and designed to help customers and potential customers better understand health insurance terms, financial help, and the Vermont Health Connect system.

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

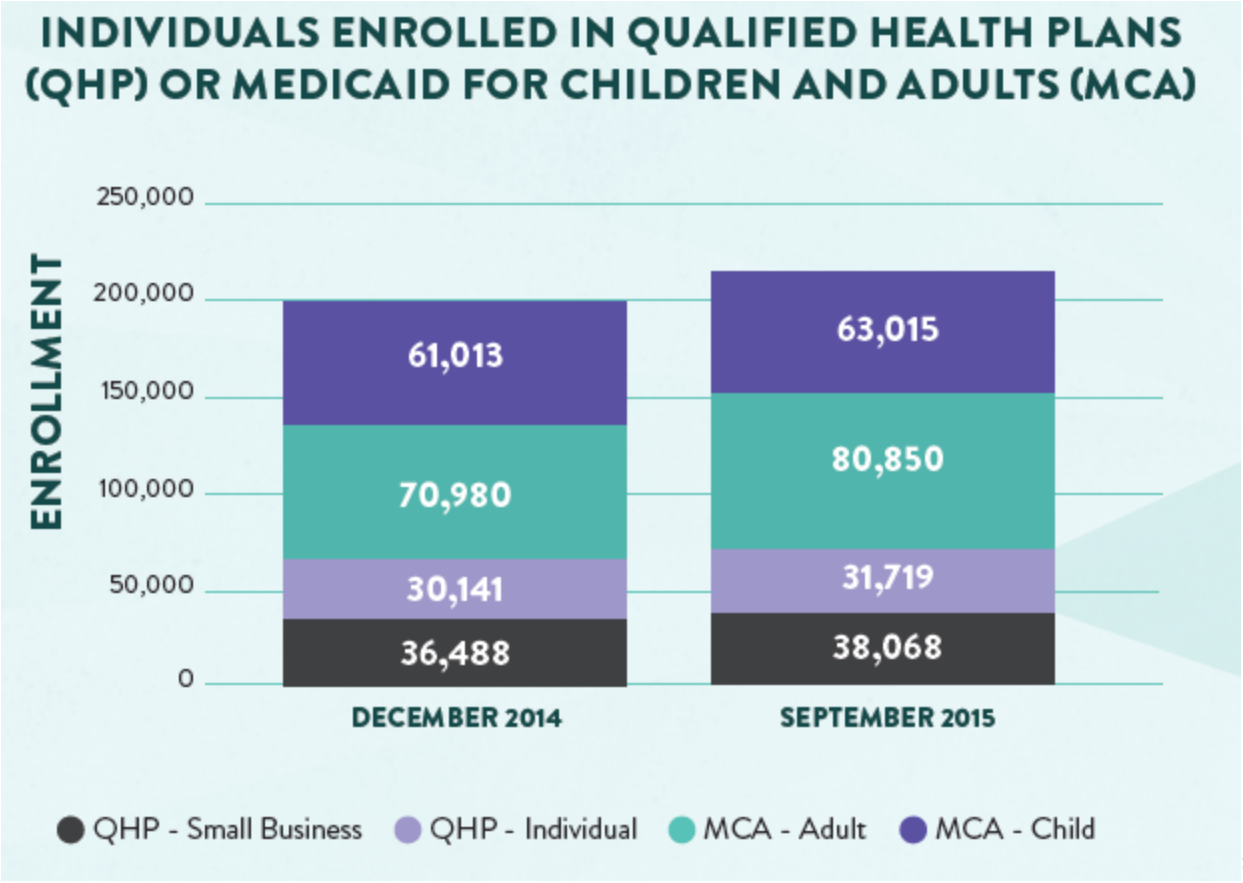
In September Navigators collectively conducted 993 consultations with Vermonters – defined as unique interactions of ten minutes or more. This was up from 855 consultations in August and is expected to continue to rise as Open Enrollment approaches.

In addition to hosting Health Insurance 101 events, libraries have played a key outreach role. More than 50 libraries are displaying Vermont Health Connect educational material in advance of 2016 Open Enrollment. In addition, community organizations, district offices, pharmacies and other partners across the state are playing an essential role in connecting Vermonters to in-person assistance.

Vermonters can get more details on events by clicking "News and Events" at VermontHealthConnect.gov or by calling the Customer Support Center at 1-855-899-9600 (toll-free). To find an Assister near them, they can click "Find an Assister in your Community" or call the Customer Support Center.

Enrollment Update (data through September 30, 2015)

Current Coverage



[1]

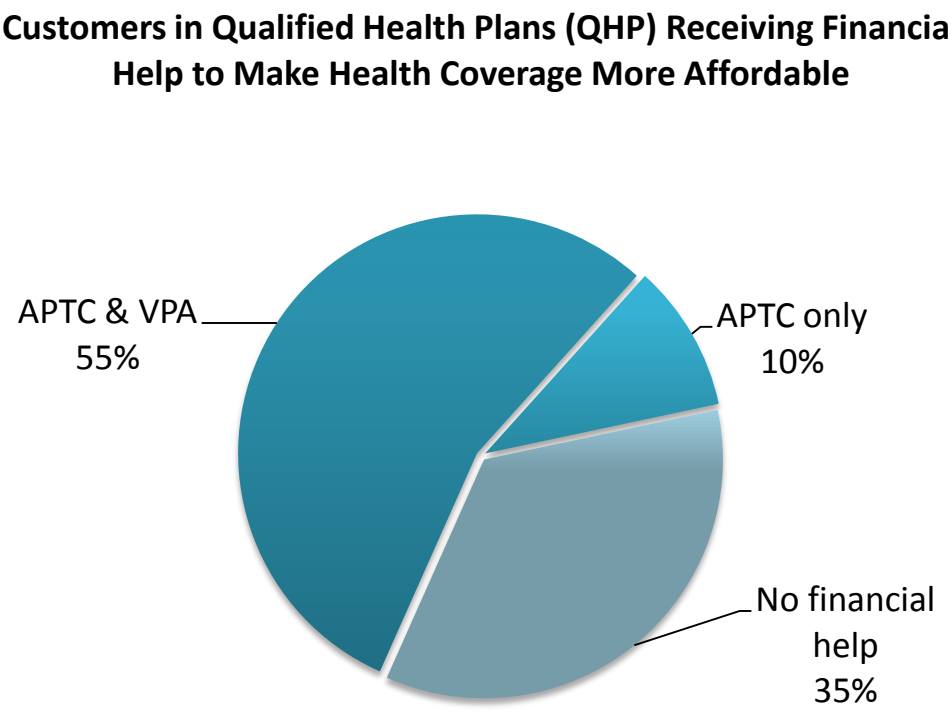
A combination of reports from insurers, Vermont Health Connect, and the State's legacy ACCESS system suggest that Vermont is continuing to reduce its second-lowest-in-the-nation uninsured rate. The number of Vermonters covered by Vermont Health Connect qualified health plans (QHPs) increased by more than 3,000 from December 2014 to September 2015, while the number covered by Medicaid/Dr. Dynasaur increased by more than 10,000. This growth was driven by a strong turnout during the QHP Open Enrollment (November 15 to February 15) and beyond.

Of customers in QHPs:

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

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

Financial Help – Premium Assistance



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

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

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

The amount of financial help varies depending on household size and income. In 2015, an individual making less than $46,680 or a family of four making less than $95,400 a year may qualify for financial help. For example, an individual who has an income of about $24,000 per year receives approximately $340 in APTC and VPA per month. This means she could pay $120 for a Silver health plan that costs $460 per month.

In 2016, an individual making less than $47,080 or a family of four making less than $97,000 a year may qualify for financial help.

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:

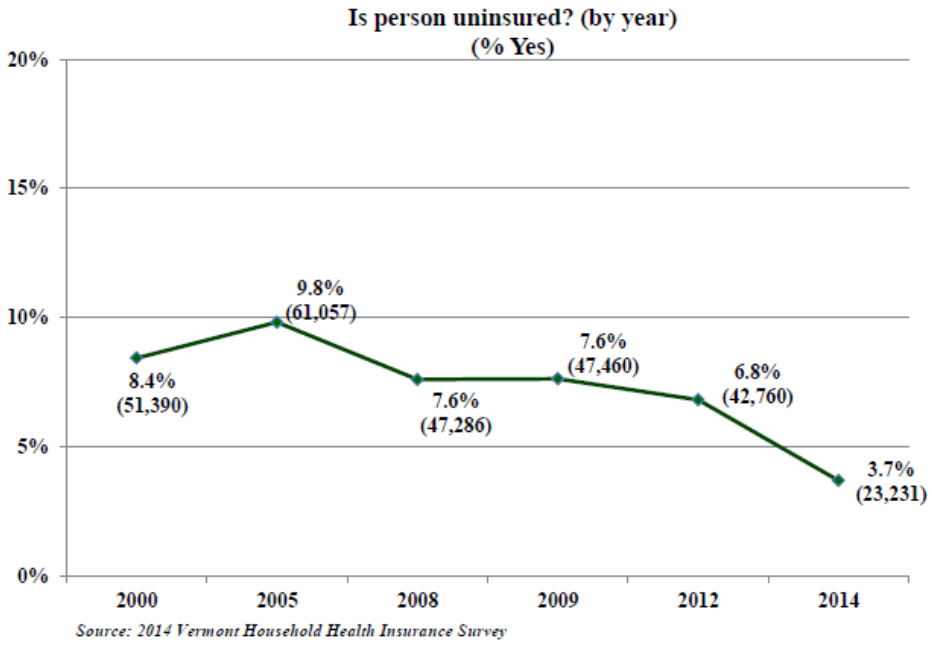
- The typical (median) individual receiving CSR is enrolled in a Standard Silver 87 plan with a $600 medical deductible and $1,250 maximum out-of-pocket (compared to a $1,900 medical deductible and $5,100 maximum out-of-pocket in an unsubsidized Standard Silver plan).
- This individual, whose benefits translate to an income of just over $21,000 per year for a single person, also receives $362 in premium assistance. If she purchased a Standard Silver plan with a full-cost of $466, it would cost her $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 the 2015 version of Vermont Health Connect's 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. Last winter VHHIS revealed that Vermont's uninsured rate was cut nearly in half over the past two years. The survey also reported that Vermont had done particularly well in terms of covering children in the state. The number of uninsured children in Vermont fell from nearly 2,800 in 2012 to fewer than 1,300 in 2014.

In September, the U.S. Census Bureau announced similar results. The Census reported that Vermont had leapfrogged Hawaii and Washington, D.C. to attain the second lowest uninsured rate in the nation.

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 have access to quality health coverage.