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: December 1, 2015
RE: Vermont Health Connect Monthly Report

I am pleased to submit the seventh 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 October. 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 November 16.

With the successful deployment of automated change and automated renewal functionality, we are fortunate to be in a far different place than we were a year ago. We now have a system that can support the customer service levels that Vermonters deserve. While work remains, the nature of that work is completely different. Having built the system, we can now focus on fine tuning our operations and, most importantly, on empowering Vermonters to take control of their health insurance decision making.

With few exceptions enrolled Vermonters should expect that their 2016 health plans and subsidies will be clearly stated on their December invoice; that they should be easily able to change plans if they wish to do so during 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.

We have Service Level Agreements in place to ensure that those experiences are the rule and not the exception. Our Customer Support Center aims for at least a 90% answer rate and to answer more than three out of four calls within 24 seconds. They have exceeded those targets 11 out of the last 12 months. Our Systems Integrator strives to keep our system online 99.9% of the time and to keep average page loads under two seconds. They have surpassed those targets every month since our spring system upgrades were deployed. Having cleared the backlog of change requests earlier this fall, our Eligibility and Enrollment team will aim to complete new requests submitted in the first half of the month in time to appear on the following invoice, and changes submitted in the second half on one of the following two invoices.

On the empowerment side, we can do more with our insurance carriers, Assister organizations, and other partners to promote health insurance literacy. In the weeks ahead, we will roll out new tools and resources to help Vermonters understand their subsidies, assess how various plan designs and

deductibles could impact their total health care costs, and feel confident in choosing a plan and putting it to use for their family. We will also work with our partners to clearly communicate details about grace periods and the importance of paying bills on time – as well as new payment options which now make it easier for customers to do so.

This Thanksgiving, I appreciate our dedicated state workers and Assisters, our insurance carrier partners and contractors, and all of you.

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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 December 1, 2015

December 1, 2015

Contents

2016 Open Enrollment and Renewal

2016 Open Enrollment began November 1 and runs until January 31. 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 received a letter in late October to let them know that, as long as they keep paying their monthly bill, they will automatically 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 are able to do so by calling the Customer Support Center or logging into their online account.

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 help Vermonters prepare for Open Enrollment. After customers received Vermont Health Connect's renewal notice, the carriers followed up with mailings that provide information on each customer's 2016 plans and rates.

More than three out five 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 premium decrease. For example, 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 per month.

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.

Open Enrollment is also a great time for Vermonters who need health insurance to join the more than 96% of Vermonters who already have coverage. According to calculations from data in last year's Household Health Insurance Survey, most uninsured Vermonters can get basic coverage for less than $90 per month. In addition, most could buy a Silver plan with cost-sharing reductions for less than $180 per month – this would have low out-of-pocket costs, more like a Gold or Platinum plan, but with a much lower premium.

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'd prefer to first explore health plans and see how much financial help they might qualify for, they can find a Subsidy Estimator and plan comparison materials at VermontHealthConnect.gov.

By signing up for health coverage, Vermonters can avoid having to pay the individual shared responsibility fee – which increases significantly in 2016 – when they file their federal taxes. The federal fee for not having health insurance increases in 2016 – the typical uninsured individual will pay $695 when they file their 2016 taxes (in spring 2017). Those with higher incomes will pay more – 2.5% of their household income above the filing threshold – and could have to pay for all of their own health care costs on top of that.

Project Development (updates as of November 16, 2015)

Status of Deliverables Related to 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. This risk was eliminated at the end of the month when a "passive renewal" file was generated to communicate with the Federal Data Services Hub and determine 2016 eligibility for customers' accounts.

Four out of five cases were automatically renewed through the passive file. Any cases that could not be completed in this manner – if, for example, a customer did not answer an application question that was previously optional and is now required – are being worked by Vermont Health Connect's Eligibility and Enrollment unit.

Prior to closing its doors, Exeter delivered code to support such additional upgrades as Medicaid redetermination integration, Department of Labor verifications, billing and payment functionality, and notices. In order to avoid major changes to workflows during the open enrollment season, the project plan was adjusted to split these upgrades into two major releases. The first release, targeted for the end of the year, will focus on Medicaid renewals, verifications, and notices. This will be followed by a second release in 2016 which will focus on case management and non-functional requirements.

The State and its contractors are in the process of testing the code and will take steps to manage scope and deliver the best service for Vermonters.

Regarding security, the State continues to work the Plan of Action and Milestones within the guidelines set by its federal partners.

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.

- Any defects found in OneGate testing could impact the timing and scope of near-term deployments while human resource talent is transitioned from Exeter to Optum and other staffing channels to maintain a consistency of product knowledge.
- 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.

Recently Mitigated Risk (Closed since Last Month's Report)

The following risks that were identified in last month's report have since been mitigated:

Former Risk	Comment
• Inflexible delivery dates pose a risk in the event that unexpected issues arise during testing.	Vermont Health Connect successfully deployed automated renewals.
• Outside dependencies carry a risk to any project's deadlines, and the automated renewal deployment is very dependent on insurance carrier engagement. Frequent meetings and collaboration are chief among the efforts to mitigate this risk.	Vermont Health Connect successfully deployed automated renewals.

Actions to Address State Auditor's Recommendations (updates as of November 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 October (middle column) and November (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), the Release 2 (R2) scope statement is complete. The RTM is directly tied to the VHC release schedule. As such, the RTM will be finalized after the final scheduled release. The test plan for the R2c release (December 2015) is complete.

Topic/Finding	VHC Status Update, Oct 2015	VHC Status Update, Nov 2015
1. Expeditiously complete the VHC project management plan documents for the 2015 releases, including a scope statement, requirements traceability matrix, and test plan	Testing for Release 2b (R2b) 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 VHC release schedule. As such, the RTM will be finalized after the final scheduled release.	The Release 2 (R2) scope statement is complete. The RTM is directly tied to the VHC release schedule. As such, the RTM will be finalized after the final scheduled release. The test plan for the R2c release (December 2015) is complete.
2. Include in future VHC system development contracts clauses that provide monetary consequences tied to the contractor's performance.	VHC has been working with legal counsel to develop a competitive process consistent with Bulletin 3.5 for small business (SHOP) functionality.	VHC 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 VHC, including explicitly laying out decision-making responsibilities and collaboration	We are continuing to work through job descriptions across the matrixed unit. We have updated roles & responsibility documents for eligibility, ops leadership, and workforce management teams. We are now turning our 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	We are continuing to work through job descriptions across the matrixed unit. We have updated roles & responsibility documents for eligibility, ops leadership, and workforce management teams. We are now turning our 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

requirements.	additional clarity on decision making and collaboration requirements.	making and collaboration requirements.
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.	The maintenance & operations and hosting contracts have been executed and include 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, hosting, and premium processing contracts have been executed and include provisions for service level agreements, payment credits, and performance metrics.

5. Establish a process and expeditiously perform reconciliations of enrollment data between the VHC, Benaissance, and the carriers' systems	**Regarding 2015 reconciliation:** • All discrepancies on coverage periods, premiums, and premium assistance amounts on BCBSVT policies as of 8/25 have been reconciled at VHC, BCBS, 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 9/15; the VHC system is being updated real time, as needed, while updates are being sent for processing to the 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 VHC 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 BCBS plans. A similar plan is being considered for MVP and NEDD plans and is pending data and collaborative conversations with the involved parties.	**Regarding 2015 reconciliation:** • All discrepancies on coverage periods, premiums, and premium assistance amounts on policies at BCBSVT (8/25 data), MVP (10/5 data), and NEDD (9/15 data) have been updated at VHC and/or delivered for updating at the carrier and/or payment processor, where needed. • Recognition of system issues based on 10/15 reports has warranted another round of work on coverage periods at BCBS, coupled with root cause analysis; this is now in progress. • The approach for long-term reconciliation reporting has been 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. o Collaboration with the carriers is underway to reach agreement on the data transport method of system extracts. • Financial reconciliation will be addressed following completion of the reconciliation of system enrollment data. Preliminary discussions have begun with BCBSVT. **Regarding 2014 reconciliation:** • A solution is currently being drafted to further address enrollment data reconciliation between the carrier, payment processing, and VHC 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 BCBS 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 VHC system and the relevant Medicaid system(s).	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.	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 VHC system who meet the State's termination criteria.	The estimates from Benaissance and Optum were completed on 8/20. The State is working directly with Benaissance to deliver a more cost-effective solution. Scope meetings with Benaissance were completed as of 9/25. The sizing of the revised scope of work was completed by Benaissance on 10/5. The State is now working with Optum to complete the integration sizing of the revised scope for leadership review and consideration.	The State intends to comply with applicable Medicaid billing requirements. We are actively exploring our options to implement a technical solution and resolve delinquent cases.
9. Expeditiously develop VHC 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 VHC bank account and monitor this account to ensure that payments are being remitted appropriately and in a timely manner.	See #9 above	See #9 above
11. Establish a process and expeditiously perform reconciliations of payment data among the VHC, Benaissance, and the carriers' systems.	See #5 above and note that automated reconciliation continues to be under development.	See #5 above and note that automated reconciliation continues to be under development.

Operations Update (data through November 4, 2015)

Change Processing

Change Requests		
Date of Change Request	**# of Change Requests**	**% Completed by 4th of Next Month (First Invoice)**
6/16-7/15	3,455	52%
7/16-8/15	3,704	73%
8/16-9/15	3,447	86%
9/16-10/15	3,122	81%

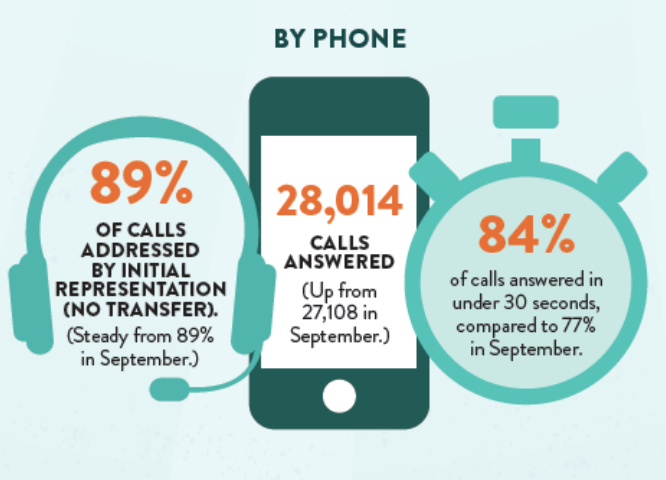
On October 1, Vermont Health Connect announced that the backlog of change requests had been cleared; that the marketplace was operating at a vastly improved customer service level for change requests; and customers would be able to report many changes online. This accomplishment marked a major milestone 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.

Instead of taking several months for a change to process, customers who report a change by the 15th of a month should now expect to see that change reflected on their next bill. Changes submitted in the second half of a month should be reflected on one of the following two invoices. The Eligibility and Enrollment team will track progress toward this target.

For the month ending October 15, four out of five (81%) change requests were processed by the following invoice. Of the remaining requests, some were awaiting information from the customer before they could be completed while others were impacted by the need to put change-processing on hold for much of the second half of October to avoid creating discrepancies with the renewal files that were being prepared.

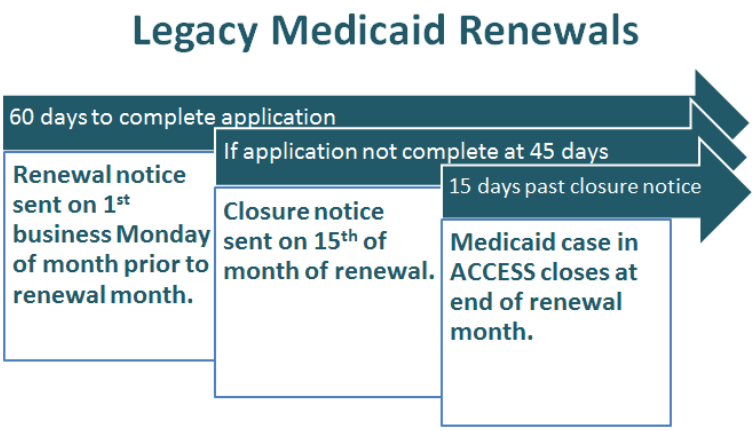
Customer Support Center (Maximus Call Center)



Month	Calls Offered	Answer Rate	Calls Answered	Calls Answered <30 Seconds	Transfer Rate
August 2015	27,486	89%	24,489	61%	9%
September 2015	28,536	95%	27,108	77%	11%
October 2015	29,230	96%	28,014	84%	11%

In October, the Customer Support Center received 29,230 calls. They answered 28,014 and had 1,216 customer hang ups for an answer rate of 96%. More than four out of five calls (84%) were answered in less than 30 seconds, up from 77% in August. Common reasons for calling included requests for change of circumstance (COC) and change of information (COI), making payments by phone, questions about verifications notice, questions about invoices and payments, and Access to Care issues. Nearly nine out of ten calls (89%) were able to be resolved without transferring, matching August's rate.

Medicaid Renewals



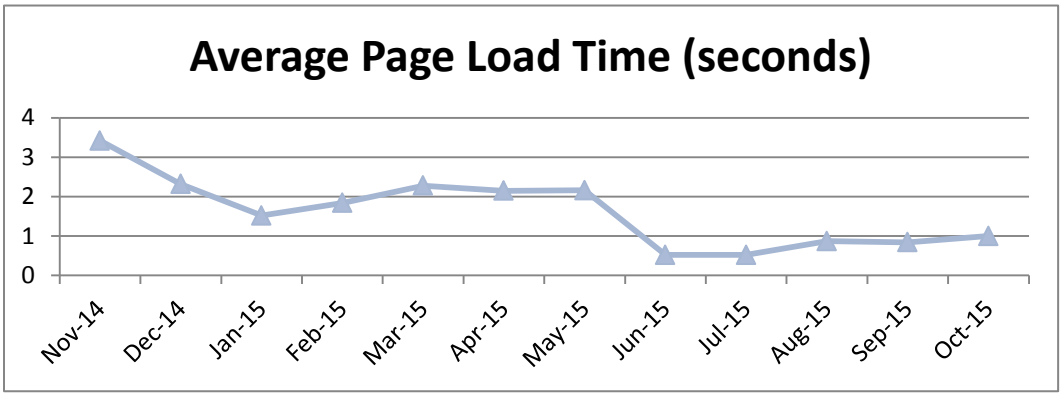
DCF and DVHA's matrixed Eligibility and Enrollment unit is beginning the renewal process for 27,000 households with accounts on the State's legacy ACCESS system. Starting in January and continuing each month until October 2016, Vermont will mail notices to nearly 3,000 households that have at least one 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, in October, the Eligibility and Enrollment unit began contacting 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

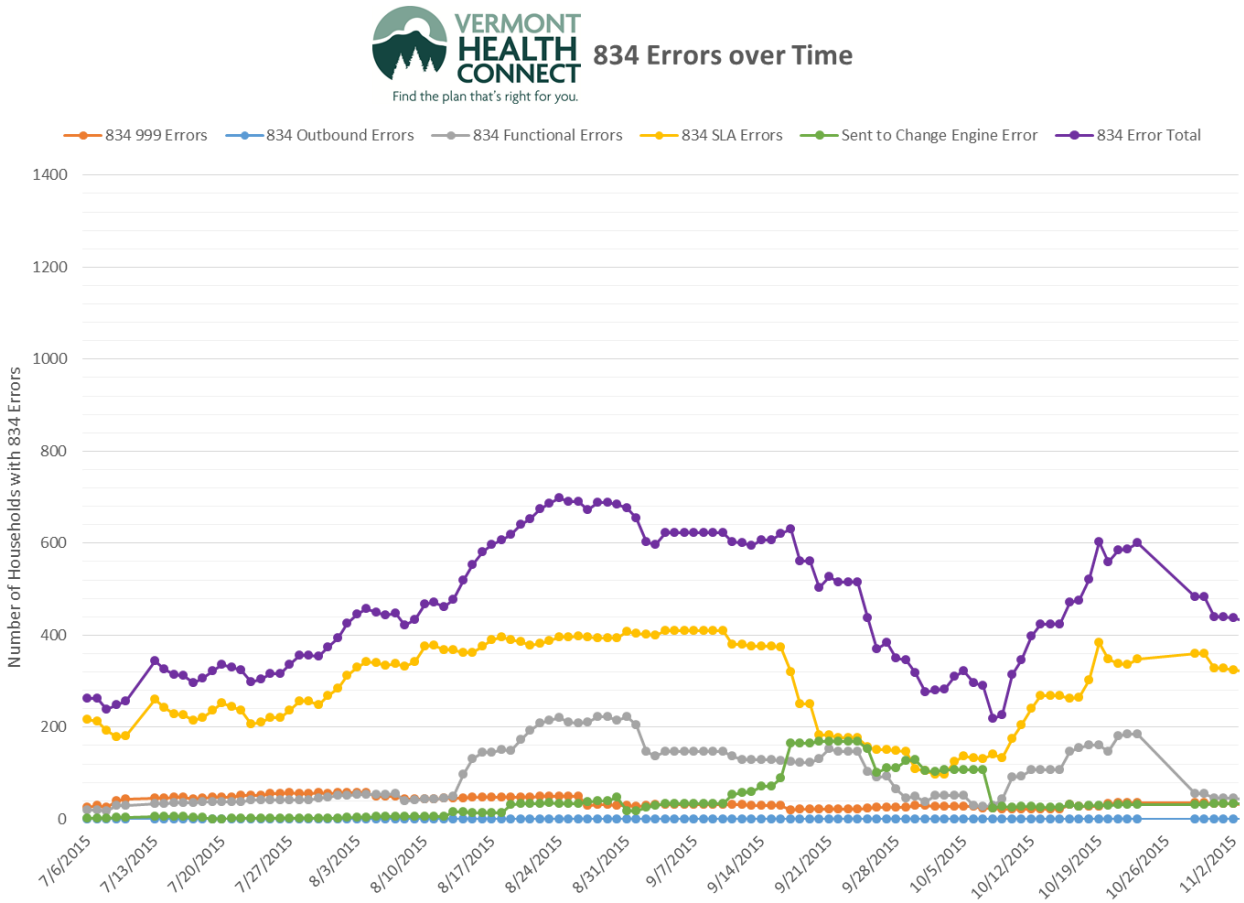


Month	Availability	Avg Page Load Time (seconds)	Max Peak User	Visits
August 2015	99.98%	0.87	126	43,975
September 2015	99.91%	0.84	101	50,799
October 2015	99.92%	1.00	105	49,316

Vermont Health Connect's web traffic decreased slightly to just under 50,000 visits in October. Average page load time ticked up to one second but remained significantly faster than the load times prior to the spring system upgrade.

Vermont Health Connect's systems achieved 99.92% availability in October, similar to the September performance 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.

Carrier Integration



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.

The inventory of 834 transaction and premium processing errors increased in early October due to a system defect at one of Vermont Health Connect's carrier partners. This issue, which impacted the ability to send a confirmation of cases with multiple transactions back to Vermont Health Connect's system, was resolved in late October and led to a decrease in inventory.

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. Vermont Health Connect mailed the first reminder notice on October 5. A final reminder notice was mailed to 1,145 households on November 4.

If any items remain unresolved after 90 days, Vermont Health Connect will proceed with disenrollment for 2016. Termination notices will include information about full-cost individual direct enrollment as well as the availability of special enrollment periods should documentation subsequently become available to customers outside of Open Enrollment.

In-Person Assistance

Vermont Health Connect continued its series of “Health Insurance 101” workshops in partnership with Vermont’s community libraries. October events were held in Newport, Rutland, Burlington, Essex, Lyndon, Barton, Barre, Brattleboro, and Bennington. The sessions were 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.

The Vermont Health Connect Assister Program continued to work with Navigators, Certified Application Counselors, and Brokers to prepare for Open Enrollment. 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.

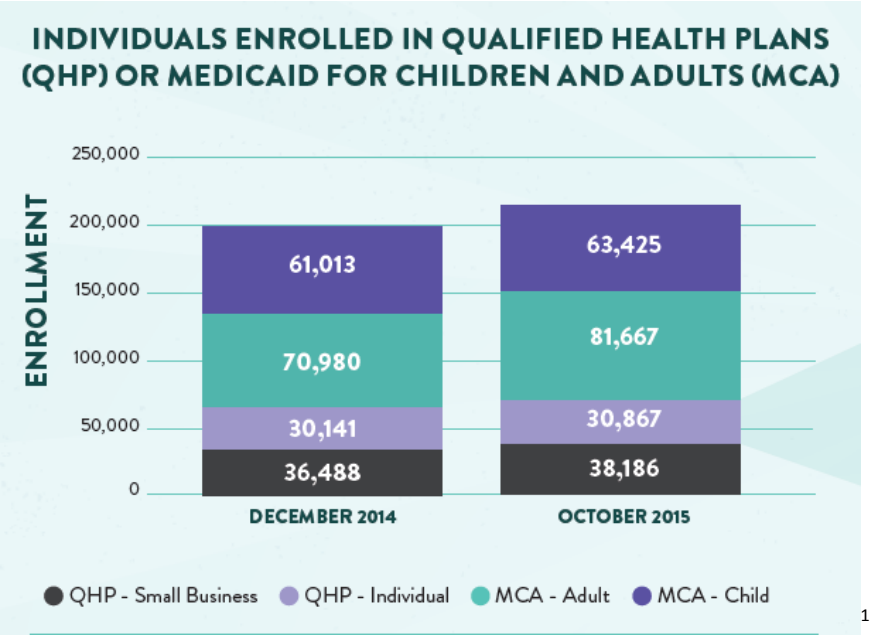
In October Navigators collectively conducted 535 consultations with Vermonters – defined as unique interactions of ten minutes or more. This was down from 993 consultations in September.

Vermont Health Connect also prepared for Open Enrollment by distributing promotional and educational materials to libraries and Assister organizations as well as Agency of Human Services District Offices, federally qualified health centers, pharmacies, the Tax Department, Vermont Lottery Commission, and other customer-facing partners.

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 October 31, 2015)

Current Coverage



[1]

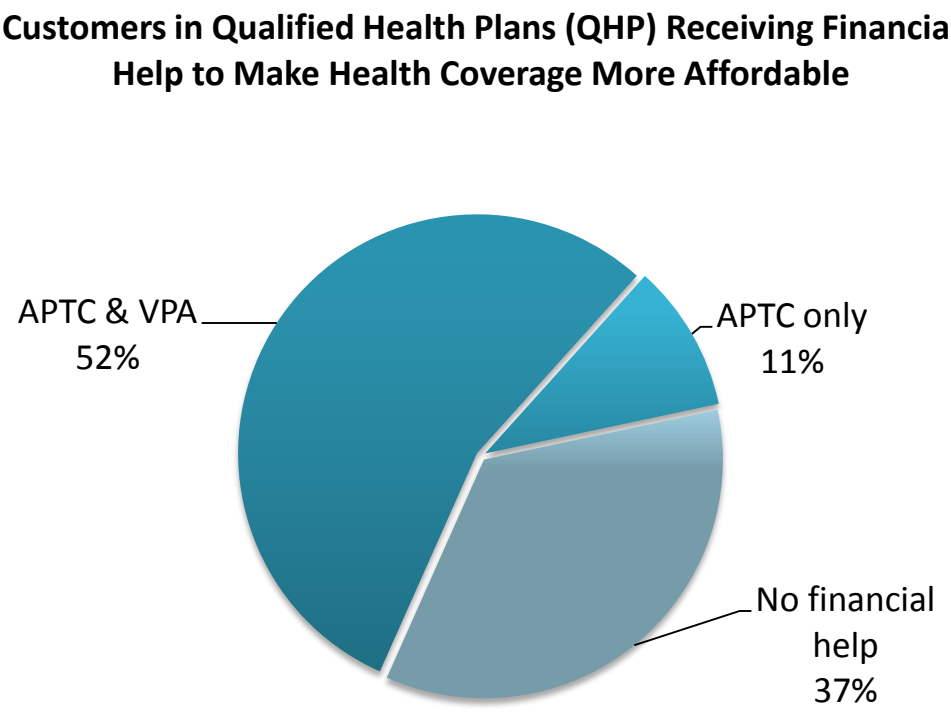
A combination of reports from insurers, Vermont Health Connect, and the State's legacy ACCESS system suggest that Vermont is continuing to reduce its uninsured rate. The number of Vermonters covered by Vermont Health Connect qualified health plans (QHPs) increased by more than 2,000 from December 2014 to October 2015, while the number covered by Medicaid/Dr. Dynasaur increased by more than 13,000.

Of customers in QHPs:

- Over half (52%) are female,
- Three in five (59%) 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). October 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 (63%) qualified for federal Advanced Premium Tax Credits (APTC).
- More than half (52%) qualified for cost-sharing reductions (CSR) and Vermont Premium Assistance (VPA).

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 up to $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:

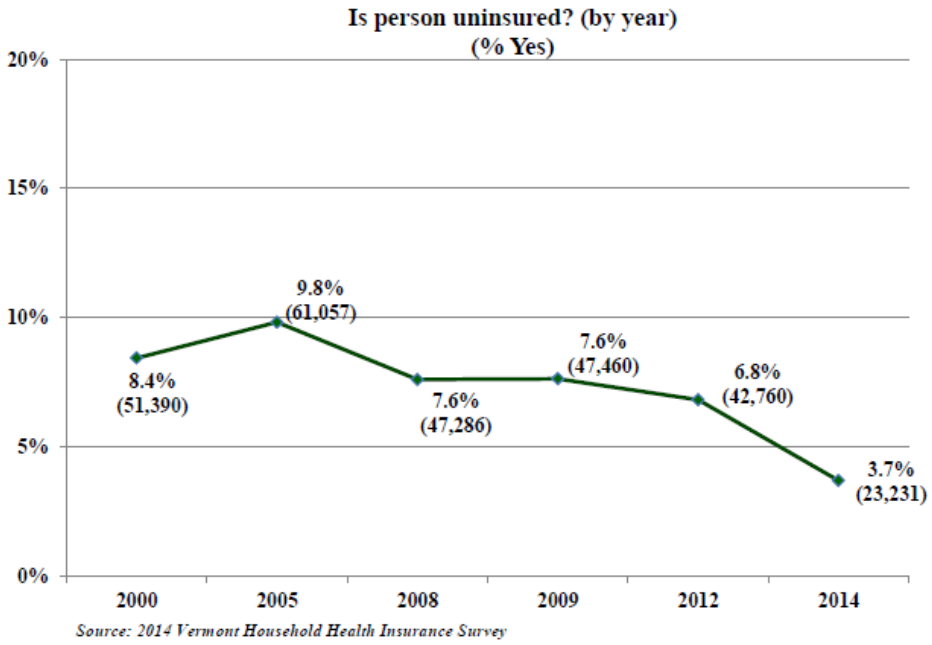
- The typical (median) individual receiving CSR is enrolled in a Standard Silver 87 plan with a $600 medical deductible and $1,250 maximum out-of-pocket (compared to a $1,900 medical deductible and $5,100 maximum out-of-pocket in an unsubsidized Standard Silver plan).
- This individual, whose benefits 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 in the 2016 version of Vermont Health Connect's Subsidy Estimator,
- CSR information in notices,
- Increased emphasis on CSR in call center staff training,
- Health Insurance 101 materials and events to help Vermonters understand out-of-pocket costs and key insurance terms,
- Additional engagement to make sure Silver 87 and 94-eligible customers understand CSR.

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.

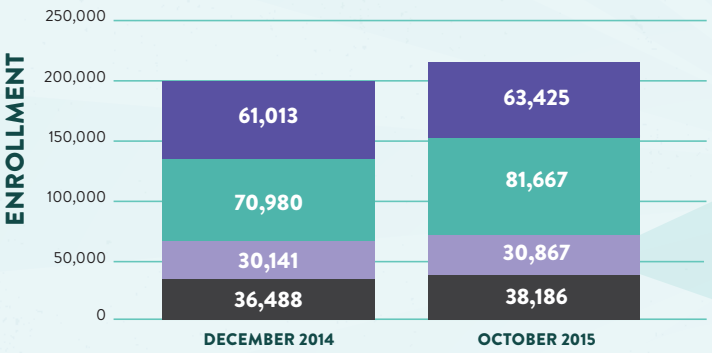
In September, the U.S. Census Bureau announced similar results. The Census reported that Vermont had leapfrogged Hawaii and Washington, D.C. to attain one of the two lowest uninsured rates in the nation (behind only Massachusetts).

Nonetheless, until every Vermonter has quality health coverage, there will be room for improvement. With healthy numbers of new applicants coming to Vermont Health Connect in 2015 and strong momentum heading into 2016 Open Enrollment, Vermont is continuing to move closer to the goal of ensuring that all Vermonters have access to quality health coverage.

VERMONT HEALTH CONNECT OCTOBER 2015 DASHBOARD

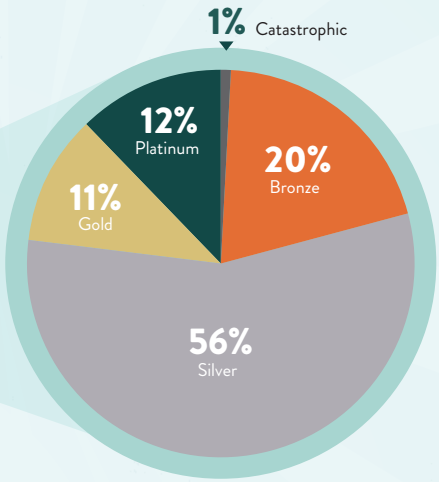
COVERED VERMONTERS

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). October 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).

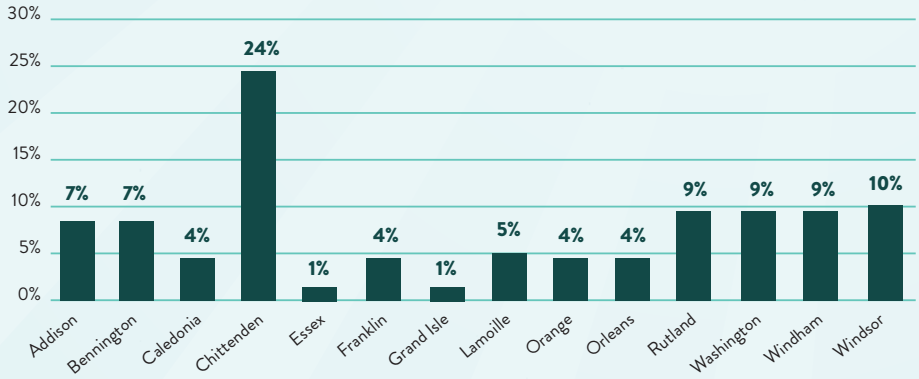
QHP INDIVIDUAL COVERAGE BY METAL LEVEL

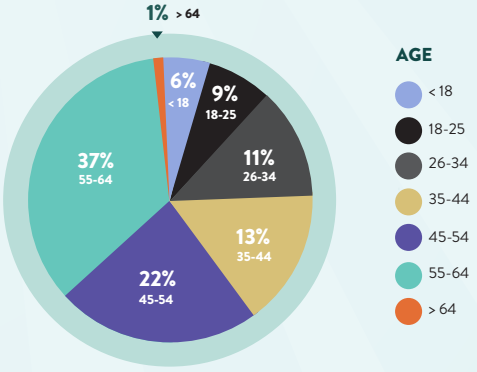


DEMOGRAPHICS

WHO IS COVERED BY QUALIFIED HEALTH PLANS?

Individual QHP Population by County





CUSTOMER SUPPORT

ONLINE

WEBSITE AVAILABILITY* IN OCTOBER 2015:
99.92%
(was 99.91% in September)

*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).
(Steady from 89% in September.)

28,014
CALLS ANSWERED
(Up from 27,108 in September.)

84%
of calls answered in under 30 seconds, compared to 77% in September.

IN PERSON

OCTOBER 2015 NAVIGATOR CONSULTATIONS*
535

*Unique interactions with individuals lasting at least 10 minutes.

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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

52% of enrolled individuals

300% - 400% Federal Poverty Level

ELIGIBLE FOR:
Advanced Premium Tax Credits Only

11% of enrolled individuals

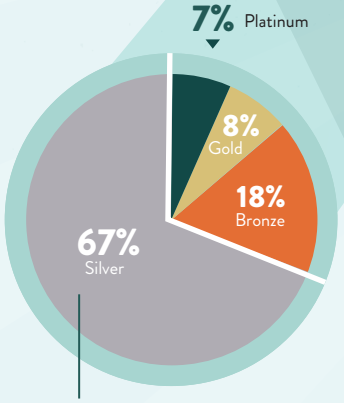
> 400% Federal Poverty Level

NOT ELIGIBLE FOR:
Financial Help

37% of enrolled individuals

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

PLAN SELECTION

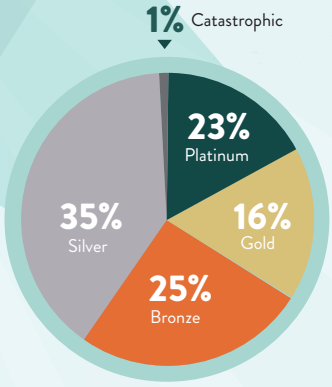


PLAN SELECTION AMONG INDIVIDUALS ELIGIBLE FOR COST-SHARING REDUCTION

PREMIUM

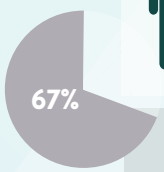
MONTHLY PREMIUM FOR MOST COMMON SILVER PLAN*

PLAN SELECTION



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

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



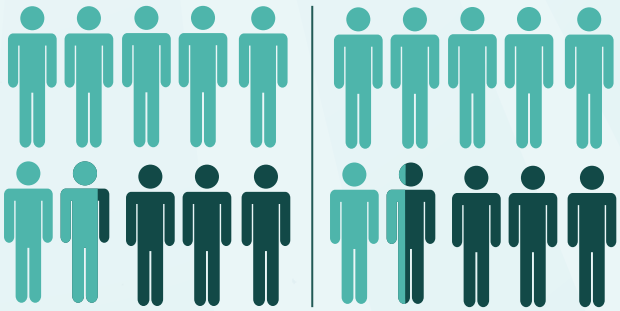
Typical (median) individual receiving Cost-Sharing Reductions**
Income: $21,500
Plan Type: BCBSVT Standard Silver 87 Plan

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



68% of new enrollments

62% 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.