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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

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Project Development (updates as of September 17, 2015)

Status of Deliverables Related to Fall System Upgrades

On September 9, Vermont Health Connect completed its system hosting transition, a key step to allow for the delivery of automated renewal functionality by the end of this month. The hosting transition involved moving Vermont Health Connect system infrastructure from CGI to Optum. While system development work was transitioned from CGI to Optum last October, CGI continued to provide system hosting services. Those system hosting services have now been transitioned to Optum.

The system hosting transition had been flagged as a key dependency needing to be addressed in advance of the fall system upgrades that will deliver functionality needed to support automated renewals. With the hosting transition complete, Vermont Health Connect and Optum are focused on testing and preparing to deploy the automated renewal functionality.

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.
- Development, testing, and execution of a system enhancement to support business processes for corrections of operational errors and system errors that are returned from the carriers (834 errors) needs to be finalized. In August, Optum and Vermont Health Connect teams developed a path to resolution for critical 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 risk that was identified in last month's report has since been mitigated:

Former Risk	Comment
• Vermont Health Connect's hosting is transitioning from CGI to Optum. In mid-August the State received "Authority to	Vermont Health Connect successfully transitioned hosting to Optum Labor Day weekend.

Connect" approval from the Centers for Medicaid and Medicare Services (CMS) and began migrating data to the production environment. The timing of the data center migration involved in this transition poses a risk to the development timelines for fall system upgrades. The VHC project team and the hosting team need to remain closely aligned on schedule and upcoming activities to avoid any negative impacts. The Project Manager assigned to the hosting contract by the Health Services Enterprise Project Management Office is being included in VHC project planning activities to ensure this alignment occurs.	

Actions to Address State Auditor's Recommendations (updates as of September 17, 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 August (middle column) and September (right-hand column).

Notable updates for the past month include:

- Regarding the recommendation to expeditiously complete the VHC project management plan documents for the 2015 releases, including a scope statement, requirements traceability matrix, and test plan (Finding #1), project management plan documents for the Automated Renewals release have been completed.
- Regarding the recommendation to expeditiously develop VHC financial reports to implement stronger financial controls (Finding #3), the premium processing contract has been finalized and includes provisions for service level agreements, payment credits, and performance metrics.

Topic/Finding	VHC Status Update, August 2015	VHC Status Update, Sept. 2015
1. Expeditiously complete the VHC project management plan documents for the 2015 releases, including a scope statement, requirements traceability matrix, and test plan.	All documents described in the column to the left relate to Release 1, Automated Change Processing, and have been completed. The Integrated Master Schedule for Release 2, Automated Renewals, was completed on July 13. The scope statement and test plan delivery dates have been revised, with the scope statement due on August 21, and test plan on August 26. The requirements traceability matrix is due on September 15.	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.
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 requirements.	The MOU between DCF and DVHA was signed in July. The effort to finalize job descriptions across the matrixed unit is ongoing.	The MOU between DCF and DVHA was signed in July. The effort to finalize job descriptions across the matrixed unit is ongoing.
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, including provisions for service level agreements, payment credits, and performance metrics. The premium processing contract will include provisions for service level agreements, payment credits, and performance metrics. The target completion date has been moved to August 30, 2015, covering an additional year of service. Once the State receives final agreement with the Vendor, internal approval process will commence.	The Maintenance & Operations and Hosting contracts have been executed, including 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 VHC, Benaissance, and the carriers' systems	Regarding reconciliation of 2015 cases: • Data collected at the end of May (before Release 1) was used to "correct" a VHC formula for calculating CSR (Cost-Sharing Reduction) values that caused more than 1,500 one penny discrepancies with BCBSVT; it wasn't that the pennies were so important, but that 834 errors could result from the discrepancies; • Most other discrepancies could not be corrected due to lack of staff to resolve discrepancies due to other priorities and lack of processes to correct cases and/or fix systems due to continuing development efforts. • Discrepancy data from all systems was updated at the end of July; needed data corrections & systems fixes will be identified & pursued • A long-term reconciliation process is being developed, tested & implemented; a data feed from BCBSVT has been successfully received & MVP, NorthEast Delta Dental & Benaissance are in the works; ultimately, weekly reporting, analysis & correction is anticipated. Regarding reconciliation of 2014 cases: Work continued on bringing the Benaissance VPA balance to $0 and is nearing completion. We expect to be complete by the end of August. As mentioned last month the non VPA balance will be addressed in August. By the end of August our goal is to have a $0 VPA balance, a significantly reduced non-VPA balance, and a plan to reduce the balance to $0 in September.	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 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, VHC and BCBSVT completed 2014 reconciliation. The net result will be a payment to BCBSVT of $1.6 million upon final review of agreed-upon numbers by an independent auditing firm. • Benaissance and VHC 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).
6. Establish a process and expeditiously perform reconciliations of enrollment data between the VHC 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 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.

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.	Optum's current contract with Benaissance does not allow for new Benaissance development work. The contract only includes integrating current Benaissance functionality into the VHC system. A change request has been entered to both Optum and Benaissance to process this functionality in staged releases, including schedule and cost. When the State receives those estimates, which are due by August 29th, leadership will decide the best approach to obtaining the functionality.	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.

9. Expeditiously develop VHC financial reports to implement stronger financial controls.	Revisions to the premium processing contract have been made, including a requirement for the vendor to work with the state to design and implement financial reports. The vendor has reviewed and approved SLAs and performance requirements, and the contract is currently undergoing legal review prior to final sign-off. The target completion date has been moved to August 30th, 2015. There were several aspects of the contract that needed review by general counsel, Benaissance counsel and State Risk Management to ensure that potential exposure was minimized by proper insurance coverage to protect the State especially as Benaissance acts as fiduciary for the custodial checking account. The needed input and expertise has delayed the signing of the contract.	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 September 2, 2015)

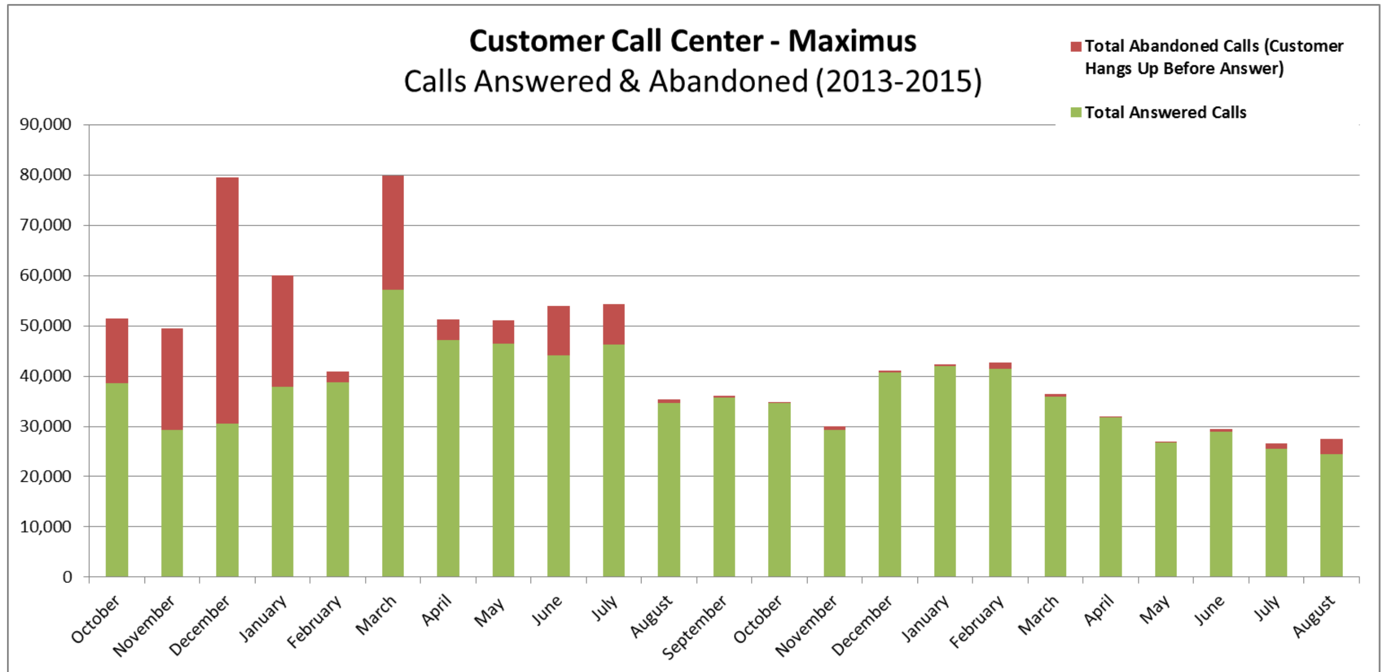
Change Processing

Using the new technology that was deployed at the end of May, Vermont Health Connect and its insurance issuer partners continue to work through the queue of requested changes to customer accounts. Some changes, known as "qualifying events," allow customers to sign up for health insurance or change health plans outside of the annual Open Enrollment period. Examples of qualifying events include getting married or losing job-sponsored insurance. Other changes, such as income changes, can impact the amount of financial help a customer receives. Finally, some changes are simply adjustments to personal information, such as a name change, an address change, or even a preference to be called on their cell phone instead of their home phone.

As of September 2, just under 3,200 households had change requests waiting to be processed. This marked Vermont Health Connect's smallest queue of change requests since December 2013. Even accounting for roughly 100 incoming requests per day, approximately 7,100 fewer households were awaiting changes on September 2 than at the time of the system upgrades at the end of May.

Much of this progress can be attributed to the advances that customer service staff have made processing changes in real-time. In August, Maximus added requested terminations, citizenship status, and pregnancy to the types of changes (including income changes) that they had already been processing immediately over the phone. Because customer outreach is so time-consuming, the ability to process changes in real-time is freeing up staff to make significant progress on the queue of change requests.

Customer Support Center (Maximus Call Center)



Last Month

In August, the Customer Support Center answered 24,489 calls and had 2,997 customer hang ups for an abandoned rate of 10.9%. More than three out of five calls (61%) were answered in less than 30 seconds, down from 77% in July. The average wait time was 3.1 minutes. The uptick in wait times was largely attributed to an increase in training sessions as staff continue to expand the types of change requests that they process over the phone. Nine out of ten calls (91%) were able to be resolved without transferring.

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

Legacy Medicaid Renewal Pilot

This March, Vermont Health Connect began to implement its plan to transition approximately 30,000 Medicaid for Children and Adults (MCA) households from the State's legacy ACCESS system to Vermont Health Connect to receive their Modified Adjusted Gross Income (MAGI) Medicaid eligibility determination. The plan began with a pilot of the highest income households, scheduled over a three-month period of time to allow Vermont Health Connect to assess the success of its renewal strategy. Outreach consisted of an initial notice telling the recipient that they needed to apply at Vermont Health Connect within 30 days, followed by a second notice and paper application four weeks later. At the same time, customer service representatives (CSRs) at Maximus made two to three attempts to reach each household by phone. If they reached a recipient, the CSRs offered to fill out the application over the phone.

In August, the Centers for Medicaid and Medicare Services (CMS) approved Vermont's plan to send final notices and then close Medicaid coverage for the following households from the pilot:

- Households that applied at VHC, were found not eligible for Medicaid, and have not completed all of the steps to enroll in a qualified health plan (QHP).
- Households that did not respond to any of the outreach efforts.

The goal is to mail final notices to these households before the end of September, then end Medicaid coverage on October 31, 2015. This timeline gives impacted households – all of whom had been outreached multiple times this spring – a few additional weeks to complete the steps to enrolling in a new health plan.

Medicaid Renewals Beyond the Pilot

Vermont Health Connect has submitted to CMS a plan and schedule for renewing the remainder of Vermont's three Medicaid populations, specifically:

- Legacy MCA renewals - moving the MCA population from ACCESS to VHC, with notices to the first group tentatively beginning in October.
- Legacy Medicaid for the Aged, Blind and Disabled (MABD) renewals – with notices to the first group tentatively beginning in October.
- VHC Medicaid renewals – renewing recipients who are already in the VHC system, with notices to the first group tentatively beginning in January.

The goal is to complete Medicaid renewals before Open Enrollment in fall 2016 and is contingent on HAEU resources being assigned to process the renewals and accompanying verifications. The plan has been submitted to CMS and is awaiting approval.

System Performance and Traffic

Month	Availability	Avg Page Load Time (seconds)	Max Peak User	Visits
May 2015	100.00%	2.0	82	30,926
June 2015	100.00%	0.5	69	34,837
July 2015	99.87%	0.6	93	37,116
August 2015	99.98%	0.8	126	43,975

Last Month

Vermont Health Connect's web traffic increased to nearly 44,000 visits in August. Average page load time ticked up slightly but remained under one second – significantly faster than the load times prior to the spring system upgrade.

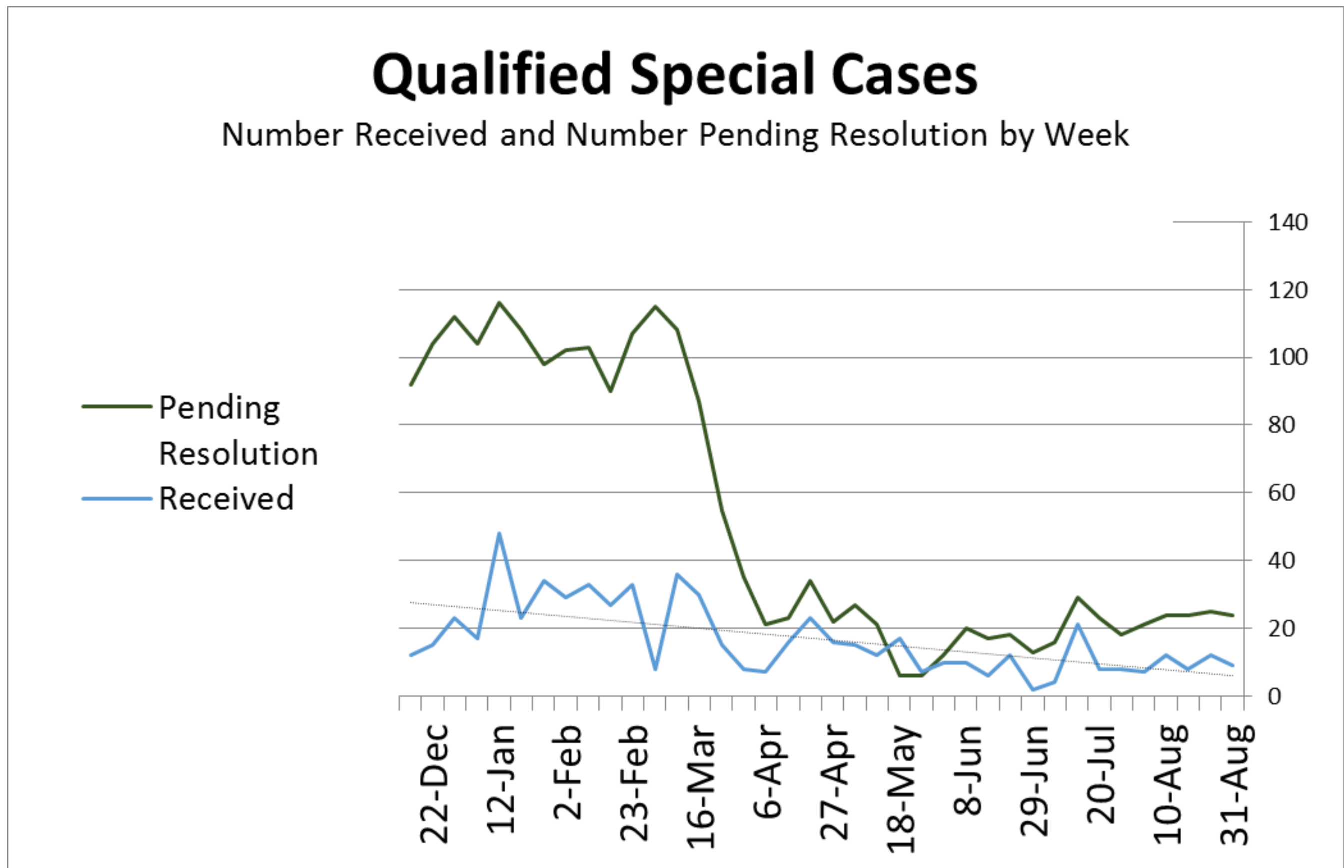
Vermont Health Connect's systems achieved 99.98% availability in August, an improvement from 99.87% the month before. The availability metric measures the amount of time systems are up and running relative to the amount of time they are expected to be. Scheduled maintenance periods, such as those that occur from 1am to 5am each morning, are not counted.

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.

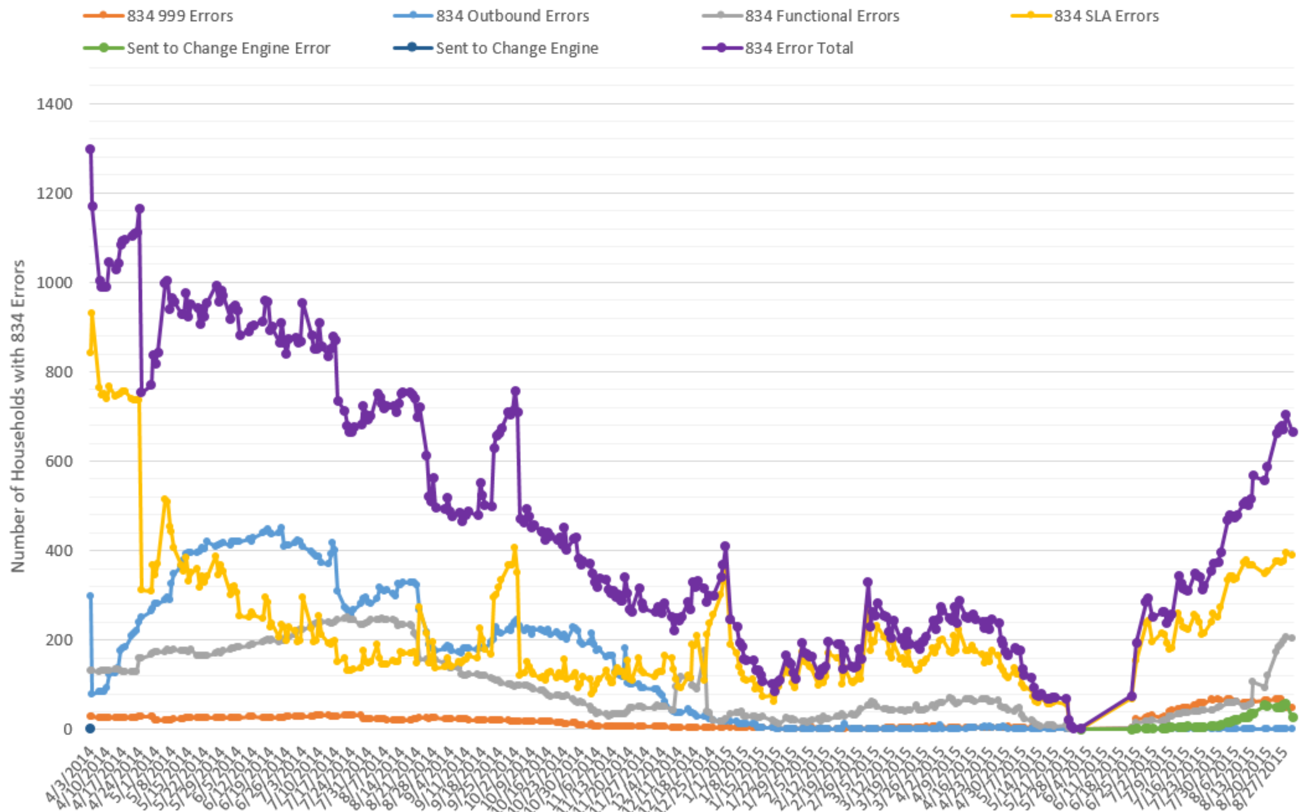
Qualified Special Cases



Qualified Special Cases are cases that are escalated to a dedicated customer service team due to their complexity, medical or financial urgency, or inability to be resolved through normal channels.

Revamped training earlier this year resulted in a reduction in the number of cases that needed to be escalated. Combined with strong work by the dedicated team, the number of pending Qualified Special Cases was cut 80% (from 115 to 22 cases) over a nine-week period this spring. Progress continued throughout the month of May and the team ended the month with just six open cases. The process of adjusting to the new system in June saw a temporary uptick in the number of cases that needed to be escalated, though still significantly lower than winter levels.

Carrier Integration



One of Vermont Health Connect's current top priorities is to resolve 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. Optum is assisting the State in streamlining the resolution process and identifying mechanisms for reducing the generation of errors.

It is important to note that as VHC continues to enroll Vermonters into coverage there will always be some number of electronic enrollment files that have been sent but not yet fully processed. Therefore, the number of 834 errors will never reach zero. In addition, a dramatic increase in integration activity – such as has been the case as Vermont Health Connect ramps up change processing - can be expected to be accompanied by a corresponding increase in errors.

The majority of 834 errors relate to Vermont Health Connect's Service Level Agreement (SLA), which requires insurance carriers to respond within 24 hours with either a confirmation that coverage has been effectuated, a rejection, or a request for more time. This response allows Vermont Health Connect to confirm that the information in its system and the insurers' systems is aligned. SLA errors occur when such confirmation does not occur in time. Because insurance carriers do not process files on weekends and holidays, more SLA errors tend to show up on Mondays and Tuesdays in comparison to the rest of the week.

A large number of cases with SLA errors have the correct information in the VHC, carrier, and payment processor systems and just need a snapshot with the correct statuses to confirm successful integration.

Fortunately for these customers, because their coverage or change has already taken effect on the insurance carriers' systems, they can typically use their health plan benefits seamlessly while Vermont Health Connect and the carriers iron out the confirmation. Other cases need a new snapshot to update all systems with matching information.

Starting in late August, errors resulting from carriers' requests for more processing time began to show up as functional errors rather than SLA errors. Vermont Health Connect and Optum teams identified the issue and began reprocessing impacted cases.

Cases receiving 999 errors often pertained to an issue with alternate phone numbers not being compatible with a carrier's system. This issue has been resolved. Relevant cases have been retriggered and cleared.

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 to address errors that might be caused by carrier systems.

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 VHC system. Following these efforts, State staff developed an outreach plan for contacting the remaining 3,126 customers who needed to provide supporting documentation.

The first step was a notice sent in late August asking customers to mail copies of verification items. If customers feel uncomfortable mailing copies of personal documents, they also have the option to bring the copies to their local 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.

In-Person Assistance

This summer, the Vermont Health Connect Assister Program focused on training and certifying Navigators, Certified Application Counselors, and Brokers 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 August Navigators also collectively conducted 855 consultations with Vermonters – defined as unique interactions of ten minutes or more.

In addition, community organizations, district offices, pharmacies and other partners across the state play an essential role in connecting Vermonters to in person assistance. The state's libraries were a key focus of this summer's outreach work. Over the last two years, Vermont Health Connect has partnered with libraries across the state to display enrollment information and host sessions with Assisters. VHC is expanding that relationship this summer. Working in conjunction with the State Librarian and regional Department of Libraries staff members, VHC has fulfilled requests from more than 50 libraries for educational material in advance of 2016 Open Enrollment.

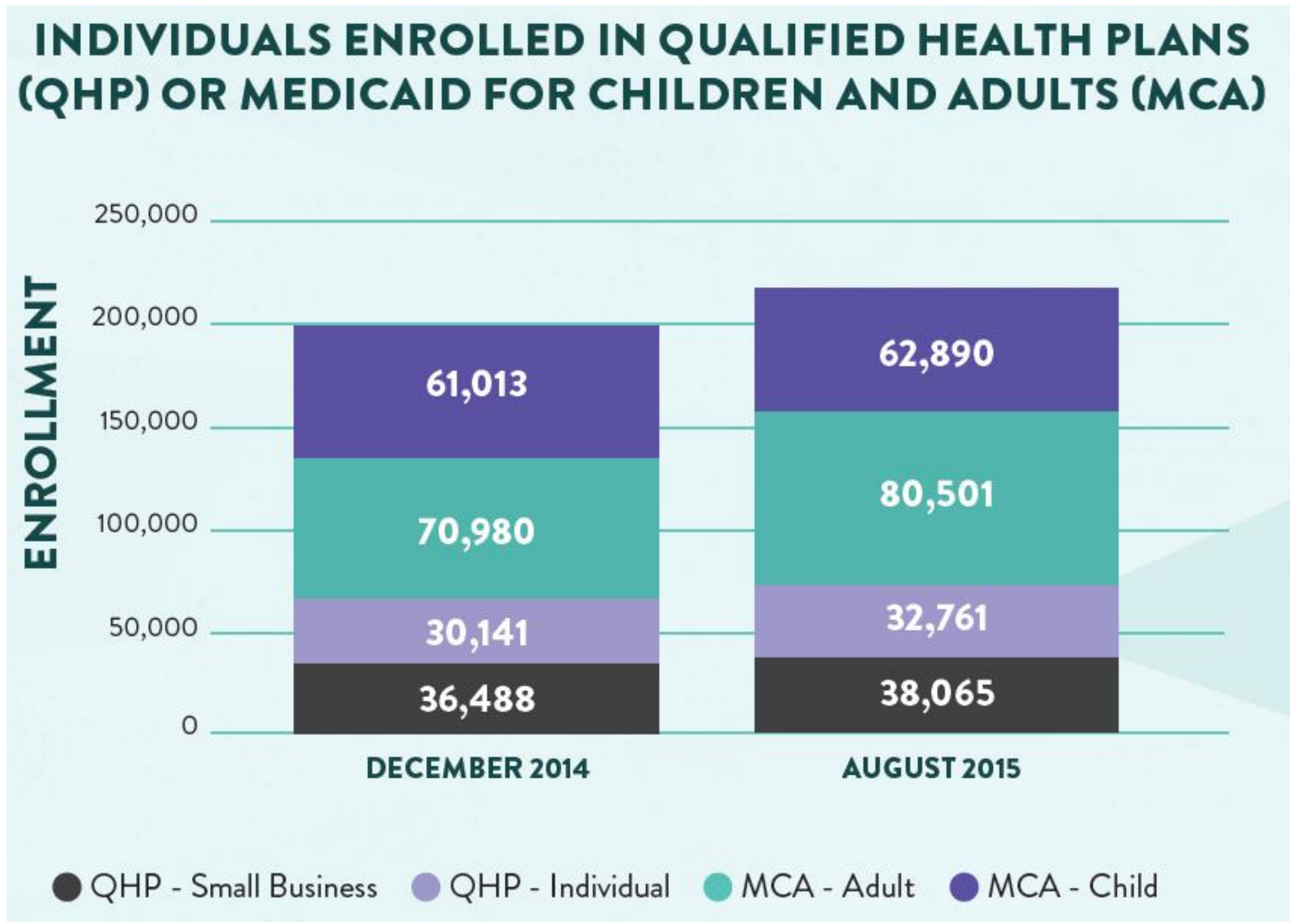
Vermont Health Connect has worked with partners to schedule "Health Insurance 101" sessions in advance of Open Enrollment. These events are free to the public and designed to help customers and potential customers better understand health insurance terms, financial help, and the Vermont Health Connect system. The goal is to equip them with the information they need to choose the right health plan for their needs and budget. Events will involve Navigators and state staff and include sessions at FQHCs, a series of events at Kinney Drugs stores across the state on November 11, as well as events at the following libraries:

- Sept. 28: Canaan 5:30pm
- Oct. 3: Newport 10am
- Oct. 6: Rutland 5:30pm
- Oct. 7: Burlington 5:30pm
- Oct. 8: Essex 6pm
- Oct. 13: Lyndon 5:30pm
- Oct. 19: Barton 5:30pm
- Oct. 20: Barre 5:30pm
- Oct. 21: Brattleboro 5:30pm
- Oct. 22: Bennington 5:30pm

Vermonters can get more details on events by clicking "News and Events" at http://VermontHealthConnect.gov or by calling 1-855-899-9600 (toll-free). They can also find an Assister near them by using the directory or interactive map at http://info.healthconnect.vermont.gov/find or by calling 1-855-899-9600.

Enrollment Update (data through August 31, 2015)

Current Coverage



[1]

A combination of reports from insurers, VHC, and the State's legacy ACCESS system suggest that Vermont is continuing to reduce its second-lowest-in-the-nation uninsured rate. The number of Vermonters covered by Vermont Health Connect Qualified Health Plans (QHPs) increased by nearly 4,000 from December 2014 to August 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.

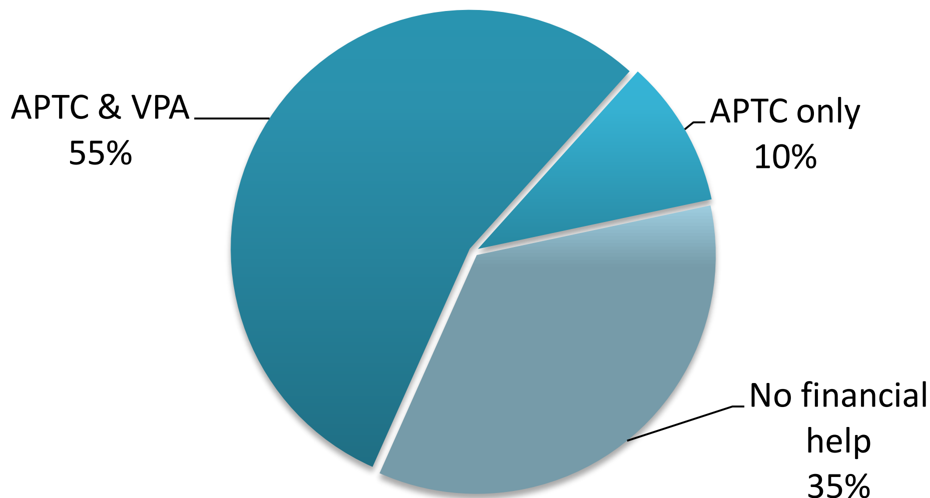
Of customers in QHPs:

- 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. Dec. 2014 Individual QHP as reported by insurers to the Centers for Medicaid and Medicare Services (CMS). August 2015 Individual QHP as reported by insurers to VHC. Medicaid for Children and Adults (MCA) as reported by Vermont Health Connect and Vermont's legacy ACCESS system. MCA includes Dr. Dynasaur and CHIP but does not include Medicaid for the Aged, Blind, and Disabled (MABD).

Financial Help – Premium Assistance

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



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

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

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

The amount of financial help varies depending on household size and income. 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.

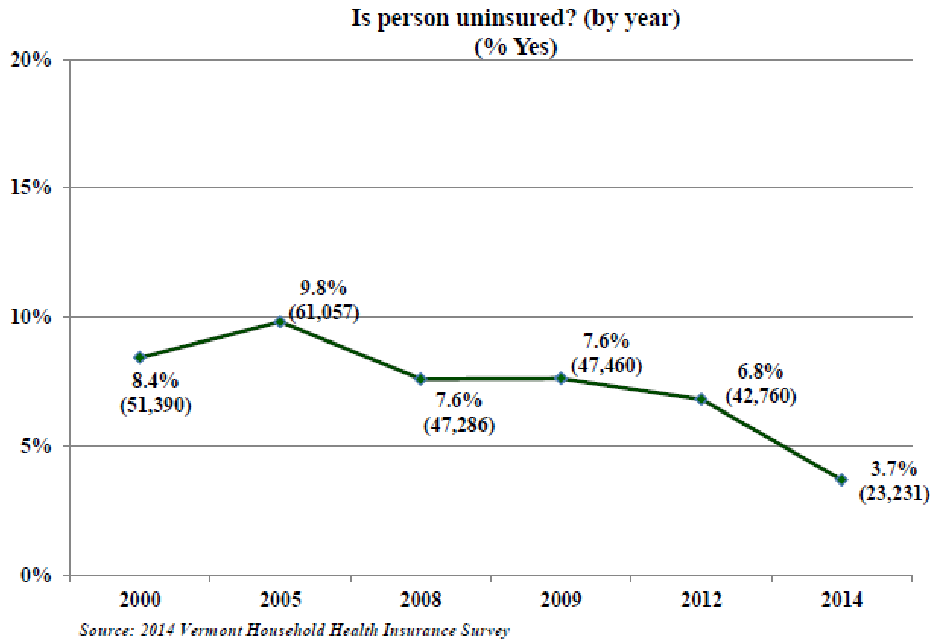
There are four levels of CSR, which Vermonters qualify for based on household income relative to the federal poverty level. Vermonters with lower incomes qualify for CSR levels that offer steeper reductions in out-of-pocket costs. Consider:

- 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 VHC'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 Vermont Household Health Insurance Survey (VHHIS) provides the most comprehensive look into the state of health coverage in Vermont. In January we learned that Vermont's uninsured rate was cut nearly in half over the past two years. With just 3.7% (23,000) of our population uninsured, Vermont is second in the nation in health coverage. Vermont leads the nation in terms of insuring our children, having cut the number of uninsured children in our state from nearly 2,800 in 2012 to fewer than 1,300 in 2014.

Nonetheless, until every Vermonter has quality health coverage, there will be room for improvement. With strong numbers of new applicants coming to Vermont Health Connect in 2015, Vermont is continuing to move closer to the goal of ensuring that all Vermonters are covered.