CONNECT for HEALTH COLORADO®

BY THE NUMBERS:
COLORADO'S SECOND OPEN ENROLLMENT PERIOD

Board Update

March 9, 2015

By the Numbers

Report on Colorado's Second Open Enrollment Period

- 2015 Open Enrollment exceeded the first open enrollment period
- Enrollments in 2015 Individual/Family Medical Plans – 141,639
- 54% of customers received financial assistance ($228.95/mo. ave APTC)
- 46% of customers had no financial assistance
- 26.3% of enrollees are between 18 and 34 years old
- Half of all enrollees are individuals (versus families)
- Every county (except one) had an increase in enrollments during second enrollment period compared with active policies in December 2014
- Rural counties represent 8% of state population and 10% of Marketplace enrollments in 2015
- Over 619,000 unique website visits; 2.4M page views

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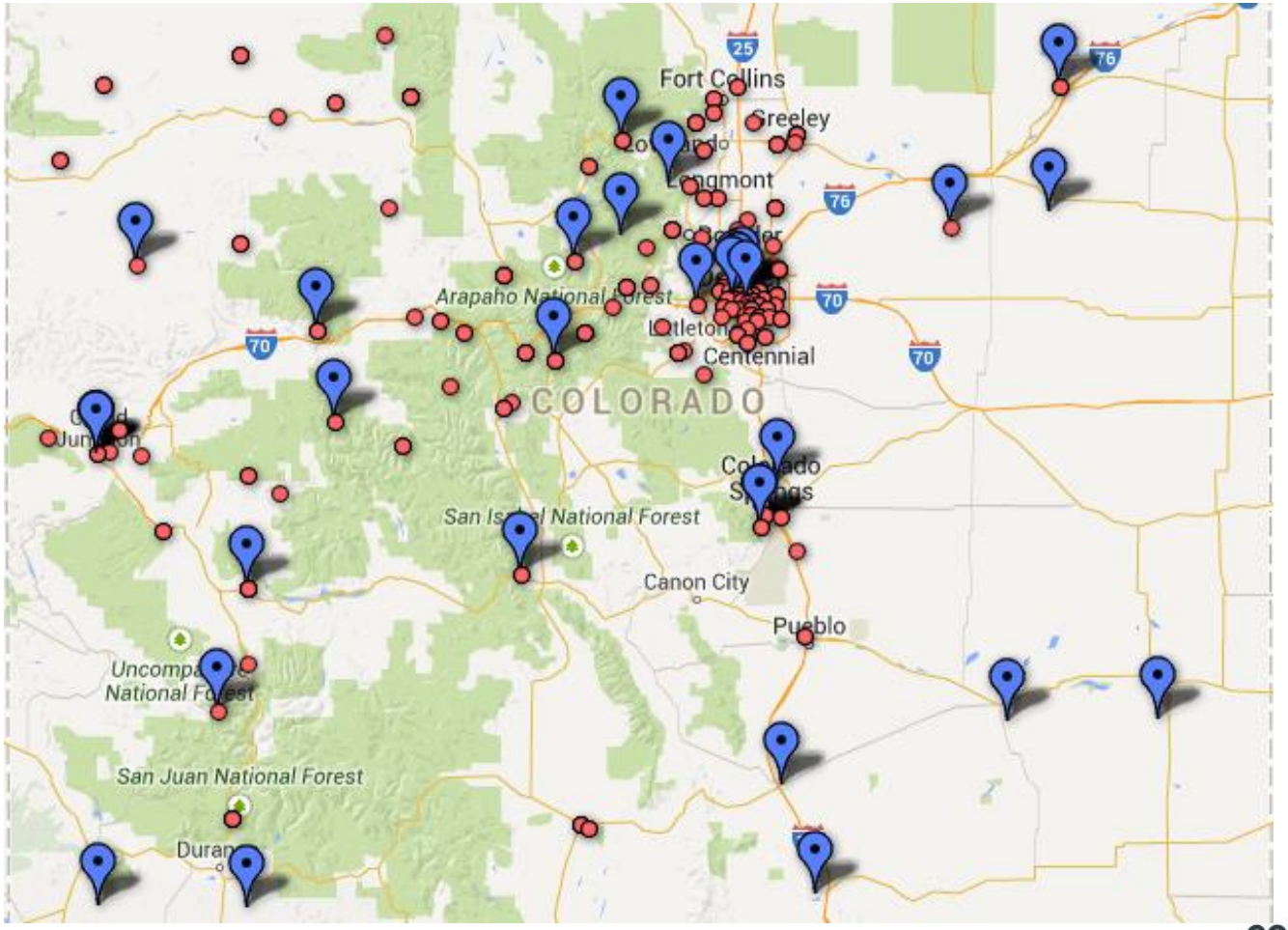
Outreach and Enrollment Events

More than 500 events by Connect for Health Colorado, Assistance Network, Brokers



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OPEN ENROLLMENT/SALES-2015

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By the Numbers: Sales Channels

As of February 28

- 2015 Individual Covered Lives = 141,639
  - Top-5 highest private insurance enrollments among state-based marketplaces (California, New York, Washington, Colorado/Massachusetts)
- 94,385 returning customers (67%)
- 47, 254 new customers (33%)
- 74% Toward Year-End 2015 Goal
- Peak enrollment days:
  - Dec. 16 – 52,692 covered lives (includes renewals)
  - Dec. 15 – 10,820 covered lives
- Broker Individual Sales 40%
- Assistance Network Individual Sales 6%
- Small Group current stats:
  - 339 businesses
  - 3,716 covered lives

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By the Numbers: Training, Special Campaigns

- More than 250 hours of training conducted for sales channels
- Certified:
  - 1,300 Brokers
  - 471 Health Coverage Guides
  - 169 Certified Application Counselors

- Special Outbound campaigns
  - 84,446 auto-renewal notices
  - 16,666 notices of inability to auto-renew
  - 170 Small Business renewal notices
  - 108,167 tax forms (1095-A)

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SHARED ELIGIBILITY SYSTEM: 2015 OPEN ENROLLMENT METRICS

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By the Numbers: Shared Eligibility System

Shared Eligibility System

- Total 224,171 applications for financial assistance were submitted through the new Shared Eligibility System from all sources
- 76,783 applications for Shared Eligibility System originated from Connect for Health Colorado during these 3 months
- 78% of Marketplace customers who went through the single application in the Shared Eligibility System received a real-time eligibility determination
- Of the 224,171 total applications in SES:
  - 22,658 were denied Medicaid and sent to the Marketplace eligible for a tax credit
  - 29,040 were denied Medicaid and sent to the Marketplace eligible for both a tax credit and cost-sharing reduction

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UPDATE ON ISSUES AND RISKS

Issues update

Overarching issue	Specific examples	Customer Impact	Actions Taken	Continuing Activities
Eligibility determination questions and issues / confusing application process / missing payloads	• People who didn't answer the questions correctly • Legally present residents < 5 year bar • Seasonal workers, small business owners & self-employed	• ~10K incidents reported >90% resolved • ~700 still being worked, ~ 400 outreach to customer complete, waiting for response	• Some system fixes applied to SES and Marketplace • CGI developed tools to override some inaccurate results to allow applicants to continue enrollment	• Identified 100+ fixes to the SES; working with HCPF/OIT/Deloitte to develop a release plan • Looking at alternatives to SES
Multiple calls to service center required to get to resolution and lack of follow-up / long wait times	• Customers 'bounced' between our Customer Service Center, HCPF, Maximus and counties. No one taking accountability for end-to-end resolution of eligibility issues	• ~160K calls to the individual sales lines with ~45% abandon rate average speed to answer ~20min, average talk time ~26 minutes	• Implemented a 'buddy program' where C4HCO customer service reps and a HCPF back-office 'buddy' work together to resolve complicated cases • Ongoing training for service center reps	• End to end process review planned, expected outcomes include changes to tools, processes and technology • Continuing to tune CSC processes and tools as constrained by budget
Inconsistent information between Marketplace and carriers	• Customers with auto debit invoiced twice in Dec/Jan • Dental customers not able to access benefits	• We have received a number of calls and emails about this. The exact number of incidents is not available at this time.	• Worked with carriers to refund monies taken in error • Significant improvements in tracking 834 progress with carriers	• Continued streamlining of EDI processes and improved coordination with carriers

SHARED ELIGIBILITY SYSTEM UPDATE

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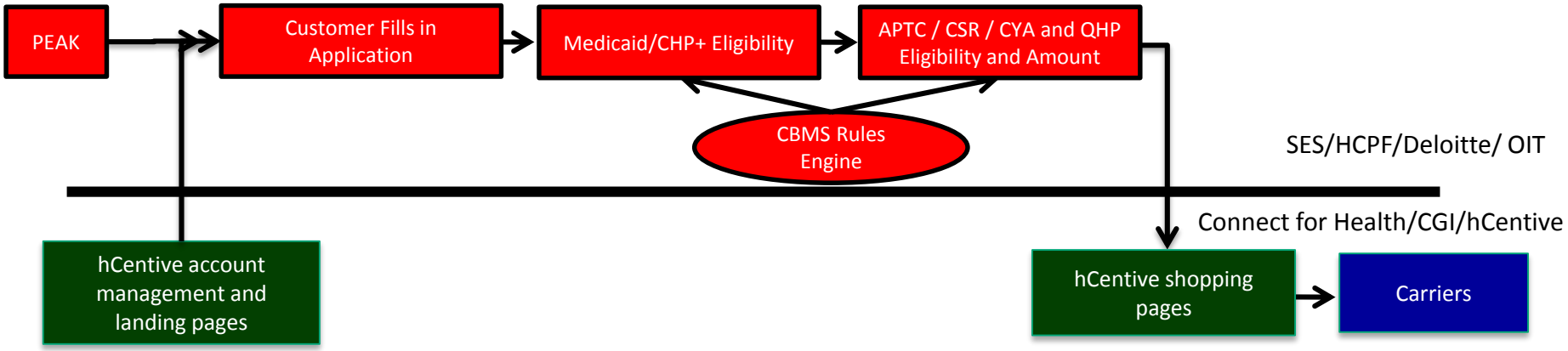
SES/HCPF/Deloitte

C4HCO/CGI/hCentive

Current System Overview and Issues



Challenges with current solution:

- Doesn't work well where Medicaid and APTC / CSR policies do not align, for populations of returning customers or people with complex income or family situations
- Is resulting in a large number of Medicaid calls to the Marketplace customer sales and support channels; and unanticipated numbers of Marketplace calls to Medicaid
- Doesn't work for APTC/CSR customers who wish to report a change and has issues in both systems that impede data transfer from SES to the Marketplace
- Marketplace service representatives, brokers and Health Coverage Guides don't have visibility into the eligibility portion of the application and can't assist customers with questions about how their eligibility was determined, they also can't modify data in CBMS to correct eligibility determination errors caused by incorrect income entries or incomplete relationship definitions

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Why Are Options Needed?

- Operational costs to support customers using SES are significantly higher than planned
- Stakeholders are fervent in their expectations that the customer experience will be easier and more streamlined at next Open Enrollment Period
- Medicaid AND Marketplace customers deserve efficacy of determination, service and maintenance
- Other Marketplaces provide a proof of concept for streamlined processes
- Counties, HCPF and Maximus service centers are devoting unanticipated resources to-Marketplace customers (not in their budgets)
- We are projecting continued overruns in our operational costs to address simultaneous enrollment, reconciliation and support activities

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Technology Solutions Being Explored

Option B. "Fix, Expedited in SES":

- Fix the current problems and build an expedited path for APTC/CSR customers within the SES
- Option currently being evaluated as front-runner

Option 2a, Developed By HCPF:

- Technology Option B with additional items related to governance, vendor relationship, requirements definition and service center

Option C. "Add Expedited, Use hCentive and SES":

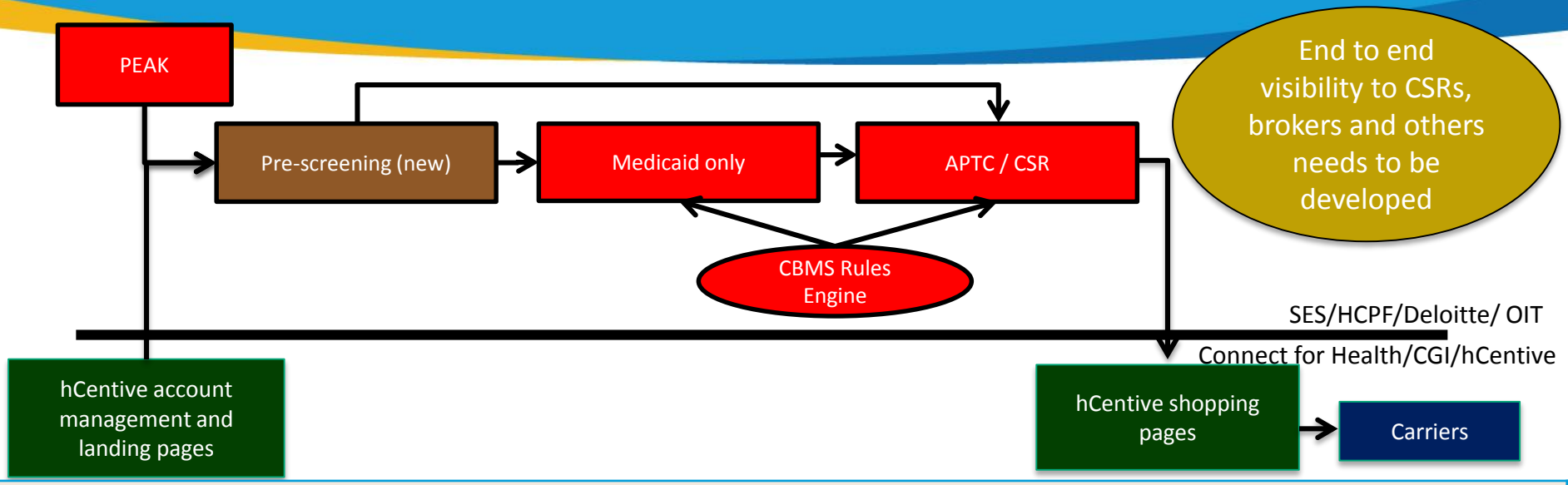
- Build an expedited path that directs customers to either an enhanced Marketplace system for APTC/CSR/CYA and QHP customers or SES/PEAK for Medicaid customers and mixed families
- These systems would share a rules engine and enroll the applicants in the appropriate insurance program.
- Data would be shared between systems
- This Option streamlines processing for 25% of Marketplace customers (bringing the total who are able to complete their application in one system to ~75%) but would be more complex for the 25% of our customers who are mixed families or are susceptible to churning between Medicaid and Marketplace

Note: We must have a working, tested system in our test environments in August to allow user testing and corrections before OEP begins November 1, 2015

SES/HCPF/Deloitte

C4HCO/CGI/hCentive

Option B "Fix Problems, Expedite in SES"



Critical Assumptions	
• CMS will allow pre-screening • APTC/CSR determination without Medicaid denial allowed • Dedicated Deloitte team focusing on development and testing • Development of new function to correct applications (not RMC) • Marketplace customers not subject to Medicaid periodic redetermination	• Standalone RMC functions for Marketplace customers • Expedited approval of changes and streamlined governance model • Clearer eligibility results so customers /brokers can diagnose issues • Improved access to CBMS for C4HCO service center representatives • Additional application screening developed to streamline process

Pros	Cons	Outstanding questions
Asks customers to answer the minimum required questions necessary for their eligibility	Teams are uncovering operational issues (verifications, customer maintenance, simultaneous enrolment) that may not be solved by just fixing the current known issues	Costs – implementation and ongoing. Costs not fully developed, estimate $~2-3M to implement
Utilizes only contracts and resources currently in place	Does not address end to end operational issues or issues the service center, brokers and HCG have in supporting customers	Feasibility – what can be delivered and tested by next OEP. Want user testing in July/Aug at the latest
		What does 'dedicated Deloitte team' really mean? Can C4HCO really define priorities and manage their work? What does the governance look like?

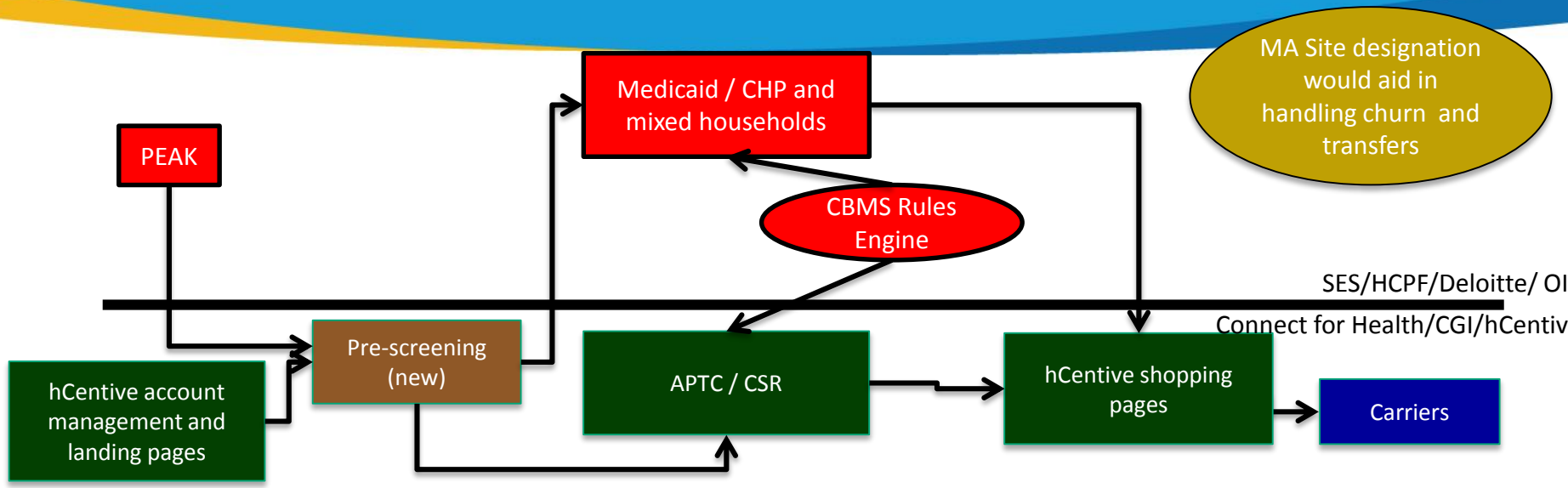
“Option 2a” Overview

- Technology solution is “Option B”, with the following exceptions and additions
  - The hCentive system is only be used for shopping and selection of QHPS (i.e., SES would be used for both FA and NFA customers)
  - Connect for Health Colorado hires Deloitte as their end-to-end system integrator to manage all vendors associated with eligibility and enrollment activities. Deloitte would provide project management and business analyst staff to Connect for Health. All current Marketplace contracts would be evaluated by Deloitte and HCPF who would take the lead in renegotiating these contracts.
  - HCPF staff would take the lead in developing and seeking approval of policy and application changes with CMS/CCIIO for the Marketplace
  - Additional funding for OIT would be needed to support increased UAT, service desk staff and an architecture
- In addition, Connect for Health Colorado and would HCPF establish joint operations for customer service, communications, application processing and training
  - A steering committee would be formed to direct and coordinate activities between both organizations to ensure we are working towards the same goals
  - The Connect for Health Colorado customer service center would convert to using the same Customer Relationship Management (CRM) tool as HCPF. Connect for Health Colorado would need to license the HCPF CRM system and pay hCentive to integrate with it.
  - We would develop technologies for warm hand-off between service centers and have an integrated IVR
  - HCPF would become a more active partner in joint communications, training and broker certification to avoid ‘misguided complaints’ from users of the SES
  - HCPF would take the lead in helping the Marketplace become an MA site.

SES/HCPF/Deloitte

C4HCO/CGI/hCentive

Option C: "Add Expedited, use hCentive and SES"



Critical Assumptions	
• CMS will allow pre-screening • APTC/CSR determination without Medicaid denial allowed • Dedicated Deloitte team focusing on development and testing	• Requires all SES improvements listed on prior option for PEAK customers • Requires Deloitte to create web service access to CBMS rules engine • hCentive eligibility solution can be deployed on CGI SOA layer

Pros	Cons	Outstanding questions
Eliminates payload and end-to–end visibility problems for most marketplace customers	Two systems would require segregation of customer service and/or two customer service systems.	Costs not fully determined. Estimate ~$3M to implement
Marketplace service reps can use one tool to support most Marketplace customers	Eligibility data resides in two separate systems, particularly complex for mixed households	Feasibility – what can be delivered and tested by next OEP.
Ongoing maintenance costs for pure marketplace upgrades handled under hCentive license and support fees (no need for custom development)	PEAK/SES and Marketplace systems all need to be maintained. Need to determine how to handle churn and data transfer between systems.	Specifics of the solution unclear, particularly how mixed households would be handled
	Does not address all of the operational and support issues raised by service center, brokers, HCGS	

Timeline for decision making

	3/8/15 – 3/14/15	3/15/15- 3/21/15	3/22/15- 3/28/15	3/29/15 - 4/4/15	4/5/15- 4/11/15	4/12/15- 4/18/15
Resolve open questions and assumptions						
Review Option B costs and release plan*						
Review Option C solution descriptions**						
Review Option C costs and release plan***						
Presentation of full option information to stakeholders and select option to pursue						
Present option to Board Committees and CBMS ESC						
Approval to start						

Note: this gives us 5 months to design, develop and fully test the solution. This is an extremely aggressive timeline. We must have a decision at or by the next Board meeting. Can we target a special board meeting for late March to review recommendations and make a decision so we have more time to build and test?

Critical assumption re: timeline – we are not changing vendor relationships, program governance, responsibility for defining requirements or the role of Marketplace in handling Medicaid customers

* assumes we received costs/release plan on Friday 3/6/15
** assumes we receive solution descriptions from hCentive by 3/11/15
*** assumes we receive plan from hCentive by 3/16/15

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1095 UPDATE

1095 Update

- 1095 calls
  - Routed to 1095 sub-menu = 4580
  - Callers who received an answer from the IVR message = 1666 (37% diversion rate)
  - Callers who stayed on to talk to customer service rep = 2914
  - Calls answered = 2038
- 1095 incidents (note an incident may not be entered if the question asked did not require follow up)
  - Total incidents = 3449
  - Total incidents as a result of calls = 1403
  - Returned mail incidents = 2046
- Incident status
  - Total closed 1581
    - Returned mail = 1227
    - Other = 354
  - Total open = 1868
    - Returned mail = 819
    - Other = 1049

- APTC validation = 60
- Demographic validations = 33
- Multiple validations = 29
- Missing 1095/request for duplicate = 105
- Plan premium validation= 16
- Other = 111

- APTC validation = 137
- Demographic validation = 61
- Multiple validations = 99
- Missing 1095/request for duplicate = 257
- Plan premium validation = 66
- Sent to carrier for resolution = 94
- Other = 335

SERVICE CENTER UPDATE

Key Service Center Metrics

Call Volume and Headcount – Forecast to Actuals

	Forecast	Actual	Variance	Approved	Actual
November	120,805	59,429	-61,376	239	200
December	79,347	110,136	30,789	341	225
January	87,521	93,974	6,453	176	190
February	92,961	101,600	8,639	220	220
TOTAL	380,634	365,139	-15,495	N/A	N/A

Performance Metrics

	Primary Site	Secondary Site	Total	Target
Calls Received	237,062	128,077	365,139	N/A
Calls Answered	176,469	70,368	246,837	95% of calls received
Abandon Rate	26%	45%	32%	<5% - Note: 30% abandon rate is consistent with our experience during 2014 OEP peak shopping periods
Average Handle Time (minutes)	18.58	23.45	21.01	16-17
Average Speed to Answer (ASA) (minutes)	12.49	13.93	12.71	N/A

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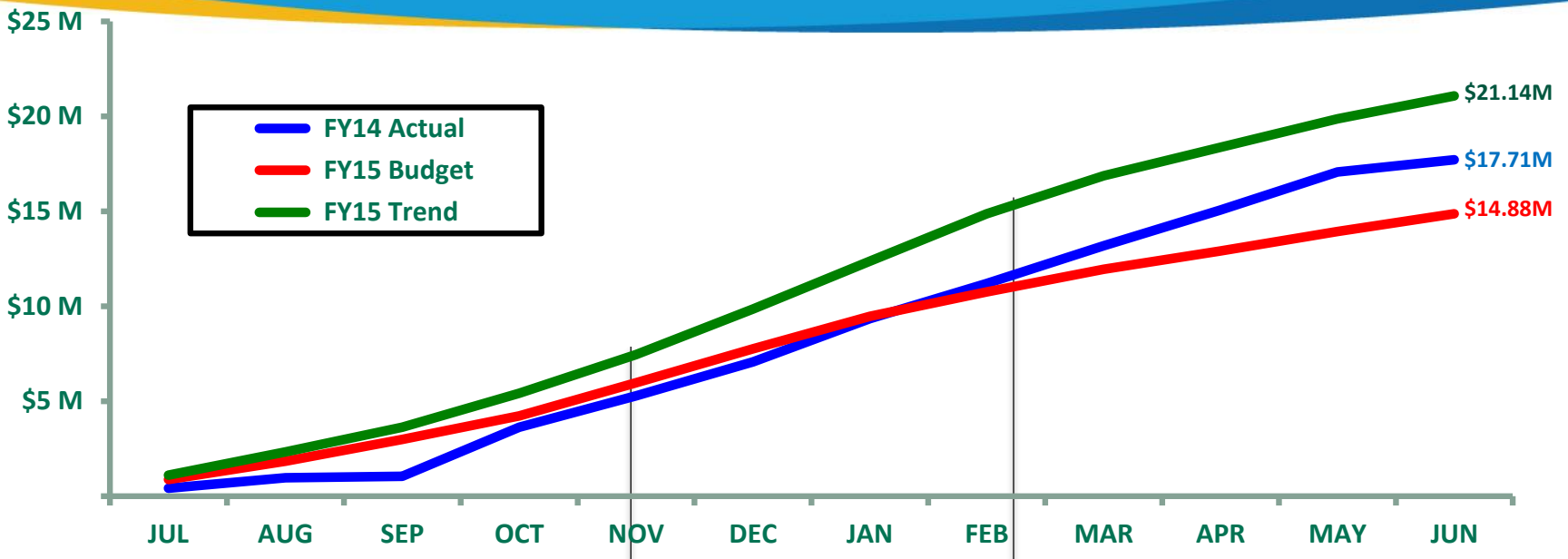
Customer Service Center Cost Drivers



Pre-OEP Cost Drivers

- *Life change events (4K/month)*
- *Notices about changes in APTC due to market dynamics (Oct-Nov)*

Open Enrollment Cost Drivers

- *Eligibility determination issues*
- *Medicaid/CHP+ questions*
- *1095 questions*
- *Completing enrollments*
- *Renewals*
- *Life and account changes*

Post OEP Cost Drivers (current and projected)

- *Eligibility determination issues and backlog cleanup*
- *Medicaid/CHP+ questions*
- *Completing enrollments*
- *1095 questions*
- *RRV questions*
- *Simultaneous Enrollment outbound calls*
- *Verifications processing*
- *Life and account changes*
- *Potential Special Enrollment Period in April for tax filers*

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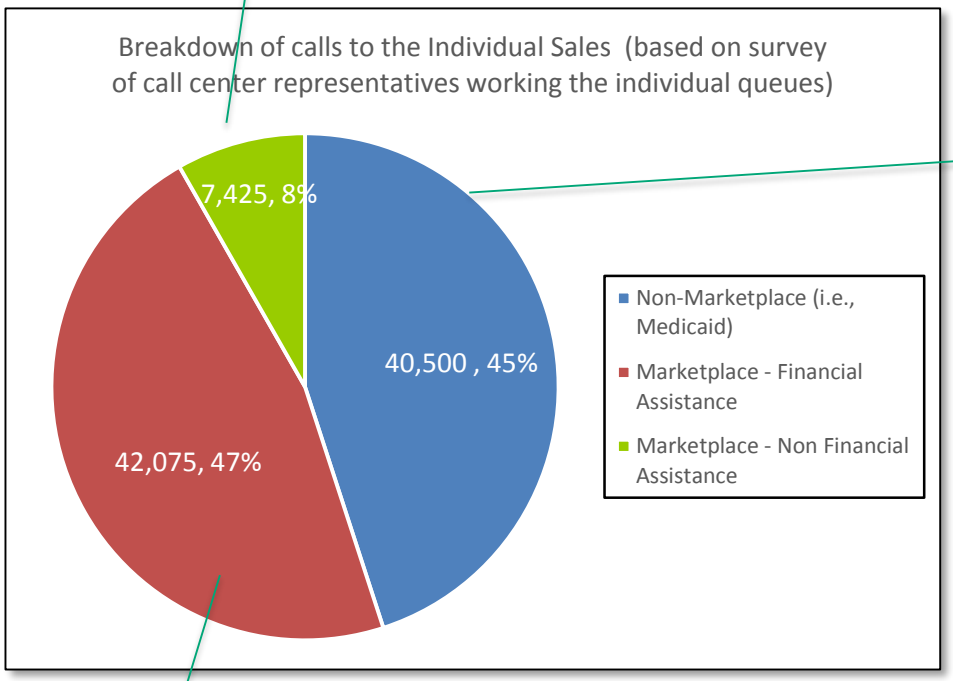
Call analysis and cost drivers

Call Details – Non Financial Assistance Customers (based on sample of ~100 calls)

- Average call time – 30minutes 19seconds



Non-Marketplace calls and chats

- Service center representatives reported that between 65% and 70% of all chats serviced by the service center were for customers who are eligible for or receiving Medicaid, CHP+ and other HCPF program benefits
- Service center representatives reported that between 40% and 45% of all calls serviced in the Individual New and Individual Sales queues were for customers who are eligible for or receiving Medicaid, CHP+, and other HCPF program benefits

Call Details - Financial Assistance Customers (based on sample of ~100 calls)

- Average call time - 1hr 19minutes 54seconds
- Average SES component of calls – 35minutes 3 seconds

Additional Cost Driver: Resolution of issues encountered by customers while enrolling in a QHP with financial assistance

- During the 2015 Open Enrollment Period, the service center received and resolved between 8-10K incidents (reports of issues – not the same as customers) for customers who had problems/questions either with their eligibility application or with using their eligibility result to shop on the Marketplace. Resolution of these incidents often required coordination between service center representatives, IT resources, back-office staff and HCPF contractors and took between 3-4hrs on average.

SIMULTANEOUS ENROLLMENT UPDATE

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Simultaneous enrollment update

- Connect for Health Colorado and HCPF have identified individuals who were simultaneously enrolled since January 2015. These individuals fall into the following categories (NOTE: these numbers have not been fully verified – data cleanup is currently underway – final numbers will be available by 3/13)
  - Prospective – individuals who will become SE in the future = 12
  - Current – individuals currently simultaneously enrolled in Medicaid/CHP+ and a QHP = 2534
  - Historical – individuals who were simultaneously enrolled in January, February and/or March in one plan = 293
  - Churn – individuals who went from a QHP to Medicaid/CHP+ or visa-versa = 583

- Going forward, monthly, Connect for Health Colorado and HCPF will follow their defined process to identify individuals who will become simultaneously enrolled on a prospective basis
  - Initial report is generated by HCPF and sent to Connect for Health
  - Connect for Health gathers additional data fields (this step will be automated in June)
  - Final report sent to Connect for Health customer service for outreach campaign
  - Final report by carrier sent to carriers

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IT UPDATE

Board Meeting 2/9/2015

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IT update – 3/9/2015

IT contracts

- End to end IT sourcing study in flight. RFS packet has been distributed
- Cloud hosting ROI in progress

Business Intelligence

- End of Open Enrollment reporting complete
- Broker update report complete
- Simultaneous enrollment report executed but investigating why numbers are high
- ASP / CCIIO metrics submitted
- 1095 corrections process continues to be executed.

Security

- New Privacy and Security Office hired .. Michael Stephen
- Working with HCPF on submitted their Authority To Connect
- Annual Coalfire vulnerability assessment wrapping up
- New incident management processes fully implemented.

Carrier integration

- Close to the closure of reconciliation of 2014 data
- Working with carriers to modify the reconciliation process for 2015
- EDI maintenance testing has commenced
- Actively building out internal carrier coordination team.

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IT update – 3/9/2015

IT operations

- 3 incidents this period:
  - 2/6 – Brief Colorado.gov site outage. RCA in progress
  - 2/6 – i3 telephony outage in the service center. RCA complete -> i3 server license corruption
  - 2/13 – Call routing outage to C3. RCA complete -> c3 scheduling issue

SES end to end review SOW - scope

The evaluation shall include a review of the following:

- Shared Eligibility System and the integration points with upstream and downstream systems for example C4's module for shopping and enrolling in a plan
- Vendors under contract by HCPF, OIT, and the Exchange related to the SES system build and operations
- Governance of the systems, policies, and operations related to the SES
- Federal and state law, regulations, policies, and operational standards related to the SES system build and operations.

SES end to end review SOW – key questions

The Contractor will provide a report with recommendations on how to resolve the technology issues that are preventing a seamless user experience for the consumer. The report must address the following questions:

- What are the main technical and operational issues that are preventing consumers from receiving a seamless user experience, eligibility determination and permission to shop and enroll in a Qualified Health Plan?
- How should these issues be addressed and what is the timeline for doing so?
- Which of the current technology options under review is the most prudent and would be most effective at addressing technical issues while aligning to the overall mission and scope of each stakeholder?
- Are there alternate technology options that may achieve these goals more expeditiously and efficiently?

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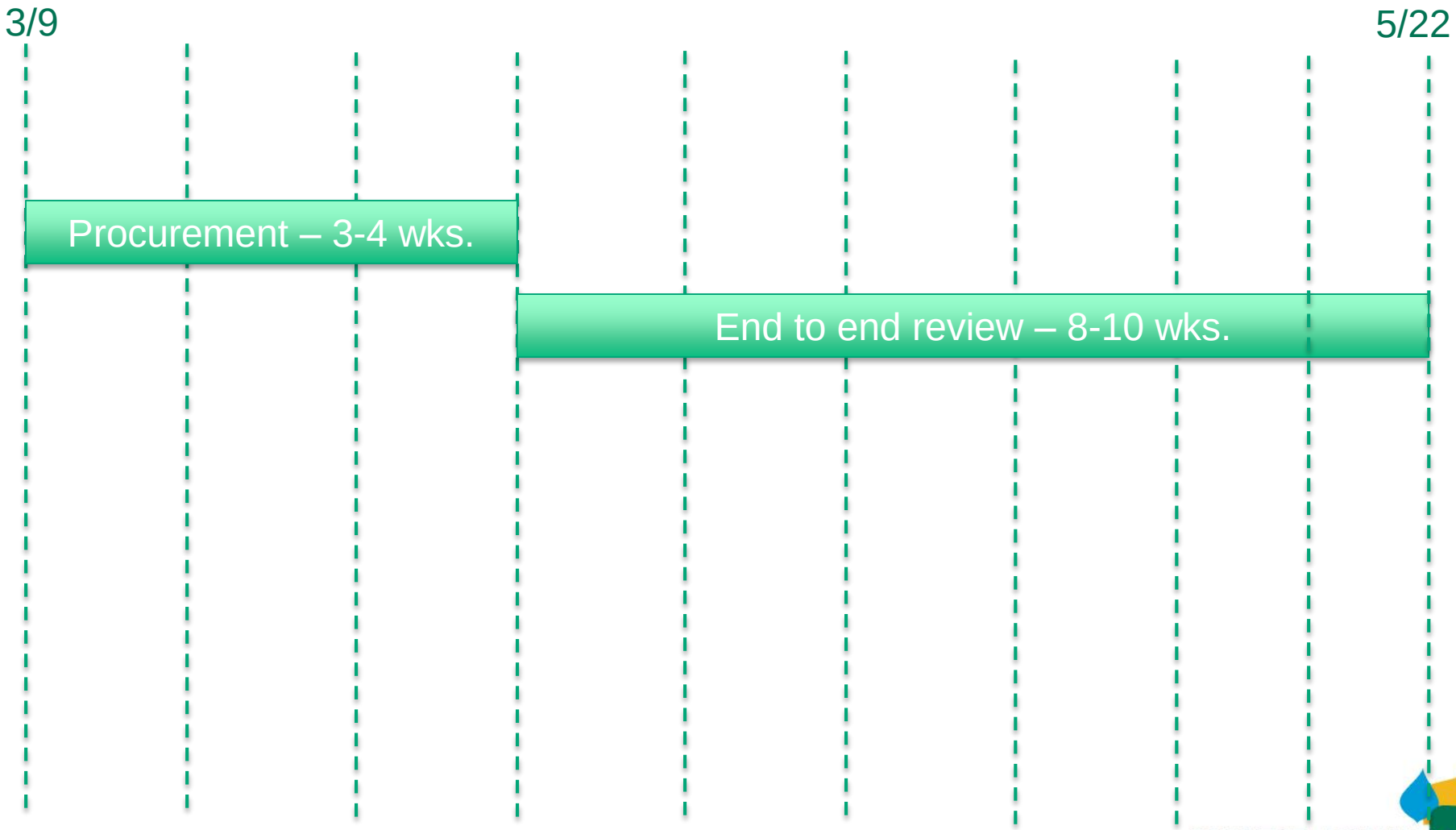
SES end to end review SOW – likely timeline



FINANCE REPORT

February 2015

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Financial Position	12/31/2014	12/31/2013
Total Current Assets	72.4	51.4
Total Long-term Assets less Depreciation	40.5	28.6
Total Assets	**112.9**	**80.0**
Total Liabilities	27.3	29.5
Net Assets	85.6	50.5
Total Net Assets & Liabilities	**112.9**	**80.0**
Statement of Activities	**Budget**	**Actual**
Grant Revenue	44.4	44.4
Program Revenue	16.1	21.5
Total Revenue	**60.5**	**65.9**
Customer Service	10.4	12.7
Marketing	4.3	3.7
Technology	10.4	9.7
G & A	3.3	3.3
Depreciation	-	4.1
Total Expense	**28.4**	**33.5**
Net Revenue	**32.1**	**32.4**

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Fee Assessments

- Preparing for 1st Quarter 2015 invoicing of Colorado Carriers for market based assessment
  - Over 400 Carriers have already registered for online account for quarterly reporting
  - Reminder notices to be sent out to remaining Carriers
  - Met with Carriers and DOI to review report and invoice templates and receive feedback
- Carrier Fees
  - Invoiced $4.4m
  - Collected: $1.8m
  - To be invoiced: $1.1m

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Audit Update

- Audits in Process
  - HHS OIG Audit – ongoing
  - CMS/CCIIO Audit – preliminary draft report has been received and responses drafted
  - CMS SMART Audit
  - Financial and Single A133 Audit
    - Began 12/1/14 and is in final stages
    - Report will be presented at March Board Meeting
- Hired auditing firm to assist with audit prep, policy improvements & compliance, internal audit design/staffing