VERMONT
Department of Vermont Health Access
312 Hurricane Lane Suite 201
Williston, VT 05495-2087
www.dvha.vermont.gov

[phone] 802-879-5900
[Fax] 802-879-5651

Agency of Human Services

Vermont Health Connect Monthly Report

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

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Contents

Overview

May System Upgrades

As of the end of May, Vermont Health Connect has delivered functionality to support:

- Changes of Circumstance (COC),
- Changes of Information (COI), and
- Reconciliation between Vermont Health Connect, premium processing (Benaissance), and the insurance carriers.

These system upgrades allow customer service staff to enter changes into the Vermont Health Connect system using a simple wizard tool with pre-populated data, and then have those changes updated automatically into the insurance carriers' and payment processor's systems.

Prior to this upgrade, requested changes required staff to re-enter entire health insurance applications – often more than one hundred fields of data – and then work with additional teams of workers to transmit and update the information into as many as six different systems over a period of weeks.

The new functionality will greatly reduce the amount of time it takes to process change requests, especially for those customers who are reporting a change for the first time. The short-term process of eliminating the backlog of previously requested changes is more involved, as staff must first review multiple past cases to ensure that all service requests are properly incorporated into the new record. However, because the upgrades eliminate the most time-intensive aspects of the former change process – the application re-entry and the manual integration across multiple systems – Vermont Health Connect operations staff are confident that they will be able to eliminate the backlog of pending requests and meet the Governor's October 1st milestone for improved customer service. That milestone called for customers who report a change to Vermont Health Connect by the 15th day of a month to be able to see that change reflected on their next invoice.

In order to ensure a smooth rollout of the new functionality a subset of customer service teams began processing change requests immediately. At the same time, all staff are being thoroughly trained to make sure they are able to smoothly and accurately process backlogged requests and new requests from customers.

At the same time, the project development team is preparing for the fall system upgrades. These upgrades involve the delivery of technology needed to enable a smooth 2016 enrollment and renewal process, as well as additional financial reconciliation and billing enhancements. In practical terms, this means that existing customers will have their 2016 health plan information reflected in all systems by the start of the year as long as they report changes by December 15.

Project Development

Status of Deliverables – Open and Recently Completed

Open Deliverable	Status Update, June 1, 2015	Action to Closure
Training Materials Development Complete	In Progress	All training material is prioritized into three distinct categories. Critical functionality (high volume) was trained prior to implementation, followed by additional training sessions post-implementation. Priority focus is to train on fully validated processes whenever possible.
Training Complete	In Progress	All training material is prioritized into three distinct categories. Critical functionality (high volume) was trained prior to implementation, followed by additional training sessions post-implementation. Priority focus is to train on fully validated processes whenever possible. On schedule.
Release 1 User Validation Test Complete	In Progress	Ongoing. As additional types of change requests are validated and incorporated into business processes and training, they are verified by end users at Vermont Health Connect, Benaissance, and the insurance issuers.

Recently Completed Deliverables (Delivered by May 31)

The following deliverables have been completed since the May 7, 2015 status update in last month's report:

- Test Design Complete
- Release 1 Ops Readiness Complete (Cutover and Implementation Activities)
- Total Test Execution Complete (Integration / Systems Integration Testing (SIT) & User Acceptance Testing (UAT) End-to-End / Carrier)
- Carrier End to End Testing Complete
- Test (Performance) Complete
- Test (Security) Complete
- Release 1 Go/No Go Decision Complete
- Release 1 Go Live (Implementation Complete)

Risks – Open and Recently Mitigated

Open Risks

The following items have been identified as risks to the timing or scope of the project.

- The State of Vermont has defined the scope of Optum's fall system upgrades. In addition, the State submitted the final draft contract for this work to CMS on April 15. CMS then approved the contract in late May, sending it back to the State for final review and execution in advance of the July 1 target date. Until this contract is in force, however, the lack of an executed contract will be listed as a risk to the timeline for fall upgrades.
- Vermont Health Connect's hosting is transitioning from CGI to Optum. The timing of the data center migration involved in this transition poses a risk to the development timelines for fall system upgrades, which include renewals functionality. The VHC project team and the hosting team need to remain closely aligned on schedule and upcoming activities to avoid any negative impacts. The Project Manager assigned to the hosting contract by the Health Services Enterprise Project Management Office is being included in VHC project planning activities to ensure this alignment occurs.

Recently Mitigated Risks (Closed in May)

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

Former Risk	Comment
The current Integrated Master Schedule for Release 1 is on a very tight timeline. Because there is little to no time allocated to defect remediation in the schedule, any major defects found during the final weeks of testing could put the delivery date at risk.	No insurmountable defects were found during the final weeks of testing. Deployment occurred on schedule.
CMS recently approved the Implementation Advance Planning Document (IAPD) submitted by the Health Services Enterprise Project Management Office. With this approval came the approval of all contracts through Amendment 6. However, CMS stated that any activities completed between the execution and approval dates will be reimbursed at a reduced rate from CMCS. The State is analyzing the financial impacts of this reduction. Any reduction in funding puts the scope at risk.	Grant was approved, as was Amendment 8, the contract for Optum to deliver fall system upgrades.
Training will extend past the deployment date, meaning that customer service staff will have a slower start to the effort of processing the backlog of change requests, handling new requests, and making progress toward the operational milestone	The training schedule and slow ramping up of change processing has coincided with business validation efforts. This ramp up is slated to continue through the end of June.

of completing change requests within 30 days by October.	
A detailed plan is needed for a set of June system updates to allow operations staff to complete critical work beyond what is delivered in the May system updates.	A plan is in place to finalize any outstanding business processes by the beginning of July. Business processes and training are being prioritized based on customer impact.
Any reconciliation work that is incomplete at the time of the system update will likely result in the need for COC corrections to be made between the State of Vermont and the insurance carriers. Until a process for accommodating these corrections is completed, proven, and tested, this reconciliation work will be at risk.	Regarding reconciliation of 2015 cases, our goal was to correct all discrepancies between VHC and Benaissance prior to the implementation of system upgrades at the end of May. We initially identified approximately 10,500 discrepancies between VHC and Benaissance, and we successfully implemented corrections to approximately 98% of them. We also identified and corrected approximately 8,000 discrepancies between VHC and BCBSVT and approximately 500 between VHC and MVP. Ongoing 2015 reconciliation will consist of: • Identifying root causes of the discrepancies and correcting those; • Correcting all discrepancies between VHC and the three carriers; • Implementing formal reconciliation systems and processes. Regarding reconciliation of 2014 cases, limited progress was made due to resource constraints and several competing priorities including 2015 reconciliation, 2015 renewals and deployment of the May system upgrades. In light of these factors, VHC decided to pause additional work on 2014 reconciliation. It is expected that work will continue in June.

Actions to Address State Auditor's Recommendations

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

SAO Recommendation	Original VHC Response, April 2015	VHC Status Update, June 2015
1. Expeditiously complete the VHC project management plan documents for the 2015 releases, including a scope statement, requirements traceability matrix, and test plan	The dates for completion for the documents are: Baseline Integrated Master Schedule: Completed April 3, 2015 Requirements documentation: Completed April 5, 2015 Scope Statement: Completed April 8, 2015 Requirements Traceability matrix: Draft under review April 8, 2015; completion target April 10 Test plan: Completion target April 14, 2015	All documents are complete.
2. Include in future VHC system development contracts clauses that provide monetary consequences tied to the contractor's performance.	Section VII.A.6 of Agency of Administration Bulletin 3.5 addresses Penalties and Retainage. Following standard contracting procedures the project team did consider, and made a substantial effort in negotiations to obtain monetary consequences tied to contractor's performance. The contractor was taking over work-in-progress from another contractor under troubled conditions and the unknowns made either fixed-price or monetary penalty difficult to achieve at a responsible price. We will continue to work to include those conditions in future contracts wherever appropriate.	VHC continues to work with legal counsel to incorporate best practices for IT contracting and ensure compliance with Bulletin 3.5 for future system licensing, development, maintenance and operations and hosting contracts. (See description of hosting in #4 below.)

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.	Vermont Health Connect is now completing a reorganization designed to provide improved customer service. As part of this we are updating all documentation of roles and responsibilities, and these updates will fulfill the recommendations laid out in the audit report. This will include updating as needed the various project charters and memoranda of understanding (MOU) that govern the participation of the multiple organizations involved.	The State continues its work finalizing job descriptions for the 141 operations staff in the matrixed DVHA DCF-ESD Unit. Job descriptions for Supervisors are complete and the State plans to have additional job descriptions finalized by the end of July. The MOU draft has been finalized and is on track for completion in July.
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.	Specific service levels are not generally applicable in a development contract, where monitoring of deliverables is the critical activity, but are an important component of all Hosting and Maintenance & Operations contracts. The new contract awaiting acceptance by the premium processing service provider does incorporate specific service level agreements; and stipulates the performance monitoring reports to be provided.	**Maintenance & Operations** - the next contract covers the period July 1, 2015 through June 30, 2016 (State FY16). This contract is written as firm fixed price, not time and materials, and includes provisions for service level agreements, payment credits, and performance metrics. There are no significant barriers to implementing these contract provisions, and the anticipated date for closure (contract execution) is June 19, 2015. **Hosting** – the new contract includes payment for performance provisions for transition services, recommended service level agreements, payment credits, and performance metrics. This contract was executed on May 14, 2015 and covers the period February 1, 2015 through December 31, 2017. **Premium Processing** - the next contract will include provisions for service level agreements, payment credits, and performance metrics. The vendor has reviewed and approved SLAs and performance requirements, and the contract is currently undergoing legal review prior to final sign-off. The target completion date is June 30, 2015, covering an additional year of service.

5. Establish a process and expeditiously perform reconciliations of enrollment data between the VHC, Benaissance, and the carriers' systems.	We have begun a reconciliation process with the carriers using an interim solution supported by our contractors. We will complete all reconciliations necessary for a successful deployment of the next release by the end of May. The system capability to support enrollment and financial reconciliation between the VHC, Benaissance, and carrier systems is included in the scope of the May 30th release. This release will provide the reporting mechanisms needed to identify discrepancies across all of the systems and perform monthly reconciliations.	Regarding reconciliation of 2015 cases, our goal was to correct all discrepancies between VHC and Benaissance prior to the implementation of system upgrades at the end of May. We initially identified approximately 10,500 discrepancies between VHC and Bennaisance, and we successfully implemented corrections to approximately 98% of them. We also identified and corrected approximately 8,000 discrepancies between VHC and BCBSVT and approximately 500 between VHC and MVP. Ongoing 2015 reconciliation will consist of: • Identifying root causes of the discrepancies and correcting those; • Correcting all discrepancies between VHC and the three carriers; • Implementing formal reconciliation systems and processes. Regarding reconciliation of 2014 cases, limited progress was made due to resource constraints and several competing priorities including 2015 reconciliation, 2015 renewals and deployment of the May system upgrades. In light of these factors, VHC decided to pause additional work on 2014 reconciliation. It is expected that work will continue in June.
6. Establish a process and expeditiously perform reconciliations of enrollment data between the VHC system and the relevant Medicaid system(s).	The system capability to support enrollment and financial reconciliation between the VHC, Benaissance, and Medicaid systems is included in the scope of the May 30th release. This release will provide the reporting mechanisms needed to identify discrepancies across all systems and allow monthly reconciliations going forward. Once this occurs we will use the process we are developing to reconcile data to ensure that all of the individuals who are eligible for and enrolled in Medicaid are correctly recorded in each system to ensure that claims are only paid for services allowed under the enrollee's specific	See #5 above and note that automated reconciliation continues to be under development.

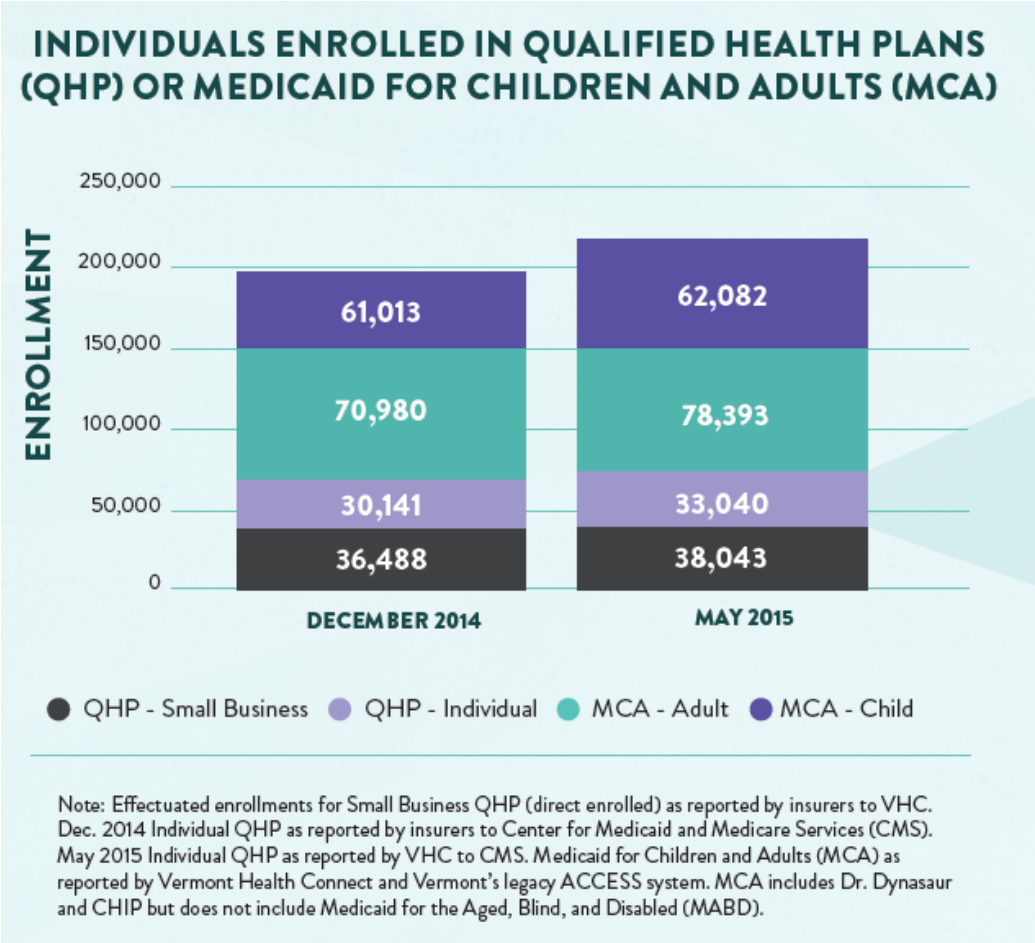
	Medicaid program.	
7. Reconsider decisions that have complicated the premium payment processing function, including the requirement that the full premium payment be at Benaissance without exception before remittance to the carriers and the split of the billing and dunning/termination processes between different organizations.	While the cause of the most challenging billing issues today will be addressed with the May 30th release, we agree that many of the underlying policies create unnecessary difficulty for customers. For example, the 100% premium paid before remittance requirement does not reflect the common industry practice that accepts a small shortfall as a complete payment and bills the balance with the following month's premium. A full reconsideration of the premium payment processing function is a critical next step, with participation of the premium processor, all carriers, and Medicaid. This is planned to occur when the 2014 reconciliation is complete so that we are in a position to review the decisions with the benefit of information from the reconciliation.	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.	This recommendation relates to Dr. Dynasaur recipients who are delinquent in their premium payments. The State intends to initiate a rulemaking process to revise a DCF-promulgated Medicaid eligibility rule (HBEE section 64.00 Premium Rules and 70.02 Premium Obligation) to implement necessary changes relating to termination for non-payment. Rule changes would allow for a 60-day grace period, and eliminate the requirement for past due premium payments prior to re-enrolling individuals whose coverage was terminated for non-payment of premiums. The rulemaking process takes approximately six months from start to finish. Rulemaking is anticipated to begin in May of 2015 with scheduled completion by the end of calendar year 2015. Effective January 2014, the State started to transition enrollment and re-enrollment for MAGI Medicaid determinations into VHC. New enrollments are currently being processed in VHC, however, due to resource and system constraints, and with the approval of CMS, annual renewal of Medicaid beneficiaries has been delayed in VHC and for those still in the legacy system, including some Dr. Dynasaur recipients. Vermont will be in compliance with standard Medicaid rules regarding non-payment of premiums once all Dr. Dynasaur-enrolled children are transitioned into VHC. The State is actively working with CMS on a migration plan to restart Medicaid renewals. The final timeline depends upon CMS approval of the plan. Programming for system functionality in VHC to terminate coverage for non-payment of premiums following a 60-day grace period is scheduled for September 2015 and implementation will be consistent with the revised rule.	VHC continues to define the requirements for automated system functionality for grace periods and terminations for non-payment of premium. Work also continues on the development of a manual workaround to be used in the interim, with a target date of July 1.

9. Expeditiously develop VHC financial reports to implement stronger financial controls.	The DVHA business office has worked with the contractors to get the necessary reports by the end of April 2015 in order to complete the interrelated reviews and reconciliations identified in recommendations 9, 10, and 11. The system capability to support enrollment and financial reconciliation between the VHC, Benaissance, and the carriers' systems is included in the scope of the May 30th release. This release will provide the reporting mechanisms needed to identify discrepancies across the three systems.	Revisions to the premium processing contract have been made, including a requirement for the vendor to work with the State to design and implement financial reports. The vendor has reviewed and approved SLAs and performance requirements, and the contract is currently undergoing legal review prior to final sign-off. The target completion date is June 30, 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.	The DVHA business office has worked with the contractors to get the necessary reports by the end of April 2015 in order to complete the interrelated reviews and reconciliations identified in recommendations 9, 10, and 11. The system capability to support enrollment and financial reconciliation between the VHC, Benaissance, and the carriers' systems is included in the scope of the May 30th release. This release will provide the reporting mechanisms needed to identify discrepancies across the three systems.	See #9 above
11. Establish a process and expeditiously perform reconciliations of payment data among the VHC, Benaissance, and the carriers' systems.	The DVHA business office has worked with the contractors to get the necessary reports by the end of April 2015 in order to complete the interrelated reviews and reconciliations identified in recommendations 9, 10, and 11. The system capability to support enrollment and financial reconciliation between the VHC, Benaissance, and the carriers' systems is included in the scope of the May 30th release. This release will provide the reporting mechanisms needed to identify discrepancies across the three systems.	See #5 above and note that automated reconciliation continues to be under development.

Enrollment Update

Current Coverage

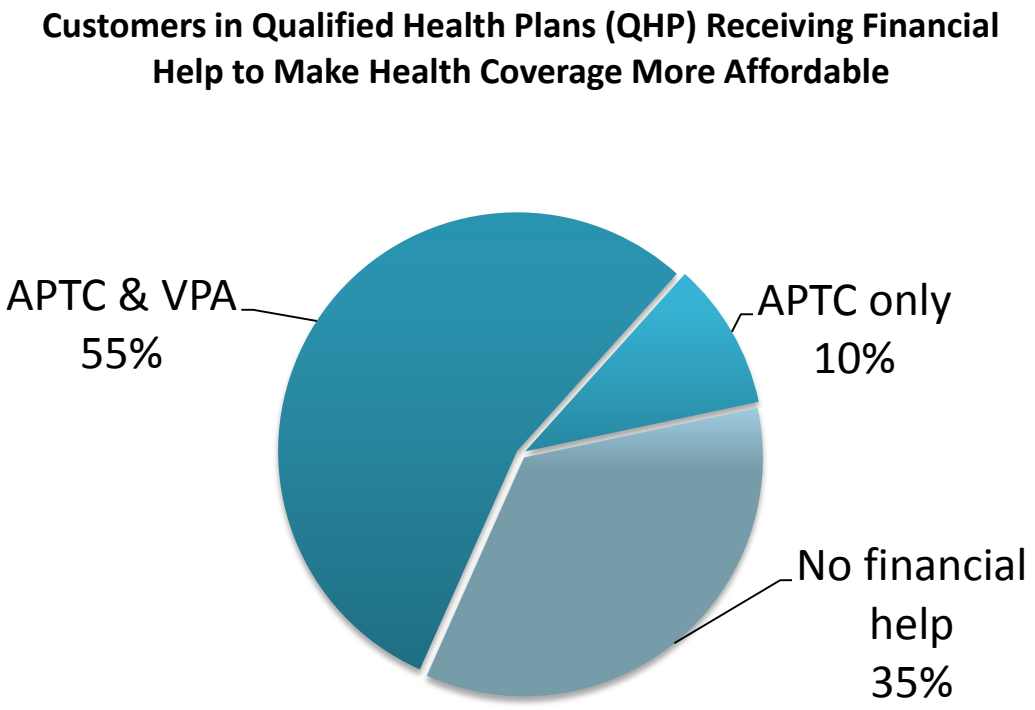


A combination of reports from insurers, VHC, and the State's legacy ACCESS system suggest that Vermont is continuing to reduce its second-lowest-in-the-nation uninsured rate. The number of Vermonters covered by Vermont Health Connect Qualified Health Plans (QHPs) increased by approximately 4,500 from December to May, while the number covered by Medicaid increased by more than 8,000. This growth was driven by a strong turnout during the QHP Open Enrollment (November 15 to February 15) and beyond.

Of customers in private qualified health plans (QHPs):

- Over half (52%) are female,
- Nearly three in five (58%) are between the ages of 45 and 64,
- Over half (56%) are in Silver plans (see page 15 for additional selection breakdowns).

Financial Help – Premium Assistance



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

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

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

The amount of financial help varies depending on household size and income. For example, an individual making less than $46,680 or a family of four making less than $95,400 a year may qualify for some assistance. Of customers receiving financial help:

- The typical (median) individual, who has an income of just under $24,000 per year, receives approximately $340 in APTC and VPA and pays $120 per month for a $460 Silver health plan.
- The typical (median) family receives $813 in APTC and VPA and pays $495 per month for a $1,308 health plan.

Financial Help – Cost-Sharing Reductions

Two out of three (67%) Vermonters who qualify for cost-sharing reductions (CSR) are taking advantage of it, by selecting a Silver Plan. One in six (18%) of these CSR-eligible customers selected a Bronze plan. The Bronze plan could save them hundreds of dollars if they don't need any medical services. If they have high medical needs, however, the Silver plan could save them thousands in out-of-pocket costs.

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

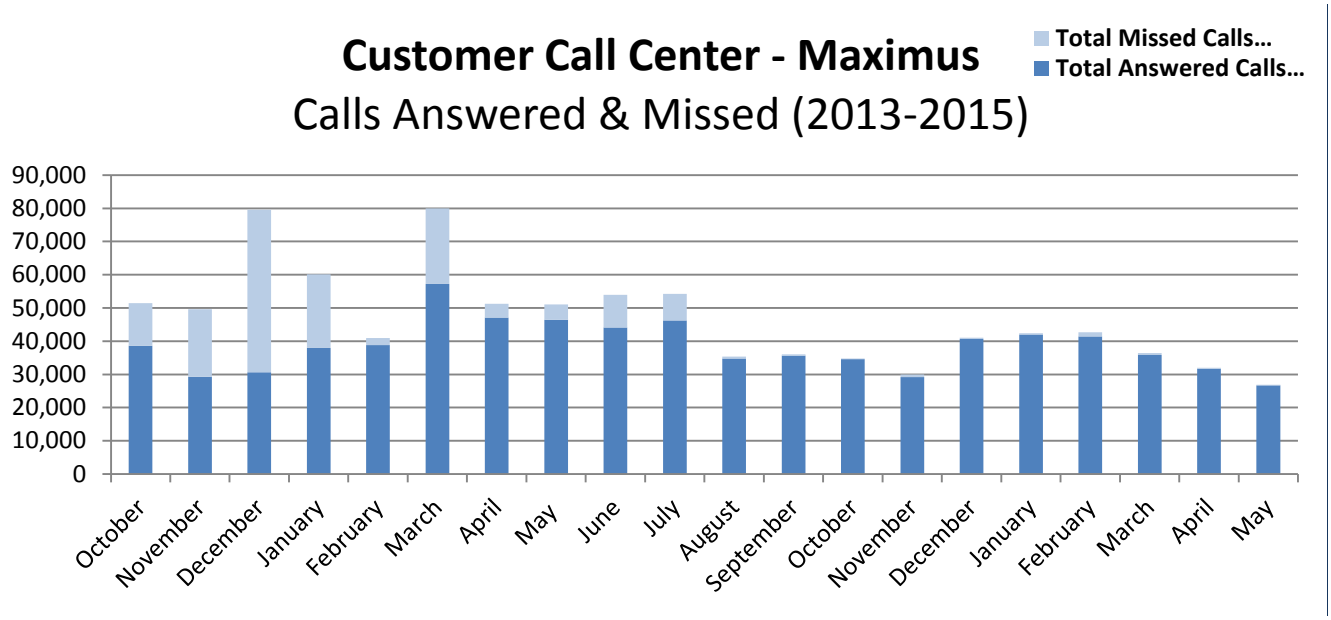
- The typical (median) individual receiving CSR is enrolled in a Standard Silver 87 plan with a $600 medical deductible and $1,250 maximum out-of-pocket (compared to a $1,900 medical deductible and $5,100 maximum out-of-pocket in an unsubsidized Standard Silver plan).
- This individual, who has an income of just over $21,000 per year, also receives $362 in premium assistance, which allows them to purchase a $466 Standard Silver plan for $104 per month.

Vermonters who qualify for the two less generous levels of CSR could conceivably have a lower total cost in a Gold or Platinum plan, depending on their medical needs. Notably, Vermonters who qualify for the two most generous levels of CSR can expect a lower total cost in a Silver plan even if they have high medical needs. Vermont Health Connect has continued to engage CSR-eligible customers, especially those who qualify for the most generous CSR levels (Silver 87 and Silver 94), to make sure they understand how cost-sharing reductions work and what they mean for their total health care costs. These outreach efforts include:

- More customized CSR explanations included last fall on 2015 version of online Subsidy Estimator,
- CSR information in notices,
- Increased emphasis on CSR in call center staff training,
- Outbound calls during open enrollment to make sure Silver 87 and 94-eligible customers understood CSR and that this was likely their last chance to change 2015 plans (barring a qualifying event),
- Additional engagement in advance of 2016 plan selection for both new and renewing customers.

Operations Update

Customer Support Center (Maximus Call Center)



Last Month

In May, the Customer Support Center answered 26,720 calls and missed 169 for an abandon rate of less than one percent. The average wait time was 12 seconds. This was an improvement over the prior month (18 seconds). More than nine out of ten calls (96%) were answered in less than 30 seconds, compared to seven out of ten (69%) in May 2014, and more than nine out of ten (93%) were able to resolved without transferring.

Open Enrollment

This year's Open Enrollment ran from November 15 to February 15. The Customer Support Center answered more than 120,000 calls, an increase over the same three month period last year, while largely avoiding long waits and missed calls. Last year's Open Enrollment abandon rate of 35.7% (over the six-month period) was cut to 1.7%.

The average wait time during this year's Open Enrollment was 40 seconds. By comparison, the average wait at the HealthCare.gov call center was more than 12 times as long (eight minutes and 16 seconds).

Nearly all calls (98%) were answered in less than four minutes, compared to just over half (53%) during the first Open Enrollment. Four out of five calls (83%) were answered in less than 30 seconds.

Renewals and Change Processing

Staff processed more than 21,000 renewal service requests this winter and spring – a crucial pre-requisite to being able to deploy the May system upgrade.

As of May 28, all but 34 subscribers had been renewed. Vermont Health Connect is working with the insurance carriers to determine if these Vermonters were auto-enrolled in 2015 health plans and if they wanted to be renewed, then reconciling their information as appropriate.

In addition to 2015 renewals, approximately 10,200 households were awaiting some form of change to be completed related to their 2015 health coverage or account as of the end of May. 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, moving to Vermont, 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.

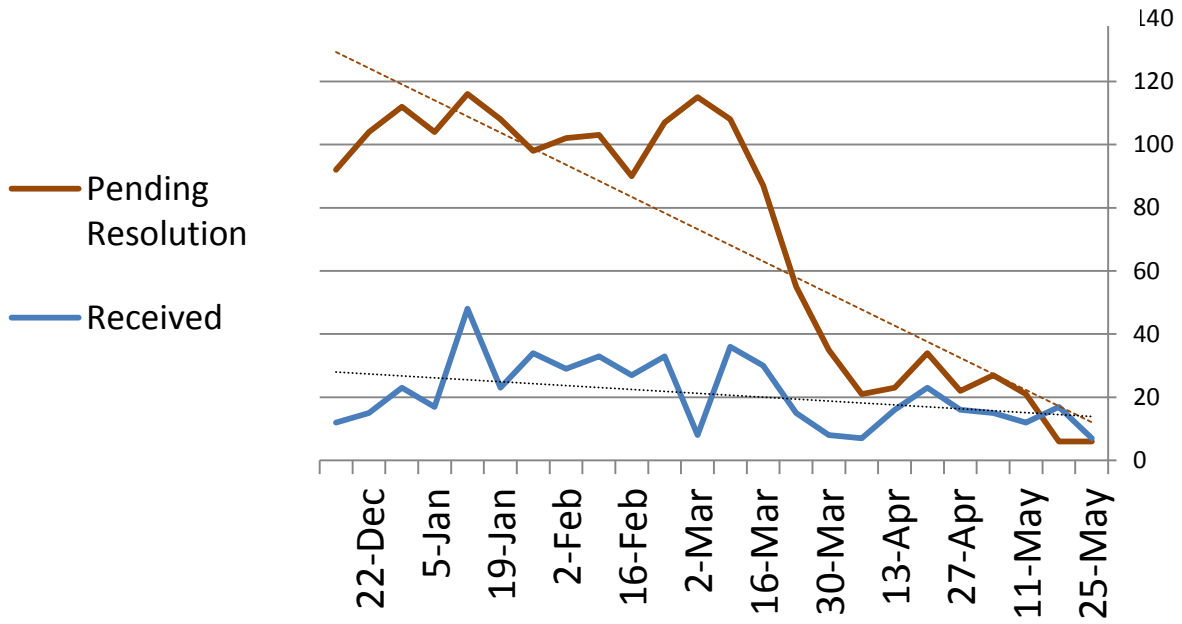
Using the new auto-change functionality that was deployed as part of the upgrades, staff will now be able to make account changes in a fraction of the time it took to process changes in the past.

All changes that were in line for processing in the old system have been carried over to the upgraded system. Staff are working the backlog of previously requested changes throughout the summer. Customers do not need to call to report the change a second time and can expect to see changes requested in the spring within two or three bills. All changes will be made with a retroactive start date that follows federal rules, based on the date of reported change.

Customers can report new changes either by clicking "Report a Change" at VermontHealthConnect.gov or by contacting Vermont Health Connect at 1-855-899-9600 (toll-free).

Information on the new functionality and system updates can be found in the "Project Development" section of this report.

Qualified Special Cases



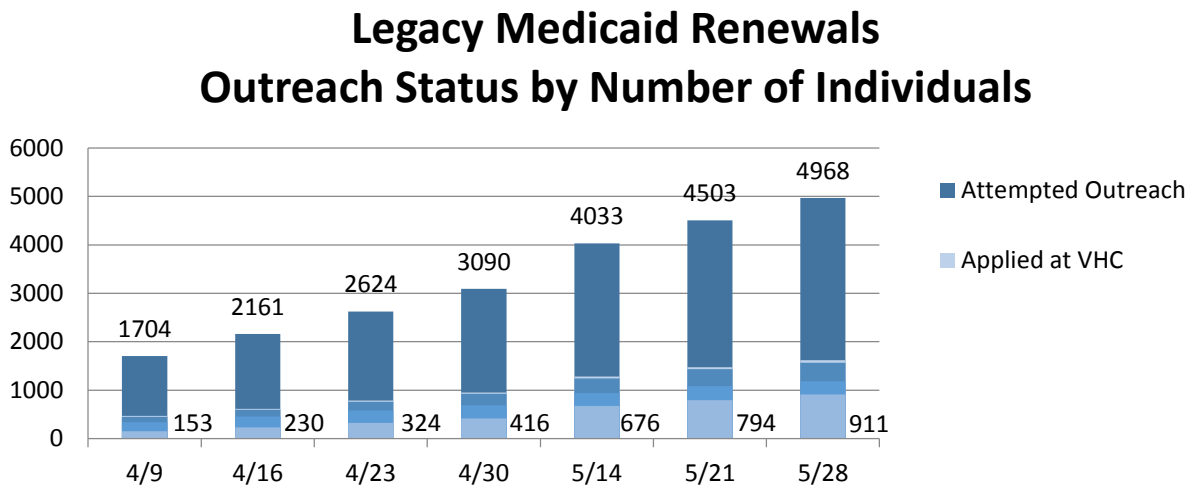
Qualified Special Cases are cases that are escalated to a dedicated customer service team due to their complexity, medical or financial urgency, or inability to be resolved through normal channels.

Recent rounds of training throughout Vermont Health Connect's various teams have resulted in a reduction in the number of cases that need to be escalated. Combined with strong work by the dedicated team, the number of pending Qualified Special Cases has fallen to fewer than two dozen.

Over the course of the nine weeks ending May 1, the team received 159 new cases, down from 267 over the previous nine weeks. Over the same period, the team resolved 262 cases, on par with 266 over the previous nine weeks. Together this resulted in a decrease in the number of Qualified Special Cases pending resolution from 115 to 22, an 80% drop.

This progress continued throughout the month of May and the team ended the month with just six cases pending resolution.

Medicaid Renewals – Legacy System Renewals



In early March, Vermont Health Connect began to implement its plan to transition 26,000 households from the State's legacy ACCESS system to Vermont Health Connect to receive their Medicaid for Children and Adults (MCA) eligibility determination.

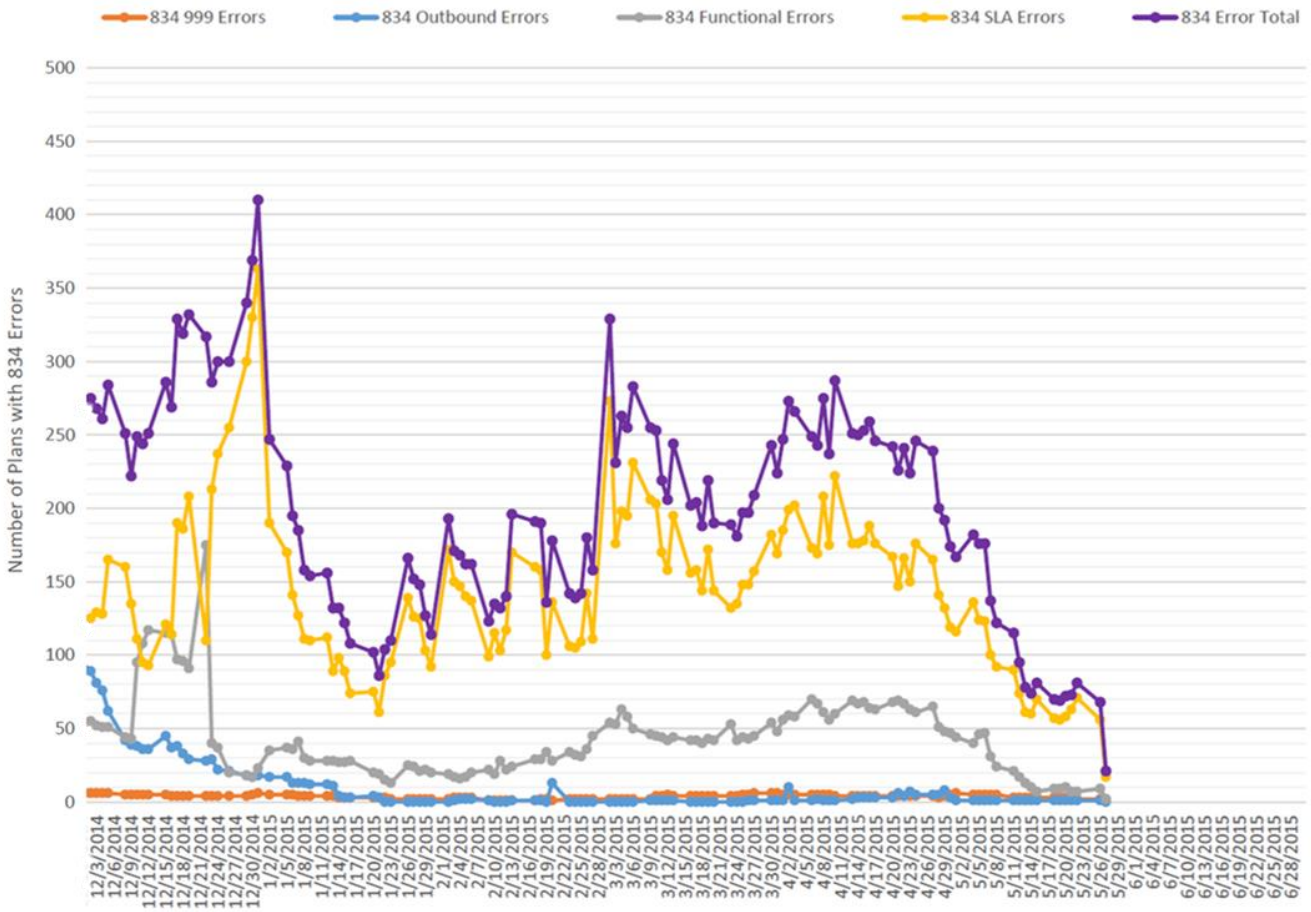
The plan began with a pilot of highest income households, as they are the most likely to no longer be eligible for Medicaid. The pilot involved small numbers of renewals, scheduled over a three-month period of time to allow Vermont Health Connect to assess the success of its renewal strategy. Once the strategy is refined and Vermont Health Connect understands which methods of outreach are most successful, the monthly renewal cadence will increase to allow for the legacy system transition to be completed by March 2016.

The eligibility team began sending 250 notices per week, beginning the first week in March. The first notice tells the recipient that they need to apply at Vermont Health Connect within 30 days, but does not include a closure date. At the same time, customer service representatives (CSRs) at Maximus make two to three attempts to reach each household by phone. If they reach a recipient, the CSRs offer to guide them through a phone application.

Four weeks after the first notice, the eligibility team sends a second notice to those who haven't yet applied. This notice includes a paper application and asks households to either call the Customer Support Center or complete and mail the application within 30 days.

State staff have been closing customer cases when those customers have asked for Medicaid to be closed and when customers' outreach letters have been returned with no forwarding address. Staff is communicating with the Center for Medicaid and Medicare Services (CMS) to discuss closing customers who haven't responded to outreach attempts.

Carrier Integration



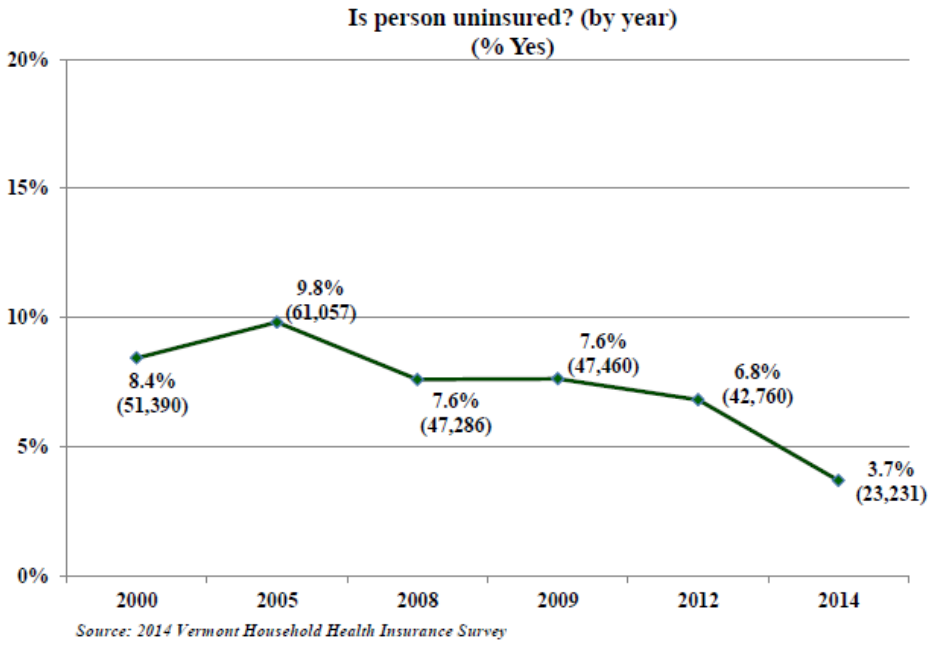
Vermont Health Connect continues to work to resolve 834 transaction and premium processing errors. An 834 is an electronic file sent from VHC to an insurance carrier with information about an individual or family's enrollment information. An 834 error indicates that this electronic file has not yet been successfully processed for some reason. Optum is assisting the State in streamlining the resolution process and identifying mechanisms for reducing the generation of errors.

Vermont Health Connect was successful in reducing the inventory of 834 errors from over 1,000 in early 2014 to under 100 by January 2015. Errors ticked up in February with heavy volume toward the end of open enrollment, then declined throughout the spring to approximately 20 by the end of May. Part of this recent reduction was due to a new process that was developed with BCBSVT to overcome a change in the BCBSVT system that did not accept duplicate contact IDs. As VHC and BCBSVT staff became more comfortable with this process, they have been able to work through errors at much higher rate.

It is important to note that as VHC continues to enroll Vermonters into coverage there will always be some number of electronic enrollment files that have been sent but not yet fully processed. The number of 834 errors will never reach zero. In particular, major system updates, such as the one scheduled for the end of May, can be expected to cause a temporary rise in errors. VHC is planning its staffing accordingly.

Vermont Health Connect and the State's Uninsured Rate

The percentage of uninsured Vermont residents in 2014 has decreased compared to 2009 and 2012.



Even when the VHC system is upgraded with improved reporting functionality, the Vermont Household Health Insurance Survey (VHHIS) will remain 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 #2 in the nation in health coverage.
- Vermont is #1 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, Vermont has room for improvement – and Vermont Health Connect is well-positioned to help.

- HHIS also reported that over half of Vermont's uninsured children would qualify for Dr. Dynasaur and three in ten uninsured adults would qualify for Medicaid.
- With strong numbers of new applicants coming to Vermont Health Connect during open enrollment, Vermont is clearly continuing to move closer to the goal of ensuring that all Vermonters are covered.