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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

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Prepared by Vermont Health Connect

May 14, 2015

Contents

Enrollment Update

Current Coverage and New Enrollments

Number of Vermonters Covered by Qualified Health Plans and Medicaid	Dec-14	Feb-15	Apr-15
QHP - Individual	33,027	34,693	34,827
QHP - Small Business	36,488	38,312	38,121
Medicaid - MAGI Child	61,013	61,142	61,953
Medicaid - MAGI Adult	70,980	74,071	77,691
Medicaid - Non-MAGI Child	5,083	5,026	4,948
Medicaid - Non-MAGI Adult	37,527	37,610	37,666
CHIP	3,216	3,223	3,220
TOTAL QHP	**69,515**	**73,005**	**72,948**
MEDICAID & CHIP	**177,819**	**181,072**	**185,478**

Note: QHP numbers as reported by insurers; Medicaid numbers as reported by Vermont Health Connect and Vermont's legacy ACCESS system.

Individuals New to VHC* Since Start of 2015 QHP Open Enrollment		
By Coverage Start Date		
Coverage Start Date	**Qualified Health Plan (BCBSVT & MVP)**	**Medicaid & Dr. Dynasaur**
January^	4,057	7,096
February	649	3,000
March	1,447	1,808
April	374	1,615
May	154	50
Total	**6,681**	**13,569**

*"New to VHC" counts individuals who were not in the VHC system in 2014. It does not count those who were customers in 2014 or who were listed as members of customers' households.

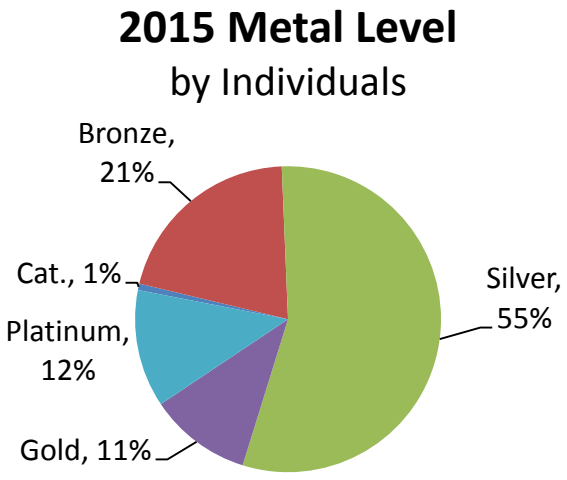
^January Medicaid numbers include individuals who enrolled during QHP Open Enrollment and received November or December start dates (because Medicaid enrollment is year-round and has retroactive start dates).

As of: 5/1/2015

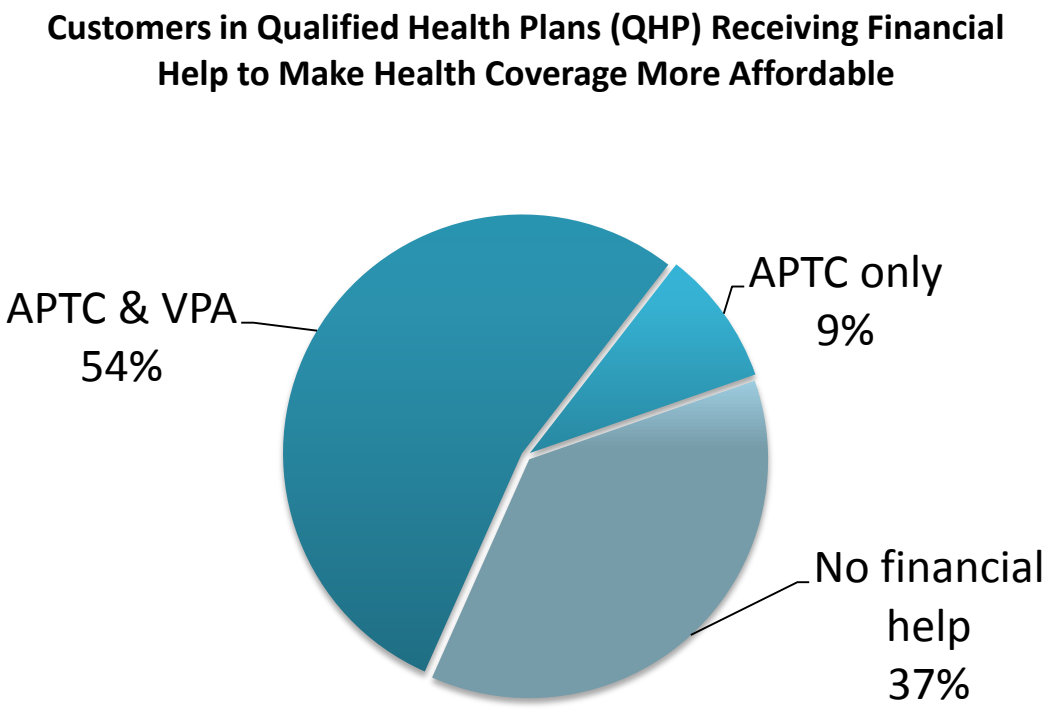
A combination of reports from insurers, VHC, and the State's legacy ACCESS system suggest that Vermont is continuing to reduce its second-lowest-in-the-nation uninsured rate. The number of Vermonters covered by Vermont Health Connect Qualified Health Plans (QHPs) increased by more than 3,000 from December to April, while the number covered by Medicaid increased by more than 7,000. This growth was driven by a strong turnout during the QHP Open Enrollment (November 15 to February 15) and beyond, with more than 20,000 individuals entering the VHC system for the first time to enroll in QHPs or Medicaid plans.

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 (55%) are in Silver plans (see page 5 for additional selection breakdowns).



Financial Help – Premium Assistance



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

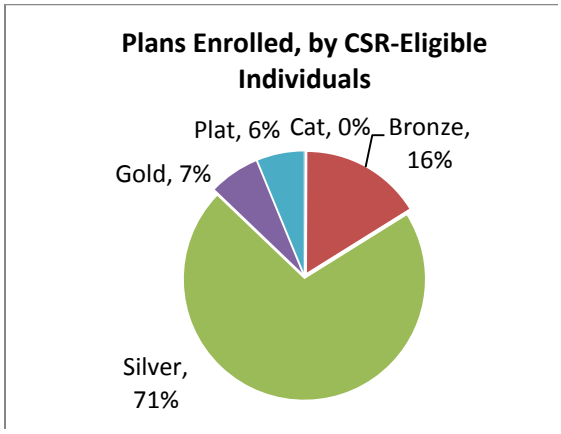
Of customers in private health plans (QHPs) in 2015:

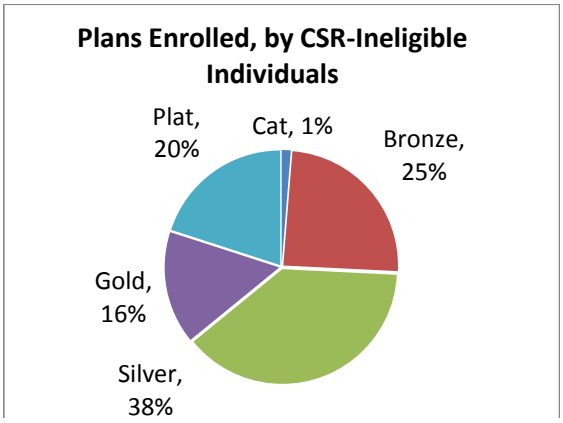
- Three out of five (63%) qualified for federal Advanced Premium Tax Credits (APTC).
- More than half (54%) qualified for Vermont Premium Assistance (VPA) and cost-sharing reductions (CSR).

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 $340 in APTC and VPA and pays $120 per month for a $460 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

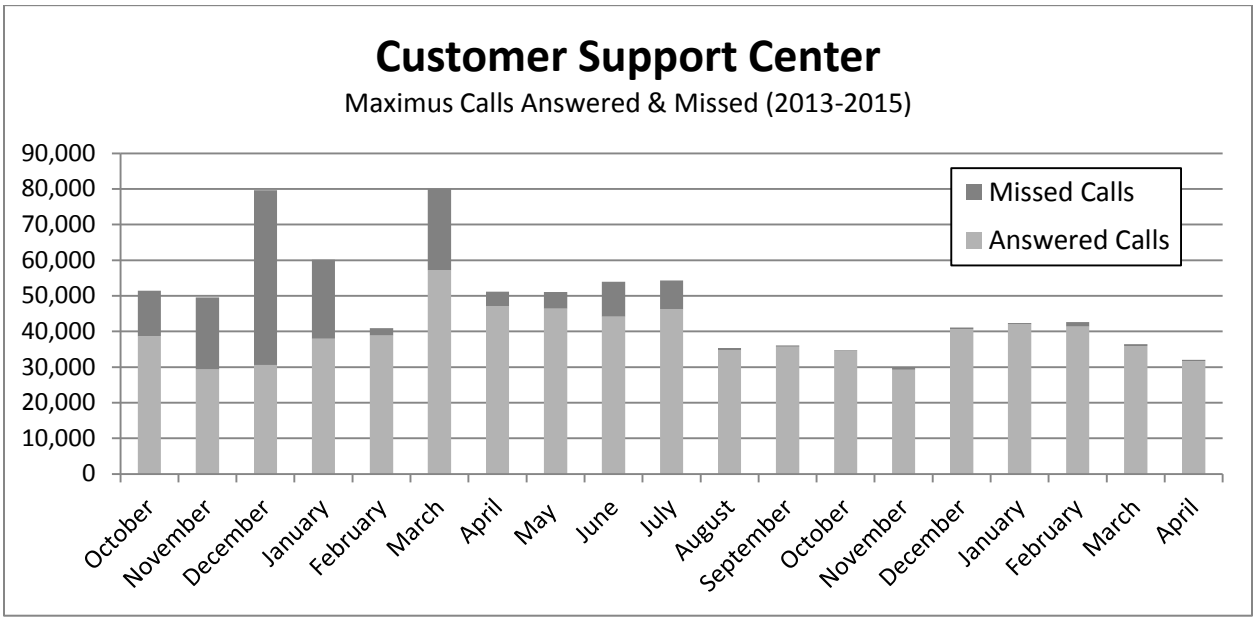




- Most (seven in 10) Vermonters who qualify for cost-sharing reductions (CSR) are taking advantage of it, by selecting a Silver Plan.
- One in seven (16%) CSR-eligible customers selected a Bronze plan. This could save them hundreds of dollars if they don't need any medical services. If they have high medical needs, however, they could pay thousands more 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.
    - 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.
- 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:
    - 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,
    - Early February outbound calls 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 April, the Customer Support Center answered 31,714 calls and missed 283 for an abandon rate of less than one percent. The average wait time was 18 seconds. This was an improvement over both the prior month (28 seconds) and the prior April (85 seconds). Nine out of ten calls (91%) were answered in less than 30 seconds.

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 Processing

2015 Renewals - Active and Closed				
Renewal Cases	In Process	In QA	Awaiting Integration	Total Closed
as of April 1	2,440	222	3,346	16,600
as of April 30	967	165	1,297	19,989

Important notes about the numbers above:

- *These renewing customers do have current coverage – they have been auto-mapped by their 2014 insurance carriers and have current coverage, even though it is not up-to-date in the VHC system.*
- *"Cases" refers to service requests, not households; one household could make separate change requests and thus have multiple service requests over the course of the renewal process.*

As of the end of April, nearly nine out of ten (89.2%) renewals had been completed. Like other types of change processing, renewal processing has been a painstaking effort with manual workarounds. Vermont Health Connect is nearing the end of the process with the goal of finishing renewals processing prior to the implementation of system updates in May.

Most of the remaining renewals are Eligibility/Plan Change Renewals or Age-offs and Program Change Renewals.

Eligibility/Plan Change Renewals are cases of households that are making changes to their health plan, income, or household information. These renewals are completed in a two-step process: first they are processed as a no-change renewal, then they are processed as a Change of Circumstance, retroactive to January 1.

Age-offs refer to households with a member whose eligibility is changing by virtue of their birthday (e.g. turning 26 and no longer qualifying to stay on a parent's plan or turning 65 and gaining Minimum Essential Coverage by virtue of qualifying for Medicare). Program changes refer to households with a member(s) whose eligibility changed by virtue of increases to the federal poverty level (e.g. a Vermonter whose income was 139% of 2013 FPL, which then became 137% of 2014 FPL, thereby newly qualifying them for Medicaid even though their income was unchanged).

Change Processing

Change of Circumstance (COC) and Change of Information (COI) requests are changes to 2015 health plans, income, or household information. These requests, which were being made at a rate of approximately 125 per day in 2014 and early 2015, have recently slowed to 75-100 per day. Nonetheless, change processing has been a heavy lift for staff with time-consuming manual workarounds, and delays for many customers, and will remain so until new functionality is delivered and the backlog is cleared.

In addition to 2015 renewals, 9,931 households were awaiting some form of change to be completed related to their 2015 health coverage or account. 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.

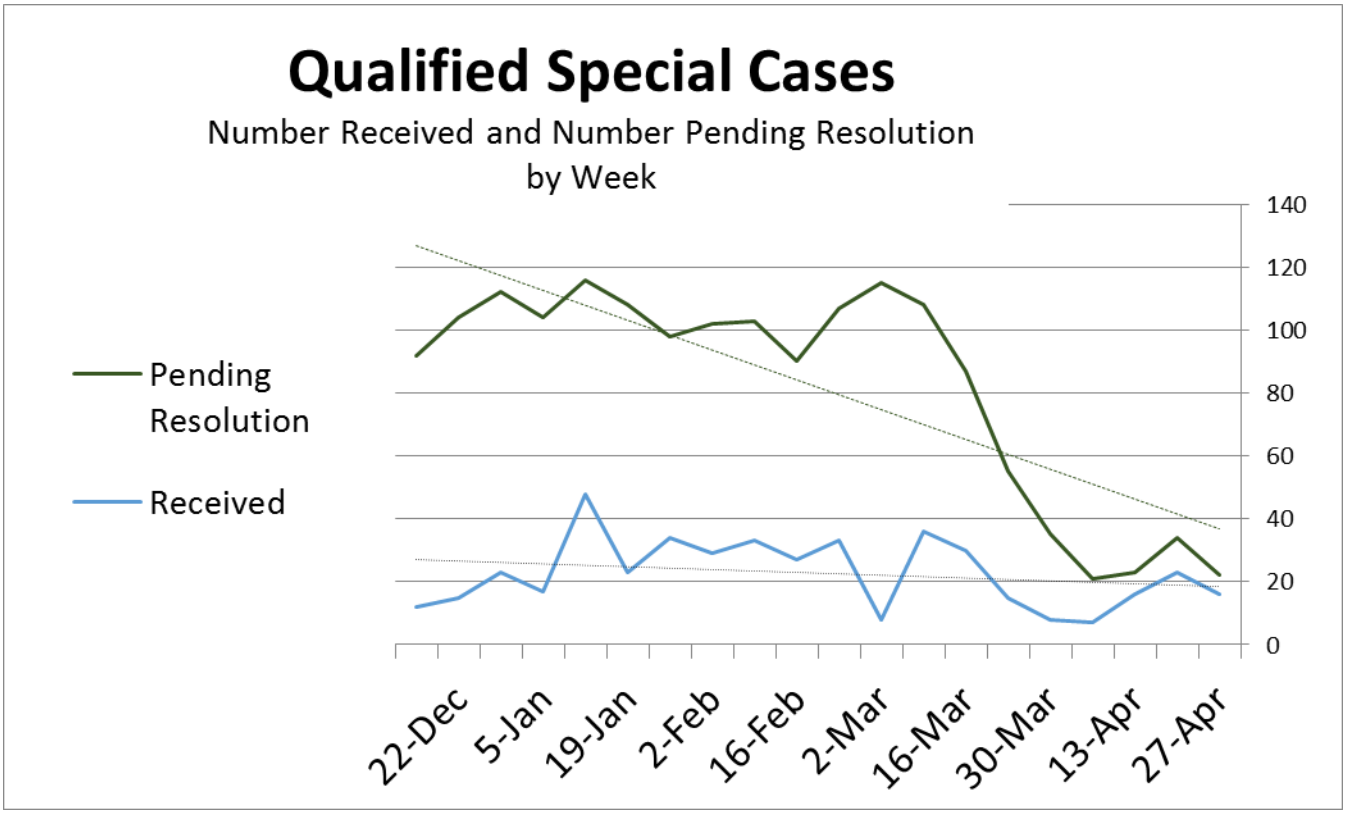
In order to minimize complications that could arise from having partially completed changes in the system, in May Vermont Health Connect will avoid starting all but the most urgent changes until the new system is in place. Processes are in place to ensure that cases involving medical and financial urgency are promptly addressed.

All changes that are in line for processing in the current system will be carried over to the updated system. Customers will not need to call again to report the change a second time. Staff will process the requested changes in the weeks following the system update. Customers can expect to see changes requested in the spring within two or three bills as Vermont Health Connect works through the backlog and progresses toward the operational milestone of completing change requests within 30 days by October. All changes will be made with a retroactive start date that follows federal rules, based on the date of reported change.

Customers can report 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

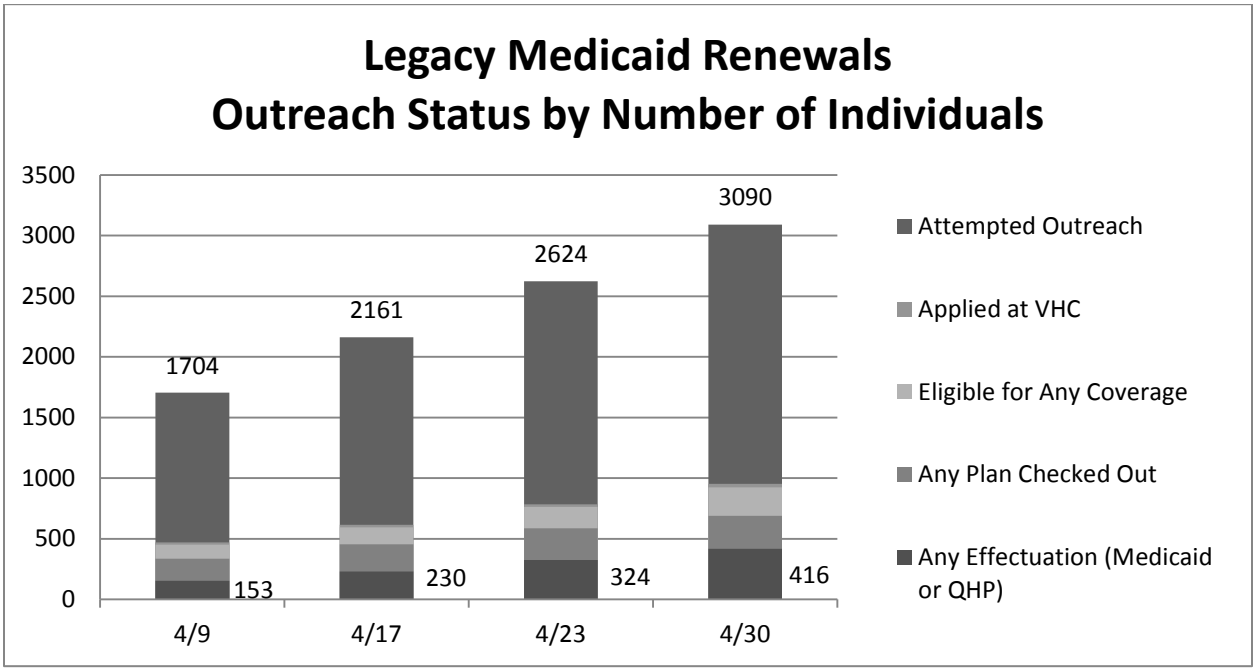


Qualified Special Cases are cases that are escalated to a dedicated customer service team due to their complexity, medical or financial urgency, or inability to be resolved through normal channels.

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.

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 MAGI Medicaid eligibility determination.

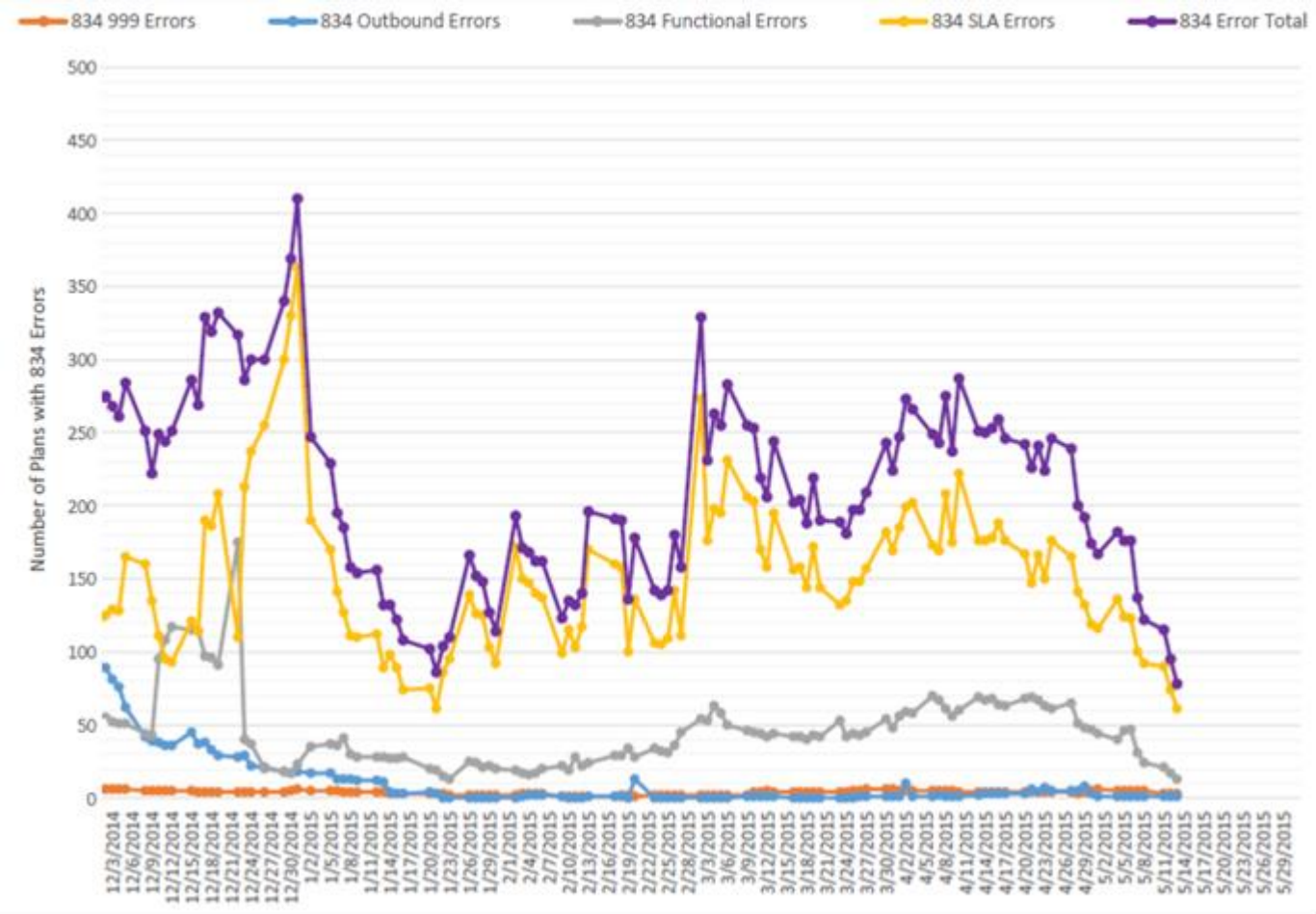
The plan began with a pilot of highest income households, as they are the most likely to no longer be eligible for Medicaid. The pilot involved small numbers of renewals, scheduled over a three-month period of time to allow Vermont Health Connect to assess the success of its renewal strategy. Once the strategy is refined and Vermont Health Connect understands which method of outreach is 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.

Four weeks after the second notice, the eligibility team will consider a process to close Medicaid in ACCESS.

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.

The State 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 in the spring, with fewer than 100 as of early 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.

Project Development

2015 System Updates

Vermont Health Connect is working towards the delivery of two major system updates. The first update, known as Release 1, is scheduled for the end of May and includes functionality to support:

- Changes of Circumstance (CoC),
- Changes of Information (CoI), and
- Reports to support reconciliation between Vermont Health Connect, premium processing (Benaissance), and the insurance carriers.

The second update, Release 2, must be completed by October to be ready for 2016 open enrollment. Release 2 includes functionality to support:

- Medicaid and QHP renewals,
- Renewal Notices,
- Additional financial reconciliation and billing enhancements, and
- CMS Enrollment Integration.

Release 1 is currently in the testing phase. Two simple CoC transactions have successfully been processed with all three carriers through Integration Testing. Detailed milestones are included in the table below.

Requirements sessions for Release 2 are currently underway.

Status of Release 1 Milestones

Deliverable	Status Update, May 7, 2015	Action to Closure
CoC Companion Guide Complete – Carrier Integration Design	Complete	N/A
Release 1 Requirements Complete	Complete	N/A
Release 1 Schedule Baseline Approval	Complete	N/A
Release 1 Scope Baseline Approval	Complete	N/A
Reconciliation Design Complete	Complete	N/A
CoC Design Complete	Complete	N/A

Reconciliation Development Complete	Complete	N/A
Test Design Complete	In Progress	Pending official State of Vermont sign-off. Draft deliverable complete. Preliminarily reviewed and approved by Optum and State.
Training Materials Development Complete	In Progress	Plan is to prioritize all training materials into three distinct buckets where all critical functionality (high volume) will be trained prior to implementation (Group 1 materials due 5/13) followed by additional training sessions post-implementation. Priority focus is to train on fully tested processes whenever possible.
CoC Carrier Unit Test/Development Complete	Complete	MVP needed extra time to complete development and unit testing. The schedule allowed for this delay and there was not an impact to the implementation date.
CoC Development Complete	Complete	Final date was dependent on the MVP development completion. The schedule allowed for this delay and there was not an impact to the implementation date.
Release 1 Ops Readiness Complete (Cutover and Implementation Activities)	In Progress	This milestone addresses system cutover and implementation activities; meeting scheduled 5/7 to review cutover options. Work-around and contingency activity is in progress.
Total Test Execution Complete (Integration / Systems Integration Testing (SIT) & User Acceptance Testing (UAT) End-to-End / Carrier)	In Progress	Release 1 testing is progressing even as the State awaits a comprehensive test plan that it can approve. Optum and State Testing Teams are working nights and weekends to complete the testing per IMS.
Carrier End to End Testing Complete	In Progress	Release 1 testing is progressing even as the State awaits a comprehensive test plan that it can approve. Optum and State Testing Teams are working nights and weekends to complete the testing per IMS.
Test (Performance) Complete	In Progress	Release 1 testing is progressing even as the State awaits a comprehensive test plan that it can approve. Optum and State Testing Teams are working nights and weekends to complete the testing per IMS.
Test (Security) Complete	In Progress	Security Testing execution to begin on 5/11 with an estimated complete date of 5/25.

Training Complete	In Progress	Plan is to prioritize all training materials into three distinct buckets where all critical functionality (high volume) will be trained prior to implementation (Group 1 materials due 5/13) followed by additional training sessions post-implementation. Priority focus is to train on fully tested processes whenever possible.
Release 1 Go/No Go Decision Complete	Not Started	Dependent on Testing Execution complete.
Release 1 Go Live (Implementation Complete)	Not Started	Dependent on Testing Execution complete.
Release 1 Unit Verification Test Complete	Not Started	Dependent on Go Live.
Archetype Auto CoC Phase 1 Reporting Complete	Not Started	Dependent on Go Live.
Archetype CMS Integration Report Complete	Not Started	Dependent on Go Live.

Risks

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

- 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.
- 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 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.
- 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.
- The State of Vermont has defined the scope of Optum's Release 2 work. In addition, the State submitted the final draft contract for this work to CMS on April 15. CMS can take up to 60 days to review and approve any contracts. Until this contract is approved, the lack of a contract puts the timeline for Release 2 at risk.
- 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 (down from 65.5% to 50%) from CMCS. The State is analyzing the financial impacts of this reduction. Any reduction in funding puts the scope at risk.
- 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 Change of Circumstance and Renewals functionalities. 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

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, May 11, 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	1. Baseline Integrated Master Schedule: Completed April 3, 2015 2. Requirements documentation: Completed April 5, 2015 3. Scope Statement: Completed April 8, 2015 4. Requirements Traceability Matrix: Document completed May 10, 2015. 5. Test Plan: Document completed, to be routed for signature upon finalization of Requirements Traceability Matrix.
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 ensure compliance with Bulletin 3.5 for any future system development contracts.

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 that govern the participation of the multiple organizations involved.	VHC has completed a revision to the operations organizational structure, including roles and responsibilities. Job descriptions are being updated for each member of the operations leadership team, followed by a review of roles and responsibilities across all staff in the organization. Finally, an interdepartmental agreement between DVHA and DCF-ESD regarding VHC operations that has been in place since March 2013 is being revised and updated to reflect the revised and refined organizational structure. VHC anticipates completion of this document by July 2015.
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-and-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.	The next Maintenance & Operations 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 award) is June 19, 2015. The Hosting contract includes provisions for service level agreements, payment credits, and performance metrics. Negotiations are underway, and are expected to be completed this week. The Premium processing contract includes provisions for service level agreements, payment credits, and performance metrics, and negotiations are continuing.
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	We are continuing to make progress on payment and enrollment reconciliation efforts. Regarding reconciliation of 2014 cases, we are analyzing and correcting any discrepancies between VHC and Benaissance data. We have received enrollment and payment data from our carrier partners and have begun to compare carrier data with updated VHC/Benaissance data.

	needed to identify discrepancies across all of the systems and perform monthly reconciliations.	Regarding 2015 cases we have received carrier data from BCBSVT and NEDD and expect it soon from MVP. For resolution of 2015 discrepancies, priority will be given to resolution of high-volume errors through automated system methods. Release 1 continues to include system capability to support enrollment and financial reconciliation between the VHC, Benaissance, Medicaid, and carrier systems. A request has been made to generate an ACCESS report to support Medicaid enrollment reconciliation, targeted for completion in July 2015.
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 Medicaid program.	See # 5 above.

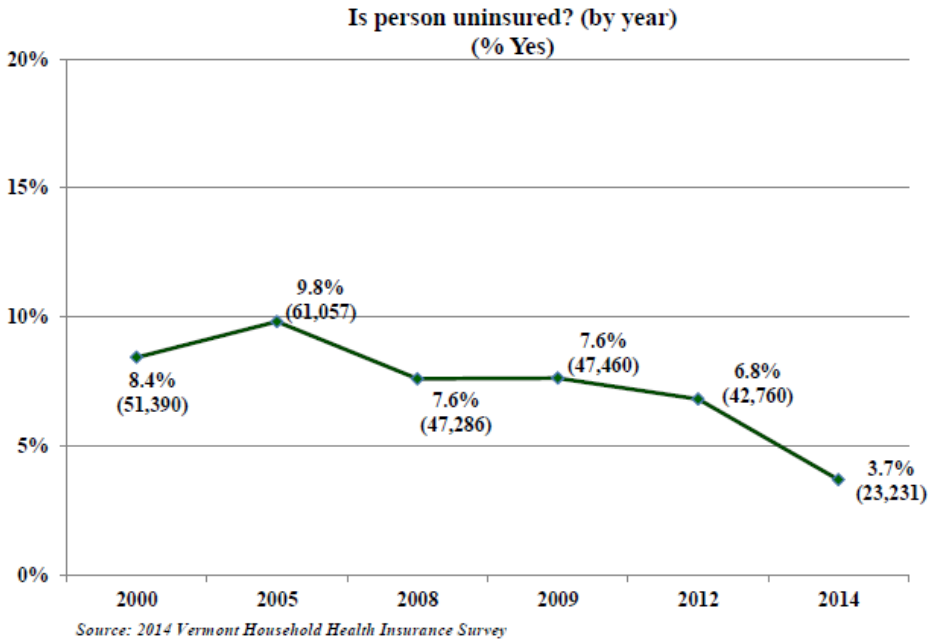
7. Reconsider decisions that have complicated the premium payment processing function, including the requirement that the full premium payment be at Benaissance without exception before remittance to the carriers and the split of the billing and dunning/termination processes between different organizations.	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.	Preliminary discussions have occurred regarding options for DVHA to modify payment processing methodologies to ensure payment processing occurs in the most efficient manner. Further analysis of options has been deferred until after the successful implementation of Release 1 and completion of 2014 and 2015 reconciliation activities.

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 is in the process of defining requirements for automated system functionality to terminate coverage for non-payment of Dr. Dynasaur premium following an anticipated 60-day grace period, with an anticipated delivery date of September 2015. The State intends to engage in rulemaking to revise the rule regarding the 60-day grace period for premium-paying Dr. Dynasaur customers such that the rule change coincides with implementation of the automated process. Prior to implementation of the automated solution we have begun development of a manual workaround, with a target date for implementation at the end of June.

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.	DVHA is continuing to work with the respective vendors to address financial reporting shortcomings.
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

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.