Alternatives to Vermont Health Connect:
Considerations & Cost Estimates – Individual Marketplace and Medicaid

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VERMONT
HEALTH CARE REFORM

Goal

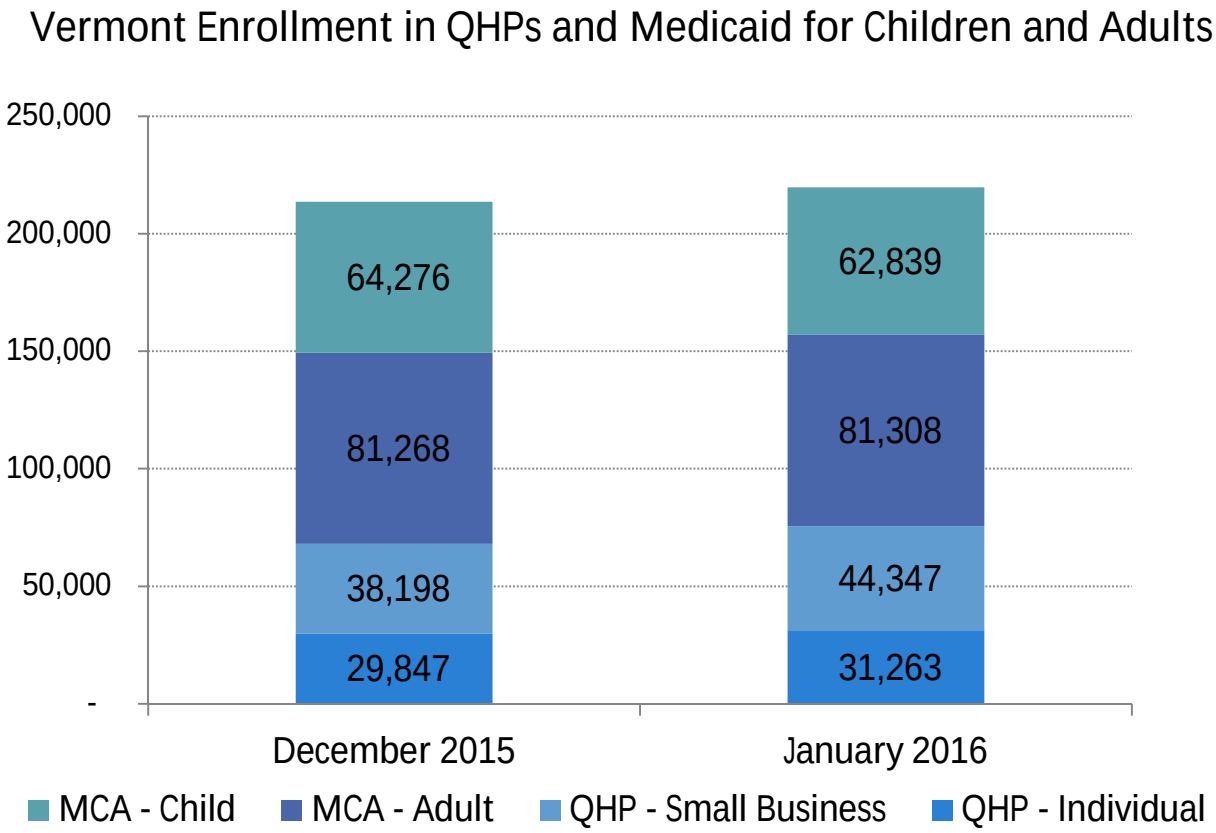
Regardless of which health insurance marketplace model Vermont uses, we all want every Vermonter who uses the marketplace to be happy with the experience

To get there…

- What needs to happen on the phones?
- What needs to happen online?
- What needs to happen with in-person assistance?
- What needs to happen with billing?
- What needs to happen with affordability?
- What needs to happen with the impact on the state budget?

Who are we talking about?

Nearly 220,000 Vermonters are covered by VHC Qualified Health Plans and Medicaid for Children and Adults



What research did we do?

- Research & analysis was done by cross department team & contractors
- Research included interviews with other state officials and vendors, as well as reviewing federal guidance for other models:
  - Officials from states which had transitioned from a state based marketplace to *either* the federal exchange technology or to another state's technology
  - Interview conducted Summer 2015; Updated February 2016

What research did we do?

- Developed cost estimates for use of federal exchange
  - Based on costs incurred by other states, prior Vermont procurements or pending bids (IE), prior experience with vendors, informal estimates and comments from vendors
  - Reviewed with JFO to obtain feedback & questions
- Written report was peer reviewed by State Health Reform Assistance Network (out of Princeton University) and Joel Ario from Mannatt

What other states did we talk to?
Medicaid & Individual Exchange

State	Description of Exchange
Hawaii	Transitioned to Supported State Based Marketplace for Individual Market
Maryland	State Based Marketplace for Individuals (purchased and modified Connecticut's technology)
Nevada	Transitioned to a Supported State Based Marketplace for Individual Market; Considering State Based Marketplace due to new federal user fee
Oregon	Transitioned to a Supported State Based Marketplace for Individual Market. Issued an RFP for State Based Marketplace due to new federal user fee
Kentucky	Currently a State Based Marketplace; Announced move away from SBM. Interview being scheduled

What did we consider?

Cost Impacts

- **Transition Costs**
  - Decommissioning VHC technology & data
  - Education & Outreach
  - Technology development (VPA/VCSR & Medicaid)
  - Gap Analysis
- **On-going operations**
  - Impact of federal user fee
  - Call Center
  - Operations
- Repayment of federal funds

Policy & Operations Implications

- Feasibility of VPA/VCSR
- Impact on insurance rate review & hospital budgets
- Impact on future policy initiatives (e.g. limitations on 1332 waiver)
- Integration of operations across programs or lack thereof

Consumer Experience

- Engaging with one versus two call centers
- Enrolling in one versus two systems for mixed households & VPA/VCSR
- Transition to new system requires new enrollment

New Technology Risk

- Vendor experience
- Timeframe for development
- Impact on operations
- Potential to require policy changes

Why did we recommend staying the course?

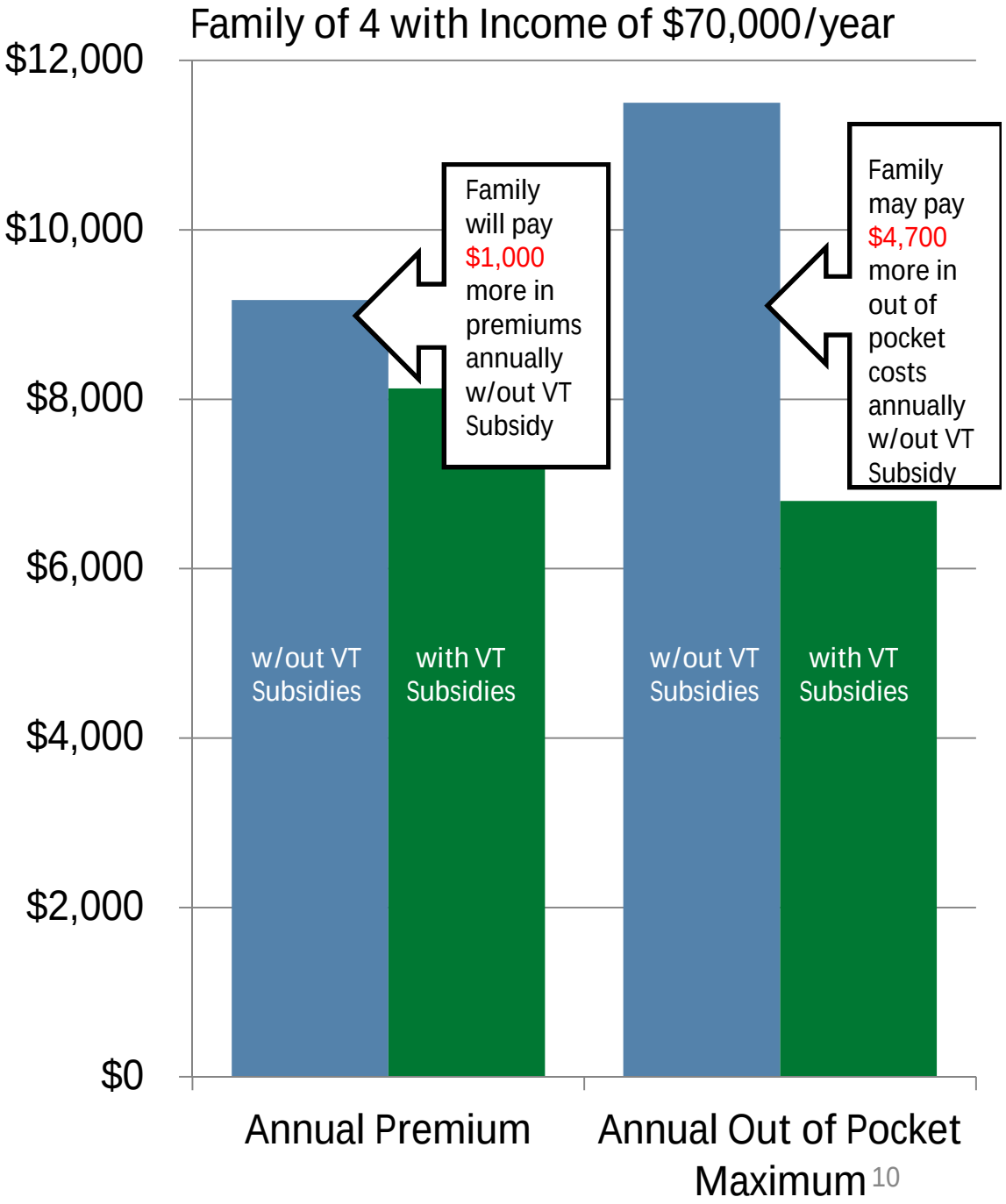
- Most cost-effective approach for remaining development and for on-going operations costs
  - It's inexpensive to move the individual market to the federal technology, but it is expensive to meet the Medicaid requirements, which we currently do through VHC.
- Maintains consolidated approach to covering individuals across all income levels
- Most likely to maintain 96-97% insured rate & not lose people in the transition
- Maintains state authority over health policy & health care reform
  - Draft federal guidance creates additional uncertainty about state flexibility in FFM or states using fed technology
  - Feds seem to be moving toward standard plan designs in the FFM
    - Currently optional, but hints that this may become mandatory

Why did we recommend staying the course?

- Only option for maintaining seamless VPA/VCSR enrollment to ensure consumer affordability
  - Other options would require consumer to do two enrollment processes to sign up for VPA/VCSR
- Only option for maintaining seamless enrollment for mixed households (Medicaid/QHP)
  - Other options require consumer to do two enrollment processes to sign up for Medicaid & QHPs

Health Care Coverage Affordability

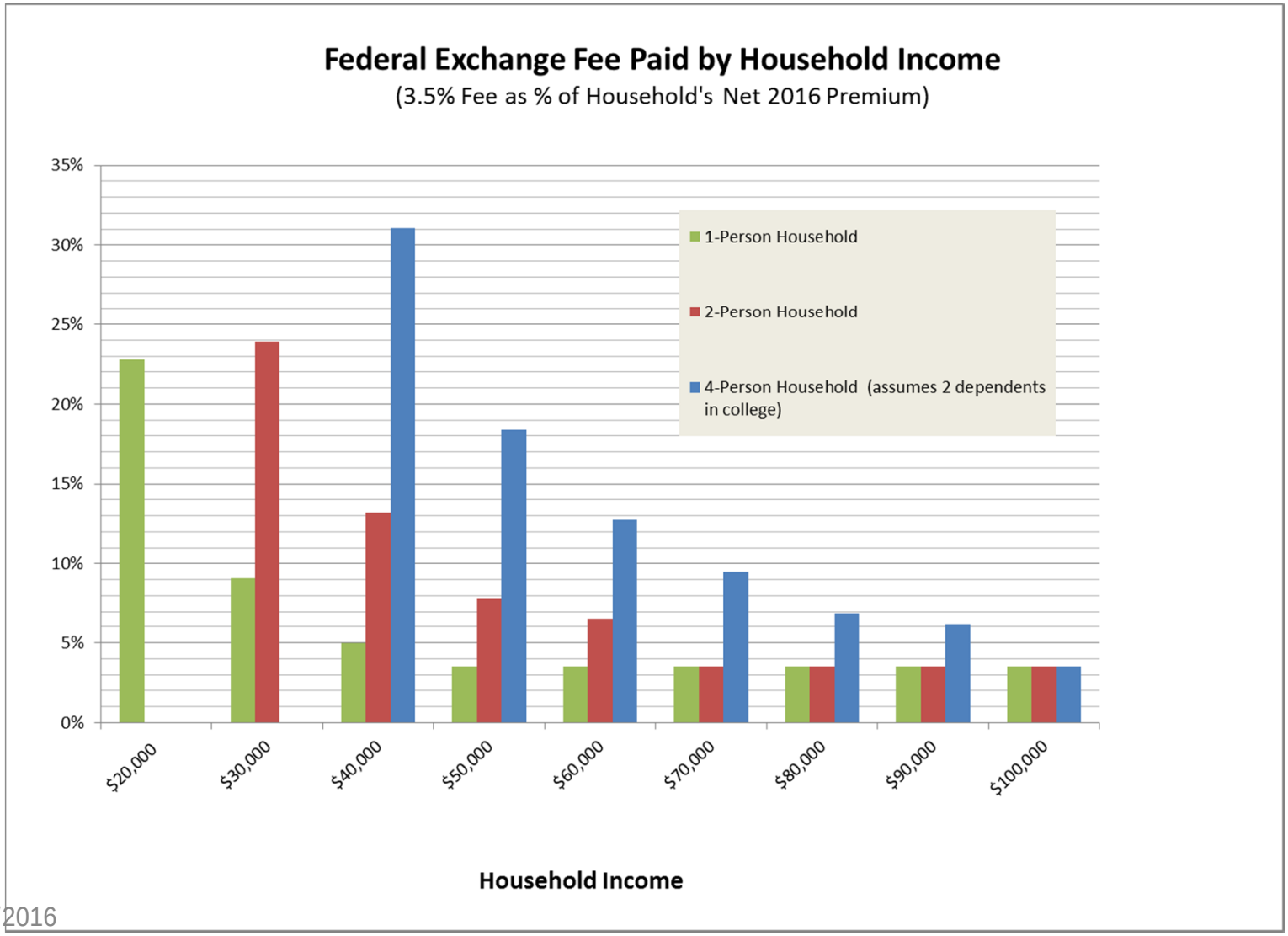
- Other alternatives require 2 separate enrollment processes & some people will not sign up
- Cost is the #1 reason Vermonters are uninsured
- Over half of the individuals in VHC receive Vermont subsidies– about 16,000 Vermonters
- Since Vermont Health Connect and VT subsidies, uninsured rate has been cut nearly in half– 6.8% to 3.7%
- Vermont's premium subsidy receives Medicaid match funding
- If families are unable to afford their out of pocket costs, providers will assume these costs as bad debt.



Federal User Fee

- Insurers collect on top of premium and remit to the federal government
  - State could pay for consumers to ensure that premiums net of VPA stay consistent
  - State could pass onto consumers as is done in other states
- 2017 fees
  - FFM 3.5% of gross premiums = $6.3 Million
  - Proposed for SSBM 3.0% =$5.4 Million
    - Possibility of 1.5% ($2.7M) or 2.0% ($3.6M) in first year
    - Draft rules came out on November 20, 2015

Federal User Fee Increases Costs to Lowest Income Vermonters



Accountability

	SBM	Other Models
Service Level Agreements (SLAs)	Vermont decides what levels of service (call wait times, system downtimes, etc.) are acceptable and the penalties for not meeting targets.	Less control
When there is a problem	Call Lawrence or Cass on their cell phone.	Call federal contacts
If legislature wants oversight	Call hearings, require reports, set milestones.	Less control

Achieving Our Goal

If the alternatives will not achieve our objectives, how do we achieve our goal with Vermont Health Connect?

Three critical steps are:

1) Make the technology efficient and stable enough to avoid backlogs
2) Prioritize ongoing reconciliation efforts
3) Work with partners to identify policy improvements, and paths to implementation, based on our three years of operational experience

BACKGROUND ON COST ESTIMATES

What was the legislative charge?

- If a milestone was not met, research:
  - all feasible alternatives to Vermont Health Connect, including a transition to a federally supported State-based marketplace (SSBM) for implementation in CY 2017
- We looked at:
  - alternatives for both the individual and small group marketplaces
  - impacts on Vermont's Medicaid program
  - feasibility of maintaining Vermont Premium Assistance and Vermont Cost Sharing Reduction
  - impacts on Vermonters who access coverage through Medicaid or the insurance marketplace

Options	
Regional Exchange	• Not feasible for 2017; • A multi-state governance process with willing other state partners would be challenging to implement in a timely fashion • Extensive state legislation & policy changes are required to align Medicaid eligibility, insurance regulation, Exchange process, rate review & other regulatory processes • For example, Vermont has a merged individual and small group market. Only Massachusetts has merged the markets of the NE states • Lose leverage to promote Blueprint for Health participation and payment reform • Vermont has greater small business enrollment than other states & thus may be expected to pay a larger percentage of expenses for that population

Use federal technology	• On-going Exchange operating expense is not substantial
	• Substantial transition & operations costs for Medicaid
	• High level of confusion for mixed households & those with VPA/CSR
	• Requires separate eligibility system for VPA/VSCR
	• Re-enrollment into federal system required
	• 2017 enrollment presents a timing risk
	• Requires modification of rate review timeline &/or process
	• Reduced ability to pursue comprehensive Section 1332 waiver
	  • No state specific modifications of federal technology, so waiving eligibility or enrollment components is not feasible
	• Limited data available from the federal government
	  • Restricts information available for policy & planning
	• Vermont call center performance is better than the federal government's

Options	
Purchase new technology	• Policy changes likely necessary • Transition and operations cost for Medicaid, but may be less disruptive than using federal technology • High level of confusion for mixed households & those with VPA/VCSR • May require separate eligibility system for VPA/VSCR • If customizable, requires additional financial investment • More costly than finishing VHC • 2017 enrollment presents a timing risk

Hawaii

Individual Market Tech Costs	$2-$2.5 million
Decommissioning Costs	Procuring a data archival solution with bids ranging $3.5 to $7 million
Medicaid Tech Costs	$21 million (updated 2/2016)
Gap Analysis	Completed. Medicaid components implemented in 3 phases.
Amount Spent Pre-Switch	$120-$130 million
Identified Issues	Re-enrollment on FFM; no state access to data in FFM; families in mixed plans having trouble *New 2/2016*: Not all Medicaid enrollments from FFM are automated.
Other Costs	$4 million for navigators/assistors
Call Center	No access to federal accounts presents challenge for mixed households
Other	Pursing Sec. 1332 SHOP waiver to maintain pre-ACA business insurance mandate

Maryland

Individual Market Tech Costs	$45 million for both individual market & MAGI Medicaid, development costs
Decommissioning Costs	Unknown
Medicaid Tech Costs	$5-$10 million to connect to Fed Technology + $40-$50 million to build MAGI Medicaid tech
Gap Analysis	Analyzed options for moving from SBM to FFM, other state technology, brand new system from scratch
Amount Spent Pre-Switch	$72M, settled lawsuit with original (fired) vendor for $45M
Identified Issues	DDI continuing to fix things that didn't work well in CT technology when code was frozen.
Call Center	Interviewee didn’t have information

Nevada

Individual Market Tech Costs	$10M DDI to switch; total around $18M plus $7M to upgrade call center
Decommissioning Costs	$27,544.28 for IRS data. Nevada reported needing to store 3 TB of data (Vermont's data, by comparison, is about 100TB of data)
Medicaid Tech Costs	$25 million
Gap Analysis	1) fix original system - costs were unknown; 2) SBM using fed platform 3) Using the CT system - $50-60M; 4) FFM - Medicaid costs per above.
Amount Spent Pre-Switch	$50-60M total; $18M on Exchange DDI
Identified Issues	Insufficient data & reporting from the FFM; when customers have a problem, limited ability for state to get feds to fix the issue. No information on appeals. New federal user fee is too much for them to maintain this option. Considering switch back to SBM.
Other Costs	$2-3M Outreach
Call Center	$300-$400K/year. Can only facilitate b/c they do not have

Oregon

Individual Market Tech Costs	Ongoing costs to maintain data for 7 years - $200-400,000/year. Budget not received in time for report
Decommissioning Costs	Oregon came in with $1-5M as their bid range. For vendors who are unfamiliar with their system, their bids came in $3-5M range, because that vendor would need to learn the system. They estimate M&O on the archived data to be around $200,000
Medicaid Tech Costs	$62M
Gap Analysis Description	$10M gap analysis for reusability (included in above)
Amount Spent Pre-Switch	Spent $300M on Oracle technology, which never went live
Identified Issues	KY code was transferred in. They needed to change some Medicaid eligibility rules but picked KY because rules were very similar to begin with. They had trouble with CMS data files for awhile - they didn't have staff with right skills and had to hire. New federal user fee is an issue. RFP out to consider SBM.
Other Costs	Outreach and Educ $1M
Call Center	400 temp positions to handle paper processing

Kentucky – interview being scheduled

Individual Market System Description	Gov. Bevin announced he is dismantling Kynect in 2017. Unclear which federal option is being pursued from public news reports.
Decommissioning Costs	Reports estimate $23 million to dismantle
Amount Spent Pre-Switch	$28 million annual budget for Kynect

Transition Costs for Alternative Technology

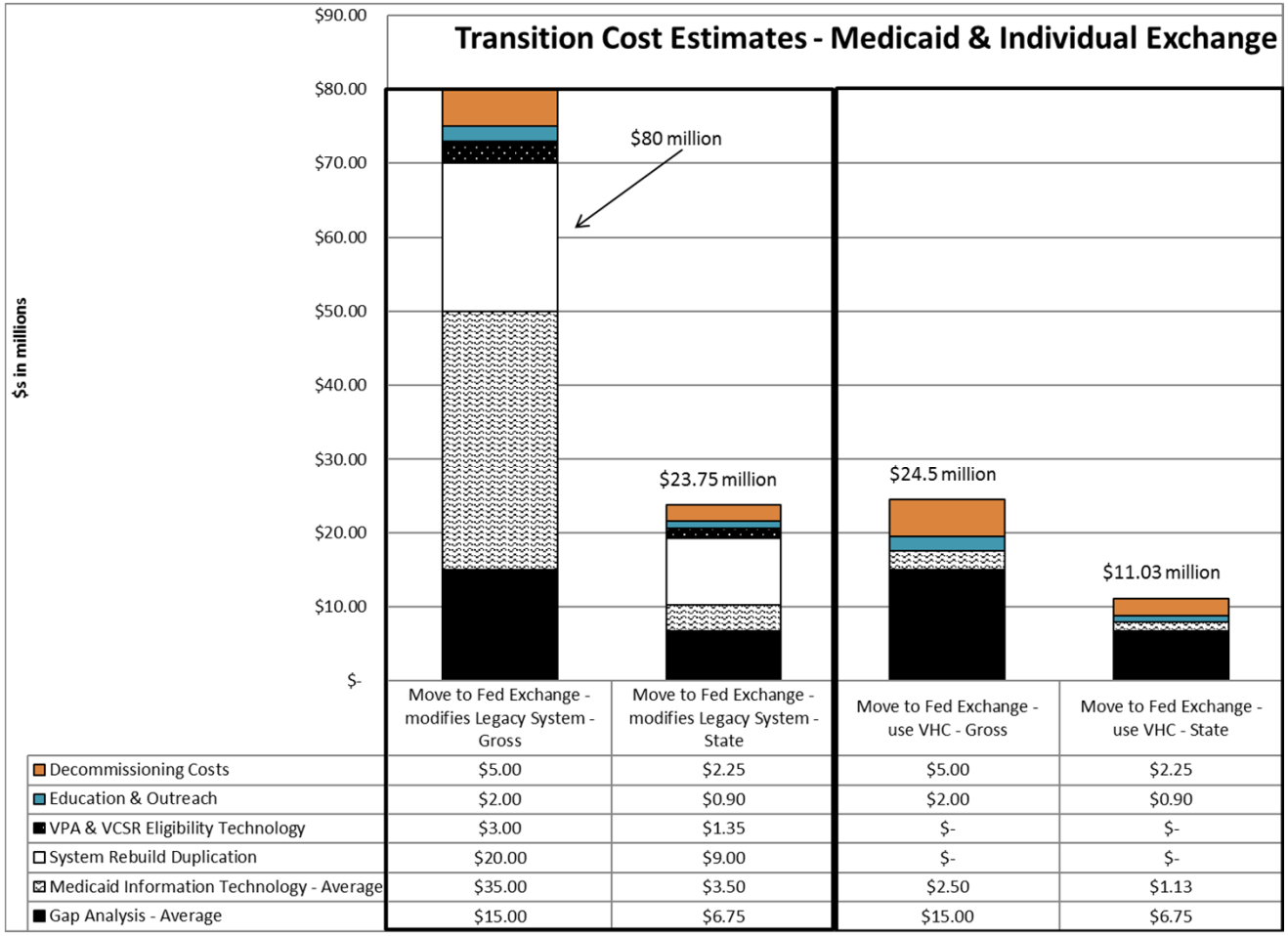
- Functional Gap Analysis
  - Required by CMMI to determine whether some technology is re-usable and how it compares to new technology
- Medicaid information technology:
  - Federal Exchange – Medicaid requirements
    - Account transfers from federal technology
    - Website & on-line portal for enrollment now required
    - Screening tool to send people to the right place (FFM or state Medicaid)
    - Need to finish VHC technology to use for MAGI
    - VPA/VCSR would need a separate eligibility system & would require customers to sign up in both systems. System would need to be developed.
  - Other State Exchange:
    - Depends on other state's technology
    - Would likely require modification to Vermont's Medicaid rules
    - Will not have Vermont Premium Assistance/Cost Sharing Reduction capability, so would need to build this
- Carrier Integration & costs will vary depending on capability, likely not large cost
- Education and Outreach to Vermonters:
  - Vermonters will have to reapply to the federal exchange
- Decommissioning Costs
  - Requires archive solution for data, IT systems
  - May also require running parallel systems for 12 to 15 months; this cost is not reflected
  - Must meet IRS & CMS requirements
  - Estimates based on current procurements in other states
  - No state has completed this yet

Operation Costs for Using Alternative Technology

- Federal User Fee
  - 3.5% of gross premiums for FFM
  - Draft federal rules received November 20, 2015 suggest that user fee for SSBM states will be 3.0%. This is not yet final.
- Call Center costs remain for Medicaid & VPA/VCSR
  - Other FFM states reported some increases to Medicaid call centers due to people mistakenly calling the state for federal issues
  - Households with someone covered by Medicaid, Dr. Dynasaur or VPA/VCSR would need to use both federal & state call centers
  - High level of confusion expected for mixed households
- Technology costs remain for Medicaid & VPA/VCSR
- Decommissioning Costs
  - 10 year cost for storing IRS and Exchange data
  - CMS requires ability to pull/change information from the system
  - Does not reflect costs of running parallel systems during transition for 12-15 monhts

Transition Costs by Type

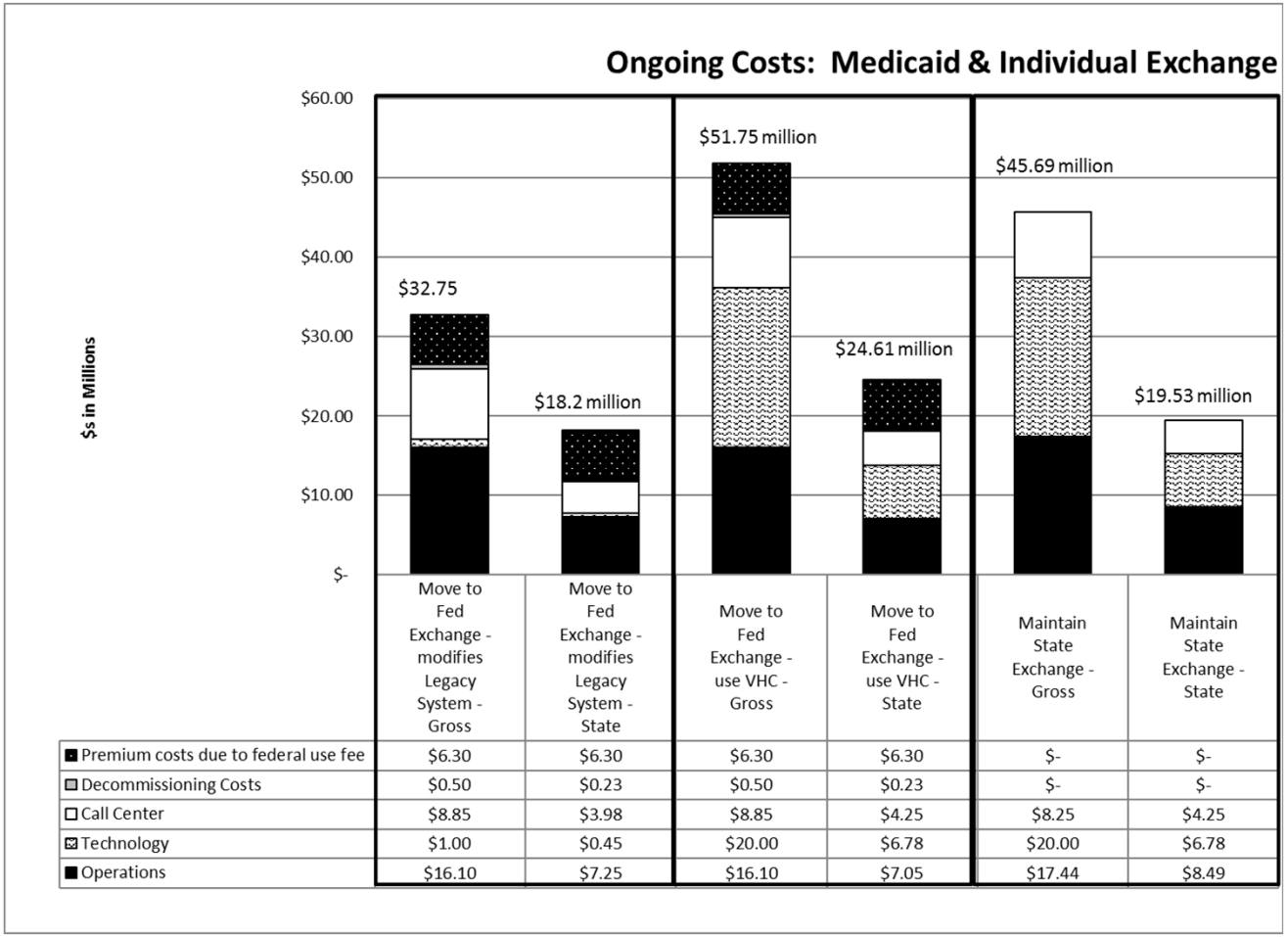
VHC v. Using Federal Technology (in Millions)



	Move to Fed Exchange - modifies Legacy System - Gross	Move to Fed Exchange - modifies Legacy System - State	Move to Fed Exchange - use VHC - Gross	Move to Fed Exchange - use VHC - State
Decommissioning Costs	$5.00	$2.25	$5.00	$2.25
Education & Outreach	$2.00	$0.90	$2.00	$0.90
VPA & VCSR Eligibility Technology	$3.00	$1.35	$-	$-
System Rebuild Duplication	$20.00	$9.00	$-	$-
Medicaid Information Technology - Average	$35.00	$3.50	$2.50	$1.13
Gap Analysis - Average	$15.00	$6.75	$15.00	$6.75

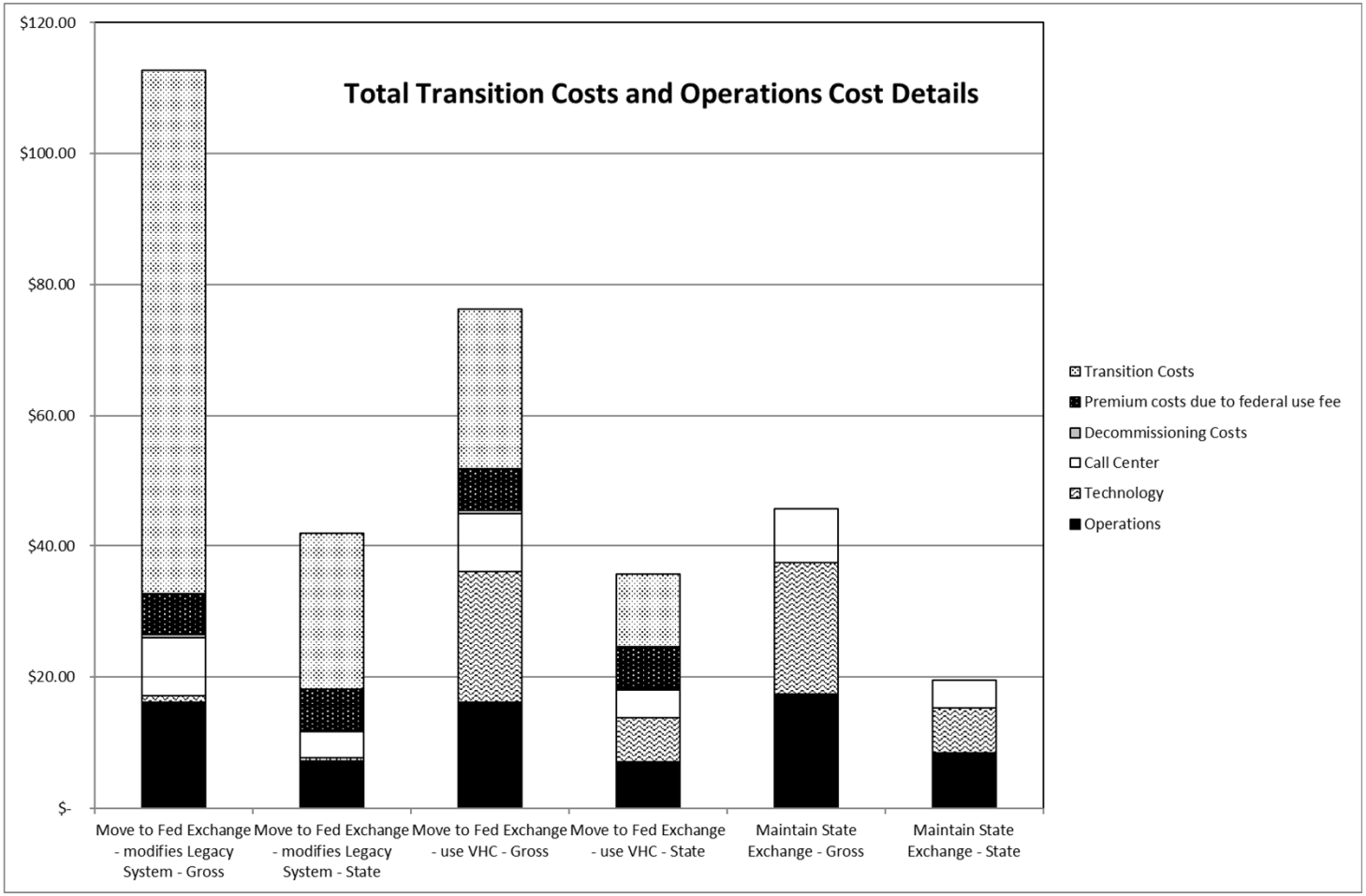
Operating Costs By Type

VHC v. Using Federal Technology (in Millions)



	Move to Fed Exchange - modifies Legacy System - Gross	Move to Fed Exchange - modifies Legacy System - State	Move to Fed Exchange - use VHC - Gross	Move to Fed Exchange - use VHC - State	Maintain State Exchange - Gross	Maintain State Exchange - State
Premium costs due to federal use fee	$6.30	$6.30	$6.30	$6.30	$-	$-
Decommissioning Costs	$0.50	$0.23	$0.50	$0.23	$-	$-
Call Center	$8.85	$3.98	$8.85	$4.25	$8.25	$4.25
Technology	$1.00	$0.45	$20.00	$6.78	$20.00	$6.78
Operations	$16.10	$7.25	$16.10	$7.05	$17.44	$8.49

Total Cost Comparison By Type:
VHC v. Using Federal Technology (in Millions)



Total Cost Comparison By Funding Sources:
VHC v. Using Federal Technology (in Millions)