



Vermont Health Connect: Exchange Options for 2017

An Assessment of the Alternatives

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Table of Contents

Executive Summary	3
Introduction & Legislative Charge	5
Research Methodology & Assumptions	7
Regional Exchange.....	11
Individual Marketplace, Medicaid, & Vermont Affordability Programs.....	13
Vermont’s Affordability Programs – Feasibility Analysis.....	35
Small Business Exchange	45
Conclusion	52

Executive Summary

The general assembly directed the Secretary of Administration and the Chief of Health Care Reform to identify “all feasible alternatives to Vermont Health Connect, including a transition to a federally supported State-based marketplace” (SSBM). This report explores the alternatives for both the individual and small group marketplaces, and analyzes the impacts on Vermont’s Medicaid program, insurers, and Vermonters who access coverage through Medicaid or the insurance marketplace. The legislation anticipates that pursuing an alternative, after review by the Joint Fiscal Committee and the Health Reform Oversight Committee, would begin in December 2015 for implementation for the Fall 2016 open enrollment period for insurance plan year 2017.

After completing the research and analysis of current information technology partners, application developers who have been successful in other states, and various federal solutions, the Secretary and the Chief recommend:

- Completing Vermont Health Connect for MAGI Medicaid and the individual marketplace, because there is an unacceptable risk of failure in moving to another solution, due to the cost and complexity of such a transition and the currently improved status of Vermont Health Connect’s technology
- For the small business marketplace, using a two-pronged approach:
 - Request a 1332 waiver to continue using direct enrollment for the small business exchange indefinitely.
 - At the same time, conduct a Simplified Bid Process to solicit bids from 3 – 5 prequalified vendors who have deployed SHOP solutions successfully in other states as a contingency if Vermont fails to receive a 1332 waiver.

A summary of the options are included in the following Table:

Table 1. Summary of Recommendation and Options

	Current VHC IT Functions		Small Business Marketplace (SHOP)
Options	MAGI Medicaid	Individual Market	Small Business Market
<i>Regional Exchange</i>	Not feasible for 2017; Requires regional interest, governance, and substantial policy changes to align with other states.		
<i>Use federal technology</i>	<ul style="list-style-type: none"> 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 system for VPA/CSR Re-enrollment into federal system required 2017 enrollment presents a timing risk 		<ul style="list-style-type: none"> Use of federal technology only for small businesses is not feasible for 2017 Substantial policy changes required
<i>Purchase new technology</i>	<ul style="list-style-type: none"> Policy changes likely necessary Transition and operations costs for Medicaid, but may be less disruptive than using federal technology High level of confusion for mixed households & those with VPA/CSR Requires separate eligibility system for VPA/CSR If customizable, requires additional financial investment 		<ul style="list-style-type: none"> Recommended above

<p><i>Complete Vermont Health Connect technology</i></p>	<ul style="list-style-type: none"> • Recommended above 	<ul style="list-style-type: none"> • Completing last version of VHC small business technology has substantial cost • High level of complexity & risk
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The administration’s recommendation is to complete the Vermont Health Connect technology for the individual marketplace and Medicaid. This approach is the least costly approach, when considering both the operations and transitional costs, maintains the state’s integration across health care programs, minimizes costs to Medicaid, ensures the continuation of Vermont’s affordability program, and provides for the least disruption for consumers. For the small business exchange, the best approach would be to pursue a waiver while also pursuing a modified procurement process for a commercial off the shelf product.

Introduction & Legislative Charge

Section C.106.3 of Act 58 of 2015 directs the Secretary of Administration and the Chief of Health Care Reform to research and analyze potential alternatives to Vermont Health Connect and make a recommendation to the Joint Fiscal Committee at its November meeting. This analysis was completed with the assistance of staff at the Agency of Administration’s Office of Health Care Reform, the Agency of Human Services Central Office, and the Department of Vermont Health Access from both the Medicaid and Vermont Health Connect divisions.

Sec. C.106.3 requires that the report include the following analysis:

- (1) the outcome of *King v. Burwell*, Docket No. 14-114 (U.S. Supreme Court), relating to whether federal advance premium tax credits will be available to reduce the cost of health insurance provided through a federally facilitated exchange, and the likely impacts on Vermont individuals and families if the State moves to an SSBM or to another exchange model;
- (2) whether it is feasible to offer State premium and cost-sharing assistance to individuals and families purchasing qualified health plans through an SSBM or through another exchange

- model, how such assistance could be implemented, whether federal financial participation would be available through the Medicaid program, and applicable cost implications;
- (3) how the Department of Financial Regulation's and Green Mountain Care Board's regulatory authority over health insurers and qualified health plans would be affected, including the timing of health insurance rate and form review;
 - (4) any impacts on the State's other health care reform efforts, including the Blueprint for Health and payment reform initiatives;
 - (5) any available estimates of the costs attributable to a transition from a State-based exchange to an SSBM or to another exchange model; and
 - (6) whether any new developments have occurred that affect the availability of additional alternatives that would be more beneficial to Vermonters by minimizing negative effects on individuals and families enrolling in qualified health plans, reducing the financial impacts of the transition to an alternative model, lessening the administrative burden of the transition on the registered carriers, and decreasing the potential impacts on the State's health insurance regulatory framework.

At the time of passage of Act 58 (2015), the U.S. Supreme Court had not yet issued an opinion in *King v. Burwell* on whether or not eligible individuals with coverage through federal exchanges could receive federal subsidies in the form of premium tax credits and cost-sharing reductions. On June 25, 2015, the Supreme Court issued an opinion stating that eligible individuals could receive federal subsidies regardless of whether they received their coverage through a federal or state-based exchange.¹ As a result, Vermont's choice of exchange will not affect whether Vermonters receive federal subsidies and a more extensive analysis is not necessary at this time.

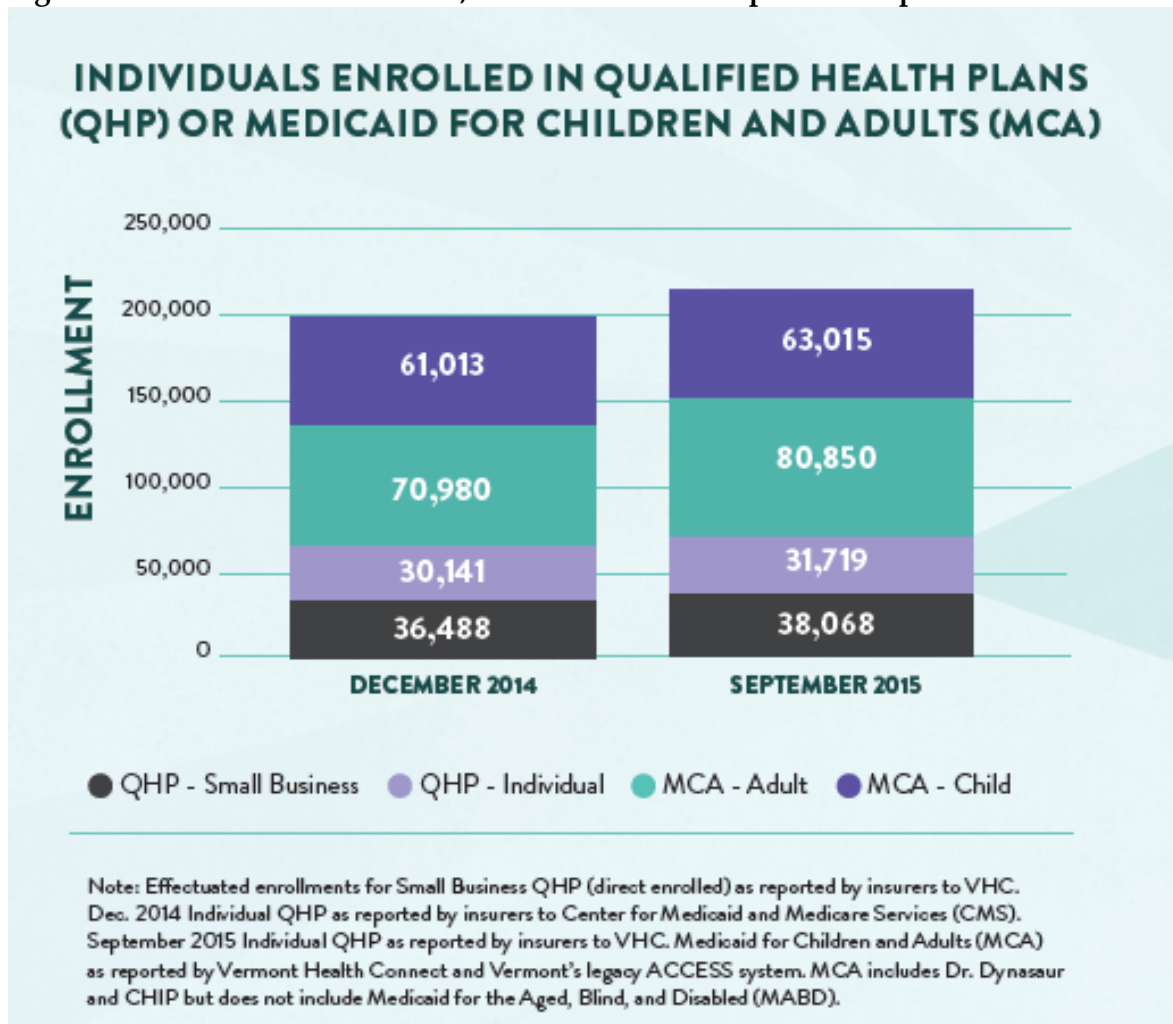
This report is organized as follows and provides the information and analysis for multiple options for both the individual and small business marketplaces:

- Research Methodology and Assumptions
- Regional Exchange
- Individual Marketplace, Medicaid, and Vermont Affordability Programs
- Small Business Marketplace

As background, the following chart provides information on how many Vermonters are enrolled in individual market QHPs and Medicaid.

¹ *King v. Burwell*, 135 S.Ct. 2480, 192 L.Ed.2d 483 (2015).

Figure 1. Enrollment Information, December 2014 Compared to September 2015



Vermont is currently operating its small business exchange through direct enrollment with the insurers. This option has been allowed by the federal government on a transitional basis, but it is technically out of compliance with the ACA. Because of this, the state has exhaustively examined the options for how to operationalize a small business exchange in this report.

Research Methodology & Assumptions

As noted in the Introduction, the team researched multiple alternatives to completing the technology for Vermont Health Connect. Any alternative would need to allow:

- Individuals to sign up for Medicaid coverage under the Modified Adjusted Gross Income (MAGI) eligibility category;
- Individuals to purchase qualified health plans (QHP) as individuals;
- Individuals to sign up for Vermont Premium Assistance (VPA) and/or Vermont Cost-Sharing Reduction (VCSR) in order to defray the costs of purchasing and using a QHP; and
- Small businesses and their employees to purchase group insurance plans.

The options researched and analyzed include the following alternatives summarized in the Table below.

Table 2. Summary of Options Analyzed

Description	Individual Marketplace (QHP)	Small Businesses Only
Use Federal Exchange Technology (with State Technology for Medicaid & Vermont Affordability Programs)	X	X
Establish a Regional Exchange	X	X
Complete a State Based Marketplace	X	Options Include: <ul style="list-style-type: none"> • Use existing vendors • Purchase a commercial off the shelf product • Seek a Section 1332 Waiver

These options were evaluated according to their expected ability to deliver an adequately tested and fully operational solution; adhere to an agreed-upon budget; deliver the solution by agreed-upon deadlines; minimize state legislation or other policy changes required; maintain the Vermont Premium

Assistance and Cost-Sharing Reduction programs; and minimize any other impacts on insurers, consumers, and health care providers. The levels of risk associated with these options were also considered.

The team interviewed officials from states which had transitioned from a state based marketplace to *either* the federal exchange technology or to another state’s technology. We spoke with officials in four states.

Table 3. Summary of States Interviewed

State	Description of Exchange
Hawaii	<p>Transitioning to a Supported State Based Marketplace for Individual Market (in process)</p> <p>Small businesses are directly enrolling with Kaiser for 2016; Seeking 1332 waiver for 2017</p>
Maryland	<p>State Based Marketplace for Individuals (purchased and modified Connecticut’s technology)</p> <p>State directly contracted with 3 third party administrators to run their SHOP</p>
Nevada	<p>Transitioned to a Supported State Based Marketplace for Individual Market</p> <p>Using own technology for small businesses</p>
Oregon	<p>Transitioning to a Supported State Based Marketplace for Individual Market</p> <p>Using a paper process for small businesses</p>

In most states, we solicited information from multiple officials due to the fact that the Exchanges in these states were not integrated with the Medicaid program, were run by different entities, and had separately budgeted for the transition from the other involved state agencies. In order to obtain a

complete picture of the transition, we performed an analysis of the impacts on Medicaid, as well as the individual marketplace.

To assess potential vendors for a commercial off the shelf software solution for small businesses, the team researched existing small businesses exchanges and created an initial list of qualified vendors. Software vendors who have not successfully stood up a small business exchange in at least one state were excluded from consideration in order to minimize the potential risk in implementing a new technology. The qualified vendors were sent a questionnaire, spanning various categories of requirements, to complete and submit for review. In order to comply with state procurement rules, the cover letter accompanying the questionnaire specifically stated that it was not a request for proposal, bid, or pricing, but rather an opportunity for the state to learn more about the capabilities of the vendor. The completed questionnaires were analyzed individually and comparatively to determine who would be considered in a subsequent bid process. A blank vendor questionnaire is provided in Appendix A, interview questions are provided in Appendix B, and summaries of the interviews with other states are provided in a chart in Appendix C.

Precise cost estimates for information technology solutions were not obtained for any of the options, because this would require a procurement process, which was premature at this time. Cost estimates and assumptions were based on the costs incurred by other states, prior VHC experience with vendors, informal estimates and comments about expected costs from vendors, and bid submissions for the Integrated Eligibility project (where applicable). All of the options require the availability of project and operations resources in order to be implemented and feasible. If the necessary internal and/or contracted personnel are not budgeted for that would, of course, impact the feasibility of all options.

Presented below are all of the options for providing health care coverage for Vermonters for the 2017 plan year. The first option, a regional Exchange, likely cannot be implemented for the 2017 plan year for either individual health care coverage or small business health care coverage. The remainder of the report presents all alternatives and recommendations for the Individual Marketplace, Medicaid, and Vermont Affordability Programs and Small Business Marketplace.

Regional Exchange

A regional exchange presents a number of attractive possibilities in theory, including operational economies of scale, increased leverage with vendors, and opportunities for sharing best practices among the participating states. However, there are a number of unknowns and risks when attempting to align policy and operations across multiple states, which would make this option time consuming to pursue and implement. It is not reasonable to expect implementation of this option by open enrollment in Fall 2016 for the 2017 plan year.

Downside considerations include the need to design and implement a governance structure that meets the needs of participating states while equitably distributing expenses, coordinating diverse states' procurement practices and regulations, and addressing competing political and budgetary priorities within tight timeframes.

Per federal regulations (45 CFR §155.140), a regional Exchange must meet the following requirements:

A State may participate in a regional Exchange if:

- the Exchange spans two or more states, regardless of whether the states are contiguous
- the regional Exchange submits a single Exchange Blueprint and is approved to operate consistent with federal regulations

Each regional or subsidiary Exchange must:

- Otherwise meet the federal requirements of an Exchange
- Meet the following standards for SHOP:
 - Perform the functions of a SHOP for its service area in accordance with federal regulations;
 - Encompass a geographic area that matches the combined geographic areas of the individual market Exchanges established to serve the same set of states establishing the regional SHOP

Because of the federal requirements, a regional exchange would need to have consistent policy frameworks, common insurance rate review timelines, common insurance premium tiers, and the ability to agree on benefit frameworks in order to be able to use the same technology. In addition, the

state would need to find one or more states willing to participate and potentially modify their policies and procedures.

- **Pros:**

- There are potential cost savings through consolidating management, staff, IT systems, and supporting infrastructure (e.g., marketing and financial/administrative functions).
- There likely are economies of scale available through joint purchasing of products and outsourced services (e.g., software licenses, call centers, premium processing).
- States would increase the opportunities for sharing best practices and lessons learned.
- Vermont would have the ability to adopt IT systems from other states with proven performance capabilities.

- **Cons:**

- Transition to a regional SHOP exchange will require a formal, regional Exchange Blueprint, to be approved by CMS in time to be fully tested and operational for the 2017 plan year open enrollment period. Lead time for such an exercise likely would exceed 12 months.
- All states would have to agree on a funding formula for distributing costs between states. Most states have enacted a fee on each plan to fund their exchanges, which has been rejected by the Vermont legislature in past sessions due to the increased costs for consumers.
- If implemented for small businesses only, Vermont may be expected to shoulder a disproportionate percentage of expenses, based on enrollment numbers. For example, VT small group enrollment is ~32x that of CT; more than CA and NY – the #2 and #3 small business exchanges in size – combined.
- This option may require modifications to Vermont insurance statutes and regulations; in particular, a regional exchange is likely incompatible with Vermont's merged individual and small group market.
- All participating states may have to use same software and systems integrator (SI). This may entail using different SI and/or premium processors for individual and Medicaid systems if the regional exchange does not incorporate individual exchange, small business exchange, and Medicaid.
- It is unclear how MAGI Medicaid would be handled in the regional exchange; therefore, impacts on mixed households are unclear.
- It is unlikely that Vermont Premium Assistance and Cost-Sharing Reduction could be implemented in a regional individual exchange, unless Massachusetts was the other state. Only MA has state premium assistance offered to those purchasing QHPs.

- If a regional exchange does not cover the individual exchange and Medicaid as well as small businesses, eligibility and verification processes will require cross-platform coordination or two separate processes.
- This option requires coordination of state procurement regulations and government decision-making bodies for all contracts, budgets, and allocations of cost overruns or outsourcing to an independent entity.
- Tight time frame for implementation means policy decisions must be expedited by all parties participating in the regional exchange.
- There is little time available to design and staff a regional governing body.
- Cost allocation policies must be drafted and agreed upon prior to negotiating any contracts.
- Opportunities for change and innovation may be restricted by competing political and budgetary priorities.
- States that have considered this approach (CO, DE, KY, MA, MD, RI, WV) have concluded the obstacles to implementation outweigh the theoretical benefits; no regional exchanges have been established to date.
- This option requires state statutory modifications.
- This option impedes a state's ability to seek a Section 1332 of the ACA waiver in the future, because the regional technology will not be easy to change and likely is not customizable.

Given the number of unknowns and risks for planning and implementing a regional exchange, it is not reasonable to expect implementation of this option by open enrollment in Fall 2016 for the 2017 plan year.

Individual Marketplace, Medicaid, & Vermont Affordability Programs

This section analyzes options for operating an individual marketplace, including using the federal technology, purchasing another state's technology, and completing the Vermont Health Connect technology. It also analyzes the impacts on Medicaid and Vermont's affordability programs, Vermont Premium Assistance and Cost-Sharing Reduction.

Option A: Using the Federal Technology

Overview and General Considerations

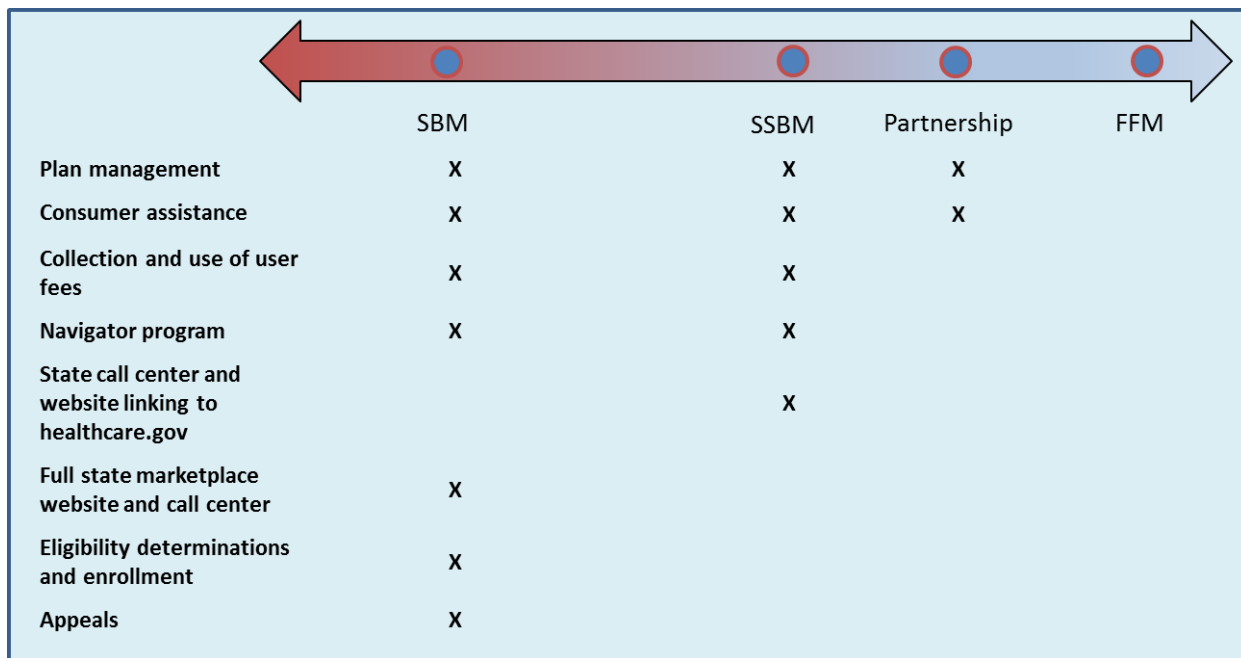
The Federal Marketplace offers several different insurance marketplace models for consideration:

- the Federally Facilitated Marketplace/Exchange (FFM/FFE)
- the Federally-Supported State-Based Marketplace (SSBM)
- the State Partnership Marketplace (SPM).

The primary difference between the models is the type and extent of insurance marketplace activities performed by the state. For example, a state using the FFM does not retain plan management functions, such as insurance premium rate review and insurance plan design. In all other types, this function is retained by the state.

The following chart² summarizes the *insurance marketplace* functions performed by the state in each model. Please note that the chart does not include Medicaid functions.

Figure 2. Insurance Marketplace Functions by Type of Marketplace



The team did the most extensive analysis of the impacts of moving to the SSBM, because this model uses the federal technology, but maximizes the state’s ability to continue insurance regulation, cost-containment and health care reform activities. Integration with the Medicaid program is extremely limited when using the federal technology, but there is more ability to integrate some components with

² This chart was created by the National Governor’s Association and is used with permission.

an SSBM. The SSBM model is relatively new and the federal government has not yet issued guidance on how this model is to be governed and priced. This information is expected from CMS within the next several months. The model, however, is used or underway in four states,³ with others considering this approach. The reasons for using this approach are:

1. Desire to maintain control of key functional areas:
 - a. Call center services
 - b. Plan management
 - c. Assister programs (including Navigators and Brokers)
2. Risk management

States with an SSBM are considered by CMS to have an SBM and are responsible for performing all marketplace functions, except that each state will rely on the federal IT platform.

State Insurance Regulation and Health Care Reform Considerations

Under the SSBM, Vermont would continue to review policy forms and rate filings as part of its qualified health plan (QHP) certification process; however, Vermont would have to align its process with the federal process.⁴ This would likely make the regulatory timeline much more aggressive for insurance carriers and may require insurance carriers to duplicate their efforts. According to the federal timeline for 2016 plans, the state's rate review and QHP certification process needs to be completed by May 15, 2015. On Vermont's timeline, the rate review and QHP certification process was completed by August 21, 2015. In order to use the federal technology, Vermont would have to either move back the rate review process by approximately three months or pursue a shorter process than is currently provided for in statute and the Green Mountain Care Board's (GMCB) rate review. This could mean that the insurance rates would be more disconnected from the hospital budget process, thus reducing the regulatory effectiveness of the GMCB. In addition, pushing up Vermont's process by

³ At this time, SSBM states are HI, NM, NV, and OR. HI is in the process of transitioning to this model, shutting down its SBM by the end of 2015, and running both the individual exchange and SHOP on the federal IT platform next year. NM runs SHOP as an SBM, with the individual exchange using the SSBM model on the federal platform. NV is an SSBM that uses HealthCare.gov for both its individual and SHOP exchanges. Oregon currently uses direct enrollment for SHOP (as does VT); it will transition to an SSBM model to support SHOP using the federal IT platform for eligibility and enrollment in 2016. Oregon's individual exchange has already transitioned to the federal IT platform. Idaho began as an SSBM, but recently transitioned from an SSBM to using its own technology.

⁴Department of Health & Human Services, Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight (CCIIO), "FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces," Feb. 20, 2015, <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf>

several months will likely make it difficult for insurance carriers to set accurate rates and may result in a reduction in public participation in Vermont’s current process in order to meet a more aggressive timeline.

Medicaid – General Considerations

In all models, the state is required to operate the Medicaid program, including eligibility for the “new adult” population established by the ACA. This population is eligible for Medicaid due to income, which is calculated using modified adjusted gross income (MAGI).⁵ The federal technology provides an assessment of Medicaid MAGI eligibility when the consumer goes to HealthCare.gov in order to determine whether the individual should be re-routed to the state for enrollment in Medicaid or whether the individual is eligible for an individual marketplace insurance plan. For states using the federal technology, there are connectivity requirements for the Medicaid program that must be assessed in order to have a complete view of the financial impacts and impacts on consumers.

A state transitioning to the federal technology must consider the costs and impacts to the Medicaid program as well as to the state based exchange. While this seems obvious in Vermont, where the same Department oversees both programs, other states have not comprehensively provided this analysis all in one place. This is due to the fact that most other state based marketplaces are governed by a non-governmental Board, not the same agencies as the state Medicaid program. This section includes information about impacts to both programs, as well as impacts on insurance regulation, cost-containment and other health care reform activities. There are three categories of costs analyzed: transition costs, operational costs, and other financial risks. Transition costs include one-time costs for moving to the SSBM, such as new information technology costs and outreach costs. Operational costs include the on-going costs of operating the different systems. Estimated costs of moving to the Federal Exchange are discussed in more depth below and a complete spreadsheet is provided in Appendix D, *Summary of Estimated Financial Impacts*.

Enrollment and Eligibility Considerations

If Vermont transitioned to the SSBM for its individual marketplace, Vermonters would access coverage for insurance products through HealthCare.gov. Vermonters who are eligible for Medicaid or Dr. Dynasaur would access coverage for these programs through the state’s information technology system. If a family included parents buying a qualified health plan (QHP) and children eligible for Dr. Dynasaur, the family would need to enroll through HealthCare.gov for the QHP and with the state for Dr. Dynasaur. If the parents started at HealthCare.gov, they would be able to enroll in a plan and

⁵ Unlike other eligibility groups, the ACA established eligibility for this group based on income without requiring an additional characteristic, such as a disability or age. This is similar to the criteria Vermont had previously established for the Vermont Health Access Program (VHAP).

access the advance premium tax credits and cost-sharing reductions for themselves but then would be referred to the state for Dr. Dynasaur enrollment. As discussed in depth later in this section, if the parents were eligible for a Vermont premium assistance or cost-sharing reduction, they would apply for those programs separately with the state.

The federal government will not modify HealthCare.gov for state-specific parameters. This is why mixed households (those with both Medicaid and QHP eligibility) would need to use two distinct systems to enroll their family. This would also mean that they would receive customer service from two different call centers if they had trouble with their coverage.

The inability to customize the federal technology also impacts the ability of a state to seek a Section 1332 waiver. While Section 1332 technically allows states to modify all parameters of an individual marketplace, if the state does not have the ability to modify operations for eligibility and enrollment, the state in essence is unable to waive or change those legal requirements. Using the federal technology, therefore, hinders Vermont from seeking a waiver in the future to establish Green Mountain Care, or other type of universal and unified coverage program.

In addition, the federal government will not accept state enrollment data, so in order to transition to HealthCare.gov, approximately 32,760 Vermonters currently in QHPs would have to re-enroll directly through the federal website.⁶ The state would need to invest in an extensive outreach and education campaign in order to ensure that these Vermonters understood the requirement to re-enroll at HealthCare.gov. Considering the level of confusion with the implementation of the ACA, the team recommends investing a similar level of funds as was appropriated with initial implementation, about \$2 million.

Furthermore, there is risk as to how well the federal technology would function with Vermont's Medicaid program. According to a recent report from the Government Accountability Office, seven states using the federal marketplace technology "could not transfer applications for health insurance coverage between their state Medicaid systems and the federal data services hub or had not completed testing or certification of these functions."⁷ These are new functions that the state would need to build and are discussed in the next section.

Medicaid Technology Requirements

⁶ Currently, the state has a re-enrollment methodology, which allows individuals to remain enrolled in the same product as the default. This policy minimizes churn and reduces administrative hassle for consumers.

⁷ Government Accountability Office. (2015). State Health Insurance Marketplaces CMS Should Improve Oversight of State Information Technology Projects. (GAO Publication No. 15-527). Washington, D.C.: U.S. Government Printing Office, pg. 39.

There are substantial operational complications when transitioning the individual exchange to any of the three federal models described above (FFM, SPM, SSBM), many of which are related to integrating Medicaid with the federal system. Medicaid programs in states using the federal technology have specific requirements that would be new in Vermont. The state information technology would need to be adapted in order to accept accounts from HealthCare.gov, which is how the federal government refers people who go to HealthCare.gov, but are eligible for Medicaid. The state's information technology would also need to be modified in order to transfer Minimum Essential Coverage determinations to the federal government for individuals on Medicaid. Neither of these functions are required of state based exchanges, are not currently built in Vermont Health Connect, and so represent a new transition cost. Lastly, data exchanges between the federal exchange and state Medicaid programs have been problematic and cumbersome, making it difficult for states to manage Medicaid eligibility and enrollment when people access coverage through HealthCare.gov. While this interchange has improved since 2014, it is still far from smooth and often requires state staff to re-do the eligibility assessments.⁸

In addition, Vermont built an integrated system across Medicaid and its individual marketplace through Vermont Health Connect. This includes the following functions, which Medicaid would be required to continue to provide – either through VHC or through new technology:

- a website with a streamlined Medicaid application;
- MAGI eligibility determinations;
- Change of circumstance modifications for MAGI Medicaid.

There are two technology options we have considered for operating a Medicaid program with an SSBM. The first is to complete the Vermont Health Connect functionality and modify it to include the new functions for Medicaid's use moving forward. The second is to create a new eligibility pathway using the old ACCESS system for implementation in the short term while building a new pathway in the Integrated Eligibility system in the longer term. Each of these is described in the following section.

Lastly, it is virtually impossible to integrate benefits from other state-based social safety net programs with the federal exchange, which poses a potentially insurmountable challenge to the Integrated Eligibility project.

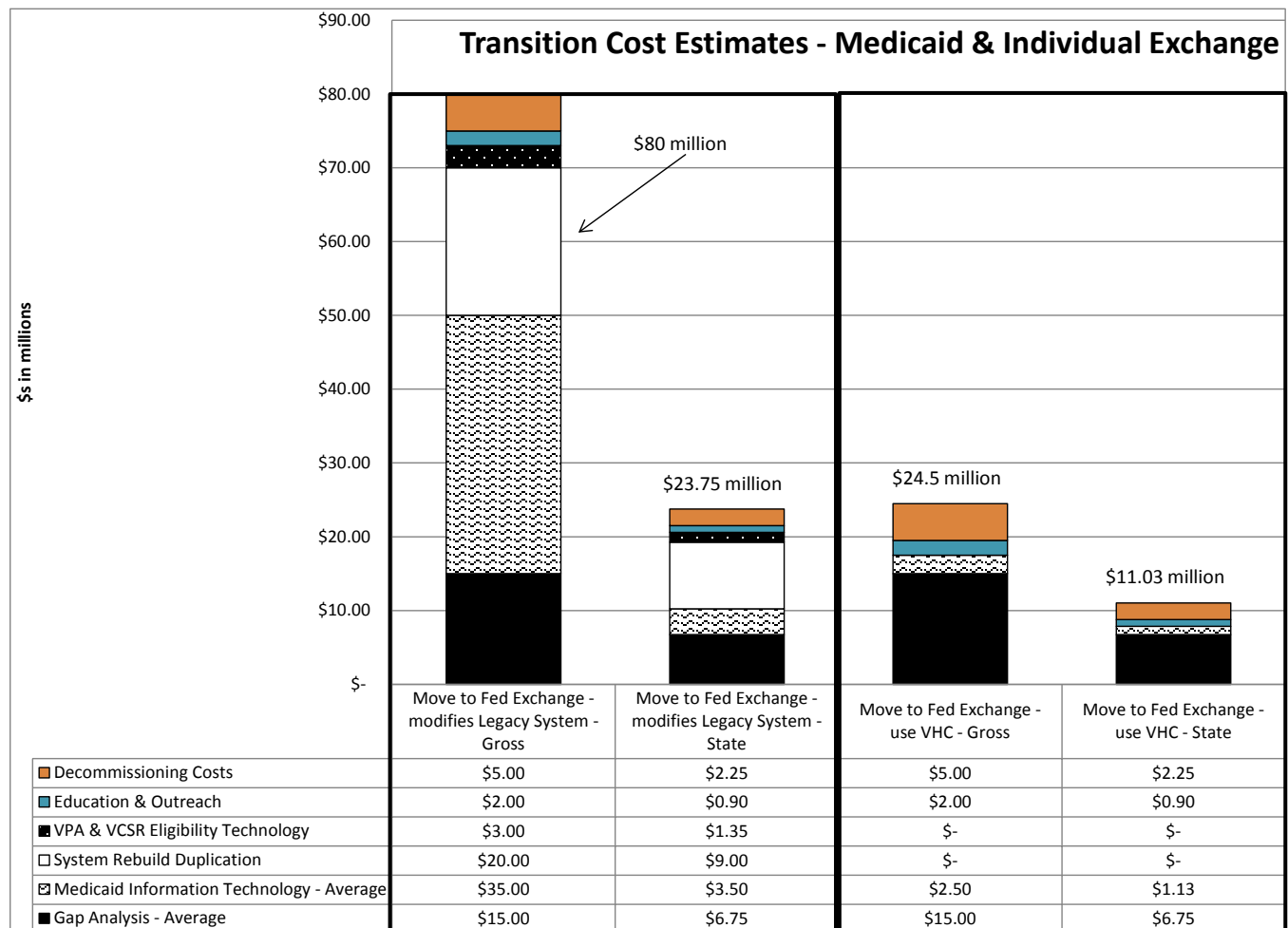
Transition Costs

There are a number of transition costs to consider if the state were to move to HealthCare.gov. These include a number of one-time or time-limited costs, such as new information technology required for

⁸ Ibid.

Medicaid to interact with HealthCare.gov, education and outreach, and re-creating the Vermont Premium Assistance eligibility system. These costs are described in more detail below. To determine the ranges, we looked at two potential ways to approach the new information technology needs: adding onto the existing Legacy system or finishing Vermont Health Connect to use for Medicaid, VPA and VCSR. The first approach – linking the new eligibility and other processes to the thirty-plus year old Legacy information system – is not desirable because this system is outdated and needs to be replaced. By building new functionality onto a system that needs to be replaced, we would be in essence planning to pay twice for the work over time. Second, we looked at completing Vermont Health Connect for Medicaid and Vermont Premium Assistance and building the new functionality onto this system. The Figure below includes a summary of these cost estimate ranges.

Figure 3. Summary of Transition Cost Estimates



CMS requires each state to complete a gap analysis for Medicaid and the CMS-approved Exchange Blueprint prior to moving from an SBM to any other type of exchange. The purpose of the gap analysis and the Blueprint are to determine whether there are information technology components that may be re-used for Medicaid, to determine what new information technology requirements are needed for Medicaid, and to determine where there are policy and operational modifications needed for either the Exchange or Medicaid programs. Based on reports from other states, these costs varied from \$10-20 million. An average is used in the above Figure.

As discussed earlier, there are two information technology costs we would incur:

- modification of information technology for Medicaid functionality; and
- creating or modifying information technology to enroll people into the Vermont Premium Assistance and Cost-Sharing Reduction programs.

As described above, we estimated the cost in two ways – adding functions to the Legacy system and completing VHC for Medicaid, VPA, and VCSR. We estimate the cost of building onto the Legacy system to be \$80 Million gross and \$23.75 Million in State funds. The incremental cost of reusing VHC, once completed, is \$24.5 Million gross and \$11 Million in State funds.

There are also costs to decommission Vermont Health Connect. We split up the decommissioning costs into one-time and on-going costs. There is an on-going cost because the state is required under federal law to maintain all data for a period of 10 years.⁹ There is extensive federal law and guidance on records and data retention, recovery, protection, and destruction.¹⁰ In essence, the state is required to have an overall IT Decommission Plan, which provides for software, documentation, and data retention archiving. Each of these archives is intended to provide sufficient stored information or software so that the system could be re-initiated and used, if needed. Simply storing the information would not meet the requirements. We estimated this cost by reviewing the current operational costs for storing information in the cloud in a secure environment, as well as reviewing information from three other states¹¹ that are in the decommissioning process. None of the states are fully compliant with the federal guidance and two are currently in procurement for an archive system, estimated to cost between \$3-5 million. More information about the information technology requirements is available from the attached CMS guidance in Appendix E.

⁹ While 10 years is admittedly time-limited, it is such a long time that we decided it made sense to include it in on-going costs as the cost would more difficult to compare to other one time transition costs and would skew those results.

¹⁰ See CMS' State-based Marketplace (SBM) IT Decommission and Data Retention Planning guidance, See Appendix E.

¹¹ The states are Nevada, Oregon and Hawaii.

Providing education and outreach to Vermonters about the transition to minimize confusion and ensure enrollment in HealthCare.gov is a transition cost and is estimated at \$2 million gross or \$900,000 in general fund.¹² We developed this estimate by reviewing the initial outreach and education amounts spent for the initial roll-out of Vermont Health Connect. We used this cost estimate, because all Vermonters currently enrolled in individual market QHPs through the VHC technology – 32,761 – would need to re-enroll through HealthCare.gov. The consequences of failing to provide sufficient education and outreach could be Vermonters inadvertently losing coverage because they did not complete the re-enrollment process. In addition, navigators and application assistors would need to be re-trained on HealthCare.gov’s information technology system, the federal call center, how to escalate cases federally, federal appeals process, and how to distinguish when a Vermonter needed to apply through HealthCare.gov versus the state’s eligibility system or both.

Lastly, there are operational costs to transition as well. These include running concurrent systems (state and HealthCare.gov) for 12-18 months, which is federally required during the transition. *This cost is not included in the above chart*, because it is difficult to illustrate in an apples to apples comparison.

Operational Cost Comparisons

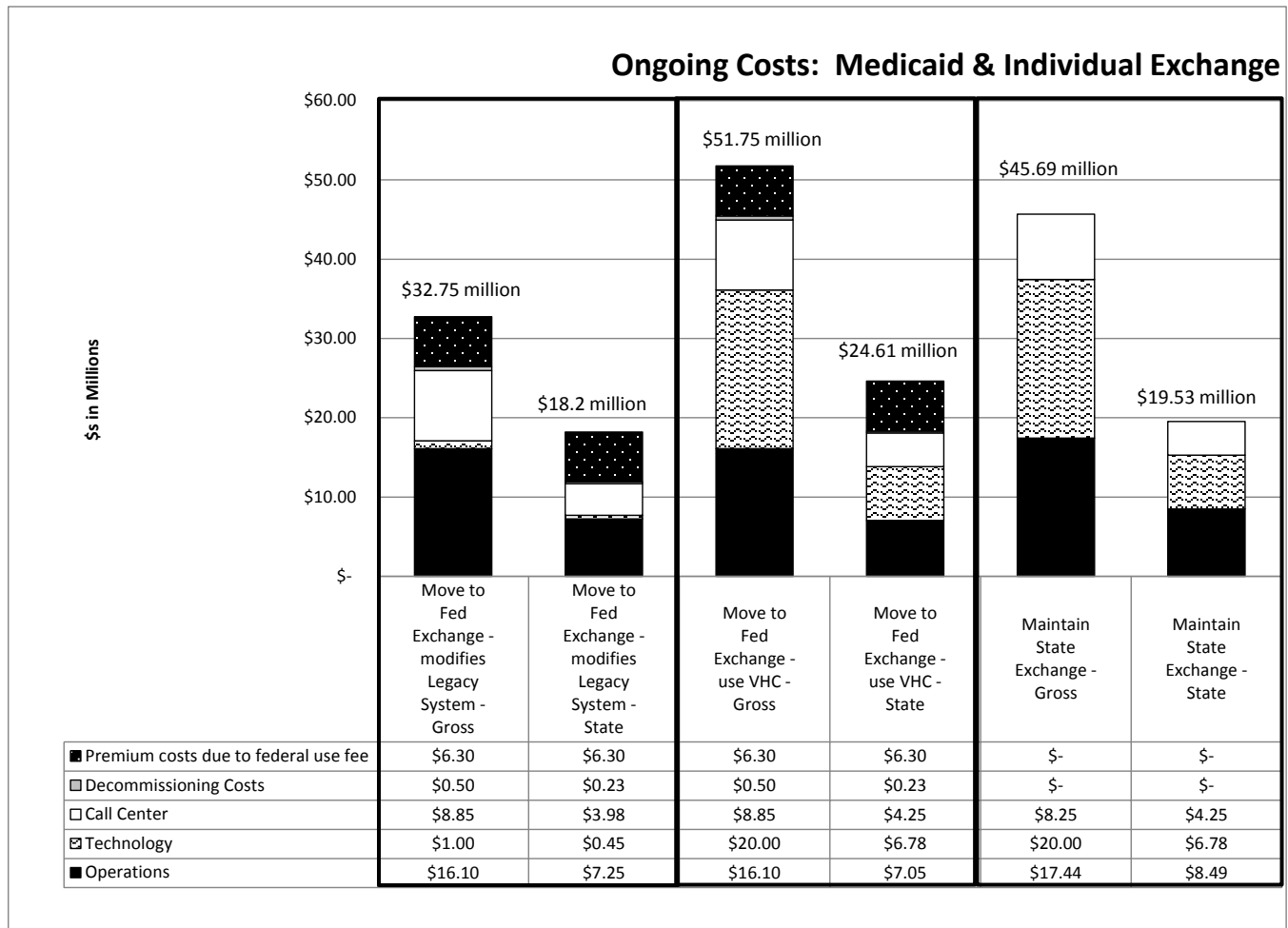
This section of the report compares the on-going costs of operating both Medicaid and Exchange functions under three scenarios:

- Maintaining Vermont Health Connect for the individual marketplace, Medicaid, VPA, and VCSR;
- Moving the individual marketplace to HealthCare.gov as a supported state based marketplace and using the Legacy system for Medicaid, VPA, and VCSR; and
- Moving the individual marketplace to HealthCare.gov as a supported state based marketplace and using the VHC system for Medicaid, VPA, and VCSR

The state would incur higher cumulative operating costs using the federal platform than VHC does at present, as there are incremental costs to support Medicaid, VPA, VSCR, as well as the added expense of using the federal system. The Figure below illustrates the cost estimates, each of which are described in more detail below.

¹² These costs are included in the totals above.

Figure 4. Summary of On-Going Operational Cost Estimates



There are several categories of costs which are impacted regardless of which system is used. These include call center costs, information technology maintenance costs, and overall operations costs. There are two additional costs associated with moving the federal technology, which include decommissioning costs and the federal user fee.

For all operational costs, we considered fixed costs versus costs which vary based on the population being served and adjusted accordingly. We did not decrease the overall call center costs if the state were to move to the federal technology. This is because Vermonters with family members enrolled in Vermont Premium Assistance, Vermont Cost-Sharing Reduction, Dr. Dynasaur, or Medicaid would continue to use the Vermont call center, as well as the federal call center for their QHP services. Using two call centers will increase the likelihood of confusion and increase the overall number of calls to the

call center. In addition, many states using the federal exchange report seeing an increase in their Medicaid call center costs due to people contacting the state for help, even though the state is not able to assist with HealthCare.gov problems.

As noted above, the decommissioning costs included in this section are for maintaining all data, software, and documentation in a retrievable format for a period of 10 years. We estimated this cost by reviewing the current operational costs for storing information in the cloud in a secure environment, as well as speaking with the three other states noted above. The average cost of this activity was approximately \$500,000 annually.

In addition, CMS charges a user fee when a state uses the federal technology. The fee is charged to the issuers, who then pass along the fee to consumers. This fee has been exclusively charged in FFM states to date, but CMS has indicated that they will be extending this fee to those from any state using HealthCare.gov. Draft guidance is expected this fall, but was not available at the time of submitting this report. The fee for an FFM state is currently 3.5% of gross premiums statewide, so we used this amount as it is the only available information on the fee at this time.¹³ Once the guidance is out, we will have better information with which to estimate the cost.

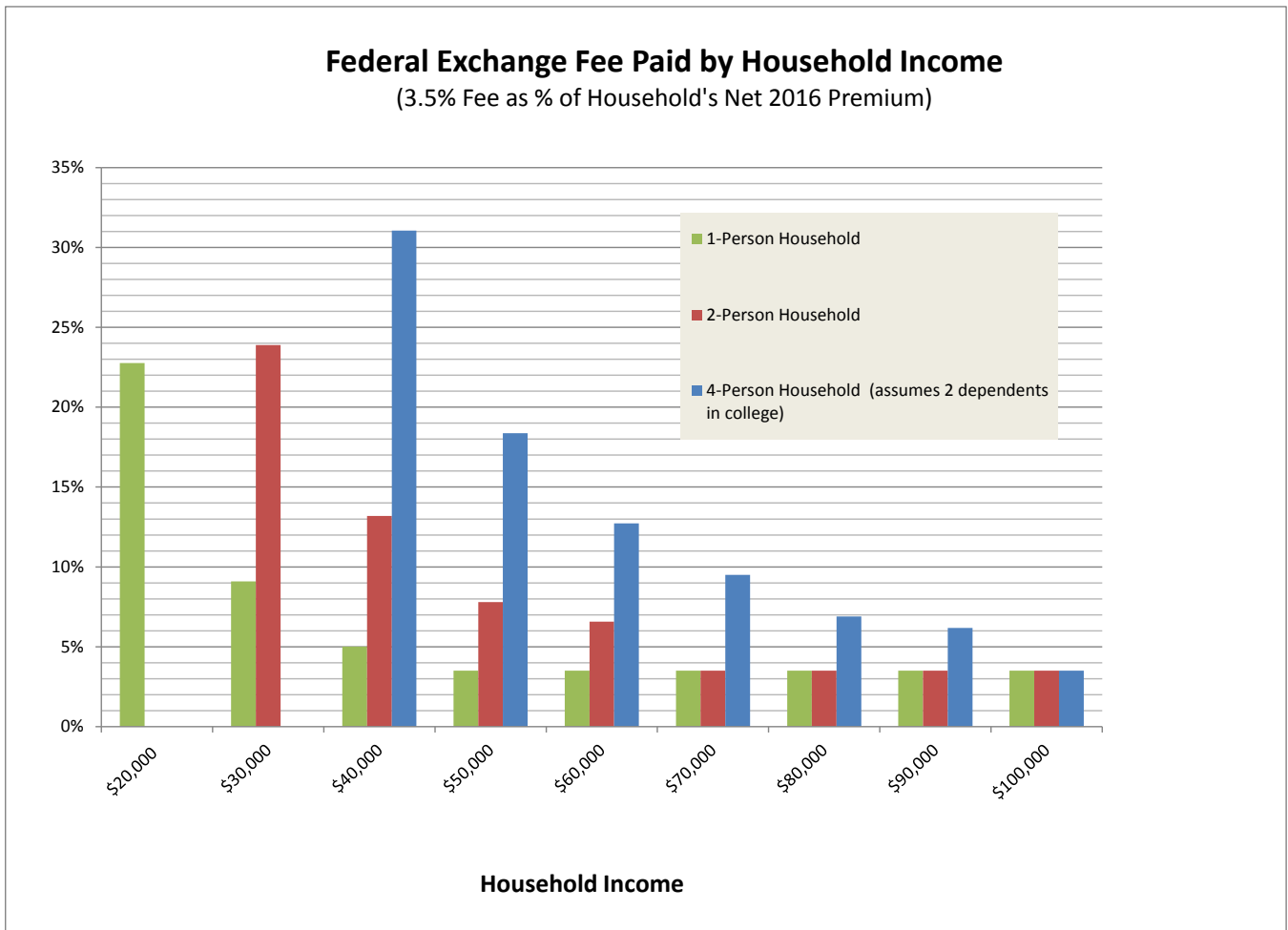
Because the federal fee is generally attached to the premium bill as a surcharge, Vermonters could directly face these usage fees and would experience them as a premium increase. Because Vermont's current policy is to reduce premiums through the VPA program, for purposes of this analysis, we have included the usage fee as a state operating cost. It is important to note that the legislature would face a policy decision about whether to absorb the cost or whether to allow premiums to be increased for Vermonters. We have estimated this cost to be approximately \$5 million, which must be paid for with all state funds as federal Medicaid funds would not be available to pay the federal fee.¹⁴

Because this fee would be applied to every premium bill, without regard to tax credits, it disproportionately impacts low-income Vermonters. In the table below, we have illustrated the impact by income level on a 2 person household. Additional examples are included in Appendix F.

¹³ In addition, there has been some discussion nationally about CMS raising this fee for FFM states. It is expected to also be included in the guidance coming out this fall.

¹⁴ This amount does not include usage fees for employees of small businesses using a federal SHOP exchange in order to keep the comparison between costs associated with the individual marketplace and Medicaid.

Figure 5. Impact of Federal Fee on Vermonters as a Percentage of Household Net Premium



It is also important to note that higher *net* premiums may also result from the potential loss of VPA and VCSR subsidies, which could not be accessed through the HealthCare.gov platform and would only be available if individuals separately pursued the program through the state. Total costs are estimated to be roughly \$18.2 to 19.4 million annually, at current plan rates. This is discussed in more depth in below.

Lastly, *while we did not include these costs in the Figure 5 above*, it is important to note that if Vermonters do not enroll in VCSR because it is a two-step process, there could be increases in bad debt to health care providers from those who are unable to pay their cost-sharing. The total VCSR is estimated at \$3.5 Million in state fiscal year 2016. It is difficult to estimate the reduction in take up in the program without actual experience, so it is unknown what the increase in bad debt might be.

Miscellaneous Financial Risks to the State

In addition to known transition and operating costs, there are potential financial risks to the state which must be noted and considered. The greatest of these is the risk of repayment of the federal grant funds. Vermont received a total of \$198 million to build a state based Exchange. To date, the federal government has not required the states moving from an SBM to the federal technology to repay the grant funds. These states, however, did not have systems which were as far along as VHC, so it is possible that the federal government will request repayment of funds.

In addition, it is important to note that the costs provided in the above section are estimates and typically averages in a range of costs. This means that the actual cost of implementing this option could be substantially different than the estimate.

Summary of Considerations

This section analyzes options for using the federal technology for the individual market while also developing state technology necessary for Medicaid and Vermont's affordability programs for premium assistance and cost-sharing reductions, which the federal technology does not support or include. There are several pros and cons of each option, which are summarized in the table below.

Table 4: Individual Exchange Using Federal Technology; Medicaid and Vermont Programs Using State Technology

Pro:	Applies to:	Legacy Upgrade Finish VHC
Stops work on VHC	X	
Does not build on an obsolete Legacy system		X
Allows continuation of Vermont affordability programs through separate state technology	X	X
Insurer costs to connect to federal technology appear minimal	X	X
Other states report satisfaction with Exchange technology ¹⁵	n/a	n/a

Cons:

Consumers need to re-enroll at HealthCare.gov		
Some families will need to enroll in two systems (Mixed QHP/Medicaid/VPA)	X	X
Some families will need to interact with two customer service centers ((Mixed QHP/Medicaid/VPA)	X	X
Less integration among health care programs and between health care and human services programs ¹⁶	X	X
Reduced ability to pursue comprehensive Section 1332 waiver	X	X
Inability to perform data analysis and report information about Vermonters in QHPs ¹⁷	X	X
Federal call center service level (wait time statistics) less favorable than VHC ¹⁸	X	X

¹⁵ Giovannelli and Lucia, “The Experiences of State-Run Insurance Marketplaces That Use HealthCare.gov” The Commonwealth Fund, September 2015.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ During the last Open Enrollment period in Fall 2014, the average wait time at Vermont Health Connect’s Customer Support Center period 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). Even in August 2015, when Vermont call

Other states report issues with federal call center ¹⁹	X	X
Operations for separate affordability programs are complicated and burdensome to families and potentially burdensome to insurers	X	X
Builds on an obsolete system & requires re-doing technology later on	X	
Increases financial risk to the state	X	
Federal User Fee must be absorbed by the state or it will increase premiums	X	X
Lack of data on individuals in QHPs from HHS limits outreach and enrollment strategies ²⁰	X	X

Option B: Purchasing or Using an Off the Shelf Product or Another State’s Technology

Several vendors and at least two states are offering solutions for SBMs’ Individual and Family Exchanges that purport to be off-the-shelf solutions.²¹ These can be summarized as:

- comprehensive lease-based plans, incorporating
 - software-as-a-service (SaaS)
 - per-member per-month (PMPM) pricing
 - hosting
 - call center support, and
 - premium processing, or
- a software purchase option
 - state provides the various required support services
- a quasi-regional, shared-platform solution

center times were up (3.1 minute average wait; with 61% of calls answered under 30 seconds), this is less than half of federal wait times from Open Enrollment.

¹⁹ Giovannelli and Lucia, “The Experiences of State-Run Insurance Marketplaces That Use HealthCare.gov” , The Commonwealth Fund, September 2015.

²⁰ Giovannelli and Lucia, “The Experiences of State-Run Insurance Marketplaces That Use HealthCare.gov” , The Commonwealth Fund, September 2015

²¹ For a detailed discussion of vendors seeking to provide SBM solutions, see *Assessing a New Option: The Feasibility of Contracting With a Single Firm to Build and Operate a State’s Marketplace*, issue brief written by Jon Kingsdale of Wakely Consulting Group, published July 2015 in *The State Reform Assistance Network*, Robert Wood Johnson Foundation.

- offers many of the cost-sharing advantages of a regional exchange
- does not require a regional management entity
- a hybrid “lean” solution that leverages HealthCare.gov for certain capabilities

Customizations may be available with some of these products, although this deviates from a true off-the-shelf solution and is likely to incur both an up-front development cost and either an increase to the PMPM cost, a negotiated maintenance and operations cost in addition to the PMPM cost, or both additional costs. Reliable pricing information cannot be obtained for either a straight commercial-off-the-shelf (COTS) solution or one involving some degree of customization without issuing a request for proposals; at this time, no states are using a COTS solution, and the states offering a similar service have no confirmed clients to date.

One state, Maryland, acquired the technology code used in Connecticut in June 2014.²² At the time Maryland obtained the technology, it was not fully complete and the cost of completing the product was assumed by Maryland, even though Connecticut was also paying to complete the product. In order to use the technology, Maryland also had to change its state policy in order to conform to the policy embedded in the technology. In addition, the technology does not provide integrated Medicaid and individual exchange eligibility and enrollment. This means that the Medicaid program has increased operational costs from manually entering data from a PDF created by the Maryland Exchange.

Comprehensive, lease-based plans

Many of the vendors seeking SBM business have no experience with the public sector, and some are primarily IT vendors with little or no experience operating either public or private exchanges. There are, however, two vendors offering “exchange in a box” solutions that have worked with SBMs. These two vendors were involved with states launching SBMs. Neither was contracted to provide a comprehensive solution; both supplied partial solutions with support services and systems integration provided by others. Although one state is currently implementing a small business solution from one of these vendors, other states originally using their solutions have purchased and extensively customized the code in house or moved to other solutions. One of the two had the misfortune to be part of an integrated solution that relied on a rules engine which performed very poorly, resulting in

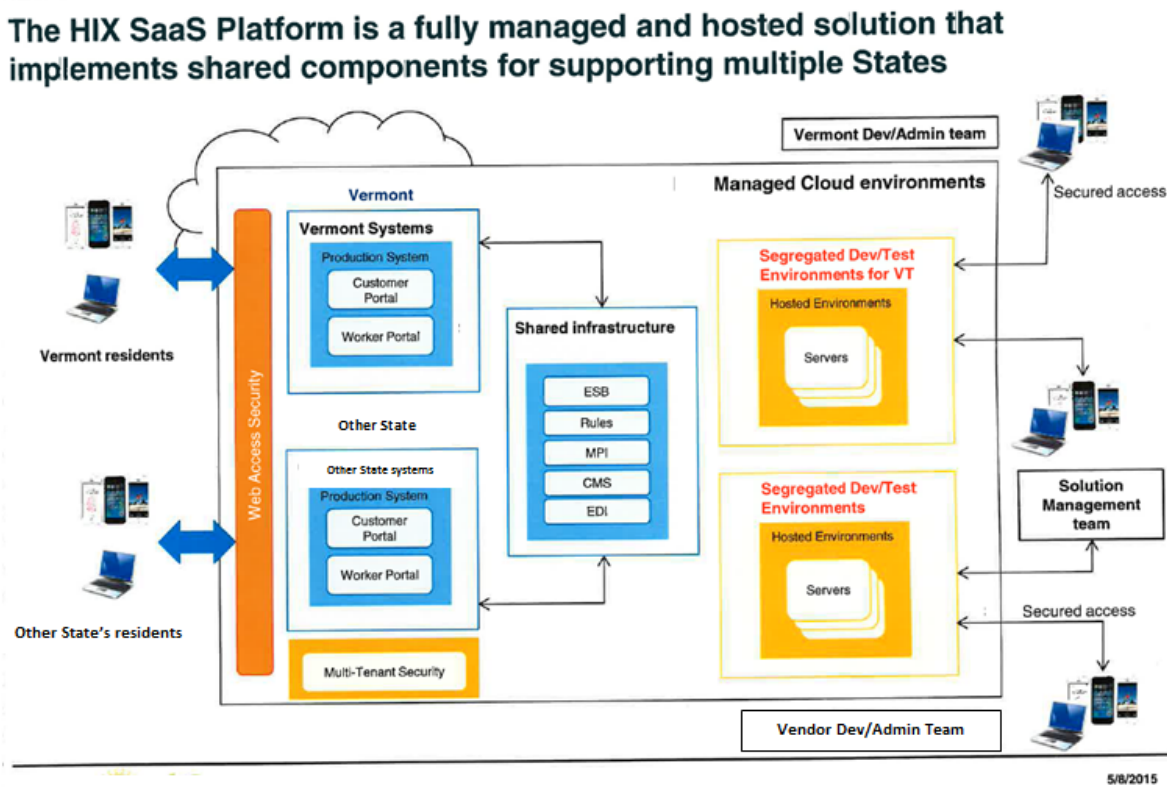
²² MD obtained the CT code at no cost, as it was developed using federal funds. MD did pay CT for training, and paid to finish the functionality.

the entire integrated solution being abandoned by the three states using it; this vendor was not the primary vendor in any of these states.

It must be noted that the solutions offered today by these two vendors have matured since their earlier solutions were adopted and abandoned by various states. Both vendors now also offer solutions for the Individual marketplace that can incorporate support for MAGI Medicaid. Given the variations in state Medicaid programs, it is unclear what degree of customization may be necessary to meet Vermont requirements.

Two states have working solutions that they now are promoting to other states. One has created a new subsidiary to provide business services to other SBMs and private sector exchanges. The other is offering to provide full support for other SBMs, using its code, IT staff and support service subcontractors.

Figure 6. Platform Architecture for one HIX SaaS Solution



Maryland acquired and implemented an earlier version of another state's code, but the solution did not include all required functionality, and MD was required to develop its own code to fill the gaps. It was also necessary to make policy changes to accommodate rules embedded in the code.

Because the code development was funded with federal grants, the code itself is available to any other state at no cost. The costs associated with these states' offerings relate to system maintenance and operations, hosting and providing call center and premium processing. Any examination of these offers will need to carefully consider what policy compromises may be implicit in adopting the service. As noted, MD found it had to make a number of policy changes when it adopted another state's code; the promotional material recently provided by one state to VT shows a shared rules engine. See Figure 6 above. While custom branding of the portal is relatively simple to provide, and some degree of configurability may be easy to implement, more fundamental policy decisions may be baked into code that cannot be customized in a cost-effective manner, if at all. In other words, to effectively implement this option, Vermont may need to substantially modify its state Medicaid and Exchange policies and refrain for future changes that vary from the technology requirements.

Vendors claim they can implement a cost-effective solution in roughly six months, but the approvals required by CMS prior to undertaking such a transition would likely make this alternative unfeasible for a 2017 plan year implementation, even if the potential software-imposed policy restrictions could be overcome or accepted. The expense of obtaining CMS approval for a transition, discussed in detail elsewhere in this report, also works against consideration of this option.

Software Purchase Option

Both vendors offering leased solutions discussed above and several others in the market offer solutions that can be purchased and hosted in-house. Purchased solutions are likely to offer greater opportunities for customization than SaaS products, but those opportunities carry greater risk and expense as well. The costs of hosting a purchased software solution, ongoing software maintenance/upgrades, call center and premium processing support must all be added to the base cost of the software purchase, as must the CMS-imposed transition approval expenses. Extensive customization may mean the software cannot be routinely upgraded by the vendor, as is the case with the current VHC implementation of Siebel, an Oracle product.

As noted earlier, most of the vendors offering these alternatives have little or no experience with the public sector, and may not have experience operating an exchange. One vendor, acting as a systems integrator, has had a solid track record of implementing SBMs, but does not offer an off-the-shelf solution – its successes have been based on state-specific projects. The lack of proven success with implementing and/or operating an off-the-shelf exchange solution suggests these vendors' offerings represent an unacceptable degree of risk and should not be given further consideration. A further negative consideration, which has caused a number of states to move away from even the moderately successful implementations of purchased code, has been that the ongoing license fees for the

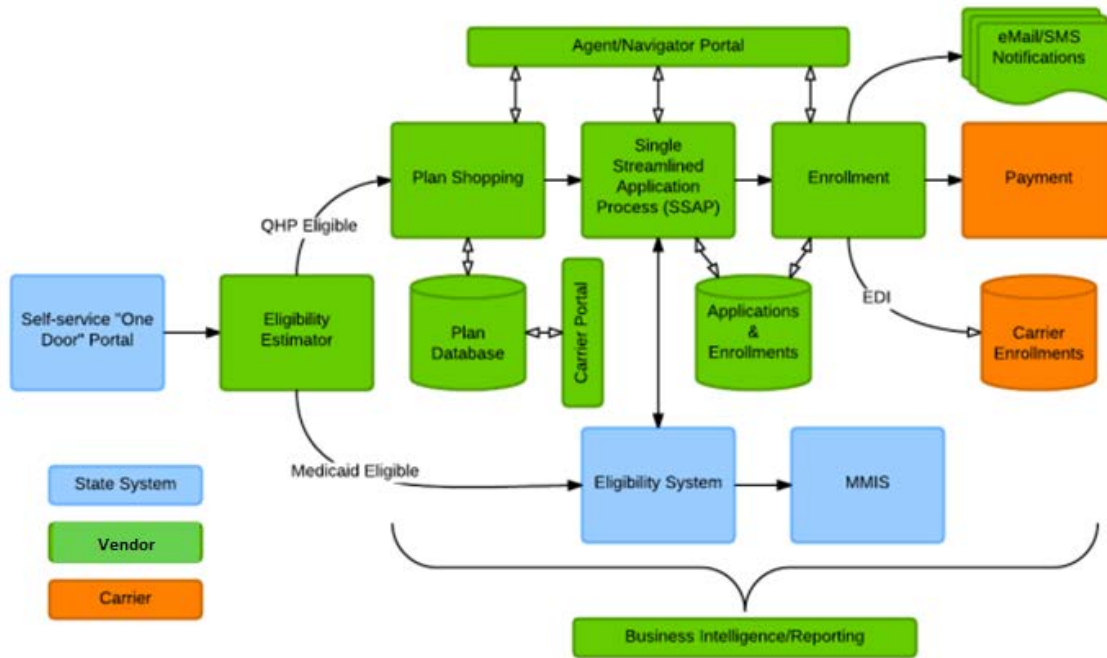
underlying proprietary software make it difficult for the exchanges to be self-sustaining while keeping plan expense at acceptable levels.

A Quasi-Regional Solution

One COTS product exploits the potential economies of scale of a regional model, without the organizational challenges inherent in that model. The product “leverages functionality and services that have already been built, approved by CMS, deployed, and used by millions for the past two years.”

As shown in the Figure below, this product provides for a state-branded front end portal. It is unclear from the marketing materials provided by the vendor whether Vermont could use an AHS-oriented “one door” portal with options for other IE programs as well as QHPs, or whether the portal is a custom-configured version of the vendor’s product restricted to QHPs alone. It is more likely the latter – restricted to QHPs. Plan data is specific to the state. Once the customer enters the required application data, eligibility for MAGI Medicaid is determined, and the customer is either routed to the shared platform or to a separate, state-provided Medicaid system.

Figure 7. A Shared HIX Platform



Call center support must be provided by the state, with limited training provided to customer service representatives by the vendor prior to system go-live. Payment processing is handled directly with the carriers, with payment information from the carriers returned to the State.

Upgrades to the system are dependent on consensus among the states using the system: “[A] state that adopts the shared HIX platform implicitly agrees to cooperate with other state customers to evolve the platform. In doing so, such a state minimizes many of its custom requirements (or such requirements that are not shared with other states).”

A consensus model may stifle future efforts at innovation by either the general assembly or the executive branch. It most certainly would foreclose the option to pursue a Section 1332 waiver that impacts eligibility or enrollment. It is also unclear whether this solution co-mingles multiple states’ data within a single database, potentially making it more difficult to acquire Vermont-specific data. Furthermore, without ownership of the data, Vermont may have limited ability to do detailed data analysis when research is required to analyze and support proposed innovations.

Although the system addresses APTC and CSR, it is uncertain how VPA and VCSR would be handled, with potential additional expense to build a parallel eligibility system for these benefits. The complications and consumer confusion such a parallel system entails have been discussed in previous

sections of this report; this solution would present similar challenges. The quasi-regional solution is not recommended for these reasons.

A Hybrid "Lean" Solution

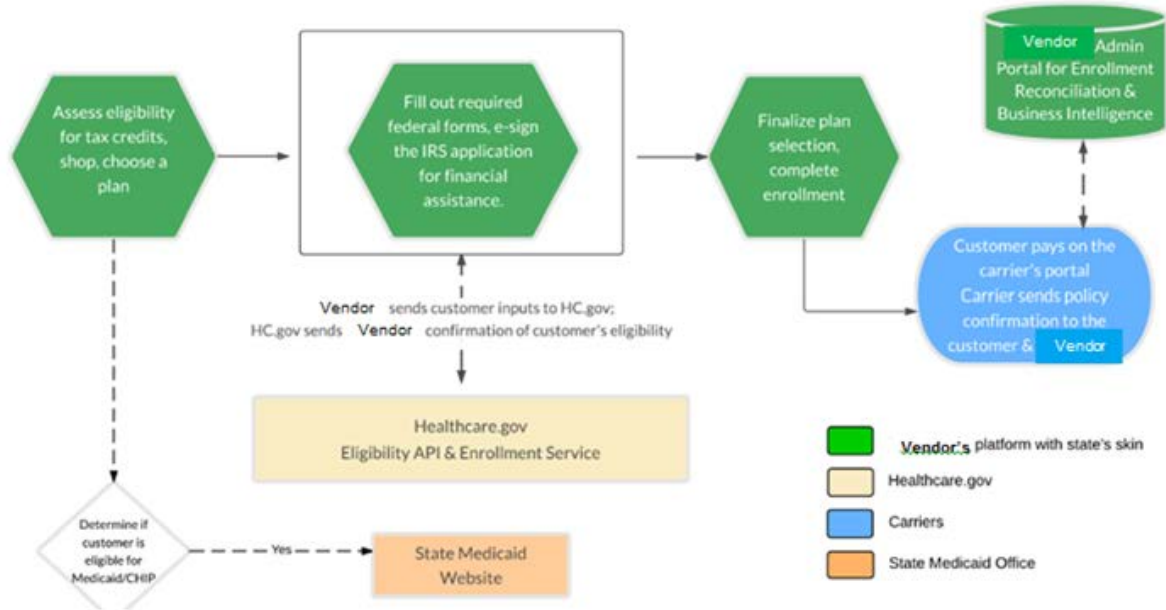
A "Lean State-Based Marketplace," anticipates supplying most exchange functionality with an off-the-shelf SaaS approach, using HealthCare.gov for eligibility and enrollment, with other functionality supplied by the State (call center, Medicaid) or by the carriers (payment processing). This solution is essentially an SSBM approach to building an exchange, with one-time configuration and set-up fees at the outset, and monthly PMPM pricing thereafter. Fees for use of HealthCare.gov have not been confirmed; see the earlier SSBM discussion regarding these fees and other concerns about the SSBM model in general.

In addition to the issues outlined in the earlier discussion, adoption of this solution presents some other concerns:

- Post-signup issues are managed by the carrier
- Enrollment and payment data reporting is reliant on the carriers
- Funding mechanism for future improvements is uncertain
- Assumes that carriers are already on the federal platform
- Ownership of customer data lies with carriers and Federal government, not with the State.

The vendor claims it can launch this solution within 60 days, and references "phase one" implementation and timing in multiple places. It does not define what may be required or supplied in any later phases, or what those phases may number, other than to say, "Subsequent improvements to a lean SBM may be (i) available at no cost, (ii) shared with other states, and/or (iii) funded through PMPM assessments."

Figure 8. Solution Architecture for Lean State-based Marketplace



This alternative is not recommended, for the same reasons as the SSBM model described earlier was rejected.

Option C: Completing Vermont Health Connect

Lastly, all of the options should be compared to completing and operating the current technology product. Completing the functionality has been a long road with many frustrations for all concerned. The current cost estimate for completing VHC is approximately \$25 Million, all of which is currently encumbered with the work underway this fall. The current cost estimates for on-going operations for VHC are as follows:

Table 5. On-Going Operations Cost Estimates for VHC

Description	Gross (in millions)	State (in millions)
Technology	\$20.00	\$6.78
Operations	\$17.44	\$8.49
Call Center	\$8.25	\$4.25

Total	\$45.69	\$19.53
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The pros and cons of this option are:

Pros:

- Maintains Vermont Premium Assistance and Cost-Sharing Reduction programs in an integrated manner with eligibility determinations, so consumers can see the net premium cost upon purchase
- Maintains Medicaid match for VPA
- Maintains integration with Medicaid programs
- Unified customer service for Vermonters
- Call center wait times are less than federal call center
- Less disruption for families renewing plans than re-enrolling through HealthCare.gov or another system
- Preserves state’s ability to pursue a 1332 waiver in the future, if desired
- Maintains state’s ability to provide data and information about enrollment
- Does not require modification to rate review process or timing

Cons:

- Potentially maintains customer and public frustration with upgrade process
- Requires completion of the technology

Vermont’s Affordability Programs – Feasibility Analysis

This section of the report provides background information on Vermont’s state premium assistance and cost-sharing reduction program, an analysis of the impacts on Vermonters if this program were discontinued, and an analysis of the two options for maintaining the program if the state were to move away from a state-based marketplace.

As a state-based marketplace, Vermont had the flexibility to establish its own affordability programs to ensure that Vermonters were not worse off by the implementation of the Affordable Care Act. As explored earlier, if the state were to use the federal information technology, there is no customization available, so the state would have to create a different way for Vermonters to apply for the existing programs. Similarly, if the state were to move to a regional exchange, customization would not be feasible as the state would need to agree on common policies with other states.

Maintaining an integrated program, where the Vermonter understands his or her premium amount net of both the Advance Premium Tax Credit and the Vermont Premium Assistance is not feasible using federal or regional technology. It is possible to re-create VPA and CSR as a separate program with separate enrollment. This approach, however, will be confusing to people, provide information in a disjointed way, and will have many challenges for consumers desiring to access the program.

Background: VHAP and Catamount Health set the standard for affordable health care

Vermont has a history of reducing the number of uninsured residents through providing affordable health care coverage. When the Affordable Care Act (ACA) was passed, Vermont maintained its affordability standard under the VHAP and Catamount Health programs by adding state subsidies in addition to the ACA subsidies through its state-based exchange, Vermont Health Connect.

The Affordable Care Act introduced premium and cost-sharing subsidies to make coverage more affordable for many Americans. However, these subsidies did not go far enough for the 11,000 Vermonters who already had an affordable health care plan through the Vermont Health Access Plan (VHAP) and Catamount Health, programs that Vermont had in place for several years before the ACA.

With the VHAP program, Vermont used its Global Commitment Medicaid waiver to extend Medicaid to childless adults with household income up to 150% federal poverty level (FPL) and adults with children with household income up to 185% FPL. Vermonters who participated in the program paid premiums ranging from \$7 to \$49 per month and minimal out of pocket costs.

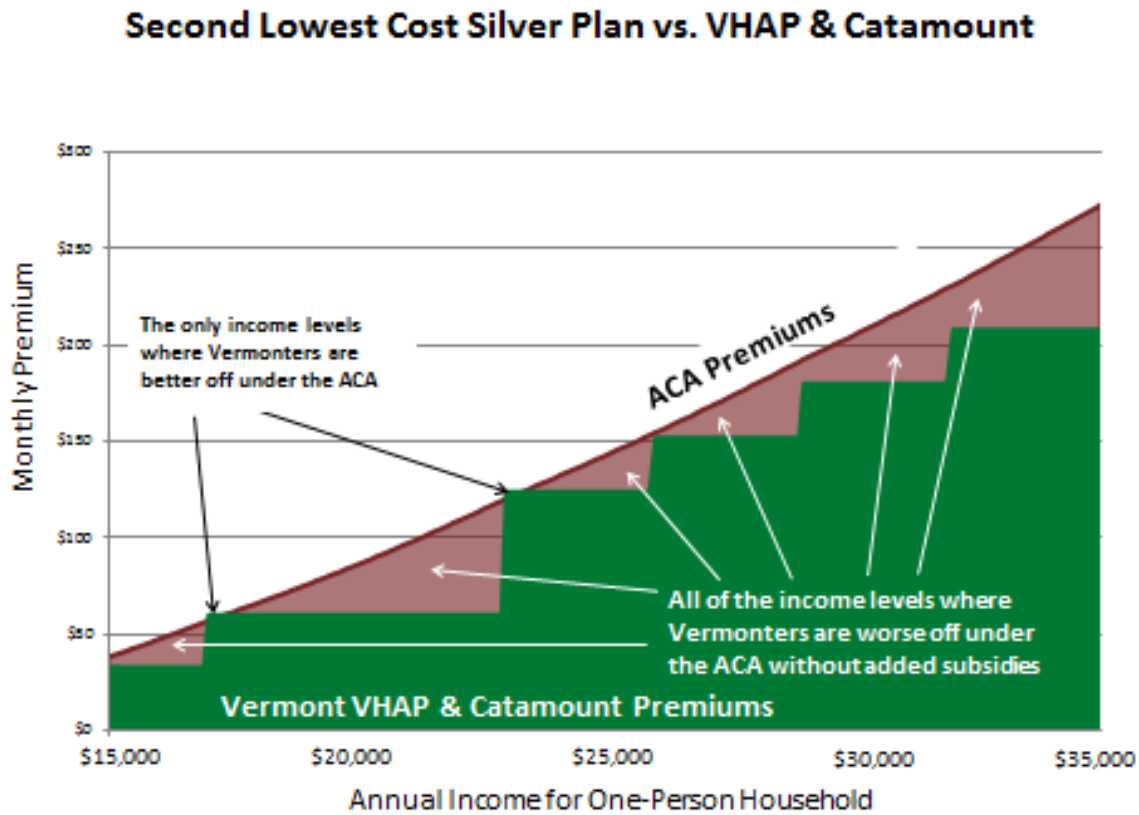
Under Catamount Health, the State of Vermont partnered with Blue Cross Blue Shield and MVP to offer a health care plan with low out of pocket costs for all uninsured Vermonters. The Catamount Health deductible was \$500 per year with an out of pocket maximum of \$1050, regardless of income. For premiums, Vermonters with incomes below 300% (FPL) paid an income-sensitive premium of \$60 to \$208 per month for an individual, and the state of Vermont made up the difference in cost with the insurance companies. These subsidized premiums were also funded in part by the federal government through Vermont's Global Commitment Medicaid waiver.

ACA Premium Tax Credits

VHAP and Catamount Health provided income-sensitive premium subsidies based on discrete income ranges. The ACA provided premium tax credits based on a percentage of income that was a near-linear progression for individuals and families under 300% FPL. This was an improvement on Vermont's programs because it eliminated affordability "cliffs." Unfortunately, the progressive percentages used by the ACA created an affordability curve that was less affordable than the premiums under VHAP and Catamount Health. See Figure below. At the same time, VHAP and Catamount

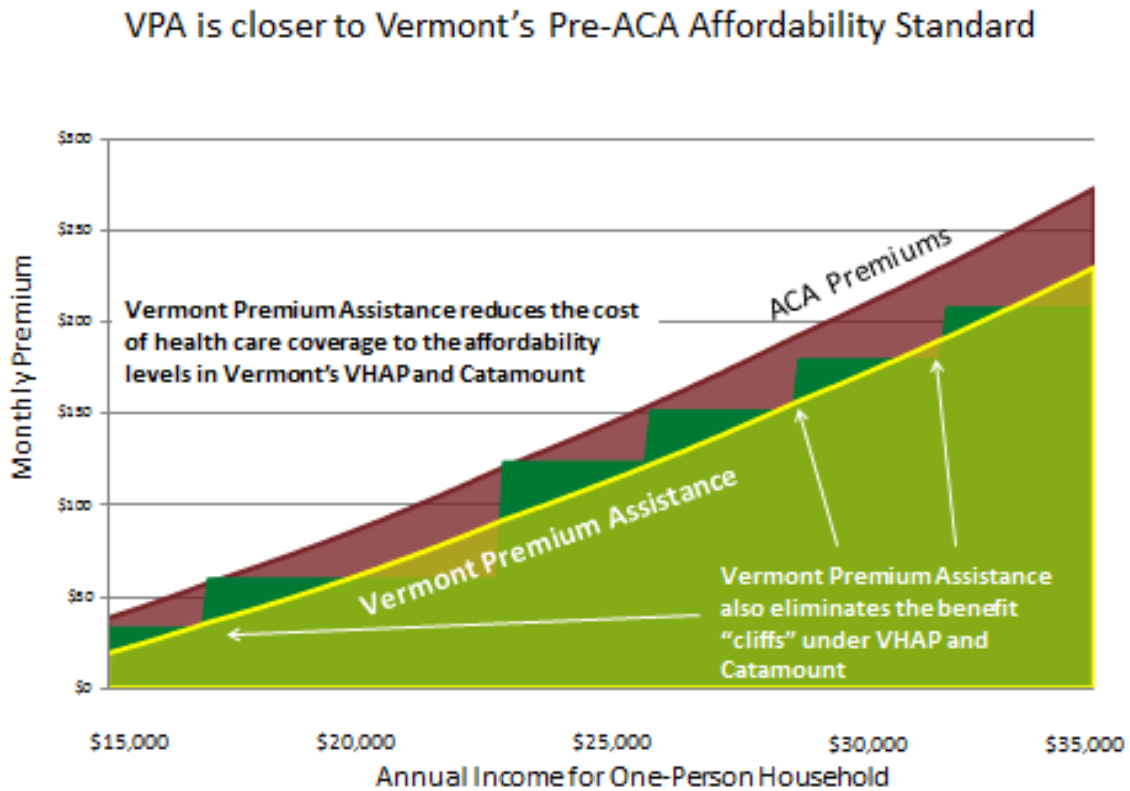
Health did not fit within ACA requirements and would end in 2014. As a result, if Vermont failed to add additional subsidies, virtually all Vermonters would pay more for subsidized ACA premiums than they did with VHAP and Catamount Health.

Figure 9. Affordability Comparison: ACA with VHAP & Catamount



To avoid Vermonters having to pay more under the Affordable Care Act, the State further subsidized the ACA premium tax credits by lowering the progressive percentage of income under the ACA by 1.5%. This put the affordability for health care premiums closer to what it was under VHAP and Catamount Health while maintaining the fairness of the ACA’s progressive percentage of income. See Figure below. These premium subsidies are currently calculated through Vermont Health Connect and the payment is sent through Vermont Health Connect’s premium processor. The Vermont premium subsidies are funded in part by the federal government through Vermont’s Global Commitment Medicaid waiver.

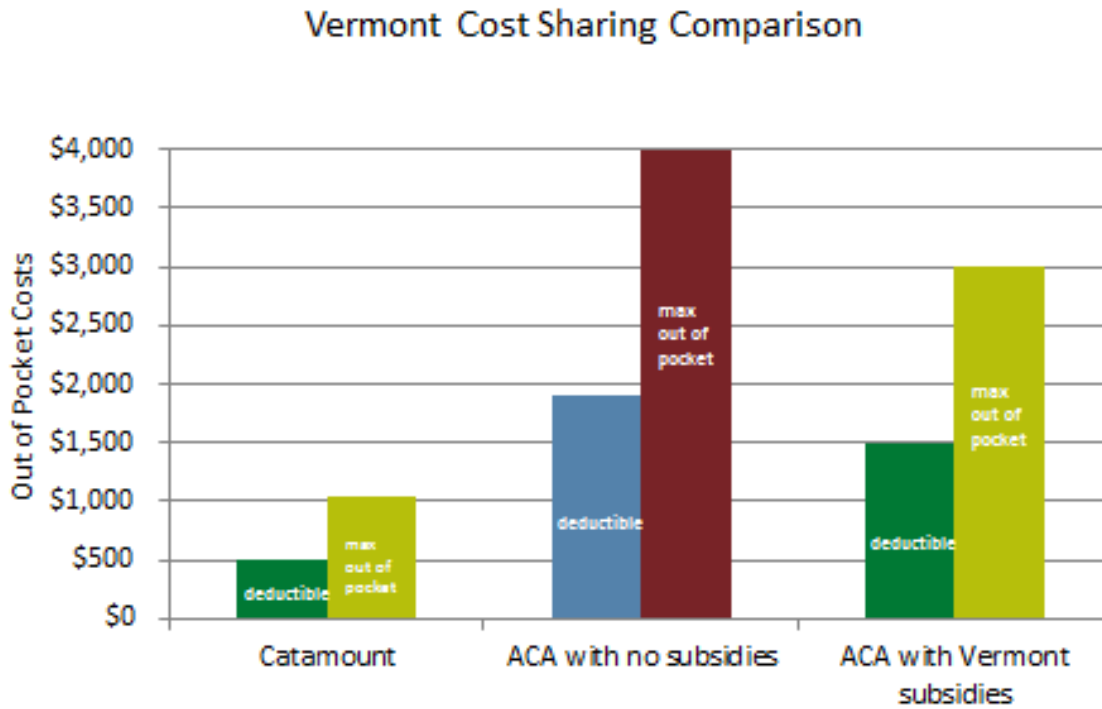
Figure 10. Affordability Comparison: VPA with VHAP & Catamount Premiums



ACA Cost-Sharing Reductions

In addition to less affordable premiums, the ACA subsidies also failed to match out of pocket costs compared to the VHAP and Catamount Health programs. The VHAP program had almost no out of pocket costs and Catamount Health had an 87% actuarial value (AV). Under the ACA, Vermonters in the 200-250% FPL range would have a silver plan with a 73% AV, and anyone above 250% FPL would receive no assistance towards out of pocket costs. This created a significant increase in potential out of pocket costs for anyone above 200% FPL. To help alleviate these increased costs, Vermont further subsidized silver plans for Vermonters with household income between 200% and 300% FPL.

Figure 11. Cost-Sharing Comparison

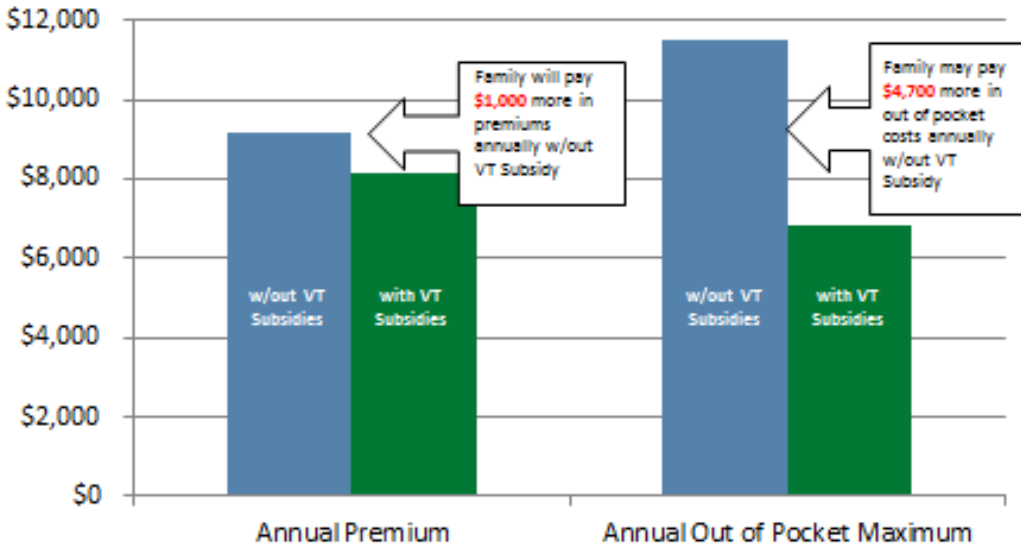


Examples of individual/family impact at different FPLs

Almost 16,000, or over 50% of enrolled Vermonters, receive a Vermont subsidy through Vermont Health Connect. Without Vermont subsidies, an individual making about \$34,000 per year will have to pay over \$500 in increased premiums per year and could have increased out of pocket medical costs of \$2,350. A family of four making about \$70,000 per year will pay over \$1,000 in increased premium per year and could have increased out of pocket cost medical costs of \$4,700.

Figure 12. Impacts on a Family of 4

Comparison: Family of 4 with income of \$70,000/year



Since the implementation of Vermont Health Connect, the uninsured rate has been cut in half. For those who continue to remain uninsured, cost is the primary reason for lack of health insurance coverage, with over 65% of those who are uninsured falling within the population currently targeted by the Vermont subsidies.²³ Without Vermont subsidies, the insured population will likely decrease due to unaffordable premiums and cost-sharing. It is difficult to estimate how creating a separate program would impact the uninsured rate, but it is reasonable to assume based on past experience with Catamount Health that requiring duplicative, separate processes will reduce enrollment in Vermont’s affordability programs, resulting in net higher premiums and increased cost-sharing. As noted above, increased cost-sharing could also have an impact on health care providers if some individuals do not pay the provider for their cost-sharing.

²³ 2014 Vermont Household Health Insurance Survey.

AHS Benefit

Vermont has offered premium subsidies in the past through Catamount Health, so it could offer subsidies again in a similar manner through AHS. The federal government will not provide AHS with eligibility data, so AHS would have to create an eligibility system that runs parallel to the federal exchange.

Pros:

- Would directly benefit Vermonters in a timely manner through monthly payments to insurers.
- Would likely not affect the Medicaid match status of the premium subsidy, because the federal government provided matching funds through this sort of system in the past.

Cons:

- Vermonters may think their insurance premium increased substantially when buying insurance from the federal website, even if they receive a separate monthly subsidy from the state.
- Would set up a redundant eligibility system, increasing financial and administrative burden to the state.
- Would require extensive interaction and cooperation with the health insurance carriers, especially for determining cost-sharing subsidies. This would be burdensome for the insurers.
- Would be burdensome for Vermonters, who would be dealing with two different eligibility systems and customer service systems. Vermont would likely end up with more uninsured, higher premiums for those who do not enroll in VPA, and higher out of pocket costs for those who do not enroll in VCSR.

Tax Credit

If Vermont does not offer its premium and cost-sharing subsidies as a benefit through AHS, its only other option is to offer it as a state tax credit.

Advantages:

- Generally, tax credits are straightforward to administer, however, the Department of Tax is undergoing its own technology upgrade at this time.

- Would allow for reconciliation of the Vermont subsidy at the end of the year to ensure accurate distribution of the benefit.

Challenges

- Vermonters will think that their insurance increased substantially when buying from the federal website, even if they are repaid later by a tax credit.
- The value and purpose of the tax credit may be lost when it is lumped in with everything else on a tax form.
- A traditional state tax credit provided after the tax year creates a cash flow problem for Vermonters when they are paying their monthly premium and their medical out of pocket costs
 - *Solution to cash flow problem is complex.*
 - Providing the tax credit each month would require a redundant eligibility system
 - Could provide tax credit prospectively as a prebate, but no guarantee that eligible Vermonters will use the prebate on premiums
- System requires either a new tax base or a substantial change to the education property tax Household Income definition. Modified Adjusted Gross Income (MAGI), which is how the ACA calculates its premium tax credit, is not a state tax concept. Optimally, Vermont would change its property tax Household Income to align with the ACA's MAGI definition to avoid creating another tax base.
- It is unclear if Vermont would continue to receive its federal match on premium assistance if it provides premium assistance as a tax credit,²⁴ which would substantially increase the cost to the state.

Due to all of the above considerations, maintaining the current Individual Marketplace is the best way to ensure premium and cost-sharing subsidies reach Vermonters and will keep Vermont on the path to health care coverage for all of its residents.

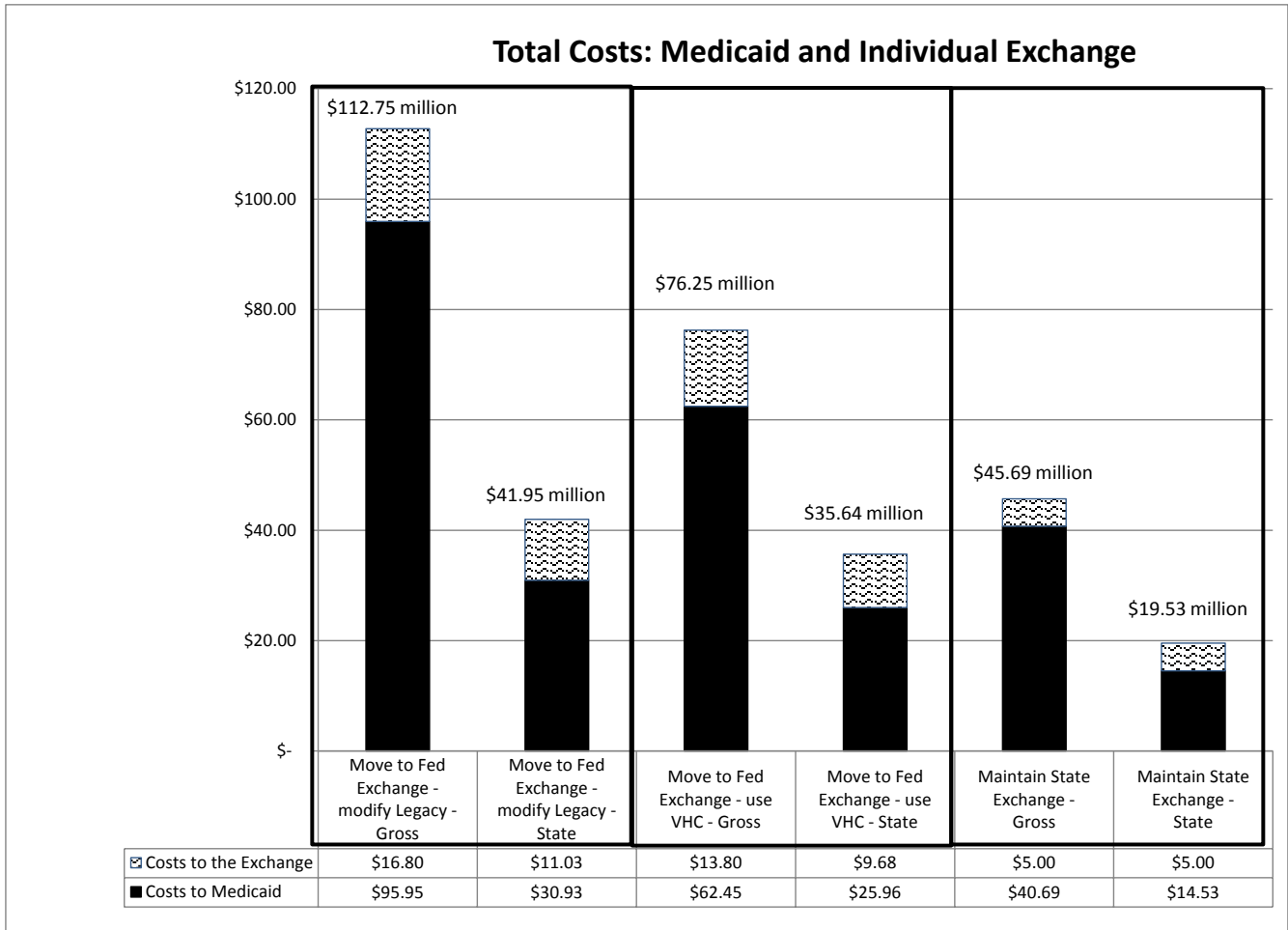
²⁴ 42 CFR § 433.51.

Recommendation

The administration's recommendation is to complete the Vermont Health Connect technology for the individual marketplace and Medicaid. This approach is the least costly approach, when considering both the operational and transitional costs, maintains the state's integration across health care programs, ensures the continuation of Vermont's affordability programs, and provides for the least disruption for consumers.

The table below compares the total costs to Medicaid and the individual market using VHC of moving to the federal technology by modifying the Legacy system, moving to the federal technology by using VHC, or completing VHC. As illustrated, the state cost of maintaining VHC is \$14.53 million, compared to \$26 to \$30.49 million.

Figure 13. Cost Comparison: Federal Technology versus Vermont Health Connect



On balance, when looking at the full range of considerations from policy to customer service to cost, completing and maintaining Vermont Health Connect is preferable to moving to another, also incomplete, technology option.

Small Business Exchange

This section of the report looks at several options for establishing a small business exchange, including using the federal technology, upgrading the current VHC technology, purchasing technology from another state or off the shelf, and seeking a waiver of the requirements to have technology supporting a small business exchange.

Option A: Transition the Small Business Exchange Using Federal Technology

Vermont is currently operating its small business exchange through direct enrollment with the insurers. This option has been allowed by the federal government on a transitional basis, but it is technically out of compliance with the ACA. Because of this, the state has exhaustively examined the options for how to operationalize a small business exchange in this report.

Under current federal law and regulation, a state-based individual exchange with a federally-run small business exchange is not allowed; however, we explored this possibility to determine whether it was operationally feasible. If it was feasible, the state could pursue this option through a waiver.

As noted earlier in this report, there are three options for using the federal technology.

In an FFM, U.S. Health & Human Services (HHS) performs all marketplace functions. Consumers in states with an FFM apply for and enroll in coverage through HealthCare.gov. States entering into a State Partnership Model (SPM) may administer specified plan management functions (recommending health plans for certification, plan oversight and monitoring), in-person consumer assistance and/or outreach and education, with HHS performing the remaining marketplace functions. See chart earlier in the report for more information. Consumers in such states apply for and enroll in coverage through HealthCare.gov. Similar to the individual market, with an SSBM, the state retains regulatory oversight while using the federal technology.

The chart below summarizes the pros and cons of moving just small businesses into the federal technology.

Table 6. Small Business Exchange Using Federal Technology: Pros and Cons

Pros:	Applies to Option:		
	FFM	SPM	SSBM
• Costs savings from eliminating marketing and financial/administrative functions	X		
• State participation in customer assistance and plan certification		X	X
• State oversight of Navigator and Assister programs			X
• Established and operational, though not evaluated for specific small business capability	X	X	X
• Transition “lessons learned” available from other states such as Hawaii	X		X

• The State maintains regulatory oversight of insurance product, minimizes policy issues, minimizes insurance rating issues			X
• Maintains more robust Customer Assistance program than FFM		X	X
• Minimize IT risks, upgrade costs, and contracting costs	X	X	X

Cons:

• Needs a waiver to implement as a stand-alone option	X	X	X
• Timing Risk - A lead time of 10 to 12 months is required to convey intent to participate	X	X	X
• A gap analysis is required prior to final CMS approval	X	X	X
• No practical contingency plan is available if CMS rejects transition request	X	X	X
• Enrollment data from prior years must be obtained from Carriers, stored in machine-readable form for ten years, and produced upon request from a Federal agency	X	X	X
• Current system must be run in parallel for first 12 mos. of Federal IT support ²⁵	X	X	X
• HHS controls plan management; VT may recommend but is not final decision maker	X	X	
• Federal plan information timeline is inconsistent with Vermont's rate review timeline, requiring modifications	X	X	X
• Loss of control in certification of plans – FFM determines certification	X		
• HHS is the final authority and responsible for all activities including, “coordination of consumer-assistance programs and review of QHP plans”	X	X	
• Loss of authority to select, award and approve Assisters	X	X	
• Subject to changes in federal control rather than state legislative initiative	X	X	
• A fee that is a percentage of premium assessment (e.g., 2.0% to 3.5%) would adversely impact plan & administrative affordability	X	X	X
• Access to data from Federal Exchange is not available	X	X	X
• The exchange is responsible for distributing funds, which could complicate existing distributions in other VT social safety net programs	X	X	
• Federal call center service levels have received mixed customers reviews ²⁶	X	X	X
• HHS selects Navigator grantees, operates training programs and approves budgets	X	X	
• Evolving model; CMS may provide guidance within next several months			X

²⁵ This information was provided verbally by CCIIO and confirmed with Oregon.

²⁶ Giovannelli and Lucia, “The Experiences of State-Run Insurance Marketplaces That Use HealthCare.gov”, The Commonwealth Fund, September 2015

Option B: Work with Current Vendor to Create a Custom Small Business Exchange

There are two ways the state could upgrade existing technology to create a small business Exchange:

- address defects in the original small business portal solution or
- develop a small business solution without utilizing the existing code.

There are significant risks in both of these options which make this an unattractive option.

Any effort to correct defects in the existing solution would be carried out under the existing time-and-materials contract, with little incentive to deliver a fully operational and adequately tested solution within the time available. Limitations to the original solution include an inability to upload employee rosters, employers not being able to make changes to their accounts, the lack of automated notices, the lack of change of circumstance (CoC) capability, and inadequate training, among others. These are substantial defects to correct. Given the level of work needed, there is a real possibility that this option would not produce an acceptable solution in time for the 2017 plan open enrollment deadline.

The cost of completing the original solution and correcting its defects has been roughly estimated as \$10-12 million.²⁷ This amount is greater than the approved \$4.1 million approved by CMS for a small business exchange.

The second option envisions the current contractors developing a small business solution without utilizing the existing product. Given the estimate of \$10-12 million to fix an already developed product, there is little reason to expect developing a new solution would cost less. Again, there is a real risk that such an approach would not produce a fully tested and properly functioning solution in time for the 2017 open enrollment period.

Both variations of this option carry unacceptable levels of risk, and are therefore not recommended.

Option C: Solicit Bids from Qualified COTS Software Vendors

A commercial-off-the-shelf (COTS) solution is another option to implement a small business exchange for plan year 2017. To assess potential vendors, the team researched existing state small business

²⁷ Because Optum is currently under contract and was a potential candidate for inclusion in the modified bid process discussed below, the team was unable to discuss detailed development plans or projected costs with Optum or with its subcontractor, Exeter.

exchanges and created an initial list of qualified vendors. A questionnaire, spanning various categories of requirements, was developed and delivered to these vendors to complete and submit for review.

The cover letter accompanying the questionnaire specifically stated that it was not a request for proposal, bid, or pricing, but rather an opportunity for us to learn more about the capabilities of the vendor. The completed questionnaires were analyzed individually and comparatively to determine who would be considered in any subsequent bid process.

At least two successful state-based exchanges are offering to share their solutions, developed using federal grants, to other states at no cost, or offering a solution with full support (software, maintenance & operations, hosting, call center, premium processing) for fees based on usage. These solutions also are being considered as part of this option.

To pursue this option a small number of prequalified vendors would be solicited under the Simplified Bid Process. An open bid process would be too time-consuming to properly vet a potentially unlimited number of submissions under the tight deadlines referenced earlier.

The team recommends the following criteria against which potential bidders would be evaluated:

- Legal issues (federal and state-specific)
- Timeline to implement
- System and data security
- Call center support
- Risk factors (time, cost, functionality)
- Potential integration with other systems
- Estimated cost
- Ease of implementation
- Available services
- Software capabilities
- Successful record of implementations
- Performance history with other states

Pros:

- Demonstrated success in at least one other exchange (state and/or federal)
- Ability to implement solution in time for the 2017 plan year
- Access to additional services: call center support, payment processing, IT hosting, etc.
- Extensible to the individual marketplace
- Predictable costs, with a variety of available pricing models

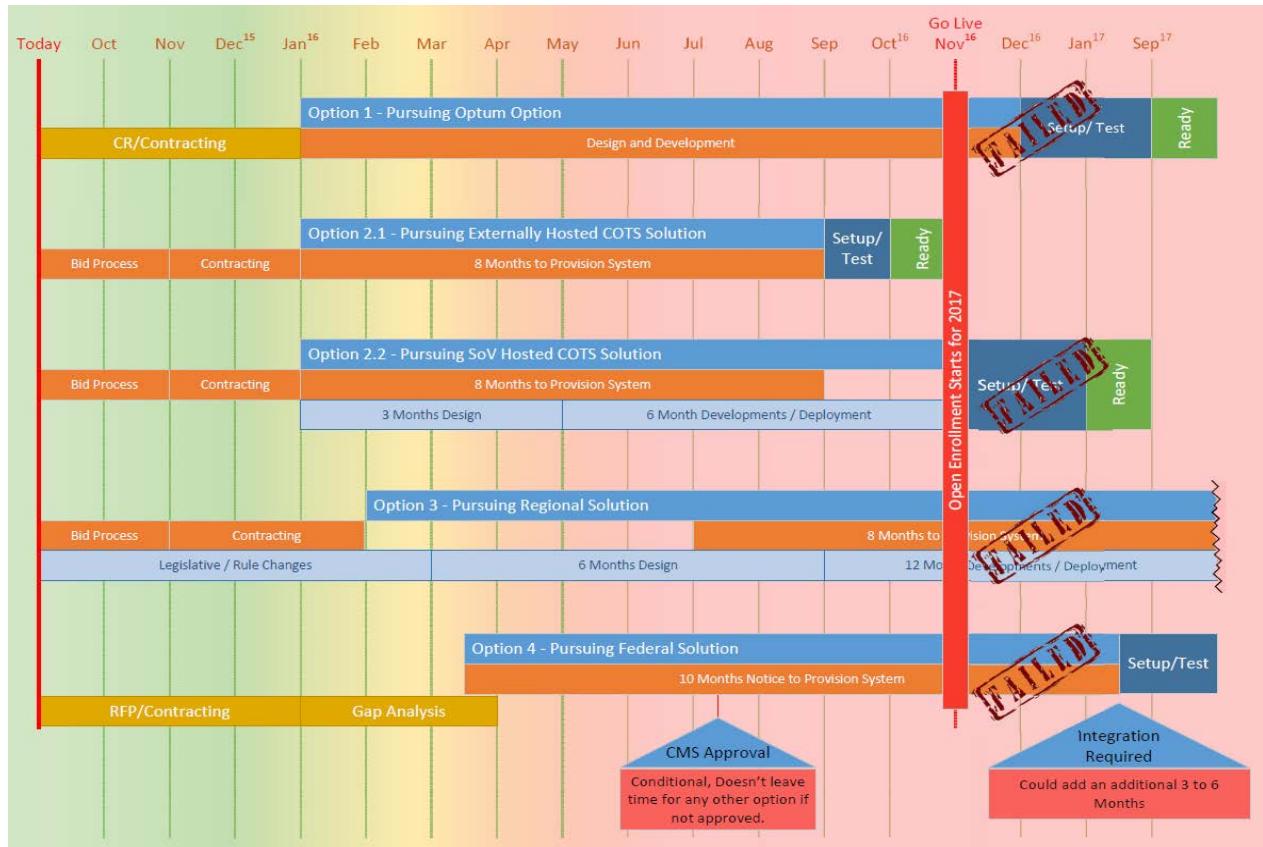
Cons:

- Detailed implementation and development costs to meet VT-specific needs are not yet known

Other states that adopted COTS solutions, but modified them to meet state-specific interests, have largely moved away from the original solution in favor of solutions developed in-house. In many cases, commercial software license fees have proven themselves too expensive to meet self-sustainability requirements for the exchanges.

The following diagram shows expected timelines to complete various development and implementation options in time for the 2017 open enrollment period. The timeline for *Pursuing Federal Solution* reflects moving just the small business exchange to the federal platform, NOT a full transition for the individual and small business exchanges, which would likely take longer.

Figure 14. Expected Timelines for Small Business Options



Option D: Obtain a 1332 Waiver and Continue Using Direct Enrollment Indefinitely

VHC requested and was provisionally granted an extension for 2016 to continue using direct enrollment for small businesses, contingent on standing up an automated small business exchange in 2017. Obtaining a 1332 waiver to adopt direct enrollment permanently is another solution we considered as it will preserve the current well-functioning small business insurance market in Vermont.

A 1332 waiver allows a state to implement innovative ways to provide access to quality health care that is at least as comprehensive and affordable as would be provided absent the waiver, provides coverage to a comparable number of residents of the state as would be provided coverage absent a waiver, and does not increase the federal deficit.

Under a 1332 waiver, the state would seek to maintain the current configuration of its small group market by eliminating the requirement to have a small business exchange website for enrollment and premium processing.²⁸ Specifically:

- The only plans available for purchase are qualified health plans with DFR form approval, GMCB rate approval, and DVHA certification.
- Enrollment takes place through the issuer instead of through a VHC website.
- There is no minimum participation requirement.
- Full employer choice of QHPs is available.
- Issuers administer premium processing.
- Issuers provide required employer and employee notices.
- DVHA provides an appeal process as needed for eligibility concerns as well as certification of eligibility for purposes of the small business tax credit.
- Issuers report enrollment data to the federal government.

At the same time, the state would request waiver of several other verification and reporting requirements at the intersection of the employer and individual markets. Each of these items is either not implemented or posing implementation challenges at VHC.

- Collection of employment information in the individual coverage application.
- Notification to an employer when its employee is found eligible for APTC or terminates APTC/QHP coverage.
- Verification related to enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan beyond the use of electronic data sources available through the federal data services hub.
- Federal reporting of employer information in the individual exchange and SHOP enrollment.

²⁸ Hawaii is also considering requesting a Section 1332 waiver in order to not offer a small business marketplace. Hawaii's concept is explained here: <http://governor.hawaii.gov/wp-content/uploads/2015/09/ACA-Waiver-Proposal-Sept-4-2015-DRAFT.pdf>

Finally, the state would consider requesting waiver of certain eligibility standards for premium tax credits including use of the self-only premium as the basis of affordability of employer sponsored coverage (ACA “family glitch”).

Waiving each of the items listed above would not compromise the comprehensiveness or affordability of coverage, total number of Vermonters covered, or the federal deficit. Instead, the waiver would streamline access to a small group market that is already robust and save costs associated with implementation of other ACA small business exchange requirements.

State innovation waivers can become effective for the first time on or after January 1, 2017. The federal government is currently accepting waiver applications; however, the review and approval process may take six months to over a year. The application must include actuarial certification, 10 year budget, state legislation providing authority to implement the proposed waiver, and a detailed implementation plan. Prior to submitting an application, a state must provide a public notice and comment period including public hearing(s).

Timing considerations, therefore, dictate that the Simplified Bid Process recommended in the Executive Summary be initiated before a decision is returned by CMS. Failure to begin the bid process now will make it difficult, if not impossible, to keep that option as a contingency in the event CMS declines Vermont’s request for a 1332 waiver. Obtaining the requested 1332 waiver would supersede the recommendation to adopt a COTS solution, and no contract would be awarded. The state would request an extension for the transition period for the small business exchange while the 1332 waiver is pending.

Pros

- Minimizes disruption to consumers, small businesses and carriers
- Maintains current functionality, plan certification and rating processes
- Minimizes operational burden on state personnel and financial resources
- Saves costs associated with implementing ACA SHOP IT requirements

Cons

- Does not fit with AHS “One Door” approach
- Does not provide comparative shopping function across carriers for business owners
- Subject to CMS approval
- Requires comprehensive preparation for waiver application including:
 - Legislation (current 1332 authority is for GMC only)
 - Actuarial analysis

- Public comment
- Stakeholder support
- Length of federal waiver review process (45 days for completeness review, 180 days for approval)

Recommendation

The administration recommends doing a modified bid for an off the shelf technology solution while also applying for a waiver of the requirement to have a technology-based small business exchange. Unlike the individual exchange, small businesses are currently enrolling directly through carriers into common plan designs offered in the individual and small group markets. This approach has been well received by small businesses, employees, and insurers. The administration prefers this approach, but it is uncertain whether the federal government would approve such a waiver. Because of the legal uncertainty, the administration would begin a modified procurement process to solicit bids for off the shelf commercial solutions in order to meet the requirements of the Affordable Care Act.

Conclusion

This report assesses multiple alternatives to Vermont Health Connect, for both the individual and small group marketplaces. It analyzes the financial and policy implications of options for Medicaid, VPA, and VCSR. After review of the available options, it is our recommendation to complete Vermont Health Connect for the individual marketplace and Medicaid. We also recommend that the state pursue a Section 1332 waiver to maintain our current direct enrollment for small businesses, while also pursuing a modified bid process to ensure that we have an alternative path if the waiver is not approved.