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STATE OF VERMONT
LEGISLATIVE JOINT FISCAL OFFICE

Memorandum

To: Members of The Health Reform Oversight Committee and The Joint Fiscal Committee; Speaker of the House, Senate President Pro Tempore
From Stephen Klein, Catherine Benham, Stephanie Barrett, and Nolan Langweil
Re: Reporting on Vermont Health Connect (VHC) Implementation
Date: November 9, 2015

Context:

Section C.106.1 of Act 58 (Big Bill) of 2015 calls for an independent analysis of the Vermont Health Connect (VHC) information technology (IT) systems by the Joint Fiscal Office (JFO).[1] This is the third analysis by the JFO. While our previous reports focused more on the operational aspects of the exchange, this report will add a focus on the budgeting and on-going cost estimates for the VHC. As with past reports, we welcome any ideas, questions or suggestions for potential further reviews of the VHC by the JFO that the legislature may feel are necessary.

This report provides the October 2015 analysis of the exchange activity and is based upon:

- Review of the administrations reports
- Independent Verification Vendor (IVV) reports
- Discussions with the administration officials and the Gartner Group
- Review of other documents related to exchange operations in general.

As highlighted in our previous reports, unlike many of the other state-based marketplaces, Vermont has used its federal financing for an integrated system that serves both Medicaid and non-Medicaid populations. While the VHC continues to make developmental gains from its rocky start, with open enrollment beginning, it is extremely important that VHC achieve maximum functionality.

[1] "The Chief of Health Care Reform shall provide the Joint Fiscal Office with the materials provided by the Independent Verification and Validation (IVV) firms evaluating Vermont Health Connect. The reports shall be provided in a manner that protects security and confidentiality as required by any memoranda of understanding entered into by the Joint Fiscal Office and the Executive Branch. The Joint Fiscal Office shall analyze the reports and shall provide information regarding Vermont Health Connect information technology systems to the Health Reform Oversight Committee, the Joint Fiscal Committee, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate in July, September, and October 2015 and at other times as appropriate."

Section C.106.3 of Act 58, required the administration to begin exploring feasible alternatives to VHC including a transition to a federally supported state-based marketplace (FSSBM) if VHC failed to meet the following milestones:

- By May 31, 2015, the vendor shall deliver the IT release providing the "back end" of the technology supporting changes in circumstance and changes in information to allow for a significant reduction in the amount of time necessary for the state to process change requests.
- By August 1, 2015, VHC shall develop a contingency plan for renewing Qualified Health Plans (QHPs) for CY 2016 and ensure that the carriers agree to the process.
- By October 1, 2015, the vendor shall deliver the IT release for the automated renewals for QHPs.
- By October 1, 2015, VHC customer service representatives shall begin processing new requests for change of circumstances and for changes in information 1) received in the first half of the month in time to be reflected on the next invoice and 2) received in the second half of the month in time to be reflected on one of the next two invoices.

While it appears that VHC has met those milestones, on November 2, the Administration still released an analysis of alternatives to VHC and potential financial implications.[2] According to the report, the nature of Vermont's exchange and its interrelationship with Medicaid has financial implications on any potential move away from the current state-based exchange to one that uses the federal exchange, Healthcare.gov.

Summary/Overview of Enrollment in VHC:

As of September 2015, there were 213,652 Vermonters enrolled in either Medicaid for Children and Adults (143,865) or Qualified Health Plans (QHPs) (69,787). Medicaid enrollment has increased by 2,692 (2%) since June and by 11,872 (9%) since December 2014. Medicaid enrollees have been auto-reenrolled which may account for some of the higher Medicaid enrollment numbers. DVHA is currently doing redeterminations (double checking that enrollees still qualify) throughout Medicaid which they plan to complete by fall 2016.

At the same time, enrollment in QHPs for individuals decreased by 7% since June but actually saw an overall net increase of 5% since last December. Of the 31,719 Vermonters enrolled in QHPs as individuals (i.e., not through an employer), nearly two-thirds (65%) receive financial assistance to reduce the cost of their monthly premium. Enrollment in QHPs for small businesses remained consistent between June through September but also saw a 5% increase since last December.

Consistent with our previous reports, the current status of the exchange will be discussed in three areas: 1) Project Scope and System Issues 2) Timing and Schedule and 3) Budgetary Concerns.

[2] The report on Exchange options can be found on the JFO website. http://www.leg.state.vt.us/jfo/jfc/2015/2015_11_13/Vermont%20Health%20Connect%20Exchange%20Options%20FINAL%20110215.pdf

1. Project Scope and System Issues

Qualified Health Plan (QHP) Auto renewal

- In early October, VHC deployed technology upgrades for an automated renewal process followed by a fine-tuning of the technology and staff training.
- VHC conducted a "passive renewal" process whereby existing QHP customers were "mapped" to the newer 2016 version of their current plan with the goal of avoiding gaps in coverage or unintended drops in enrollment as long as they continue to their pay their bill.
- Changes of circumstances were not processed during this period. The legislature received at least one constituent complaint during this time.
- The efficacy and expedience of the auto-renewal process was dependent on the effective communication and engagement between VHC and the carriers.

Small Business Health Options Program (SHOP)

- The Affordable Care Act (ACA) requires states to set up SHOP exchanges unless they have received an exemption from the Centers for Medicare and Medicaid Services (CMS). CMS has given Vermont an exemption from SHOP which means small businesses in Vermont will continue to enroll directly with the insurance carriers through 2016. However, CMS has signaled it will not grant exemptions past 2016. Because VHC does not have an approved plan or vendor contract for SHOP, this poses a risk for 2017. Potential options could include:
    - Seek a federal 1332 waiver from the ACA
    - Use a minimalist approach such as contracting SHOP out to a third-party administrator. This may or may not require a 1332 waiver.
- Creating a SHOP will have a fiscal implication and will require ongoing and sustainable funding which has not yet been identified.
- Utilization of the SHOP will depend on how the State sets it up. On 10/14/15, BCBSVT testified to the House Health Care Committee that employers would be unlikely to purchase through a SHOP if they are allowed to continue to enroll directly with insurance carriers.

Change of Circumstance Processing

- The backlog related to change of circumstance processing was a major source of consternation and dissatisfaction among VHC customers and one of the biggest barriers preventing VHC from achieving full functionality.
- At the beginning of October, VHC announced that the backlog had been cleared. Lawrence Miller testified to the House Health Care Committee on 10/14/15 that the backlog was down to about 40-80 (from a high of over 10,000 back in June). VHC continues to receive about 125 change requests a day for both QHPs and Medicaid.
- According to the report, starting in October, customers who report a change by the 15th of the month should see that change reflected in their next bill.

Small Group: change in the federal definition

- Under the ACA, the small group insurance market is defined as employers with up to 50 employees. Beginning in 2016, the definition will expand to include employers with up to 100 employees.
- It is estimated that this will affect approximately 600 employers and about 20,000 employees in Vermont.[3] It is not known if this will have any behavioral or market effects such as employers dropping insurance so employees can receive federal and state subsidies as individuals on the exchange.
- There is bipartisan legislation in Congress that would enable states to maintain their current definitions for their small group markets at 50 employees. This proposal has reportedly been gaining traction in Washington. However, the Shumlin administration is planning to move ahead with the current law definition change to 100 employees. All of the actuarial work (done by both the carriers and the State), rate submissions, rate reviews, financial analyses and planning have been done under the assumption of the small group market increasing to 100 employees. Open enrollment began November 1. Should such federal legislation pass, this is an issue the legislature may decide to consider further.

2. Timing and Schedule

Open Enrollment

- Open Enrollment began November 1 and runs through January 1, 2016. It is extremely important that VHC surpass expectation in functionality, customer experience, and performance measures in order to gain the confidence of consumers and policymakers.
- The first few days of open enrollment saw heavy call center volumes and resulting issues. Call abandonment rates on Monday, November 2, reached 25% dropping to 15.6% on Tuesday and 3.5% on Wednesday. The percentage of calls answered in 30 seconds similarly went from about 30% on Monday, November 2, to over 40% on Tuesday and over 70% on Wednesday. Overall the system appears to be handling demand with full results to be reported later in the month.

Reconciliation between the State and the carriers for coverage and related expenses

- As reported previously, reconciliation for 2014 is complete and will have a $1.6 million pressure in budget adjustment. Reconciliation for 2015 is currently underway. The goal is to eventually have monthly reconciliation as required by the ACA.
- As part of reconciliation with BCBSVT, KPMG has been hired to assess the process by which the State and the carrier reconcile their accounts. It is expected MVP (which has fewer VHC members than BCBSVT) will begin this process soon as well.
- Calendar Year 2015 reconciliation is expected to be handled as part of FY 2015 expenses as the amounts are determined. It is not clear if additional costs identified during reconciliation can be absorbed under current program operations or if further funding will be required.

[3] Based on testimony from Lawrence Miller to the House Health Care Committee, 10/14/15

834 Transaction Errors

- An 834 transaction is a technical term for how QHP enrollment information is transferred as an electronic file from VHC to the insurance carriers. There are many data elements and field variables. Because of this complexity, data files from VHC do not go straight to the insurers' production system. There is a validation process with several chances for the file to "error out." Once in production, the file drives the payment system, claim system, and is the source for the list of doctors and hospitals they need to confirm a person is eligible for benefits.
- Premium 834 transaction errors increased in both July and August, and while the number of 834 errors decreased in September, they are still much higher than they were in May and June.
- The report indicates a relationship between things such as the backlog and 834 errors due to an "increase in integration activity." It remains to be seen if the elimination of the backlog will correlate with a reduction in 834 errors going forward.
    - Reported 834 errors - estimates end of month
        - May 20
        - June 80
        - July 400
        - August 700
        - September 300

Performance Measures

Call Center Performance measures showed modest improvements from the previous month but still are not as good as May, June and July for many of the measures. The call volume increased by 10% but the abandon rate dropped from 10.9% to 5%. The resolution of the change processing issues as well staff training at the call centers hopefully should bolster performance measures during the open enrollment period. However, the previous negative customer experiences (and press) may linger with many customers or at least leave negative impressions on plan functionalities.

- Wait times: The average wait time saw an improvement over August but was still much higher than May and June:
    - May 12 seconds
    - June 31 seconds
    - July 72 seconds
    - August 3 minutes
    - September Approx. 84 seconds

  For comparison, the average wait time during the last open enrollment (November 2014 thru February 2015) was 40 seconds.

- Calls answered within 30 seconds: Similarly, calls answered within 30 seconds saw a slight improvement over August but again were not as high as May and June.
    - May 96%
    - June 84%
    - July 77%
    - August 61%

- September 83%

For comparison, the percentage of calls answered in within 30 seconds during the last open enrollment last open enrollment was 81%.

- Abandoned calls: The percent of abandoned calls dropped from August but is still higher than May through July.
  - May 0.6%
  - June 1.5%
  - July 4.1%
  - August 10.9%
  - September 5.0%

  For comparison, the percent of abandoned calls during the last open enrollment was 1.7%.

- Website usage: Website usage has continued to increase throughout the summer and fall. Website usage will likely increase even more during open enrollment. The system functionality and load time is an area that should continue to be monitored.

Month	Visits	Avg. page load time (seconds)
May	30,926	2.0
June	34,837	0.5
July	37,116	0.52
August	43,975	0.87
September	50,799	0.84

3. Budgetary Concerns

Reconciliation
There is a $1.6 million budget adjustment associated with this. See *Reconciliation* discussion on page 4 of this report.

VHC Operating Budget: organized by the following three components: (1) Qualified Health Plans (QHPs), (2) Medicaid, and (3) Small Business Health Options Program (SHOP).

(1) Qualified Health Plans (QHP) – In Vermont these costs are paid with General Fund (GF) from the state health care resources fund. Some other states that operate their own state-based exchanges have instituted an assessment or tax on plans sold through the exchange. For example:

- In Connecticut, the current FY 2016 assessment is 1.65% which raises a projected $36.2 million. Last year the assessment was 1.35% which raised $29.6 million.
- In Rhode Island, the health care premium assessment is 3.76% of total premium in the individual market and 1.05% of total premium in the group market. The assessments are expected to generate $11.2 million in FY 2017.

- The Table below, from a Rhode Island report (April 2015)[4] indicates a summary of how other states have funded their state exchanges.

Table 3
State Health Exchange Financing Summary

Method	States
Assessment only on plans purchased through exhange	CA, ID, MA, MN, WA
Broad-based assessment on plans purchased inside and outside exchange	CO, CT, DC, KY, MD, (RI)
Broad-based assessment plus state appropration	NY, HI

SOURCE: Senate Fiscal Office; Commonwealth Fund

- The federal exchange has a user fee of 3.5% on exchange premiums which is then allocated to each insurer based on their share of the exchange market. For comparison, in Rhode Island the federal user fee would raise less than their current assessment: $8.6 million vs. $11.2 million respectively.[5] The President's FY 2016 budget indicates that the federal assessment is insufficient to cover costs and there is a possibility that the rate will be increased in future years.[6]

(2) Medicaid

- VHC is the initial enrollment door for both income eligible Medicaid beneficiaries and QHP purchasers who qualify for the Vermont Premium Assistance (VPA) program.
- The Operational Advanced Planning Document (OAPD) governs the procedure by which states obtain approval for federal financial participation in the costs of acquiring automated data processing equipment and services. The administrative costs in the Medicaid Budget are typically approximately 45% general funds and 55% federal funds. For the exchange, the OAPD reached with CMS allows certain costs to be split 25% general funds and 75% federal funds. This brings the overall split to 35% general funds and 65% federal funds for the exchange related expenses.

[4] See http://www.ripec.org/pdfs/2015-HSRI.pdf.

[5] See these documents for a discussion of state exchange financing options: http://www.ripec.org/pdfs/2015-HSRI.pdf Also http://www.ripec.org/publications/Financing-the-Rhode-Island-Health-Exchange; and for Connecticut http://ctmirror.org/2015/05/28/access-health-to-increase-fee-on-insurers/

[6] https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2016-CJ-Final.pdf CMS' FY 2016 Program Management request includes $629.0 million in appropriated funding for the Marketplaces, along with $1.6 billion in projected user fee collections from all sources to fund the Marketplaces at a program level totaling $2.2 billion.

(3) Small Business Health Options Program (SHOP)

- The SHOP is a federal requirement that has been waived in Vermont through CY 2016. It will allow small business enrollment through VHC, however, the administration has signaled that it should not preclude small businesses from opting to continue direct enrollment with carriers. (See the discussion of SHOP on page 3 of this report.)
- A SHOP budgetary component will need to be included in FY 2017 to reflect development expenses and a partial year of operating costs. This amount is yet to be determined as the preferred approach for the state in fulfilling the federal SHOP requirement has not been decided. Given Vermont's small business market needs and likely preference for direct enrollment, SHOP in Vermont is likely to be little used. The November 2, 2015, Options Report by the administration suggests a two-pronged approach for SHOP, similar to that described on page 3 of this report:
    - Request a 1332 waiver to continue allowing small businesses to directly enroll with insurance carriers 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.

Comparison with Other States

In making comparisons to other states' exchange operation costs, it is important to understand which components are included in the comparison. For example, as of April 2015 the operating costs of the exchanges in Connecticut and Rhode Island included QHP and SHOP costs but no or only partial Medicaid enrollment costs.

The Table below lays out the most current estimates for VHC operating costs by the administration with limited review by JFO. These are subject to change as open enrollment and the budget-building process continues.

VHC Component	FY16 As Passed		FY16 Revised		FY17 Projected		FY18 Projected	
	GF	Total	GF	Total	GF	Total	GF	Total
QHP	4.6	4.6	6.1	6.1	5.6	5.6	5.8	5.8
Medicaid	18.2	40.4	16.0	45.5	14.6	41.8	15.1	43.0
SHOP	0.0	0.0	0.0	0.0	tbd	tbd	tbd	tbd
Total	22.7	45.0	22.1	51.6	20.3	47.4	20.9	48.8

$ in Millions. OAPD impacts FY 2016 Revised and going forward

The change in the total cost in FY 2016 from $45 million (as passed) to $51.6 million (revised) is primarily due to revised estimates associated with staffing through the current open enrollment period and to the increased workload associated with redeterminations of Medicaid enrollees subsequent to the open enrollment. There are also revised projections for some of the contract costs, including the call center. However, the total State GF required is actually reduced by roughly $600k due to the OAPD which added federal match. The GF levels estimated above assume the OAPD continues through FY 2018. Again, these are estimates and may change as federal match assumptions evolve for the out years.

FY 2017 projections include reduced personnel and overhead costs, There may be additional savings in application maintenance, operations, licensing as other Health Services Enterprise (HSE) projects come on line.

The FY 2018 VHC budget projection is the basis for comparison in the Administration's November 2, 2015 report on the VHC Exchange Options – *Assessment of the Alternatives* Report. The numbers here are similar to those presented in Figure #13 of that report.[7]

Finally, it was recently announced that Exeter would be going out of business. Exeter developed OneGate which is front end software that is to be used in the eligibility determination process. There were only two states that used Exeter OneGate for their exchange: Vermont and Hawaii. Hawaii had already stopped its use of OneGate. That left only Vermont. While this product was originally intended to be an off-the-shelf product, it will now be developed and operated by Optum. There are no identifiable cost implications at this time, however this could change.

7 http://www.leg.state.vt.us/jfo/jfc/2015/2015_11_13/Vermont%20Health%20Connect%20Exchange%20Options%20FINAL%20110215.pdf