

# **Alternatives to Vermont Health Connect: Considerations & Cost Estimates**

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November 15, 2015

# What was the charge?

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

# What process did we use?

- Research & analysis was done by cross department team & contractors
- Research included interviews with other state officials and vendors, as well as reviewing federal guidance for other models:
  - For individual marketplace & Medicaid: officials from states which had transitioned from a state based marketplace to *either* the federal exchange technology or to another state's technology
  - For small business marketplace: vendors who successfully stood up a small business exchange in at least one state

# What other states did we talk to?

## Medicaid & Individual Exchange

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

# What process did we use?

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

# What did we consider?

## Cost Impacts

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

## Policy & Operations Implications

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

## Consumer Experience

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

## New Technology Risk

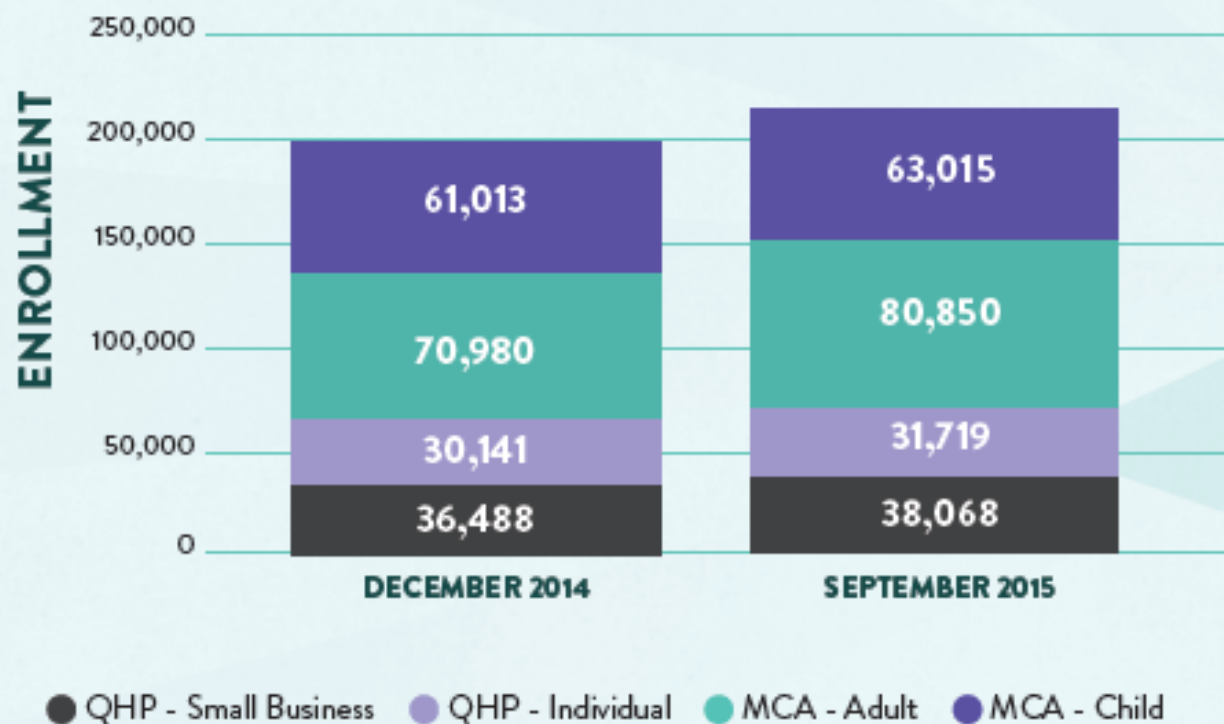
- Vendor experience
- Timeframe for development
- Impact on operations
- Potential to require policy changes

# What do we recommend?

Current VHC IT Functions		
MAGI Medicaid	Individual Market	Small Business Market
<p>Finish VHC, because:</p> <ul style="list-style-type: none"> <li>• Most cost-effective approach for remaining development and for on-going operations costs <ul style="list-style-type: none"> <li>• It's inexpensive to move the individual market to the federal technology, but it is expensive to meet the Medicaid requirements, which we currently do through VHC.</li> </ul> </li> <li>• Maintains consolidated approach to covering individuals across all income levels</li> <li>• Most likely to maintain 96-97% insured rate &amp; not lose people in the transition</li> <li>• Maintains state authority over health policy &amp; health care reform</li> <li>• Only option for maintaining <b>seamless</b> VPA/VCSR enrollment to ensure consumer affordability <ul style="list-style-type: none"> <li>• Other options would require consumer to do two enrollment processes to sign up for VPA/VCSR</li> </ul> </li> <li>• Only option for maintaining <b>seamless</b> enrollment for mixed households (Medicaid/QHP) <ul style="list-style-type: none"> <li>• Other options require consumer to do two enrollment processes to sign up for Medicaid &amp; QHPs</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>• Apply for 1332 waiver to maintain status quo of direct enrollment with carriers without further technology build <ul style="list-style-type: none"> <li>• Allows continuity for small businesses to continue current process</li> <li>• Minimizes cost</li> <li>• Note: state legislation is required</li> </ul> </li> <li>• Pursue modified bid for a commercial off the shelf solution as a contingency plan <ul style="list-style-type: none"> <li>• Least costly approach if CMS requires technology for small business marketplace</li> </ul> </li> </ul>

# Who are we talking about?

## INDIVIDUALS ENROLLED IN QUALIFIED HEALTH PLANS (QHP) OR MEDICAID FOR CHILDREN AND ADULTS (MCA)





# Finish VHC to keep Health Care Coverage Affordable

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



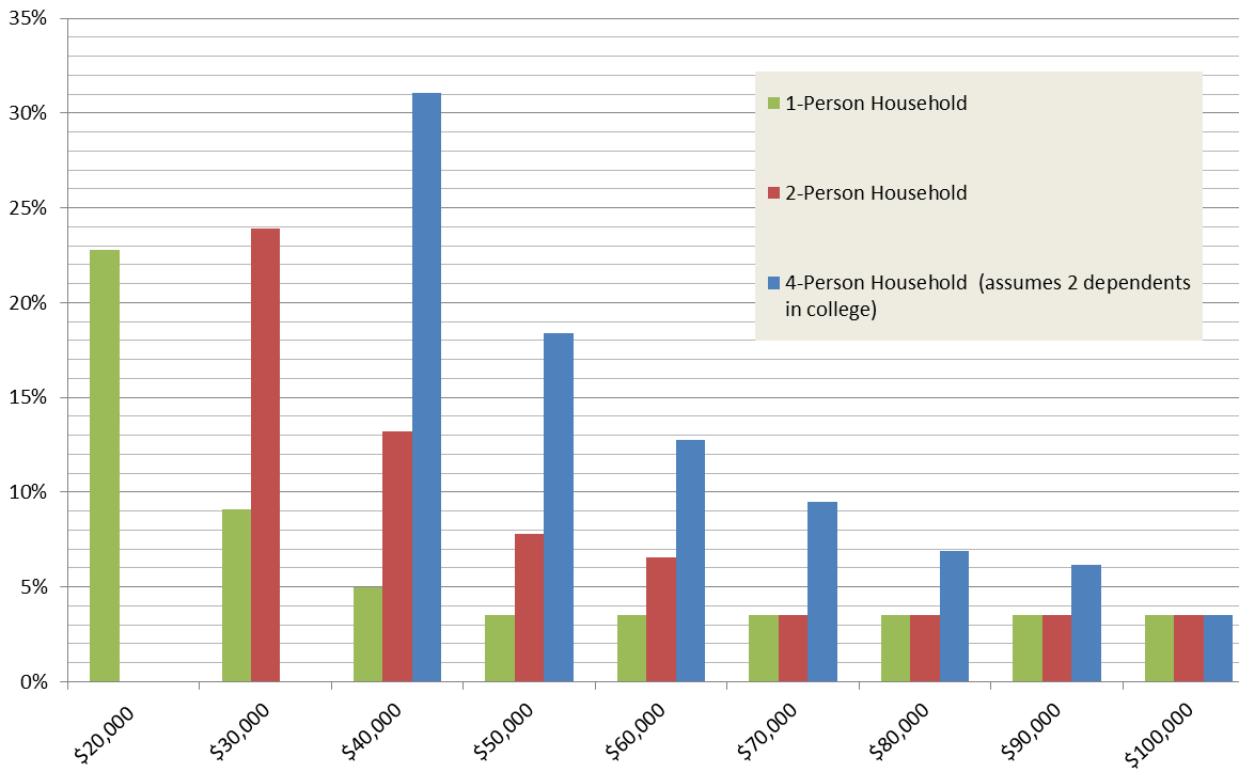
# Federal User Fee

- Insurers collect on top of premium and remit to the federal government
  - State could pay for consumers to ensure that premiums net of VPA stay consistent
  - State could pass onto consumers as is done in other states
- 2015 fee for FFM is 3.5% of gross premiums = \$6.3 Million
  - Guidance due out this month, November 2015, on next year's fee
    - Fee may be increased for FFM states
    - Fee likely charged to SSBM states beginning in 2016

# Federal User Fee Increases Costs to Lowest Income Vermonters

## Federal Exchange Fee Paid by Household Income

(3.5% Fee as % of Household's Net 2016 Premium)



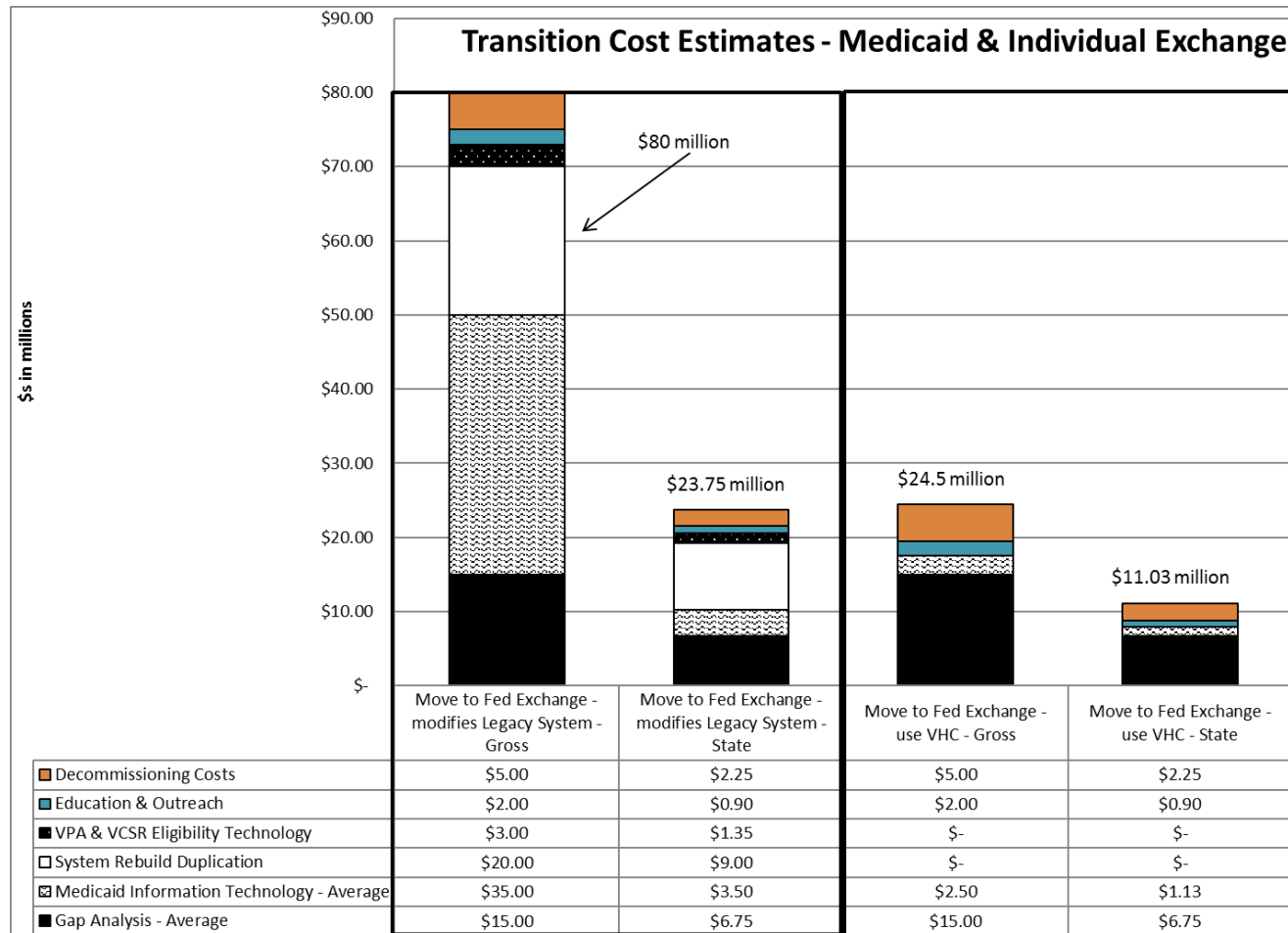
Household Income

	Current VHC IT Functions		SHOP
Options	MAGI Medicaid	Individual Market	Small Business Market
<i>Regional Exchange</i>	<ul style="list-style-type: none"> <li>Not feasible for 2017;</li> <li>A multi-state governance process with willing other state partners would be challenging to implement in a timely fashion</li> <li>Extensive state legislation &amp; policy changes are required to align Medicaid eligibility, insurance regulation, Exchange process, rate review &amp; other regulatory processes <ul style="list-style-type: none"> <li>For example, Vermont has a merged individual and small group market. Only Massachusetts has merged the markets of the NE states</li> </ul> </li> <li>Lose leverage to promote Blueprint for Health participation and payment reform</li> <li>Vermont has greater small business enrollment than other states &amp; thus may be expected to pay a larger percentage of expenses for that population</li> </ul>		
<i>Use federal technology</i>	<ul style="list-style-type: none"> <li>On-going Exchange operating expense is not substantial</li> <li>Substantial transition &amp; operations costs for Medicaid</li> <li>High level of confusion for mixed households &amp; those with VPA/CSR</li> <li>Requires separate eligibility system for VPA/VSCR</li> <li>Re-enrollment into federal system required</li> <li>2017 enrollment presents a timing risk</li> <li>Requires modification of rate review timeline &amp;/or process</li> <li>Reduced ability to pursue comprehensive Section 1332 waiver <ul style="list-style-type: none"> <li>No state specific modifications of federal technology, so waiving eligibility or enrollment components is not feasible</li> </ul> </li> <li>Limited data available from the federal government <ul style="list-style-type: none"> <li>Restricts information available for policy &amp; planning</li> </ul> </li> <li>Vermont call center performance is better than the federal government's</li> </ul>		<ul style="list-style-type: none"> <li>Use of federal technology only for small businesses is not feasible for 2017</li> <li>Substantial policy changes required</li> </ul>

	Current VHC IT Functions		SHOP
Options	MAGI Medicaid	Individual Market	Small Business Market
<i>Purchase new technology</i>	<ul style="list-style-type: none"> <li>• Policy changes likely necessary</li> <li>• Transition and operations cost for Medicaid, but may be less disruptive than using federal technology</li> <li>• High level of confusion for mixed households &amp; those with VPA/VCSR</li> <li>• May require separate eligibility system for VPA/VSCR</li> <li>• If customizable, requires additional financial investment</li> <li>• More costly than finishing VHC</li> <li>• 2017 enrollment presents a timing risk</li> </ul>		<ul style="list-style-type: none"> <li>• Recommended</li> </ul>
<i>Finish VHC</i>	<ul style="list-style-type: none"> <li>• Recommended</li> </ul>		<ul style="list-style-type: none"> <li>• Completing last version of VHC small business technology has substantial cost</li> <li>• High level of complexity &amp; risk</li> </ul>

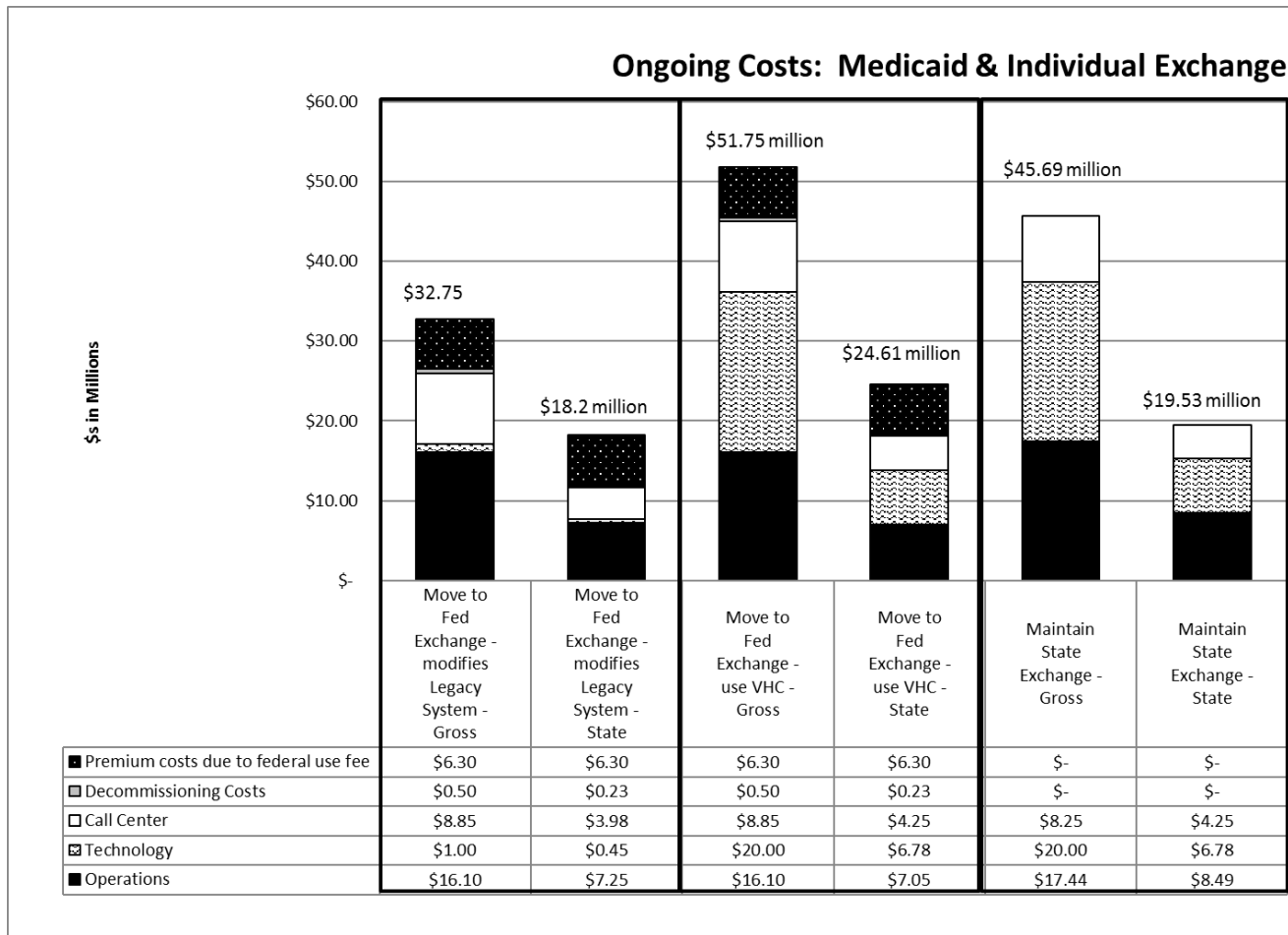
# Transition Costs by Type

## VHC v. Using Federal Technology (in Millions)



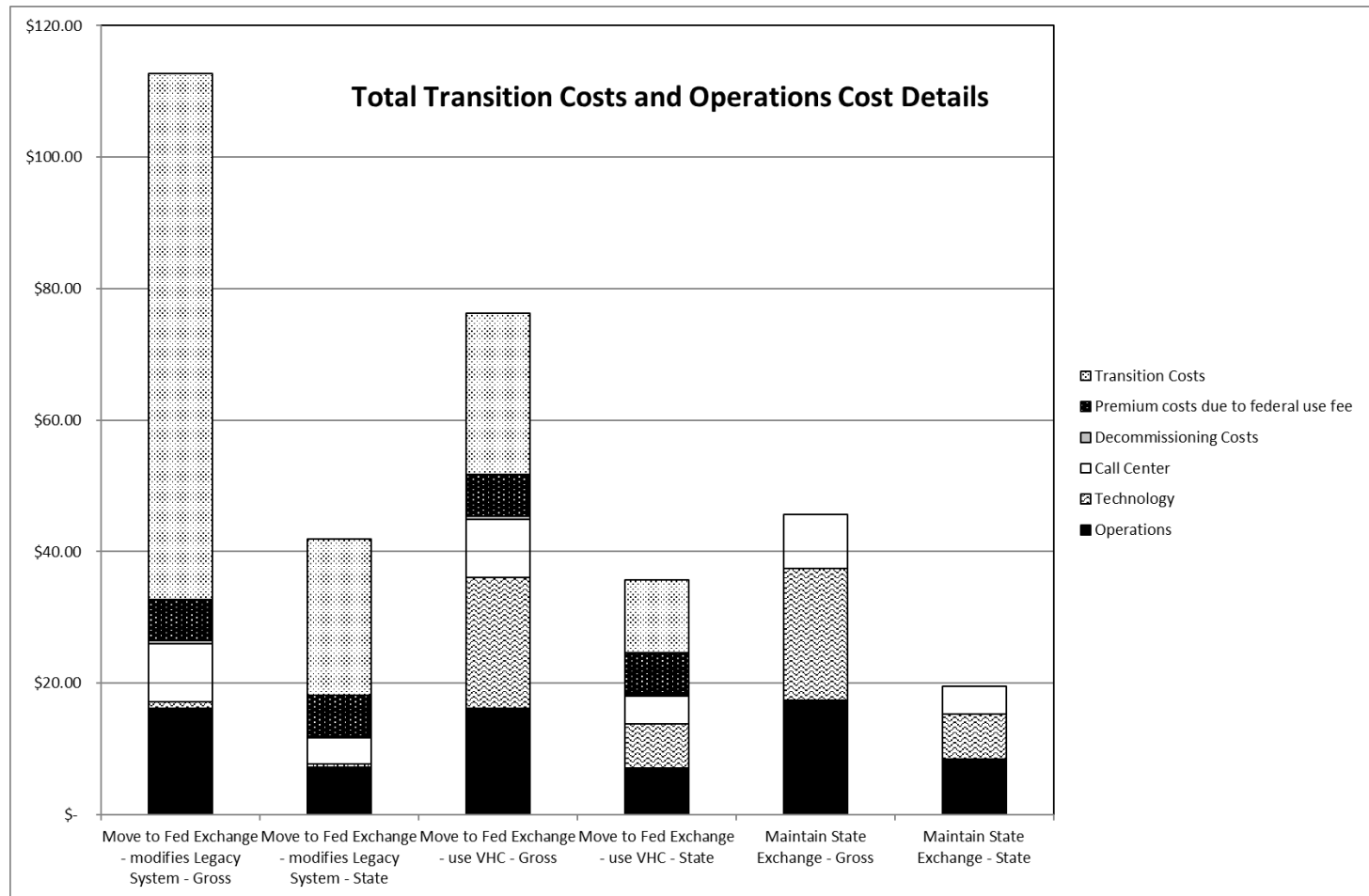
# Operating Costs By Type

## VHC v. Using Federal Technology (in Millions)



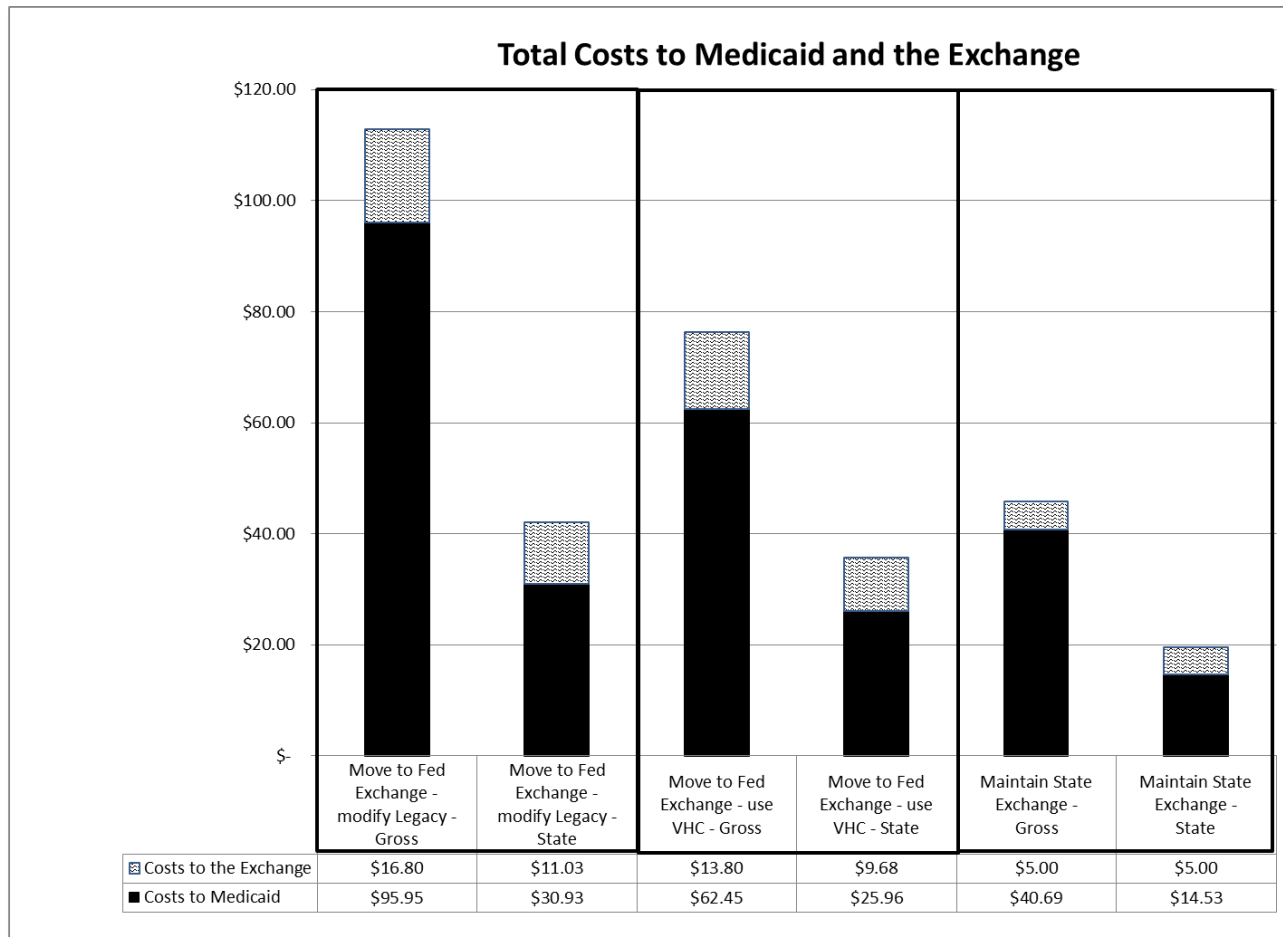
# Total Cost Comparison By Type:

## VHC v. Using Federal Technology (in Millions)





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



# Acknowledgements

- Special thanks to State of Vermont staff and contractors for their contributions to researching, writing, and editing this report:
  - Sarah Clark, Carrie Hathaway, Adaline Strumolo, Jim Whitney, Melissa Rancourt, CJ Hebert, Bob Skowronski, Martin Quatt, Sean Sheehan, Devon Green, Marisa Melamed, Richard Ketcham, and Robin Lunge
- We also want to acknowledge the generosity of Heather Howard and the State Health Reform Assistance Network Team at Princeton University for reviewing and providing comments on this report. Thank you also to Joel Ario from Manatt Health Solutions for reviewing the draft and providing comments.

# BACKGROUND ON COST ESTIMATES

# Transition Costs for Alternative Technology

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

# Operation Costs for Using Alternative Technology

- Federal User Fee
  - 3.5% of gross premiums for FFM
  - Expect federal guidance this month, November 2015
- Call Center costs remain for Medicaid & VPA/VCSR
  - Other FFM states reported some increases to Medicaid call centers due to people mistakenly calling the state for federal issues
  - Households with someone covered by Medicaid, Dr. Dynasaur or VPA/VCSR would need to use both federal & state call centers
  - High level of confusion expected for mixed households
- Technology costs remain for Medicaid & VPA/VCSR
- Decommissioning Costs
  - 10 year cost for storing IRS and Exchange data
  - CMS requires ability to pull/change information from the system
  - Does not reflect costs of running parallel systems during transition for 12-15 months