

FINAL DRAFT – FOR DISCUSSION ONLY

Progress Report on

A Proposed Exchange Design for the State of Vermont

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Executive Summary

Since the passage of the Patient Protection and Affordable Care Act (PPACA) of 2010, the State of Vermont has been taking significant steps to implement national health reform, including designing its Exchange, to serve both individuals and small employers. Vermont plans not only to implement an Exchange, but to leverage the Exchange as a foundation for its first in the nation single-payer health care system. The proposed Exchange Design described in this report meets the requirements of the PPACA and Act 48 of 2011, which specifically authorizes Vermont's Exchange and has been developed to meet the following goals:

- Achieve administrative simplification of the health care system;
- Provide a robust model that allows the Exchange to be an active purchaser;
- Maximize the purchase of insurance through the Exchange;
- Position the State to transition to single payer; and,
- Leverage existing State infrastructure for efficiencies

As envisioned by Act 48, the Exchange will sit within the Department of Vermont Health Access (DVHA) and will be managed jointly with the Medicaid program, allowing the Exchange to leverage existing staff and infrastructure to create a continuum of coverage for Vermonters across income levels and to allow Vermont to develop consistent policies across all health coverage programs. To prepare for this new responsibility, DVHA is in the process of developing a strategic plan that incorporates the administration of the Exchange into its existing responsibilities and contemplates how DVHA will utilize the Medicaid and Exchange Advisory Board, how it will interact with the Green Mountain Care Board, and how it can best work cooperatively with sister agencies, particularly the Department of Banking, Insurance, Security and Health Care Administration (BISHCA) and the Department of Children and Families.

The Exchange will need to perform a number of key functions in order to meet its federal and state statutory responsibilities. Specifically, the Exchange is responsible for the following:

- Developing an eligibility and enrollment process for individuals and businesses
- Offering Qualified Health Plans (QHPs) that meet the needs of Vermonters

- Developing a process for consumer selection of QHPs and premium payment
- Providing robust customer service
- Developing a process for outreach, education and marketing, including the development of a state-funded Navigator program

Eligibility and Enrollment: The DVHA will use a joint eligibility system to determine and coordinate eligibility for Medicaid and other public programs, as well as eligibility for premium tax credits under the Exchange. The DVHA is planning to procure a new eligibility system to meet program requirements, including the Modified Adjusted Gross Income (MAGI), and will, to the extent possible, re-use design documents and other outputs of the New England States Collaborative Insurance Exchange Systems (NESCIES) Innovator Grant. As system implementations often take longer than planned and it is unclear what of the NESCIES grant can be utilized, it is essential that DVHA develop an alternative strategy. This strategy will include updating its current system to meet PPACA requirements beginning in 2014, until a new system can come on line. Vermont will also need to develop an enrollment process for individuals and businesses.

Offering Qualified Health Plans: The Exchange must offer a minimum of three levels of coverage for individuals and employers to select from in purchasing health coverage through the Exchange. To develop the requirements for the three levels of coverage, the DVHA will need to understand the pending federal requirements for Essential Health Benefits and how they compare to the current Vermont mandated benefits. The DVHA, will work closely with the Medicaid and Exchange Advisory Board and BISHCA to develop the plan levels and certification criteria, and will negotiate directly with two or more qualified insurers that are certified to offer plans through the Exchange. In certifying plans, Act 48 requires that the Exchange must minimally consider affordability, promotion of high-quality care, prevention and wellness, promotion of access to health care, and plan participation in the State's health care reform efforts.

Developing Process for Consumer Selection of QHPs

While the Vermont Exchange will serve both individuals and businesses, it will be important for the DVHA to be mindful of the different needs of these consumers for both selecting and enrolling in QHPs. Processes will be developed to address these different needs. The Exchange will establish a website that

provides clear information to allow both individuals and employers to comparison shop across available health plans. The website will also include a calculator that allows individuals to determine the level of tax credit to which they may be entitled in enrolling in coverage through the Exchange.

Call center staff and Navigators will need detailed training on the plan selection options. The Exchange will also be responsible for collecting premiums, reconciling the payments, and sending payment to the insurers. While individuals will be encouraged to make payments through the Exchange, the PPACA requires that individuals also have the option to make payments directly to the health insurer.

A key decision for Vermont is how much choice to give employers and employees in selecting coverage through the Exchange. The Exchange Design report offers five options along a continuum that moves from the employer selecting the exact product in which an employee may enroll to eliminating any employer involvement in the selection process. There are advantages and challenges to each of the options.

Customer Service: The Exchange must provide a toll-free telephone hotline to assist individuals and small employers in all aspects of the Exchange process, from eligibility and enrollment, to plan selection and premium payment. The DVHA has significant experience, through its current vendor, in providing customer service for public health coverage programs including Medicaid, CHIP, VHAP and Catamount Health. This experience should be leveraged and capacity expanded to handle additional volume and potentially more complex calls. All call center staff should be trained on coverage available to both individuals and small employers through the Exchange. From the time enrollment in the Exchange begins in Fall 2013 through open enrollment in March 2014, the call center should provide for weekend and evening hours. After that period, the DVHA should work with its vendor to consider whether these additional hours should continue. Call center staff should be cross-trained to be able to cover either the individual or employer hotline as is necessary based on call volume. To facilitate customer service, the State's call center staff will also need to develop strong relationships with call center staff at the health insurers in order to allow for smooth transfer of individuals or employers to the correct organization, as appropriate.

Outreach, Education and Marketing: Successful implementation of the Exchange in Vermont requires extensive marketing, public education and outreach. In designing its launch for the Exchange, Vermont should leverage its successful experiences and lessons learned from previous public health program

implementations. A public campaign should focus on both individuals and employers, making sure that all entities and individuals understand their responsibilities and opportunities under the PPACA. As a first step, Vermont must develop an overall marketing and outreach plan in 2012 that:

- Is organized around a set of simple messages that emphasize the state's priorities and educates both individuals and small businesses;
- Utilizes a multi-prong approach, including numerous public education and outreach campaigns and collaborates with efforts of state agencies, community organizations and corporate and civic organizations;
- Considers the rural nature of Vermont and its current uninsured population;
- Leverages the mandatory functions of the Exchange, including the call center and the Navigator program; and,
- Is augmented by complimentary campaigns of health plans that participate in the Exchange.

In addition to a broad marketing plan, it is essential that the State develop a comprehensive training program that provides widespread training on the Exchange and its requirements to State staff and vendors, and health care stakeholders. The State must also develop education and outreach tools that are accessible both on-line and in hard copy.

The state-funded Navigator program must compliment and support the overall outreach and education strategy. Vermont should use Navigators in both its early efforts to educate and outreach to the public about Exchanges, as well as to provide specific assistance to individuals and employers with understanding qualified health plan options, availability of premium tax credits and cost-sharing subsidies, and enrollment in health plans. Navigators should be available to provide assistance either by phone, or face-to-face, as necessary. Navigators will need to use different approaches with assisting individuals and employers. In selecting Navigators, Vermont should utilize a competitive procurement process that is open to organizations that meet the requirements of the PPACA and should select two or more organizations to provide these services. Payment of Navigators should be tied to performance-based measures. As noted above, Navigators will require comprehensive training prior to implementation and ongoing training to maintain skills.

Significant planning and design activities have been completed during the first planning year towards the implementation of Vermont's Exchange. Act 48 requires over a dozen Exchange-related reports to be delivered in January and February of 2012. The State continues to refine its integration process across agencies and awaits federal guidance in a number of areas. To support the finalization of its Exchange Design, Vermont submitted a request to the Center for Consumer Information and Insurance Oversight (CCIIO) within the federal HHS for a Level One Establishment Grant to continue the efforts begun under the State's planning grant. The Establishment Grant will allow the state to hire staff for the Exchange and begin the process of implementing the Exchange Design. The Administration is finalizing an implementation plan that details the implementation process. Key milestones are identified as well as critical decision points.

1. Introduction

Since the passage of the Patient Protection and Affordable Care Act (PPACA) of 2010, the State of Vermont has been working towards its implementation of national health reform, including designing a Health Benefits Exchange. The PPACA requires the establishment of an American Health Benefit Exchange (AHBE) in each state by January 1, 2014. The Exchange must provide both an insurance marketplace for individuals purchasing insurance outside of the work place and a Small Business Health Options Program (SHOP) for small employers. If a state does not develop its own Exchange, the federal government will step in and create one. Vermont plans not only to implement an Exchange, but to leverage the Exchange as a foundation for a single-payer health care system in Vermont. As described below, the Exchange design and single-payer efforts are implicitly intertwined through Act 48 of 2011.

This Exchange design proposal brings together a series of deliverables completed under the State's Exchange Implementation Planning Grant¹ to describe the Exchange design as a whole and consider where additional state planning or further guidance from the federal government is needed. Vermont's ultimate goal of implementing a single payer plan has significantly influenced the design of its Exchange. This report presents Vermont's design proposal for its Exchange. First, a legislative overview is provided. This section is followed by a description of the organizational structure for Vermont's Exchange. Next, detailed sections on the individual and SHOP Exchange functions are provided. A concluding section details the next steps in Exchange implementation.

2. Legislative Overview for Vermont's Exchange Design

This section of the report provides a description of the legislative parameters for Vermont's Exchange design, based on the federal statutory requirements of the PPACA and related regulations, and Vermont's Act 48 which authorized the establishment of the Vermont Exchange.

a. Minimal Exchange Requirements under the PPACA

The PPACA mandates a number of minimal requirements for each state Exchange, including:

¹ Final deliverables, white papers and presentations to the Exchange Planning Advisory Committee are accessible on the Department of Vermont Health Access (DVHA) website: <http://dvha.vermont.gov/administration/health-benefits-exchange>

- *Determine and coordinate eligibility* for individuals, including seamless eligibility determination and enrollment into Medicaid and CHIP, ,administration of premium tax credits and cost-sharing subsidies, and verifying access to employer-sponsored insurance (ESI);
- *Create benefit categories of health insurance plans*, including four levels (bronze, silver, gold and platinum) for both individuals and small employers, and a catastrophic plan for individuals;²
- *Offer two multistate plans*, that cover both individuals and small employers;
- *Certify qualified health plans*, including certifying, recertifying and decertifying health plans as qualified to be offered through the Exchange for both individuals and small employers;
- *Contract with qualified health plans*, and co-ops to offer health insurance, including soliciting and negotiating bids for qualified health plans to offer coverage to individuals and small employers;
- *Maintain a call center for customer service*, to assist individuals and small employers in selecting plans;
- *Establish procedures for enrolling individuals and businesses in qualified health plans* ,including establishing an enrollment process for both individuals and employees of small businesses and assuming an aggregator role for small employers;
- *Establish a website for comparison shopping*, for both individuals and small employers including a premium tax credit and cost-sharing reduction calculator for individuals;
- *Assign quality ratings and reward quality*, based on criteria to be developed by the federal HHS and include information on the state’s Exchange website;
- *Establish a Navigator Program and conduct additional outreach and education*, the Navigator program is to be fully state funded and is to provide grants to qualified organizations to educate and assist individuals and small businesses on enrolling in health coverage through the Exchange;
- *Establish a Small Business Health Plan Options program (SHOP)* for small employers to purchase health insurance through an Exchange;
- *Establish a reporting system*, that at a minimum provides the state with the capacity to report accurate and timely information to the Internal Revenue Service (IRS); and,

² As described below, Act 48 does not include either a bronze benefit level or a catastrophic plan. Vermont will need to ask for federal permission to allow only purchase of more comprehensive coverage in Vermont’s Exchange.

- *Facilitate risk adjustment and traditional reinsurance, for individuals enrolled in coverage through the Exchange*

On July 15, 2011, HHS published draft regulations in the Federal Register³ covering some of the functions of the Exchange and the reinsurance programs. In August HHS published a second set of Exchange draft regulations, and the Treasury Department issued proposed regulations on the premium tax credit and cost-sharing subsidy. The proposed regulations provide some additional guidance to states in certain areas but leave much interpretation and flexibility for states in designing exchanges.

b. Exchange Requirements based on Vermont's Act 48

In May 2011, the Vermont legislature enacted and the Governor signed Act 48, a first in the nation single-payer plan. In moving towards single-payer, Vermont intends to leverage its Exchange and reach beyond the federally-required minimum functions to assist the State in its payment reform, cost control and administrative simplification initiatives. To the extent allowed under federal law, Vermont will leverage the Exchange to unify and simplify health plans and will include as many Vermont residents within the Exchange as early as possible. To that end, Act 48 directs the State to apply for a waiver from the Exchange requirements when available in 2017, or earlier if possible and creates Green Mountain Care – for all Vermonters - including state and municipal employees, Medicare enrollees, and those eligible for subsidized coverage through the Exchange and Medicaid.⁴

In addition to enacting the State's plan to move towards single-payer, Act 48 authorizes the establishment of an Exchange within the Department of Vermont Health Access (DVHA) for the following purposes:⁵

- to facilitate purchase of affordable, qualified health benefit plans in the individual and group markets to reduce number of uninsured and underinsured,
- to reduce disruption when individuals lose employer-based insurance,
- to reduce administrative costs in the insurance market,
- to contain costs,
- to promote health, prevention and healthy lifestyles by individuals, and

³ The proposed rules are accessible at <http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf>. The state of Vermont plans to provide comments to these rules by October 31, 2011.

⁴ See Section 2a.

⁵ See Section 4, s. 1801(b).

- to improve quality of health care.

The DVHA is charged with administering the Exchange in consultation with an advisory committee⁶ to be headed by the DVHA deputy commissioner. The Act creates an Exchange Deputy Commissioner position November 1, 2011.⁷

Under the Act, the Exchange is responsible for providing eligible individuals and small employers with qualified health plans (QHPs). To do this, the Exchange must conduct a number of activities which are described below. These activities can be conducted by DVHA staff, or the Exchange may enter into intergovernmental agreements with other State agencies, or contract with qualified entities to perform the services.

- *Determining eligibility and plan enrollment.* The Exchange must develop a process to determine eligibility for premium tax credits under the Exchange as well as Medicaid, Dr. Dynasaur, and other public programs. As part of the eligibility process, the Exchange must determine enrollee premiums and subsidies, and inform individuals of the results. In addition, the Exchange must provide electronic calculators to allow individuals to determine the cost of coverage after the premium tax credit and cost sharing subsidies are applied. Further, under Act 48, the Vermont Exchange is charged with collecting premium payments from employers and individuals⁸ and ultimately enrolling eligible individuals into qualified health plans. Under Act 48, the Exchange will begin enrollment no later than November 1, 2013.⁹ Federal proposed regulations, however, begin open enrollment on October 1, 2013.
- *Selecting health benefit plans, including multistate plans.* As part of this function the Exchange must develop a process for certification, decertification and recertification of health benefit plans, assign quality and wellness ratings to plans offered through the Exchange, and determine the level of coverage being offered (e.g., silver, gold, platinum). Prior to contracting with an insurer, the Exchange is required to consider an insurer's historic rate increases and BISHCA recommendations. In 2014, the Exchange must offer coverage through at least two Vermont health insurers, assuming

⁶ Under the Act, there is one Medicaid and Exchange Advisory Committee. The Committee must have 23 members and meet at least ten times per year. See Section 7 (Section 402).

⁷ See Section 3b(b)(d); Section 1803.

⁸ Vermont's law differs from the federal law in this respect as the draft federal regulations do not charge exchanges with collecting premiums from individuals. While the draft regulations permit exchanges to collect premiums from individuals, they require that individuals have an option to pay premiums to health plans directly.

⁹ See Section 2a(2)(a).

that there are two that are interested and willing to participate..¹⁰ In addition, the Exchange must make a determination that offering a plan through the Exchange is in the best interest of individuals and employers; and must also consider affordability, promotion of high-quality care, prevention and wellness, promotion of access to health care, participation in the state's health reform efforts, and other criteria at the discretion of the Commissioner of DVHA. Qualified health plans offered under the Exchange must provide essential health benefits as determined by HHS ; and any additional benefits determined after consultation with the advisory committee and approval from the Green Mountain Care Board. Plans must offer at least the silver level of coverage and meet minimum prevention, and quality and wellness standards, including participation in State quality improvement activities required under the Blueprint for Health. The Exchange must also define standards for marketing practices, network adequacy, and include requirements for plans to include essential community providers in underserved areas. The Exchange also must ensure that plans provide appropriate services to enable access for the underserved. Plans must meet accreditation standards, include quality improvement initiatives and provide information on quality measures for health benefit plan performance. Plans will be required to use uniform enrollment forms and descriptions of coverage and to comply with insurance and consumer information requirements.

- *Health plans must obtain premium approval through a rate review process*, including justification for any premium increases and must prominently post premium information on its website. To offer in the Exchange, insurers must offer at least one silver, and one gold level plan. At its option, an insurer may offer a plan at the platinum level. Act 48 does not contemplate insurers providing either bronze level or catastrophic plans. Insurers must charge the same premiums for the same coverage in and out of the Exchange and whether or not offered directly or by an insurance agent. The Exchange is also required to review the rate of premium growth within and outside of Exchange and to create a simplified and uniform system for the administration of health benefits.
- *Outreach and Education*. The Exchange must create and maintain consumer assistance tools, including a website on which to get standardized comparative information on qualified health plans; a toll-free hotline; and interactive online communication tools; complying with ADA. The Exchange must use standardized forms and formats for presenting health benefit options. The Exchange must

¹⁰ See Section 1831, s. 4(b).

establish a navigator program to assist individuals and employers in enrolling in coverage under the Exchange.¹¹ The Exchange is charged with selecting qualified individuals and entities to serve as navigators and award grants to such organizations to provide navigator services. Insurers cannot serve as navigators, and cannot pay navigators in connection with enrolling individuals and employers in coverage under the Exchange. As required under Act 48, navigators must be available to provide assistance in person or through interactive technology in all regions of the State in compliance with the ADA. Navigator duties shall include:

- Public education activities to raise awareness of availability of QHPs
 - Distributing fair and impartial enrollment about QHPs, and availability of premium tax credits and cost-sharing subsidies;
 - Facilitating enrollment in QHPs, Medicaid, CHIP, and other public programs;
 - Referring to the ombudsman and other appropriate agencies grievance, complaints or questions regarding health benefit plans, coverage or eligibility determination;
 - Providing information in a culturally and linguistically appropriate manner
 - Distributing information to health care professionals, community organizations and others to facilitate enrollment in Exchange, Medicaid and other public health benefit programs.
-
- *Determining exemption from insurance mandate.* The Exchange must determine whether an individual is exempt from mandate requirements based on the lack of an affordable plan through the Exchange or employer. The Exchange must transfer names of individuals, by employer, eligible for a tax credit, due to the employer not providing coverage that meets the minimum coverage levels determined by HHS; or was unaffordable;

 - *Financial Integrity.* The Exchange must keep accurate accounting of all activities, receipts and expenditures and submit reports annually as required by federal law. The Exchange must also cooperate with the federal Department of Health and Human Services or the Inspector General in any program reviews or audits.¹² The Exchange is required to publish and place on its website the average costs of licensing, regulatory fees and other payments required by Exchange; and its administrative costs; including monies lost to waste, fraud and abuse. The Exchange is prohibited

¹¹ See Section 1807.

¹² See Section 1808.

from using any funds intended for administrative and operational expenses for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or state legislative or regulatory modifications.

- *Appeals and Grievances.* The Exchange must provide easy access to grievance and appeals processes; and refer consumers to the ombudsman for assistance with grievances and appeals.
- *Evaluation.* The Exchange must conduct satisfaction surveys for consumers and health care professionals, and use other mechanisms to evaluate plan performance. The Exchange is required to inform BISHCA of its findings. The Exchange must also publish de-identified results of satisfaction surveys and other evaluations of QHPs on its website.

In addition, Act 48 provides the Exchange flexibility to expand its coverage scope and functions as described below.

- The Exchange may offer coverage to additional populations beyond those required to purchase under the Exchange in the PPACA. This may include other individuals and employers, state and municipal employees, including teachers, coverage in lieu of workers compensation, and Medicaid and Medicare beneficiaries to the extent it does not reduce existing coverage.
- The Exchange may determine its approach to a unified, simplified administration system for health insurers. These functions may include: claims administration, benefit management, billing or other components of a unified system; and may achieve simplification by contracting with a single entity; by licensing or requiring use of specific software, by requiring health insurers to conform to a standard set of systems and rules, or other methods as determined by the DVHA Commissioner.
- The Exchange may offer wellness programs and services designed to simplify administrative processes, to insurers offering plans outside of the Exchange, workers comp insurers, employers and other entities.
- The Exchange may enter into information-sharing agreements with federal/state agencies and other state exchanges with adequate protections for confidentiality.

To be successful, the Exchange must operate in alignment with a number of existing governmental programs and agencies. The Act ensures that Vermont carefully consider how to integrate the Exchange and requires a plan to be submitted to the Legislature by January 15, 2012.

The Administration must also review the State's Health Information Technology (HIT) plan and determine how the Exchange can and should be integrated within that plan. A report on how this integration will be achieved is also due to the Legislature on January 15, 2012. A third report focused on health system planning, regulation and public health is due to the Legislature on January 15, 2012. Through this report, the Administration is charged with developing uniform health system planning, including across Medicaid, the Exchange and Green Mountain Care; developing an integrated system of community health care assessments; developing a plan for the coordination of quality assurance efforts across state programs, in collaboration with the Blueprint for Health and private insurers and informed by NCQA; and developing a proposal for how to reorganize health care related activities across state government.

The Act creates a Director of Health Reform within the Agency of Administration¹³ and requires that the Director provide the legislature with the following information by February 15, 2012, if the information is available:¹⁴

- A list of federal health benefits to be offered under the Exchange
- A comparison of Vermont's mandated benefits with the federal requirements
- Information related to the bronze, silver, gold, platinum plans that may be offered in VT
- A draft of qualified health plan choices that may be offered in the Exchange
- Premium estimates, in collaboration with insurers
- Status of tax credits and cost-sharing subsidies

3. Organizational Structure of the Exchange

This section describes the organizational structure of Vermont's Exchange. The PPACA and Act 48 provide clear direction on the design of many facets of the Vermont Exchange. In addition, through its Exchange Planning Grant, the state has taken considerable steps to design the mandatory functions within the Exchange and begin to explore the potential for including some of the optional functions. This section will provide detail, where available, on how certain functions are proposed to operate within the Exchange, and will highlight what areas require further consideration. Understanding what functions the Exchange is responsible for and how those functions will be accomplished provides

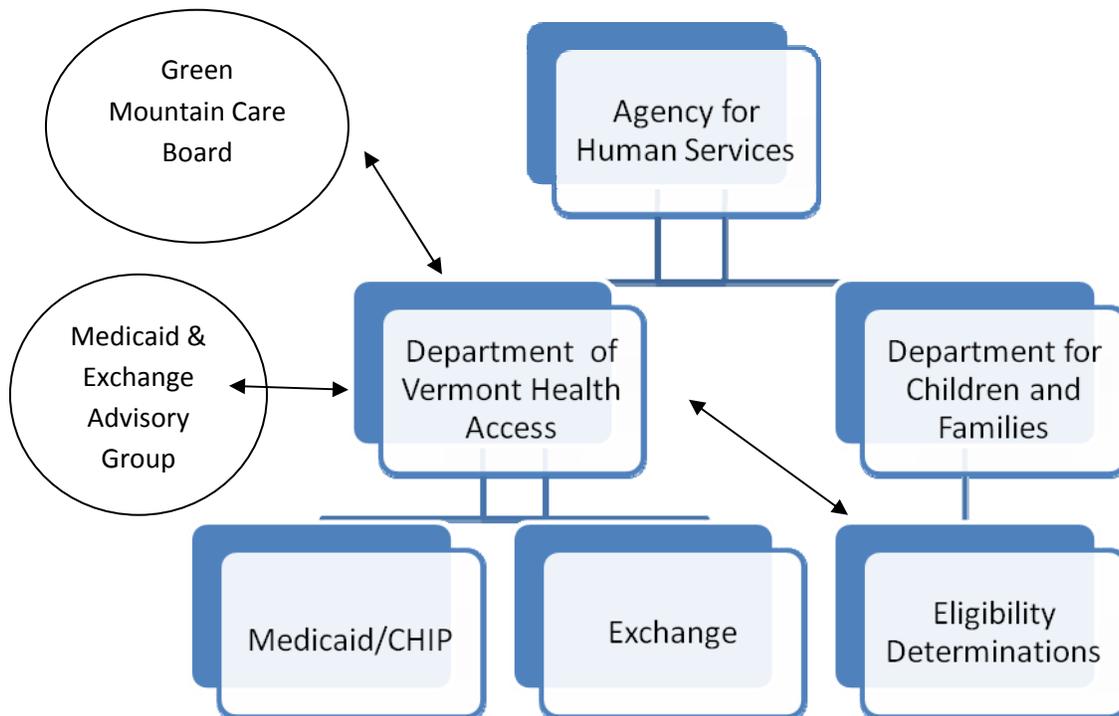
¹³ Robin Lunge assumed this role as of July 1, 2011.

¹⁴ See Section 2a(2)(b).

essential information for how the Exchange should be structured and staffed within the Department of Vermont Health Access (DVHA).

Act 48 places the Exchange within DVHA, as shown in Figure 1 and requires the hiring of a Deputy Commissioner for the Exchange. In addition, Act 48 establishes a joint Medicaid and Exchange Advisory Committee. With this structure, Vermont will be able to leverage DVHA staff and infrastructure to create a continuum of coverage for Vermonters across income levels and develop consistent policies across all health coverage programs.¹⁵ Establishing the Exchange and integrating it within DVHA will however require substantial organizational restructuring and business process redesign. It is essential that in its focus on the Exchange, the DVHA not lose needed resources to appropriately administer the Medicaid and CHIP programs.

Figure 1: The Exchange is in the Department of Vermont Health Access



As a first step in the process, the DVHA is in the process of developing a strategic plan that contemplates its dual role and includes an agency-wide conversation on how the Department should be structured to

¹⁵ In addition to managing the Medicaid program and the Exchange, DVHA is also charged with managing Vermont’s Blue Print on Health and the state’s Children Health Insurance Program. It is likely that during the health care organizational restructuring that eligibility functions may also move from DCF to DVHA.

best meet its expanded responsibilities. Each unit within the DVHA will need to consider how it can leverage its existing infrastructure and resources to support the Exchange and will develop a plan that includes what additional staff and resources may be necessary to accomplish its additional responsibilities. Likewise, the DVHA should work with the Medicaid and Exchange Advisory committee to develop a clear charge and an understanding of how the committee will operate going forward.¹⁶ This plan should include a description of what activities and policies the advisory committee will be involved in and how the committee will divide its time between Medicaid and Exchange responsibilities. Further, the plan should detail how and when the DVHA and the Advisory Committee will report to the Green Mountain Care Board. A number of agencies in addition to the DVHA will assist in the development and administration of the Exchange, in particular BISHCA, DCF, the Department of Labor, the Department of Health, and the Department of Revenue. As part of Vermont's Exchange planning process, the State is in the process of developing an integration strategy across these agencies. As an initial step, Memorandums of Understanding (MOUs) are being developed between the DVHA and the DCF and BISHCA to detail the responsibilities vis a vis the Exchange functions for each of the agencies. These memorandums will also specify how the different agencies will collaborate together for the efficient operation of the Exchange, leveraging each agency's skills and expertise.

DVHA will begin to hire dedicated Exchange staff when establishment funding becomes available from the Federal government.¹⁷ The Establishment Grant requests initial funding for approximately 12 additional staff at the DVHA in FY2012, as well as positions for other departments involved in Exchange implementation. In addition to hiring full time staff, during the implementation period, the Establishment Grant anticipates using contractors to assist in implementation, including but not limited to the development of policies and procedures, drafting regulations, and the development of Exchange educational materials and eligibility notices.

¹⁶ DVHA and the Medicaid and Exchange Advisory Committee should consider whether a separate committee or a sub-committee of the Medicaid and Exchange Advisory Committee may better serve the small employer functions of the Exchange as it will raise a number of issues that are very different than those that typical come before a Medicaid Advisory Committee.

¹⁷ The project abstract and narrative of the Level 1 Establishment Grant is accessible at <http://dvha.vermont.gov/administration/health-benefits-exchange>

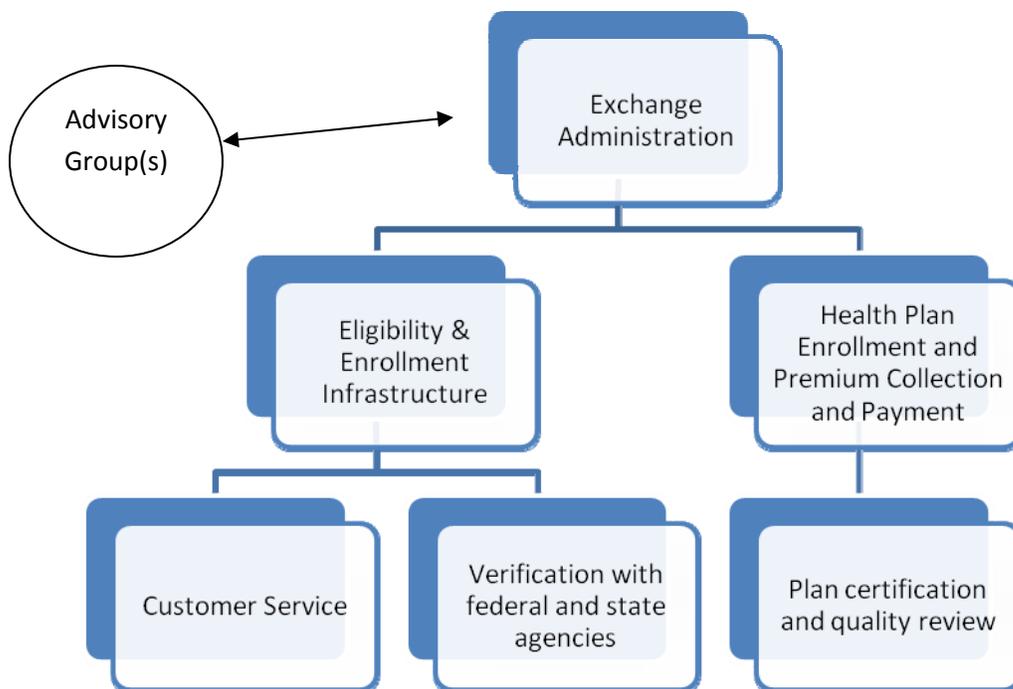
4. Proposed Individual Exchange Functions

This section provides a description of the proposed administration of Vermont’s Exchange and the specific responsibilities of the Exchange.

Governance and administration of the Exchange

As required under Act 48, the Exchange will be established within the DVHA. The Deputy Commissioner for the Exchange will be responsible for the implementation and administration of the Exchange for both individuals, and small employers purchasing coverage on behalf of their employees. Figure 2 below provides an overview of the organizational structure of the Exchange.

Figure 2: Organizational Structure of the Exchange



a. Determine and coordinate eligibility

In order to determine and coordinate eligibility for premium tax credits and cost-sharing subsidies under the Exchange and provide for seamless eligibility and enrollment for all public health coverage programs, the DVHA intends to use a single eligibility system that allows for determination of eligibility

for public programs, including verification of accessibility of employer-sponsored insurance. Determining eligibility for premium tax credits and cost-sharing subsidies is similar to the activities done within the current Medicaid eligibility system in Vermont and similar logic can be used to develop a new system incorporating PPACA parameters.

Vermont will leverage its current and planned eligibility infrastructure to support both Medicaid and Exchange eligibility going forward. Vermont plans to issue a procurement for an eligibility system that supports the new health care landscape. The State envisions a single system that determines eligibility for all public health programs using the Modified Adjusted Gross Income (MAGI) requirements of the PPACA. The system will need to accommodate different rules for Medicaid and the Exchange. For example, if an individual is eligible for Medicaid he or she will be able to enroll in coverage at any time during the year. However, if an individual is eligible for a subsidy under the Exchange, then he or she will only be able to enroll in the program during an open enrollment period, unless the individual meets criteria for a qualifying event.

An IT gap analysis is underway to determine which components, if any, of Vermont's current infrastructure can be used in establishing the new requirements. In addition, Vermont is participating with the other New England states in the New England States Collaborative Insurance Exchange Systems (NESCIES) Innovator Grant being led by Massachusetts. Under this Innovator Grant, Massachusetts is developing an Exchange infrastructure. This infrastructure will include an eligibility portal to serve individuals and employers¹⁸ with links to federal agencies to verify and share information. Massachusetts is working together with other New England states to create the infrastructure in a flexible manner that allows the maximum potential use by New England and other states. Vermont staff are closely involved in this process. A preliminary NESCIES design will be available this fall. Once it is available, Vermont will compare the NESCIES design to its own needs and make a determination regarding whether the eligibility portion of the system can be a platform for the State.

In the meantime, the State is in the process of developing a procurement for a new eligibility system to replace its current Medicaid eligibility system. That procurement will include any additional Exchange eligibility requirements, including determination of eligibility for premium tax credits and cost-sharing

¹⁸ Depending on how the Massachusetts employer module is built, Vermont may need to devote significant planning time to determining the process by which it will determine eligibility for small employer tax credits in the Exchange.

subsidies. Given that large system procurements often take more than 24 months to complete, the State is also in the process of developing an alternative plan that will allow for Exchange eligibility to be determined through modifications to the current eligibility system.

Under Act 48, the Exchange is charged with collecting premiums from employers and individuals and ultimately enrolling eligible individuals into qualified health plans. To meet these responsibilities, the new system will need to include this functionality. Consistent with the PPACA, Vermont also will provide individuals with the option of making premium payments directly to the health plan. It may be more efficient for premiums to be collected by the Exchange, as it reduces individual transactions to health plans and provides health plans with one monthly payment for individuals covered through the Exchange. Whether the insurer receives the individual's premium payment directly from the individual or through the Exchange, the insurer will receive the individual's tax credit share directly from the U.S. Treasury. The insurer will need to reconcile all the payment that it receives with the Exchange.

b. Create benefit categories of health insurance plans

The PPACA requires that Exchanges offer four levels of health insurance plans (bronze, silver, gold and platinum) for both individuals and small employers, and a catastrophic plan for individuals. The PPACA also requires that states offer two multistate plans within their Exchange. Act 48 requires only that the State create three levels of health insurance plans (silver, gold and platinum).¹⁹ Each of these levels must provide essential health benefits which will be determined by the Secretary of Health and Human Services. Additional benefits may be required in Vermont plans if current Vermont insurance benefit requirements are maintained by the Legislature. The Institute of Medicine recently released its recommendations for the development of essential health benefits. The report recommends that HHS take cost into consideration when defining what benefits are in the plan.²⁰

In creating the appropriate benefit levels and cost sharing for each level, the Exchange will need to work closely with staff from the Department of Banking, Insurance, Security and Health Care Administration (BISHCA) and an actuary. Because all plans are required to include essential health benefits, which have yet to be determined, the State is not yet able to begin development of the different benefit categories to be offered within the Exchange. However, this work must get underway soon after the federal

¹⁹ Vermont's interpretation of the PPACA is that the state can set benefit standards at a higher level than the PPACA and that Act 48 does that by setting the floor at the silver level.

²⁰ See <http://www.iom.edu/Activities/HealthServices/EssentialHealthBenefits.aspx>.

government issues guidance as states are expected to select and certify qualified health plans in 2012 to prepare for an open enrollment period to occur in mid-to-late 2013.

While most of the work in this area is in the pre-implementation phase of the Exchange, the State will need to review categories of coverage on a regular basis to determine whether the levels are appropriate and whether the State is interested in making any statutory changes to State mandated benefits.

c. Certify qualified health plans

The Exchange is responsible for certifying, recertifying and decertifying qualified health plans offered through the Exchange for both individuals and small employers. As required under Act 48, to participate in the Exchange, insurers must offer at least the silver level of coverage and meet minimum prevention, quality and wellness standards, including requiring plans to participate jointly in quality improvement activities with other plans and to participate in Vermont's Blueprint for Health. In certifying plans, the Exchange must minimally consider affordability, promotion of high-quality care, prevention, and wellness; promotion of access to health care; and participation in the State's health care reform efforts.

Act 48 also requires insurers to charge the same premium for a plan whether or not it is obtained through the Exchange. Plans seeking recertification must submit a justification for a premium increase prior to implementation of such an increase.

Today, BISHCA reviews rate and form filings from health insurers doing business in Vermont. Much of the information that will be required for certification is similar to that currently collected and reviewed by BISHCA. The Exchange should leverage BISHCA's expertise in reviewing health plans for certification. It is recommended that the Exchange, with input from its Advisory Board, and DVHA and BISHCA staff, develop the criteria to be considered in health plan certification. However, the actual process for certifying plans should leverage current efforts of BISHCA and its staff. Ideally, if allowed under the federal regulations, BISHCA staff would make recommendations to the Exchange regarding which plans to certify based on its knowledge and expertise.

Act 48 requires the Exchange to conduct satisfaction surveys with consumers regarding health plan performance and to utilize other mechanisms to evaluate plan performance. The results of these

satisfaction surveys and evaluations should play a key role in the recertification of health plans for participation within the Exchange.

d. Contract with qualified health plans

During 2012, the Exchange will begin a process of contracting with qualified health plans to offer health insurance. This activity will be closely tied to the development of benefit criteria and the process for initial plan certification as described above. In negotiating with qualified health plans to participate, the Exchange is required to consider an insurer's historic rate increases and BISHCA recommendations. Act 48 requires that the Exchange offer at least two Vermont health plans. The Act is silent on whether co-op plans may participate. Both the PPACA and Act 48 detail a number of requirements that insurers must meet to contract with an Exchange to offer coverage. While the PPACA generally offers broad categories of requirements, Act 48 includes a number of requirements that will need to be developed in significant detail in order to create a model contract for participating health plans. Specifically, the contract with health plans must define standards for marketing practices, network adequacy, essential community providers in underserved areas, appropriate services to enable access for the underserved, accreditation, quality improvement and information on quality measures for health benefit plan performance. Plans must agree to use uniform enrollment forms and descriptions of coverage and to comply with insurance and consumer information requirements. Plans must also agree to publicly report a series of information including, denied claims numbers, enrollment and disenrollment numbers, rating practices, and cost-sharing and payment practices for out-of-network coverage.

e. Maintain a call center for customer service

The PPACA mandates that Exchanges provide a toll-free telephone hotline to assist individuals and small employers in all aspects of the Exchange process, including plan selection. In order to ensure that the state, its vendors, providers, businesses and individuals are ready for the implementation of the Exchange and understand how to enroll in coverage during the designated open enrollment period, the call center should be operational during the spring or summer of 2013. The state may choose to operate the call center using its own staff or contract with a vendor for call center services.

Through a vendor, the state currently operates a call center to serve all of its Vermont's public health coverage programs.²¹ It assists enrollees and others to gain an understanding of the program's benefits and policies and responds to individual questions. Most incoming calls fall within one of the following categories:

- eligibility and client status,
- questions regarding premiums,
- information updates, and
- questions about benefits.

The call center also places outbound calls to assist new enrollees in the selection of a health plan and physician, as appropriate, depending on the program.²² The vendor is able to access back-up capacity to limit wait times during high-volume periods.

The requirements of an Exchange call center are similar but not identical. For instance, the Exchange call center will need capacity to work closely with small businesses and also will need to learn in detail PPACA eligibility requirements, particularly as it relates to provision of refundable premium tax credits and cost-sharing subsidies. The call center staff will also need to assist individuals and small businesses with plan enrollment, consistent with current assistance for Catamount Health.

Given that the state already operates a call center for its Medicaid population, Vermont should consider the potential to expand the role of the current call center to respond to Exchange inquiries. This would allow the state to leverage existing expertise and infrastructure, including space and call center technology. However, given that the call center currently serves only subsidized individuals, it is likely that a separate procurement may be necessary. As a first step, the Exchange must determine the scope of services for the call center and develop appropriate contract language for use either in a contract amendment or as part of an additional procurement. The specifications must carefully account for the additional requirements and the enhanced need for call center services in the months leading up to implementation of the Exchange and during annual open enrollment periods. To ensure that the call

²¹ This includes Medicaid, Dr. Dynasaur, Vermont Health Access Plan, Catamount Health, employer-sponsored insurance premium assistance, and various prescription assistance programs.

²² Maximus Monthly Tracking Report, January 2011

center is accessible to both individuals and small employers, the call center should be open during weekends and evenings, particularly during the first six months of operation. After a six-month time period, the State should consider whether to continue to require evening and weekend hours depending on level of use. In addition, to ensure that the vendor is able to accommodate periods of high call volume, the specifications should include provisions for excess capacity and cross training of call center staff to accommodate both individual and small business inquiries. Calls will likely be complex in nature and the call center will need to have the capabilities to meet the expected demand for a higher ratio of call center staff to callers.

The call center should provide two toll-free lines, one that serves individuals and other that serves small businesses. As is best practice for customer service contracts, the ultimate vendor should also be required to meet specific performance requirements (e.g., calls answered, wait time, abandoned calls, call resolution on first call).

The call center should also develop a strong relationship with the health plans participating in the Exchange. The State's experience with Catamount Health found that callers to the call center often needed to speak directly with the health plan to resolve problems. Ideally, the call center would have the capacity to provide a warm transfer to a health plan when appropriate.

f. *Establish procedures for enrolling individuals in qualified health plans*

The Exchange is charged with collecting premiums from eligible individuals and ultimately enrolling them into qualified health plans. Under Act 48, the Exchange must begin enrollment no later than November 1, 2013.²³ Proposed federal regulations anticipate an open enrollment period beginning in October 2013 that runs through February 2014, and an annual open enrollment period thereafter.

As noted above, Vermont has some experience in enrolling individuals in health plans through the Medicaid program and Catamount Health. In developing a process for enrolling individuals and businesses in plans, Vermont should leverage its outreach and education efforts, state eligibility and call center staff, its Navigator function, and its website. Ideally, at implementation, individuals will be able to access a real time eligibility decision and health plan enrollment through the Exchange website and eligibility portal. The Exchange must use standardized forms and formats for presenting health benefit options. The Exchange website will include this information as well as a calculator that will allow for

²³ See Section 2a(2)(a).

individuals to determine cost-sharing and benefit differences across plans to allow for an informed decision. Alternative enrollment options should also be available, including phone options with call center or Navigator assistance, and by mail. Navigators should also provide some enrollment assistance in person.

The proposed plan enrollment process is pictured below in Figure Three below. During the next phase of Exchange planning, the state will have focused design meetings with insurers and small businesses to understand potential enrollment barriers and ways to simplify the enrollment process for employers.

Figure Three: Plan Enrollment

Vendor	Assistance	Selection
<ul style="list-style-type: none"> • Exchange responsible for plan enrollment (utilize vendor, consistent with Catamount process) • Utilize customer service vendor if possible • If not, need clear communication channels between vendors 	<ul style="list-style-type: none"> • Standardized information available to individuals and employer groups on plan options • Customer service representatives and/or Navigators able to assist in selection 	<ul style="list-style-type: none"> • Individuals select plan either on-line, with assistance of a Navigator or with customer service representative • Employer groups select plan as above; employees then select based on available options (also on-line, with assistance of Navigator or with customer service representative)

g. Establish a website for comparison shopping

A key function of the Exchange is to provide a venue to allow both individuals and small employers to compare available health plans, using standardized comparative information on costs, benefits, and quality ratings of health plans participating in the Exchange. Vermont will develop a website to serve this purpose. In addition, as noted above, the Exchange website must include a premium tax credit and cost-sharing reduction calculator that allows individuals to understand their potential cost-sharing

responsibilities. Further, individuals must be able to use the Exchange website to apply for coverage and enroll online.

In developing the content for its Exchange website, Vermont may utilize some content included on the federal website, HealthCare.gov. In addition, Vermont may be able to re-use the website structure and information designed for Massachusetts under the NESCIES Innovator Grant. However, given Vermont's efforts to implement a single payer plan, it will be important for the state to develop at least some content that is Vermont-specific for use on its website. With the available information and potential for reuse, it is not anticipated that the design and execution of the website will be complex.

Today, DVHA's website includes a link to the Implementation Planning Grant activities and deliverables. As the Department transitions to the Establishment Grant and the Exchange structure begins to take form in terms of a director and staff, an early version of the Exchange website should become operational as soon as possible. This will provide an easily identifiable place for Vermonters to go in order to become educated about the Exchange. The Exchange website should also provide links to other key sources of information. The development of the website is most likely to be done by a contractor. Ongoing maintenance of the website is expected to be relatively modest.

h. Establish a Navigator Program and conduct additional outreach and education²⁴

The PPACA creates several new options for covering consumers. Successful implementation of the PPACA requires extensive marketing, public education, and outreach. Vermont can leverage its successful experience and lessons learned from the marketing and outreach related to the launch of Catamount Health to this effort. With the PPACA expansion, the State must focus its campaign on both consumers and employers. For consumers, the focus is on eligibility and the type of insurance assistance they are eligible for. For employers, the focus is on the employer choice and affordability, and ensuring employers know about the Exchange and their potential eligibility for tax credits.

To strategically inform the public about the Exchange and the availability of subsidized coverage, Vermont must develop and begin to implement a marketing and outreach plan in 2012. At a high level, the plan should:

²⁴ For more details, see the marketing and navigator plan presented to the Exchange Advisory Group on June 27, 2011, accessible at <http://dvha.vermont.gov/administration/hbe-marketing-and-navigator-plan-06-27-11.pdf>.

- be organized around a set of simple messages that emphasize the state’s priorities and educates both individuals and small businesses;
- utilize a multi-prong approach, including numerous public education and outreach campaigns, collaborating with state agencies, community organizations, and corporate and civic organizations;
- consider the rural nature of Vermont and current uninsured population;
- leverage the mandatory functions of the Exchange, including the call-center and Navigators; and,
- be augmented by campaigns of health plans that participate in the Exchange.

As a first step, Vermont should develop an overarching message and branding for its Exchange campaign and should determine early on when, to what extent and how it will weave in its ultimate goal of a single payer plan. The overarching message should be used mainly in the pre-implementation process to provide broad information about the coming availability of the Exchange and its benefit to Vermonters, including small businesses. The message may be conveyed through a variety of means, including print, television and radio advertisements, brochures, fact sheets, Q&A documents, public information forums and community events, and other means.

Based on its overarching message, the State should next develop a strategy for providing more detailed and targeted marketing as the implementation of the Exchange nears. This phase of marketing should focus on who the Exchange can begin to cover immediately and, to the extent necessary, aim to reduce any fears and clarify who is not affected by the Exchange at the start. In developing materials, the State should develop messages and tools focused specifically for individuals, employers and their employees, and the general public. The State should also leverage its previous activities, including materials developed for Catamount Health, and as implementation nears, collaborate closely with insurers that will be participating in the Exchange to have some consistent messaging.

In addition to broad marketing of the program, it will be essential to have a comprehensive training program that provides widespread training for State staff and vendors, as well as providers, advocacy organizations, small businesses, chambers of commerce and other interested organizations. In previous health insurance expansions, “Train the Trainer” models have been successful and have included options such as: Vermont Interactive Television, regional in-person and telephone/webinar trainings.

In compliance with the PPACA, Act 48 requires the Exchange to create and maintain consumer assistance tools. Act 48 appropriately includes the website and call center as part of the program's outreach and educational strategy. The Act specifies that any interactive online communication tools developed must comply with the requirements of the American's with Disabilities Act.

A key ingredient to the ultimate success of the Exchange in Vermont will be how the State uses the Navigator program to bolster the effectiveness of its plan for outreach and education. The Navigator program, while mandated by the PPACA and Act 48, must be fully state funded. The Exchange must provide grants to qualified organizations to educate and assist individuals and small businesses on enrolling in health coverage through the Exchange. The federal HHS draft regulations on the Exchange require that states contract with a minimum of two types of organizations as Navigators. As identified in the PPACA, potential navigators include: trade, industry, and professional associations, chambers of commerce, unions, and community-based non-profit groups. An entity must also demonstrate that it has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to enroll in a qualified health plan. Insurers cannot serve as navigators, and cannot pay navigators in connection with enrolling individuals and employers in coverage under the Exchange. Consistent with the PPACA, Act 48 requires that Navigator duties include:

- Public education activities to raise awareness of availability of Qualified Health Plans (QHPs)
- Distributing fair and impartial information about qualified plans, and availability of premium tax credits and cost-sharing subsidies;
- Facilitating enrollment in QHPs and other public programs;
- Referring to the ombudsman and other appropriate agency grievance, complaints or questions regarding health benefit plan, coverage or determination;
- Providing information in a culturally and linguistically appropriate manner; and,
- Distributing information to health care professionals, community organizations and others to facilitate enrollment in Exchange and other public health benefit programs.

Identifying people and places where various populations currently seek information and assistance around health insurance issues will be critical in this process. For example, there have been a series of meetings with stakeholders, community organizations, and other State and Federal partners to determine the needs of the various populations who will be served by an Exchange and how best to educate them.

The Navigator Program should play a central role in Vermont's early efforts to educate and outreach to the public about coverage available through the Exchange. Navigators should both be able to provide general and specific information on coverage available through the Exchange, including one-on-one assistance (either in person or, if needed, face-to-face) to help small employers and individuals enroll and re-enroll in health plans through the Exchange. Initially, more robust navigation assistance will likely be required. The need for navigators will remain, however to a lesser extent, to assist individuals and employers with maintaining enrollment. While it will be important to have some local presence and face-to-face capacity, it is likely that much navigation can take place over the telephone. The navigator's role should work in conjunction with State eligibility and call center staff to allow consumers and businesses the maximum amount of assistance. This, however, will require careful training across eligibility and call center staff and navigators to be clear on their differing roles, when to refer individuals and small businesses to different parts of the system, including the Health Care Ombudsman, and to ensure that a consistent message is provided to individuals and small businesses regardless of which resource they are working with.

It is clear that navigators will need to utilize different approaches in assisting individuals and small employers. It is important to note however, that often small businesses may be the self-employed. While the Exchange will treat groups of one as individuals, the approach used will likely need to be more similar to that provided to small businesses. Given the need for different approaches, it may be necessary to have different entities provide assistance to individuals and small businesses.

Vermont will select its navigators through a competitive procurement process open to organizations described above that are allowed under the federal law to serve in that capacity. The Federal regulations require that states utilize at least two different types of organizations. Entities should have the option to bid to serve either or both individuals and small businesses as navigators, but should be evaluated separately based on experience and skill. Entities should also have the option to bid to serve all areas of the State or just particular regions. Payment of navigators should be tied to performance-based measures.

All navigators, regardless of how the State contracts for such services, require a significant amount of training. Navigators should either require an appropriate license or a certification based on levels of training and understanding in order to begin to provide education and assistance to the community, individuals and employers. In addition, navigators should be required to have continual training to stay

abreast of program changes and, during regular trainings or at other regular meetings, must provide comprehensive feedback to the State on the impact of the marketing and outreach campaigns at the community, individual and employer level.

i. *Assign quality ratings and reward quality*

The Federal HHS is in the process of developing criteria for states to use to assign quality ratings and reward quality for plans covered through the Exchange.²⁵ Based on these criteria, the Exchange will assign ratings to each health plan offered in the Exchange. As noted above, quality ratings must be included on the State's Exchange website.

Prior to implementation of the Exchange, Vermont will need to do fairly limited work to develop processes and procedures to apply the Federal rating system. However, if Vermont would like to add any additional quality measures, a more resource-intensive effort may be required. Until the criteria are developed and performance measurements are selected, it will be difficult for Vermont to understand what level of resources to commit to this activity. To make the decision, it will be important for Vermont to consider whether its single payer goals require additional performance measurement from what is ultimately included in the federal quality rating criteria.

In addition to assigning quality ratings, the Exchange will need to determine how it will reward its health plans for achieving quality goals based on the Federal criteria and within what financial parameters or other incentives those rewards will be provided. The Federal quality rating criteria should also be reviewed against criteria that health insurance plans are subject to in terms of compliance with NCQA standards and BISHCA's Consumer Protection and Quality Requirements for Managed Care Organizations, Rule 2009-03.²⁶ Additionally, the Exchange should review the Medicaid Managed Care quality requirements from the Quality Assurance and Performance Improvement plan approved for Vermont Medicaid by CMS for Global Commitment.²⁷

²⁵ The proposed Exchange regulations do not include these criteria.

²⁶ <http://www.bishca.state.vt.us/reg-bul-ord/consumer-protection-and-quality-requirements-managed-care-organizations>

²⁷ <http://humanservices.vermont.gov/news-info/draft-ahs-quality-strategy/ahs-medicare-managed-care-quality-strategy-draft/view>

j. *Establish a reporting system*

The PPACA requires that each state Exchange have, at a minimum, the capacity to report accurate and timely information to the Internal Revenue Service (IRS) regarding individuals and employers for verification purposes. Through the New England Innovator's Grant, Massachusetts will be developing an Exchange portal that includes a reporting system in addition to an eligibility system. It is possible that this component of the NESCIES design may be leveraged and re-deployed for Vermont's Exchange. The State should continue to work closely with NESCIES in its design efforts to assure that features that are important to Vermont are included in the initial model. Once the preliminary NESCIES design is finalized, Vermont will have a better sense of whether the reporting system is transferrable or whether it should develop its own reporting system.

k. *Facilitate risk adjustment and traditional reinsurance*

The PPACA requires states to implement a transitional reinsurance program and a risk adjustment program for individuals enrolled in coverage through the Exchange in order to mitigate the impact of adverse selection and minimize price disruptions. Under the transitional reinsurance program, participating insurers will be required to pay into a specific fund to provide reinsurance for high-risk individuals. Similarly, the risk adjustment program will assess a charge on "low actuarial risk plans" where risk is lower than the State average. These revenues will be used to make payments for "high actuarial risk plans." The federal HHS released proposed regulations for these programs in July 2011. While the proposed regulations leave many questions unanswered, it is clear that Vermont will be responsible for collecting data necessary to support and manage these programs, including demographic, diagnostic, utilization data including inpatient, outpatient and prescription drug data. The State will likely be able to use its all-payer claims database (VHCURES) for these activities. In addition, the PPACA contemplates that states will contract with one or more non-profit reinsurance entities for the first three years of the program.

In Vermont, BISHCA will be responsible for the development, administration and oversight of these functions. Once program specifics are finalized, BISHCA will develop a procurement for a vendor to provide these programs on behalf of the State.

l. Other Exchange Functions

In addition to the mandatory Exchange functions specified in the PPACA, there are a number of additional functions that should be included within the Exchange in order for it to operate effectively. Many of these functions can leverage the existing functions within the DVHA, including appeals and grievances, financial management and program integrity. The State is in the process of working through how to enhance current responsibilities to administer these functions for the Exchange.

Financial management and program integrity is essential to any public program. In this case, given the high profile of the Exchange, it will be even more important to assure that the Exchange keep accurate records of all activities, receipts and expenditures and submit reports on an annual basis as required by the PPACA. Act 48 requires the Exchange to publish and place on its website the average costs of licensing, regulatory fees and other payments. The Exchange must also publish its administrative costs, including quantifying monies lost to waste, fraud and abuse. As with the Medicaid program, the Exchange must cooperate with federal agencies, including the Department of Human Services or the Inspector General, in any program reviews or audits.

The Exchange will be responsible for determining whether an individual should be exempt from complying with the insurance mandate. This determination will be made based on a lack of an affordable plan through an employer. This function should leverage the existing Medicaid appeals function. The Exchange will be required to develop a detailed process for how and when to request an exemption and must also define how such exemptions will be considered and ruled upon based on federal guidelines.

m. Potential Additional Functions

In developing a robust Exchange, Act 48 contemplates that the Exchange may perform a number of additional functions over time, as described below.

Act 48 calls for the Exchange to serve as many Vermonters as possible, and requires the Administration to review when and how to include additional populations in the Exchange. Additional populations include Medicaid beneficiaries, state and municipal employees (including teachers), workers compensation coverage and Medicare. The Exchange will also determine whether it should expand the

initial eligibility for the Exchange to employers with 51 to 100 employees beginning in 2014. The potential for these early expansions will be reported on to the Legislature in 2012.

Act 48 also contemplates the potential for the Exchange to broadly develop a unified simplified administrative system. Functions that may fall within this expansion may include claims administration, benefit management, and billing. This may be accomplished by contracting with single entity; by licensing or requiring use of specific software, by requiring health insurers to conform to standard set of systems and rules, or other method as determined by the DVHA Commissioner. It also contemplates the potential for the Exchange to develop and provide wellness programs and other services to health plans. This would allow for the Exchange to provide a menu of services that are often provided outside of health plans by large employers, but are less accessible to employees of small employers and may have a positive impact on both health outcomes and cost containment.

5. The Small Business Health Options Programs (SHOP) Exchange

Under Vermont's proposed Exchange Design, the State will operate one Exchange that serves both individuals and small employers. While the functions described above include serving of small employers, this section provides an in-depth view of how Vermont will implement its Small Business Health Options Programs (SHOP) Exchange to best serve Vermont's small business community.

In determining how to structure its SHOP Exchange, the State must first determine the goals for the SHOP Exchange. The following are proposed as the goals for the Vermont SHOP Exchange:

- Administrative simplification of the health care system;
- Maximizing the purchase of insurance through the Exchange by reducing the burden on the employer while enabling employee choice; and
- Leveraging existing infrastructure and functions for efficiencies, including creating similar processes for the individual and SHOP Exchange as appropriate.

Two key decisions for the SHOP Exchange design are 1) how much choice to allow small businesses and/or their employees in the selection of health plans through the Exchange, and 2) how will plan enrollment and premium payment be facilitated?. Under the federal rules, employers will be able to initially enroll in coverage through the Exchange at any time of the year; renewals will occur on an annual basis.

- a. Plan Selection Options

There is a continuum of plan selection options for the State to consider in the development of its SHOP Exchange. The options range from employers maintaining control over the plan selection for their employees to allowing employees the maximum choice of plan. Each option presents a number of benefits and challenges that must be considered before the State selects a final design. It is possible for the State to allow for more than one option, however, that approach may lead to greater administrative complexity.

At the September Advisory Group Meeting, the State presented the following five options detailed in Table 1 below. The options vary based on whether the employer selects the insurer, the tier (e.g., silver, gold or platinum) and/or the product within the tier (e.g., Plan A Silver 1, Plan B Silver 2A, Plan B Silver 2B).

Table One: Plan Selection Options

Option	Description
A	Employer selects both tier and product
B	Employer selects tier; employee selects product within the tier
C	Employer selects insurer; employee selects tier and product
D	Employer selects base tier; employee selects product at, above or below tier
E	Employer provides defined contribution for individual to purchase directly through the Exchange.

Option A is the current model used by most small businesses . The employer selects the insurer and the coverage that is provided to the employee. As this continues the status quo, it is a safe option with relatively low operational costs. In addition, it provides the potential for reduced administrative costs for the employer as it will have better access to information across insurers and the specific products available through the Exchange. However, this option may be seen as adding little value to the current market and may not provide any incentive for employers to purchase through the Exchange.

Under Option B, the employer would select the tier but allow the employee to select the insurer and product offering as shown in Figure Four below.

Figure Four: Option B: Employer Selects Tier; Employee Selects Product

	Insurer A (Product 1)	Insurer B (Product 1)	Insurer B (Product 2)
Platinum			
Gold	← Employee Selection →		
Silver			

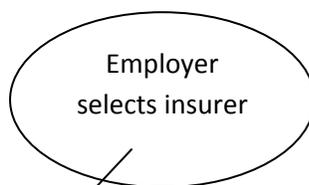


While Option B adds some employee choice, there is currently little difference among in provider networks across insurers. Insurers may also be concerned that this option creates a risk of adverse selection.

Option C (Figure 5) allows employers to select the insurer but provides the employee choice in the level of cost-sharing. Under this option, the employer will select a base level of coverage to determine the employer and employee share of the premium.

Figure 5: Option C - Employer Selects Insurer; Employee Selects Tier and Product

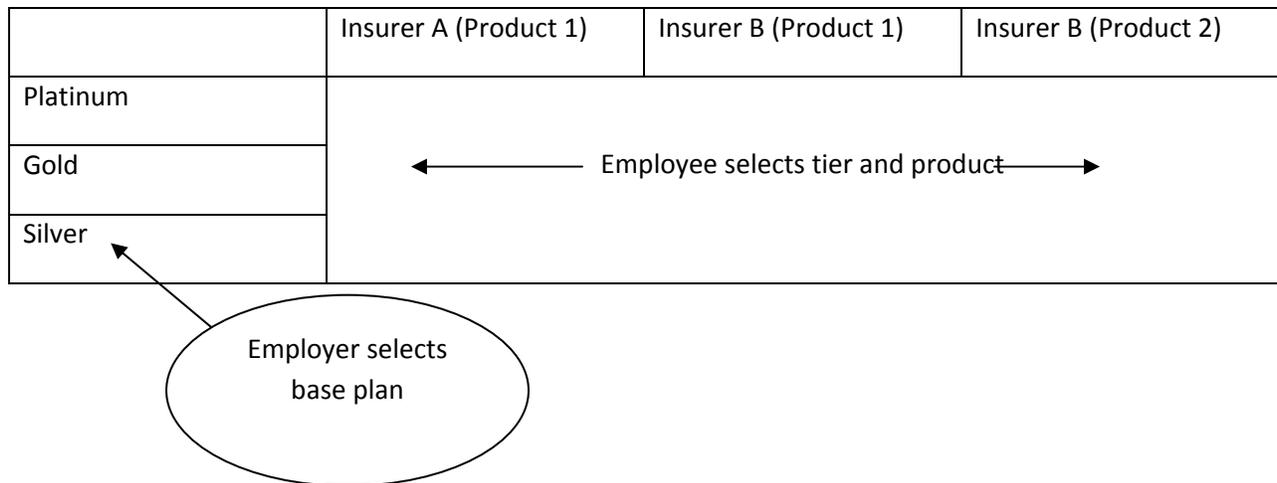
	Insurer A	Insurer B
Platinum	Employee Selection	
Gold		
Silver		



The state of Vermont currently uses Option C to in its state employee plan as do some mid-to-large employers and associations. This model is familiar to consumers and enhances employee choice by allowing selection of tier. However, it does not present the same challenges of adverse selection found in model B, as the insurer can still manage risk across the employer population.

Option D allows an employer to select a base plan for the determination of premium contributions but allows the employee full choice to select any product being offered within the Exchange, as shown below in Figure 6.

Figure 6: Employer Selects Tier to Base Payment, Employee Selects Any Product Offered in the Exchange



While Option D provides employees with the most choice, insurers and advocates expressed concern about this option at the September meeting. Insurers are concerned that there is great risk for adverse selection; while advocates worried about employee confusion. However, these concerns potentially could be addressed. First, the Exchange is required to have a reinsurance program to protect insurers from adverse selection. Second, if the Exchange provides clear information on the differences across insurers, coverage tiers and products within the Exchange as is contemplated by both the PPACA and Act 48, then employees may appreciate the increased choice. If these concerns can be addressed, Option D has the most potential to move the market. However, this option is also the most complex to administer and may increase costs for the Exchange.

Finally, Option E is at the far end of the continuum where employers offer only a defined contribution and employees use those funds to purchase coverage individually in the Exchange. This maximizes an employee’s engagement in health care decisions as they are the direct purchaser of coverage and may give part-time employees a greater opportunity to receive a contribution towards health care cost from employers. However, the contribution that they receive from their employer will not be with pre-tax

dollars, and larger employers may be subject to a penalty for not providing health insurance to their employees. Older employees may see their premiums increase in the Exchange, while younger individuals may see a decrease since the premiums will not be group rated. Regardless of whether Vermont specifically endorses this option, it is possible that employers will use this option in order to reduce their own administrative burden.

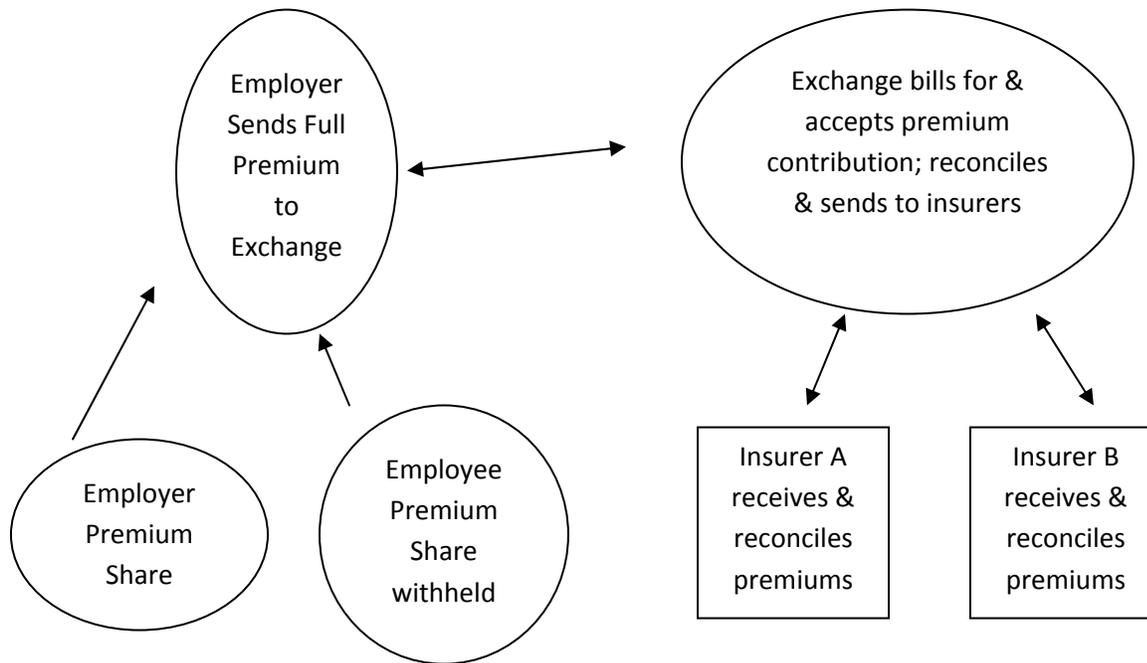
b. Plan Enrollment and Premium Payment

The second important decision is how the enrollment process and payment of premiums will operate. Within the Exchange, an employer may opt to provide coverage to employees to a certain level (e.g., silver) and then individuals may select from one or more plans. In addition, the Exchange will be designed to allow for more than one employer to contribute to an individual's health coverage and the Exchange will aggregate the premium. While small employers will have the ability to select coverage through the Exchange for its employees through the Exchange website, employers may require more individualized assistance to enroll. For this process, the Exchange can leverage specially trained call center staff and Navigators to walk small employers through the enrollment process. Once an employer has selected a plan and contribution level, its employees should be able to access any of the individual enrollment methods described above to enroll in coverage, or the employer may opt to enroll all of its employees in one particular plan.

Depending on which of the options above the State ultimately implements, the individual employee may also need to select and enroll in a plan through the State's enrollment broker. The enrollment broker will be able to provide general information on the differences across products and tiers to assist the employer and/or employee in making a selection. Navigators will also be available to assist employers and their employees with this process.

The Exchange will be responsible for collecting employer premium contributions, reconciling them and forwarding the premiums to the appropriate insurer as shown in Figure 7 below. As many employers have the capacity to add/delete individual employees as their employment changes, this capacity should continue through the Exchange.

Figure 7: Employer Group Premium Collection and Distribution Process



6. Conclusion/Finalizing Exchange Design

As described above, there has been significant design work completed towards the implementation of Vermont’s Exchange for 2014. However, much work remains. Act 48 requires over a dozen Exchange-related reports to be delivered in January and February of 2012. The State continues to develop its integration process across agencies and awaits federal guidance in a number of areas. To support the finalization of its Exchange Design, Vermont submitted a request to the Center for Consumer Information and Insurance Oversight (CCIIO) within the federal HHS for an Establishment Grant to continue the efforts begun under the state’s planning grant. The Establishment Grant will allow the state to hire staff for the Exchange and begin the process of implementing the Exchange Design. The Administration is finalizing an implementation plan that provides details and milestones for each task that needs to be completed to ensure that Vermont will be ready to launch its Exchange for January 1, 2014.